A Portfolio of Academic, Clinical and Research work, carried out by:

Roberta Fry

Submitted Sept 1996 for the Psych D in Clinical Psychology at the University of Surrey
Acknowledgements

I would like to thank my fellow trainees and all the Clinical Psychology course staff from the Psychology Department at the University of Surrey, in particular Dr Liz Campbell. Thanks must also go to my Clinical Placement Supervisors: Mrs Elspeth Bawtree, Dr Rosamund Roach, Mr Nick Kirby-Turner, Dr Corrie Meesters, Mr John Le Lievre and Dr Michael George.

Brighton and Chichester Community Alcohol Teams, along with the Cornerstone Project in Hove gave of their time and effort in providing me with research participants and rooms in which to conduct the interviews. I am very grateful for their help. Likewise the staff from Options and Worthing Psychology Department provided support, encouragement and the ability to make me smile no matter how busy I was. Final thanks go to my loving family and friends who have been patient with me throughout my training. I am truly grateful.
# Contents

Acknowledgements i

Contents ii-v

**Introduction to the Academic Chapter** 1

Essay 1: Compare the part played by the therapeutic relationship in Gestalt Psychotherapy and Cognitive-Behavioural Models 2-18

Essay 2: The role taken by the internal consultant is no different from the role taken by a therapist. Discuss. 19-33

Essay 3: Are older adults different from younger people in their needs for psychological involvement ? Discuss with reference to psychological knowledge and theories. 34-47

Essay 4: Critically discuss the contribution that Neuropsychology can make to the assessment of people who have suffered a stroke. 48-59

Essay 5: Cognitive impairment after stroke and decision about the viability of living 60-69

**Introduction to the Clinical Chapter** 70

Adult Mental Health Clinical Report Summary 71-72

Child and Adolescent Services Clinical Report Summary 73-74

Older Adults Clinical Report Summary 75-76

Neuropsychological Report Summary 77-78

Specialist Placement Clinical Report Summary 79

**Clinical Chapter Appendix** 80

Adult Mental Health Placement contract 81-83

Adult Mental Health log book 84-92

Adult Mental Health evaluation form 93-101

Learning Disabilities Placement contract 102-104

Learning Disabilities log book 105-113

Learning Disabilities evaluation form 114-121

Child and Adolescent Services Placement contract 122-123

Child and Adolescent Services log book 124-129
Introduction to Research Chapter 190
Measuring awareness of deficit after head injury: A review 191-223
First steps in treatment planning on an Adolescent Unit: A personal construct analysis 224-263
Examining the relationships between conflicting self-beliefs, emotional distress and severity of alcohol dependence in both relapsing and abstinent alcoholics 264-348
Abstract 264
Introduction 265-280
Summary of Introduction 280-282
Method 282
Procedure 287
Results 288-306
Discussion 307-318
Appendices 319-338
References 339-349
Listing of all Tables used in the final piece of research
Tables in the Introduction
Table 1.0: Standpoint by domain combinations and the resulting self-state representations 266
Table 1.1: Self-discrepancies and motivational predispositions 267
Table 1.2: Types of Self-concept discrepancies and their affective consequences

Tables in the Results section

Table One: Inter-correlations between the self-concepts using the total sample

Table Two: Inter-correlations between the self-concepts using the relapse participants only

Table Three: Inter-correlations between the self-concepts using the abstinent participants only

Table Four: Correlations between self-concept discrepancies and emotional distress for the total sample

Table Five: Correlations between self-concept discrepancies and emotional distress for the relapse participants only

Table Six: Correlations between self-concept discrepancies and emotional distress for the abstinent participants only

Table Seven: Correlations between actual-ideal discrepancies with various emotions for the total sample

Table Eight: Correlations between actual-ideal discrepancies with various emotions for the relapse participants only

Table Nine: Correlations between actual-ideal discrepancies with various emotions for the abstinent participants only

Table Ten: Correlations between actual-ought discrepancies with various emotions for the total sample

Table Eleven: Correlations between actual-ought discrepancies with various emotions for the relapse participants only

Table Twelve: Correlations between actual-ought discrepancies with various emotions for the abstinent participants only

Table Thirteen: Correlations between various emotions and units consumed per week, the consumption subscale of the sadq and the severity of alcohol dependence total

Table Fourteen: Comparisons of male and female self-concept discrepancies for the total sample

Table Fifteen: Comparisons of male and female self-concept discrepancies for the relapse participants only

Table Sixteen: Comparisons of male and female self-concept discrepancies for the abstinent participants only

Table Seventeen: Comparisons of male and female intensity of emotional distress for the total sample
<table>
<thead>
<tr>
<th>Table</th>
<th>Description</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eighteen</td>
<td>Comparisons of male and female intensity of emotional distress for the relapse participants only</td>
<td>304</td>
</tr>
<tr>
<td>Nineteen</td>
<td>Comparisons of male and female intensity of emotional distress for the abstinent participants only</td>
<td>304</td>
</tr>
<tr>
<td>Twenty</td>
<td>Comparisons of abstinent and relapsing participants self-concept discrepancies</td>
<td>305</td>
</tr>
<tr>
<td>Twenty One</td>
<td>Comparisons of abstinent and relapsing participants intensity of emotional distress</td>
<td>305</td>
</tr>
</tbody>
</table>
**Academic chapter**

The academic chapter of the portfolio consists of five essays. The first two focus upon the therapeutic relationship and the specific contribution of the therapist or internal consultant to the process of therapy. The degree of overlap between the various roles of the therapist and internal consultant are explored and, indirectly these two essays touch upon the issue of the 'active ingredients' of therapy. Thus, they focus upon the professional end of the therapist - client partnership, whereby the term client may refer to an individual, couple, family, group or entire organisation.

The third essay concerns itself with developmental and life span issues, with particular emphasis being placed upon the later stages of adulthood. This essay is more conveniently placed at the client end of the therapist - client dyad.

The final two essays turn towards the issue of assessment, examining the approach of Clinical Psychology to meet the demands of a rigorous, reliable and valid psychological assessment. The combination of quantitative and qualitative techniques alongside skilled use of models and theories of cognition and behaviour, coupled to extensive psychological information result in a unique and valuable information source.
Compare the part played by the therapeutic relationship in Gestalt Psychotherapy and Cognitive-Behavioural Models.

Introduction

Essential to the discussion comparing different priorities and degrees of emphasis upon the relationship between therapist and client within these two models of psychotherapy, will be an exploration of the concepts involved in each model's overriding philosophy of change and healing. The author assumes that the reader has a basic understanding of each model, and only those issues linked to the therapeutic relationship will be detailed at length.

Each model will be discussed separately, but points of similarity or difference will be highlighted as the essay unfolds. A summary of those comparisons will then draw the essay to a close.

Gestalt Psychotherapy Model

Zinker (1978) defined Gestalt therapy as the permission to be creative. So long as such creativity remains within the confines of ethical practice, the possibilities for different kinds of relationship between the therapist and client are many and varied. Perls (1947) introduced the idea that therapist and client grew by being actively present and engaged in the contact of the therapeutic exchange, and validated the client's moment-by-moment experience. In a similar vein, cognitive behaviour therapists emphasise flexibility in their role selection.

Gestalt therapists regard the therapeutic relationship as the cornerstone upon which change is built. 'A Gestalt therapist does not use techniques; he applies himself in and to a situation with whatever professional skill and life experience he has accumulated and integrated.' (Perls, 1977). Beck (1990) has also highlighted the therapist's life experience as a part of therapist effectiveness.
Thus, within gestalt the therapeutic relationship provides an exploratory space for clients to discover themselves and during this process the therapist is also changed. The growth of the capacity for genuine relationship forms the core of the healing process and has been described by Hycner (1995) as a relationship characterised by dialogue - a dialogic relationship.

**A Dialogic Relationship**

Buber (1958) an existential theologian, proposed that the dialogue which occurs 'between' therapist and client is marked by two polarities, the 'I-Thou' and the 'I-It.' These are a reflection of the two primary attitudes which a human being can take in relation to others, and the world in general. The 'I-It' relationship occurs when we turn others into objects. The I-Thou relationship is a stance of genuinely being interested in the person we're interacting with as a person. Both models assume the latter position in relation to clients. Clarkson (1990) has distinguished five variations on the I-Thou relationship: the working alliance, the unfinished (transferential) relationship, the reparative/developmentally-needed relationship, the 'real' or person-to-person relationship, and the transpersonal relationship. Although elements of each type of relationship can be found in both models, the gestalt emphasis is upon the person-to-person relationship, whilst cognitive behaviourists focus more upon the working alliance.

**Contact**

Human beings exist and define themselves in relation to their surroundings, to other people, other creatures and other ideas. Perls proposed that the self is not a stable, unchanging entity, but varies according to the different situations encountered. This is somewhat different from Beck's assertion that there are fairly stable personality styles, motivated to meet predominantly either achievement or affiliation needs. Perls became critical of aspects of traditional psychoanalytic practice, and moved the emphasis of psychotherapy from transference and interpretation to here-and-now
contact. He was one of the first analysts to sit face to face with clients for a part of each session. Consequently, the therapeutic relationship should be a meeting and a dialogue, an *existential encounter between* therapist and client in an equal exchange. Therapist and client meet person-to-person. Therapists simultaneously accept and affirm the client's feelings as valid in their own right in the current situation, whether or not they are also transference. The need for co-operative dialogue between therapist and client is pivotal to Gestalt psychotherapy. Cognitive behaviourists similarly welcome the need for a collaborative relationship with clients.

As contact is the meeting between a person and some aspect of his environment, the contact boundary includes all of the five senses, which can take in information from the environment, as well as those skills which can make an impact upon the environment such as making sounds and being mobile. Contact is the means by which people not only survive, but grow and change. After each rich contact experience a person has a new, possibly surprising or different sense of himself (a new gestalt).

The therapeutic relationship promotes healing because there is a sharing of inner selves, a person to person contact. The therapist acts as a "resonating chamber" (Polster and Polster, 1974) for what is going on between himself and the client. By attending to and working with *what happens in their current interaction* the therapist amplifies it so that it becomes part of the dynamic of the therapy. Thus, here-and-now contact forms the foundation upon which the therapeutic relationship is built.

The therapist at first has greater responsibility for fostering the sort of atmosphere and relationship in which authentic person-to-person meeting and communication take place. Once this is established, therapist and client are together responsible for co-creating a working partnership. Cognitive behaviour therapists similarly recognise that during the initial stages of therapy that the therapist may do more than half of the work during sessions. However, this should lessen and become equal as therapy progresses.
Contact with the 'presenting problem(s)'

Gestalt therapists recognise the need to listen to and understand what a client's presenting problem is 'saying' about this person's existence. Gestaltists believe that all parts of our existence, including our problems, are a part of us. Problems are not to be eliminated, but rather to be contacted, valued and integrated. There is a somewhat different position within Cognitive behaviour therapy, which lists thinking errors and biases and labels certain types of cognition as 'maladaptive.' Whilst such language is used to empower the client and liberate them from unhelpful ways of viewing themselves and the world, nevertheless cognitive behavioural therapists seek to establish with the client ways in which the client can successfully challenge, and ultimately weaken such cognition's. Instead of integrating such thinking as it is, the goal is to try to change it by conscious effort. Emotions tend also to be viewed as undesirable experiences that should be controlled.

Gestaltists argue that there are many levels of dialogue that we need to work with. (Remember that all five senses are involved in the contact boundary) Hycner, linking intrapsychic dialogue with the interpersonal stated that 'we need a 'dialogue' with our problems. Concurrently, this opens up a dialogue with others. As we open up to those parts of us we've disowned, that allows us to recognise our frailty and to be more compassionate with the frailty and vulnerability of others. Correspondingly, it allows us to withdraw our 'projections' from others, and truly meet them, not 'projection to projection,' but person to person.' (Hycner, 1995, pp. 123-124)

Resistance

According to Hycner, resistance 'is contact with earlier defensive needs while concurrently being interpersonal contact ...... Resistance is contact with, not merely contact against. It is not a direct 'meeting,' but rather a defensive and markedly delimited contact.' (Hycner, 1995, pp. 137-138). The challenge to the therapist is to be able to meet, and establish contact with the client at the point of his resistance. It is a task that, hopefully may become the shared venture of therapist and client.
Therapist Responsibility

Alongside developing the therapeutic relationship, the therapist's task is to facilitate the client to develop her own awareness and make contact with herself as she actually is. For this to happen the therapist initially carries (and this may last for some time depending upon the needs of the client) greater responsibility for creating the sort of atmosphere and therapeutic space in which real, person to person contact can take place. This demands considerable awareness, self-knowledge and responsibility from the therapist.

Hycner, compassionately describes the human limitations of the therapist as 'a meeting point' which needs to be embraced if the client is to trust and take risks during the therapeutic journey. (Hycner, 1995, pp. 136) Cognitive behaviour therapists also recommend that therapist's role model problem solving techniques in front of the client when they make mistakes. Linehan (1987) argues that the best therapists know what their limitations are and stay within them.

The presence and perspective of the therapist is essential as the hearer of the problem. This requires letting the 'voice' of the problem resonate within the therapist. The therapist needs to be able to listen to the problem at a deeper level than the client is currently able to. The task of the therapist is to 'translate' the message of the problem into a language that is comprehensible to the client. Likewise, cognitive behaviour therapist's listen out for the clients underlying beliefs and probe to discover the early maladaptive schemas which underpin the client's presenting problems. They too 'translate' the original problem, this time within the cognitive behavioural framework in order to provide the client with a new understanding.

Gestalt therapy paradoxically is focused on increasing awareness of what is as opposed to helping the client change. In Gestalt the empowerment occurs through the process of the client becoming increasingly aware and interested. The Gestalt approach does not support the view that the therapist has sole access to the truth about the client. Therapists are willing to be questioned, confronted and challenged. Similarly, cognitive
behaviour therapist's play down the role of expert and facilitate collaboration by use of socratic dialogue.

**Countertransference**

Countertransference is usually understood to be the therapists 'emotional attitude toward his patient, including the response to specific items of the patients behaviour' (Rycroft, 1972/1979: 25). Countertransference to the client can be destructive when based on the therapist's own unfinished business. In this way it can be the therapists contribution to lack of genuine here-and-now contact with a client. It is vital for the therapist to learn to distinguish between their here-and-now reactions to the client, their reactions to the client which are based on their own unfinished business and reactions with are evoked by the clients projection on to them. Within cognitive behaviour therapy, therapists are encouraged to examine their own thinking and to complete a dysfunctional thought record to identify their own vulnerabilities.

**Presence**

In order to be present, the therapist needs to be 'as fully available to the other person as possible, at this very moment- without interfering considerations or reservations.' (Hycner, 1995; pp 97-98) The therapist needs to enter the experiential world of the client, and to understand the resistant parts of a client's personality. Only then can a genuine relationship be built. When the therapist accepts the client for 'being' as they are. (Hycner, 1995, pp. 127)

Buber suggests that the therapist must be fully present and yet concurrently be able to reflect on what is experientially occurring at that moment. He must maintain a 'detached presence.' The psychotherapeutic process demands that both the 'subjective' and 'objective' dimensions of existence be masterfully blended.

Being fully present requires that the therapist suspend his judgements as to what the client should bring up, or even what direction the therapy is supposed to go. This means staying moment by moment with whatever emerges. This is in stark contrast to
the agenda setting style of cognitive therapy, even when this is undertaken collaboratively.

**Inclusion**

The therapist who is grounded in their own being, and yet is able to alternate between their own centre and go over and 'be' with the client in their existence, is practicing inclusion. Such inclusion comes before the therapist's genuine ability to confirm the other's existence. One of the prime tasks of the therapist is to practice inclusion and provide confirmation of the client's self and their existence as it is.

**Trust**

Both therapist and client need to trust each other if a working alliance is to be established. Such trust is fundamental to the success of both models. The client, at the start of therapy, needs to recognise the unbalanced nature of her relationship with the therapist. It may even be that such humility is essential for genuine healing to occur. As therapy progresses over a number of sessions, the client gains emotional resources, security and freedom, and the therapist comes to be seen more and more as a "real" person. The skill of the therapist lies in finding the balance between accepting the client's self definition and presenting him with an ever-widening range of choices.

'A solid working alliance is necessary for success in dealing with resistance. It is here that all the 'credits' built up in the relationship will be called upon. Ultimately it is the trust in the therapist, and the relationship, that establishes a bridge across the seeming chasm of resistance. *The trust in the relationship is what gets both through the moments of mis meeting.*' (Hycner, 1995, pp. 137)

**Ending**

The ending of the therapeutic relationship is explored at length in gestalt psychotherapy, because it is believed that satisfactory termination of the therapeutic relationship can retrospectively help heal incomplete good-byes of the past.
Cognitive Behavioural Psychotherapy

The cognitive model proposes that underlying beliefs and early maladaptive schemas are responsible for the client's presenting difficulties such as anxiety and depression. The therapist's hypothesis about the underlying mechanism, guides the selection of treatment techniques, and involves the therapist educating the client to the consequences of his central irrational belief, as well as teaching strategies for solving these problems which at the same time facilitate some adaptive change in the underlying dysfunctional beliefs. The idea that changes in cognitions and/or behaviour can produce changes in mood, is central to cognitive behaviour therapy. The interdependence of these components means that interventions directed at one component appear to create changes in all the components.

According to Beck, a positive therapeutic relationship is 'necessary but not sufficient' to ensure successful therapy. (Beck et al, 1979) Cognitive behavioural therapists tend to regard the technical interventions as the 'most active ingredients' of the therapy. However, Safran (1984) has argued that cognitive behaviour therapies would benefit from making the client's interpersonal issues a central area of exploration in therapy, rather than continuing with the view that the therapeutic relationship should really only be discussed with the client when obstacles to client progress have been identified in this area. Safran et al (1990) suggest that the client brings dysfunctional interpersonal relationship schema into the therapeutic situation that are reactivated during therapy. If the therapist responds in a manner that confirms the schema, the cycle is maintained or even made worse. If, on the other hand, the pattern is recognised and the client's negative feelings toward the therapist are examined, it is possible to disrupt the cycle and assist the client to gain a better grasp of his or her pathogenic ideas. Negative client sentiments, avoidance, or even high levels of compliance may be signs of disruption in the alliance. Thus, the therapist should attend carefully to these signals and provide support and empathy for the client in order for him to bring these conflicted feelings into full awareness.
The Working Alliance

Bordin (1979) has identified three major parts of the working alliance: (a) bonds—which refers to the degree of affinity or liking between therapist and client; (b) goals—which refers to the aims of both therapist and client; (c) tasks—which are activities carried out by both therapist and client.

Cognitive behavioural therapists emphasise the collaborative nature of therapy by paying considerable attention to establishing a working alliance with the client. This depends upon such 'non-specific' relationship factors as warmth, accurate empathy, unconditional positive regard and genuineness. Client feedback is regularly solicited by the therapist, and helps to maintain rapport, trust and collaboration. Such a cooperative relationship is often regarded as the hallmark of successful cognitive behavioural therapy. Thus, cognitive behavioural therapist's take their client's point of view seriously and downplay their role as an 'expert' and stress the importance of mutual work toward discovery and positive change (Beck et al, 1979).

It is important for therapist and client to work collaboratively toward clearly identified, shared goals. Such goals should be workable and operationally defined. Mutually agreed upon goals are most likely to minimise non-compliance and power struggles which may occur, particularly with personality disordered clients. In order to identify such shared goals it is important for therapist and client to arrive at a definition of the client's problems and for them to negotiate a shared conceptualisation of the client's problem. When working towards this conceptualisation, it is important for the therapist to use, wherever possible, the client's language and concepts, particularly when providing alternative explanations of their problems.

Effective cognitive-behaviour therapy depends in part on each participant clearly understanding their respective responsibilities in the therapeutic endeavour and upon each agreeing to discharge these responsibilities in the form of carrying out therapeutic tasks. Therapist and client should ideally be working together as a team. However, collaboration does not always have to be 50-50, and at the initial stages of therapy, the therapist may need to do more than half of the work. But, that pattern must change.
throughout the course of therapy, with the patient assuming more and more responsibility within the therapy.

Overall, it appears that the therapist has to communicate to the client the important links between therapy-specific tasks and the overall goals of treatment and maintain an awareness of the clients commitment to these activities and effectively intervene if non-compliance is present.

**Socratic Dialogue**

Cognitive behaviour therapists use indirect questioning, which they believe will lead the client to a particular conclusion. This necessitates the clients active participation and problem solving skills. Socratic dialogue involves the therapist asking thought provoking questions with the intent of getting the client to re-evaluate some of his self-defeating ideas and misperceptions. Such questioning is used to help the client arrive at his or her own solutions to the problems.

**Resistance / Non-compliance**

Cognitive behaviour therapists take a problem solving approach to instances of non-compliance. Like Gestalt therapists, they do not interpret 'resistance,' instead they use the same methods to deal with it as they do with other problems. 'Episodes of non-compliance can provide an opportunity to identify issues that are impeding progress in therapy, so that they can be addressed and become grist for the therapeutic mill.' (Beck et al 1990, pp356) A clients reactions to the therapist within the therapeutic relationship provide the therapist with the opportunity to do in vivo observation and intervention. Such a focus on the interactions between therapist and client have a strong impact because of their immediacy and the highly emotionally charged nature of the work. (Goldfried, 1985; Safran and Greenberg, 1986).

The way in which a client understands or explains to himself the therapists behaviour during therapy may 'open windows into the patient's private world' (Beck et al 1990, pp65). The assumption is that the patients behaviour with the therapist is similar to his
behaviour with others and that interactions with both the therapist and with others are driven by the patient's central underlying problem.

If patient reactions are not explored, these distorted perceptions will continue and may jeopardise the working alliance. In the same vein, resistance and transference are dealt with directly in terms of underlying dysfunctional beliefs, therapist factors (e.g. lack of understanding, insufficient explanation for the homework task), or lack of agreement on the aims, purposes, and the goals of therapy (Beck et al., 1979). It is crucial that both client's and therapists arrive at a shared understanding of the client's most pressing problem, and agree upon the action plan to undertake.

Having feedback as part of every therapy session is designed, in part, to maintain a good relationship between patient and therapist and to prevent automatic thoughts from persisting uncorrected. A sympathetic elicitation of the client's thoughts, followed by way of questioning and direct, honest feedback, will be useful for establishing rapport.

When working with personality disordered clients, therapist's may take on the roles of friend and advisor at times. As Beck and his colleagues state 'much of the therapist's role consists of drawing on his or her own life experiences and wisdom to propose possible solutions to problems, as well as to educate the patient to regarding the nature of intimate relationships.' (Beck et al, 1990, pp 66)

**Countertransference**

'The therapist's feelings and behaviours in response to the patient can yield important information, both about the patient's effect on others and about the patient's underlying irrational beliefs.' (Persons, 1989, pp 164) However, the therapist should be able to observe the relationship as well, so that he is not overwhelmed by his feelings.

'Without distance, the therapist risks becoming another player in the patient's drama.' (Persons, 1989, pp164). The therapist also needs to be aware of the possibility of holding the same dysfunctional idea as the client, such as 'things are hopeless'. In which
case, if left unchecked such a blending of beliefs will feed into the client's hopeless ideas and beliefs.

**Therapist Responsibility**

Therapist reactions to their clients are unavoidable. It is therefore important for therapists to be aware of their responses to client's to make sure that they do not impede therapeutic work. In order to obtain distance on their reactions, the therapist may use cognitive techniques such as the Dysfunctional Thought Record (Beck, Rush, Shaw, and Emery, 1979) or consult a colleague.

Cognitive-behaviour therapists need to be able to manage the therapeutic relationship effectively, and to use their personal reactions in the process of treatment. This requires cognitive therapists to be 'sensitive observers of their thoughts, feelings, and beliefs.' (Beck et al 1990, pp252) They must also develop the skill of using carefully timed, selective self-disclosure of their own reactions to the client, as this provides useful feedback for the client as well as fostering intimacy. In order to do this effectively, it is essential that they are fully aware of the vulnerabilities that they bring into the therapeutic relationship.

One of the major tasks of the cognitive behavioural therapist is to encourage the client to try out new ways of thinking and behaving, and reinforcing the client's attempts at them (Goldfried and Robins, 1983) In order for the therapist to become a source of reinforcement, the therapeutic relationship must be established. This is achieved by establishing rapport with the client, by using reflection, praise, ingratiation and self disclosure. (Egan, 1975). If the therapist makes a practice of discussing a client's expectations and concerns before each change is attempted, this is likely to reduce the client's level of anxiety regarding therapy and improve compliance. Until the client experiences symptom relief and begins to feel better, the client's attachment to the therapist will be crucial in maintaining their commitment to the therapeutic endeavour.

Wessler and Hankin-Wessler (1986) consider therapist flexibility, what Kwee and Lazarus (1986) beautifully describe as 'the authentic chameleon' a vital part of
adopting a therapeutic style that suits the client and promotes change. By being flexible, for instance by allowing client's some say in what gets discussed during the therapy hour, therapist's display their character and willingness to collaborate. Throughout the therapy process the therapist should use the working relationship flexibly by assuming a role that fits with the client's expectations, so long as this does not reinforce the client's psychological problems. The therapist will often adopt a number of roles depending upon where the client is in the problem-solving process. Patient's with different problems need different types of relationships with their therapists. This highlights the need to obtain a formulation as early as possible in the therapy process. Such roles range from educator, provider of feedback to active consultant. Overall, the relationship is active with individual problems specified, alternatives looked at and tried out, and a time for review of the experience built in. Ultimately, the cognitive behaviour therapist needs to be a 'skilled artisan' (Kwee and Lazarus, 1986, pp331) who can creatively use their scientific knowledge to the best effect with each client. Part of the artistry of cognitive therapy resides in presenting hypotheses using a variety of styles, including metaphors and anecdotes. Such ingenuity also help the relationship become a 'human educational experience.' (Beck et al 1990, pp64).

The cognitive behavioural therapist needs to teach client's about how beliefs and attitudes influence affect and behaviour, whilst fostering their attempts at behavioural experiments designed to promote adaptive cognition's. Thus, they need to be supportive of the client's efforts, whilst highlighting problems, focusing on important issues and suggesting and rehearsing specific cognitive-behavioural techniques. Therapist's must also be able to confront their clients when they break the agreed rules of therapy, whilst maintaining an atmosphere of respect and concern.

Summary and Conclusions

All effective therapies rely on the development of a constructive relationship between the client and therapist (Strupp, 1973). Maybe this is because, as Beutler (1983) has
argued, all approaches to psychotherapy can be viewed as a process of persuasion: cognitive behaviour therapist's aim to persuade clients to re-evaluate and change their dysfunctional cognition's and bring about 'a central cognitive change' (Guidano and Liotti, 1983) which involves the re-structuring of the client's attitude towards themselves. While gestalt therapist's persuade people to become self aware and accepting of who they are. According to Gestalt therapists, when the client identifies and reintegrates 'the problem' this inevitably begins the process of healing. Such a difference in therapist's understanding of therapeutic change can be identified from the therapist's attitude towards the client's presenting problem, and from the emphasis within therapy of moment by moment experience versus a more structured and agenda orientated approach. Whilst gestalt therapist's use techniques from within the context of the relationship cognitive behaviour therapist's use the formulation to try out different predictions. Gestalt therapist's place the therapeutic relationship at the centre of the healing force within therapy, and it's impact is explored frequently within sessions. Cognitive behaviour therapists recognise that the therapeutic relationship is important, especially the therapist's worth as a reinforcer. However, the relationship is only really appreciated as a vehicle from which techniques can be used. It's impact is usually only explored when difficulties arise.

However, although there are many differences between the two approaches, this may in part result from differences in terminology. For, as far as the therapeutic relationship is concerned there are also a fair number of similarities between the two approaches. Both models, regardless of the specifics of the current moment or the role assumed by the therapist rely upon an overarching principle of professional distance. Thus, Buber talks of the need for a 'detached presence' whilst Persons stresses the importance of the therapist being in a position to observe the relationship. Such professional distance enables the therapist to challenge or confront the client as well as providing the support necessary for the client to experiment with new behaviours. Both models value the therapist as a skilled artisan, recognising both the objective and subjective nature of the work. The need for flexibility is openly acknowledged in each
approach, especially the therapist's creative and judicious use of self disclosure. Collaboration is sought after in both models, and a sliding scale of therapist workload is anticipated as the therapeutic journey unfolds.

Neither model assumes expert status above the client's own understanding of their difficulties, therapist's value and work with the client's own perception of their problems even though professional confidence is obtained from their respective trainings. Both models embrace the limitations of the therapist and see this as useful for the client to witness. Another similarity is that both approaches regularly solicit client feedback, and neither model interprets resistance. Thus, it would seem that both models value and cultivate the therapeutic relationship, even though their reasons for doing so may differ.
References


Bordin, E. S. (1979). The generalizability of the psychoanalytic concept of the working alliance. *Psychotherapy: Theory, Research and Practice, 16,* 252-260


Perls, F.S. (1979) 'Planned Psychotherapy', *Gestalt Journal, 2 (2)* 5-23


The role taken by the internal consultant is no different from the role taken by a therapist. Discuss.

In this essay, the similarities and differences between the roles of a therapist and those of an internal consultant will be examined. Before doing so it would be helpful to define the terms "therapy" and "consultancy".

**Therapy : what is it ?**

Therapy in Western cultures has many meanings. Whilst there are differences among various schools of therapy, based upon the type of technique used, the nature of the goals, and the mutual expectations of both the therapist and the client, they also have a number of features in common. The term "therapy" in this essay will refer to the following non-specific factors found in many therapies: the systematic observation of behaviour, history taking and the identification of recurring patterns in the clients behaviour, and an evaluation of the intervention. The entire process requires a "working alliance" between both parties, involving values such as trust, rapport and feeling safe. As well as there being many schools of therapy, there are many client groups to which they can apply. In order to meet the aim of this essay I will focus upon work with adult clients visiting a psychology department for help with any psychological disorder.

Cockman et al (1992) regard therapy as "a specialised form of consultancy which tends to be used with people who have personal problems which they find difficult or impossible to solve on their own". Thus, the therapist tends to work with individuals, couples, groups or families who have identified personal problems that they need help with. The therapist uses his skills and knowledge about human behaviour to examine a client's history and to look at their life with them. An involved-yet-detached relationship facilitates progressive emotional disclosures, and "it is what the patient has been enabled to say to himself which is self authenticating". (Cox, 1978).
Consultancy: what is it?

Brunning and Huffington (1990) define consultancy as "a direct or indirect process enabling individuals, groups or organisations to fulfil their role, function or task better". The responsibility for the fulfilment of these roles, functions or tasks remains with the client requesting consultation, whereas the consultant is accountable for the consultancy process. Unlike a therapist, the consultant deals with a work related issue broader than the management of an individual case. There are several models of consultancy, the purchase model, the Doctor-patient model and the process model. The emphasis of this essay will rest upon the latter model. In particular, the work of Campbell and his colleagues (1991) using their systemic approach to consultation. They describe this approach as follows "we have learned to describe and examine patterns of beliefs and behaviour around specific tasks and the effect of these patterns on relationships and communication throughout the organisation" and "we believe that organisations change when people's perception of beliefs and behaviour changes. Our understanding of the organisation allows us to have conversations which lead people to make that change".

The consultant draws upon his or her skills and knowledge about the process of change to participate in a mutual exploration towards an understanding of the meaning of the problem for the organisation as a whole. The consultant's position within the system offers a different perspective from that of the client, even though he acknowledges that he is part of this co-created observing system. Both therapists and consultants benefit from being a part of a further system of consultancy from a colleague inside or outside the organisation, which enables them to maintain a sense of difference.

External consultancy involves consultancy to individuals, groups, or organisations outside the organisation of which the consultant is member. Internal consultancy involves consultancy to individuals, groups, or the whole organisation of which the consultant is also a member. The internal consultant can offer local knowledge and come in from a grass roots level. They may even identify the need for consultancy early
on, which may facilitate the development of a large base of support for change within the organisation. Because public sector organisations are increasingly looking within for help with organisational problems, only the work of internal consultants will be considered here.

Within any system there are five levels at which consultancy can occur, ranging from the individual client to the entire organisation! Between these extremes lie the interpersonal, intragroup and inter-group levels. In order to work effectively with such diverse client systems the consultant needs to possess various skills and be comfortable assuming different roles throughout the day depending upon which stage in the consultancy cycle they are at. Before describing the consultancy cycle, it will be useful to characterise the various roles that both therapists and consultants may have to assume, and to outline the skills they possess.

**Role descriptions**

Steele (1969) draws an interesting analogy of the consultant's roles as being like those of a fictional British detective! Both have only a temporary involvement in a system, during which time they focus upon gathering evidence and trying to solve the puzzles which it represents. There is the stimulation of working on several cases at once, and the potential for "dramatics". I would argue that the same could be said of the therapist's working life.

Menzel (1975) has listed a wide range of skills which he believes a consultant may employ during the process of planned change, ranging from being a researcher to a role model. There is not space to list all of the 25 skill areas here, however, it will be relevant to mention the four key roles that involve those skills. They are educating, diagnosing, consulting and linking roles. Therapists may not need to possess some of the skills listed by Menzel, however the broad role definitions are as applicable to the therapist as they are to the internal consultant.

Lippitt and Lippitt (1986) have also examined the many roles of the consultant, and identify the level of consultant activity involved during the consultation as pivotal in
determining the role they assume at any particular time. (See figure one below) During the course of individual therapy the therapist will also vary in the degree to which they are non directive, depending on the model they use and the demands of the therapeutic situation.

Figure one: directive and non directive roles (From Lippitt and Lippitt, 1986, pp61)

**Multiple roles of the consultant**

<table>
<thead>
<tr>
<th>Identifier of</th>
<th>Objective</th>
<th>Process</th>
<th>Fact alternatives</th>
<th>Joint</th>
<th>Trainer/ Educator</th>
<th>Information</th>
<th>Advocate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Observer</td>
<td>Counsellor finder and Linker resources</td>
<td>problem solving process + raises issues</td>
<td>thinking + raises</td>
<td>problem solving process + raises issues</td>
<td>problem solving process + raises issues</td>
<td>problem solving process + raises issues</td>
<td>problem solving process + raises issues</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Level of consultant activity in problem solving.**

<table>
<thead>
<tr>
<th>Non directive</th>
<th>Directive</th>
</tr>
</thead>
<tbody>
<tr>
<td>Raises questions for problem solving reflection + raises issues</td>
<td>Regards, links, + proposes guidelines, persuades, or directs in the decision-making process</td>
</tr>
<tr>
<td>Observes problem for reflection + raises issues</td>
<td>Provides policy or practice in the decision-making process</td>
</tr>
<tr>
<td>Gathers data and alternative thinking + raises issues</td>
<td>Helps assess consequences</td>
</tr>
<tr>
<td>Identifies alternatives + resources for client + helps assess consequences</td>
<td>Offers alternative client + participates in decisions</td>
</tr>
<tr>
<td>Offers alternative client + participates in decisions</td>
<td>Trains alternative clients + participates in decisions</td>
</tr>
<tr>
<td>Trains alternative clients + participates in decisions</td>
<td>Proposes guidelines, persuades, or directs in the decision-making process</td>
</tr>
</tbody>
</table>
By relating this framework to the various models of consultancy, we can see that the purchase model rests heavily on the directive end of the continuum, whilst the doctor-patient model moves from the directive end into the joint problem solver role. Systemic consultation is uniquely placed at the non directive end of the continuum, possibly reaching the identifier role. The strength of being less directive lies in the organisation being actively involved in the change process, and becoming self-reflective. "In this way, the organisation will continue to solve new problems in future moments in time, by reflecting on the relationships among the many beliefs and actions in the organisation". (Campbell et al, 1991).

**Skill descriptions**

There is a huge degree of overlap between the skills of the therapist and those of the consultant. Any differences tend to be a matter of emphasis rather than exclusion. The core skills that a therapist or a consultant must have in order to work effectively are as follows. Firstly, an awareness of your own strengths and weaknesses and the influence they have on others, alongside a plan for self-development. Being able to deal with your own feelings is a component part of knowing yourself.

If you are able to deal with your own feelings, you are much better equipped to deal with other people's feelings. Change impacts people in a variety of ways, ranging from anger and threat at one extreme to excitement, satisfaction and happiness at the other. Whatever the feelings aroused, you will need to be able to facilitate people's awareness, their acknowledgement, exploration and acceptance of them.

Therapists and consultants both need excellent interpersonal skills so that they can establish rapport with the client. Only when they trust you and feel comfortable will they reveal their thoughts and feelings. You will then need to be able to listen to them and to understand their experience, as well as being able to express your ideas to a wide range of audiences.

Observation and feedback skills are another building block for both therapist and consultant alike. "Respectful curiosity", hypothesising and circularity are the key terms
for this process within systemic approaches. Noting the significance of something observed and relating it to a theoretical framework should be a hallmark of good practice. Forming working hypotheses, and identifying evidence for or against them should form a continual feedback loop that the professional can work with. Being able to decide when and how much of your formulation, as well as how to convey it are other components of giving feedback which can be used to maximum effect. It is essential that the client regards the therapist or the consultant as neutral, so that they feel safe to explore new ideas.

Knowledge of how people learn is essential to the therapist and consultant. However, the consultant will also need a sophisticated level of problem solving and team building skills. Flexibility of thought and creativity will be useful when applying their knowledge to a variety of client groups, each with their unique needs at different stages in the consultancy process.

Identifying the 'real client' is a task for the therapist and consultant alike. However, for the consultant it is particularly useful to think about 'client systems'. Revans (1980) suggests answering the following questions to facilitate this process: who knows?, who cares?, and who can?. It is important to detect all the parts of the client system before you get too far into your intervention. To omit a key player can undermine the effectiveness of any intervention you might hope to introduce to the system.

Knowledge of group process is essential for consultants and therapists working with groups. However, for the consultant (unless their task is to examine and work with group process alone) the need to be aware of how relationships and behaviour are affecting the problem under examination may be a factor to bear in mind rather than to directly work with.

Whilst therapists may use a wide range of assessment measures, including psychometric measures and interviews, consultants may also need to draw upon whole group or sub-group exercises, group discussion and reflective discussion. During a reflective discussion the two consultants talk about the way in which their thinking about the experience of the consultations so far is affecting their hypotheses. The
participants are asked to listen and observe, but not to participate at this stage. In addition, each consultant tries to comment on the views of the other, so that the discussion connects ideas in a new way. It is important that the discussion represents different points of view. After 5 or 10 minutes the consultants invite the participants to comment on what they learned from the experience of listening to the consultants discussion. These challenges will create some tension within the interaction between the consultant and clients, and between the clients. The impetus for change derives from the tension that takes place in a context of respect and safety.

In order to work with problems at the organisational level the consultant will need to be familiar with models of organisations and organisational behaviour. It does not fall within the scope of this essay to examine such models in detail. However, in order to highlight the issues pertinent to the consultant, a brief outline will be made of two models. The organisation diagnostic model divides organisational activities into the following equally important interdependent parts: purpose and tasks, structure, people, rewards, procedures and technology. All the parts are critical to organisational success: the symptoms of a problem may show in one part, but some of the causes might lie in others. Whereas the group working model divides the organisations activities into the following three categories: the task, the systems and procedures, and the process. No matter how many people are involved, the age of the organisation, the time available or the complexity of the task, the model proposes that these three strands of activity are always involved in moving from the start to the completion of whatever the undertaking was by two or more people. Both these models enable the consultant to categorise the data available during the diagnostic phase of their work.

The essential additional knowledge and skill that a consultant must have, is that of the stages in the life cycle of an organisation. Just as the therapist appreciates the different challenges faced by a client depending upon their stage in the life cycle (Erickson, 1963) the consultant considers whether the organisation is in its pioneering, systematisation or integration phase. Such developmental stages assist consultants during the planning stage of their interventions.
Throughout both therapy and consultation, especially during the implementation stage, therapists and consultants need to maintain their belief that the client, whether an individual or an organisation can change. This may be tested at times during individual therapy, how much more so when dealing with a large client group! Cockman et al (1992) describe the following personal characteristics that a consultant needs in order to keep going. "A consultant needs a positive self-image and enough self-confidence, skill and ability to retain it in the face of adversity."

The consultancy cycle

A number of writers have outlined the stages involved in the consultancy process (See Brunning et al, 1990., Cockman et al, 1992., Lippitt and Lippitt, 1986). and these have been listed below in table one.

Table one: stages in the consultancy cycle.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Scouting</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>Entry</td>
<td>Engaging in initial contact and entry</td>
<td>Gaining entry</td>
</tr>
<tr>
<td>Contracting</td>
<td>Formulating a contract and establishing a helping relationship</td>
<td>Contracting</td>
</tr>
<tr>
<td>Data gathering</td>
<td>---</td>
<td>Collecting data</td>
</tr>
<tr>
<td>Diagnosis</td>
<td>Identifying problems through diagnostic analysis</td>
<td>Making sense of the data and diagnosing the problem</td>
</tr>
<tr>
<td>Planning</td>
<td>Setting goals and planning for action</td>
<td>Generating option, making decisions and planning</td>
</tr>
<tr>
<td>Intervention</td>
<td>Taking action and cycling feedback</td>
<td>Implementing the plan and taking action</td>
</tr>
<tr>
<td>Evaluation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Withdrawal</td>
<td>Completing the contract. (Continuity, support and termination).</td>
<td>Disengaging</td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>Follow up</td>
</tr>
</tbody>
</table>
When discussing the consultancy cycle from now on, I will be referring to the Brunning et al (1990) stages as they considered the context of the referral prior to agreeing to work with the organisation, as well as creating concise and logical stages. Such stages are equally applicable to the work of a therapist. What is likely to differ significantly are the roles assumed, the intervention decisions made and the subject matter under exploration. I will now use this framework to consider the similarities and differences between a consultant and therapist at each of the stages in the cycle.

**Scouting**

At this stage the consultant decides whether or not to 'enter' the system. This may involve negotiating legitimacy for internal consultancy within the current context of an organisation, and assessing the constraints placed upon their autonomy. Being curious about the way in which an initial request is framed can provide useful information for both therapist's and consultants. Usually, the therapist receives the request from a professional acting on behalf of the client, whereas the consultant is likely to receive the request from some part of an organisation (possibly acting on the behalf of another part within the organisation !). In both situations the consultant and therapist will assess the situation against specified criteria and decide how to proceed from there. Whilst the "client" involved in each case may be very different, the process of scouting appears similar especially if face to face contact is arranged with the client to involve them in this preliminary exercise.

**Entry**

Entry into a system involves establishing a collaborative relationship with the client as a basis for further involvement. For both consultants and therapists this will involve building rapport, trust and creating a safe space in which to discuss the issues. Fundamental to this stage (and important at all others !) is the professional's "neutrality", which should be being communicated to the client either explicitly or implicitly.
In order to engage in systemic consultancy, the consultant will need to involve all participants in the problem-determined system in a co-evolving process in which the consultant with "respectful curiosity" can ask people about their view of the problem (Cecchin, 1987). The consultant therefore, tends to have a greater number of clients to bear in mind, and because of this knowledge of group dynamics and group process are routinely called upon.

Contracting

Good contracting involves open discussion of what the expectations are and how they are to be achieved. It may involve the discussion of boundaries, confidentiality and who will do what. It is essential that consultants and therapists develop "mutual" contracts with their clients, for if an important player is left out at this stage they may well sabotage any efforts later on. Typically, therapists work with individuals, couples, families or small groups. It would seem that the smaller the number of identified clients in the system the more straightforward this process should be. As well as possibly dealing with larger groups, consultants may need to build more formal contractual arrangements into this process, such as: what service or activity they will deliver, what the time-scale is for the assignment and how much it will cost the organisation.

Data gathering

Quantitative and qualitative measures may be used by either therapists or consultants in order to obtain data. However, the consultant will have a unique interest in measuring organisational variables.

Diagnosis

Interpreting the data, feeding it back to the client and developing a joint understanding are regular tasks faced by the consultant and therapist alike, although the models used may be different depending on whether the client is an individual or an organisation.
Planning

The planning stage of the work involves identifying specific interventions, including who will do what, and how it might be evaluated. During this stage the consultant will need to bear a number of additional factors in mind. Namely, the group dynamics, the life stage of the organisation and a model of organisational behaviour. Evaluation measures will need to be decided upon with the group, so that the data can be examined by all the relevant parties within an objective framework.

Intervention

Carrying out the planned implementations. The responsibility for implementing decisions rests with the client, whether he is working with a therapist or a consultant. This can then become a second data gathering activity during which you gather data about the changed behaviour within the client system and offer feedback to your clients.

Evaluation

Evaluation of the work involves assessing the success of the interventions and the need for further action or withdrawal. This relates to the earlier need to define measures of organisational change with the client group, so that the original contract can be upheld even when the organisation is not satisfied with the results obtained. If further work is required this can then be negotiated and not merely tacked on by the organisation.

Withdrawal

The end of therapy or consultation involves the professional withdrawing from the system they joined temporarily. It is crucial that the end is decided at the start of the work, so that both parties can work towards a "good ending", which leaves the client with an enhanced understanding, and increased capacity for self-reflection. If no further action by the consultant is required, managing the termination of the organisational development work, while at the same time leaving the system with an
enhanced capacity to manage such change by itself in the future is the greatest benefit that the organisation can obtain from the consultation.

**Summary and conclusions**

In order to discuss the roles of therapists and internal consultants it has been necessary to examine the various role descriptions used in the literature, and to describe the skills needed to perform them effectively. Although there is a degree of overlap between therapists and internal consultants characteristics, nevertheless consultants need to draw upon additional knowledge and skills in order to work with organisations facing organisational problems.

The consultancy cycle provides a useful framework to consider the processes involved in both therapy and internal consultancy. Again, whilst there are similarities consultants often face larger client groups, who each have their own agenda. Establishing trust with such groups takes particular skill and expertise. Awareness of the therapeutic process is undoubtedly useful, but would not on it's own prepare a consultant for the task ahead. Knowledge of groups, organisations and and the process of change, along with systemic interventions and group exercises are potential "lifelines" for the internal consultant. The need for external support and consultancy is also paramount for the long term survival of the consultant.

Finally, the internal consultant may withdraw from a piece of consultancy work, but will still be a member of the organisation. Skillful withdrawal in such a case is needed, and is unique to the internal consultant's position. Therapists are, I believe assisted by the separateness of themselves from their client group. By separateness I mean belonging to a different group or organisation, represented most visibly in working in a different environment or context from their clients. Thus, I would argue that the internal consultant must be comfortable with, and skillful at establishing boundaries in potentially difficult or blurred contexts. They must possess a large capacity to tolerate ambiguity and confusion, and to contain the organisations anxiety during the consultancy process. As with most risky manouvres the rewards are great. A piece of
internal consultancy, which the organisation and the consultant regard as successful will provide further recognition, respect and informal power to the internal consultant, who will then have a different context in which to work, whichever of their various roles they are inhabiting at that moment in time.
References


"Are older people different from younger people in their needs for psychological involvement? Discuss with reference to psychological knowledge and theories."

Older people are different from younger people in a variety of ways, including in their needs for psychological involvement. However, age differences are secondary when considering a number of core psychological themes which run throughout the work with adults of all ages. Alongside such age related problems as decreasing physical strength, and slowing of responses, difficulties found in earlier stages of adult life may become more severe, influenced by their life stage and the presence of multiple pathology. Problems such as depression, anxiety and stress-related disorders, marital and sexual problems, will be at least as common in older adults as in younger people.

In order to identify the psychological needs of older people it will be necessary to take account of their life stage and to examine their biological, developmental, and environmental resources, as well as the demands made upon them. Dementia will also be discussed, owing to its age related specificity and its impact upon the wider system surrounding an individual.

Life stage

Erik Erikson's analytical theory of human psychological development provides a useful theory of life course changes (see Table 1). It is worth noting that this provides a useful description of a Western approach to ageing rather than an worldwide explanatory model.
Table 1: A developmental stage model of psycho social change

<table>
<thead>
<tr>
<th>Developmental Stage</th>
<th>Life Crisis to be Resolved</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Infancy</td>
<td>Basic trust v. Basic mistrust</td>
</tr>
<tr>
<td>2 Childhood (1)</td>
<td>Autonomy v. Shame or doubt</td>
</tr>
<tr>
<td>3 Childhood (2)</td>
<td>Initiative v. Guilt</td>
</tr>
<tr>
<td>4 Childhood (3)</td>
<td>Industry v. Inferiority</td>
</tr>
<tr>
<td>5 Adolescence</td>
<td>Ego identity v. Role confusion</td>
</tr>
<tr>
<td>6 Young adulthood</td>
<td>Intimacy v. Isolation</td>
</tr>
<tr>
<td>7 Adulthood</td>
<td>Generativity v. Stagnation</td>
</tr>
<tr>
<td>8 Old age</td>
<td>Integrity v. Despair</td>
</tr>
</tbody>
</table>


While the eight developmental stages are sequential, those of adulthood are not assigned to specific ages. Each stage poses specific challenges and issues. Resolution of each stage facilitates adaptation to the next developmental stage. Therefore earlier unresolved issues may hinder adjustment in later life, and may need addressing in therapy in order for a person to work through them.

A critical aspect of the psychological circumstances of old age is the perception of time left. The loss of a psychological future is a major loss in later life. Related to this is the growing awareness of one's own mortality influenced by seeing close relatives and lifelong friends of a similar age to oneself die. Erikson's theory suggests that the main themes of later life centre around maturity and death, with the polarities of ego integrity versus despair as the dominating interpersonal mechanisms. Such factors are likely to permeate the general and age specific needs for psychological involvement that older adults may bring to the psychologist. McKenzie Smith (1992) argues that in order to understand the experience of old age one needs to consider it in the context of the whole life cycle. She noted how in psycho-analytic practice, with younger adults,
the feelings of attachment, separation, loss, mourning, melancholia and bereavement are explored. These themes continue to be relevant for older adults.

**Biological Resources**

**Physical Ability**

Obvious changes with ageing can be seen in the physical characteristics of a person, such as decrease in height, hair loss or wrinkling of the skin. Ageing also has adverse effects on sensory processes. Taste, smell, vision and hearing all deteriorate (Marsh, 1980). Some of these changes have effects on the self concept, others influence psycho social adjustment.

Older people are more often afflicted with chronic diseases, such as arthritis, hypertension, heart conditions and diabetes, and are more likely to suffer disability restrictions because of health than younger people.

**Intellectual Ability**

The common assumption that intellectual performance reaches a peak in the early 20/30's then steadily declines with age, has been supported experimentally. Such evidence is limited to certain tasks and is only significant when a person is in their 80's (Schaie, 1980). The "classic ageing pattern" involves the maintenance of, or even improvement of scores on verbal tests whilst psychomotor speed tends to decline.

However, available information processing capacity does decline with age (Wright, 1981) and large deficits occur on memory tasks when they require cognitively effortful processes, whereas those regulated by automatic processes show no such decline in healthy elderly adults (Hasher and Zacks, 1979).
Developmental Factors / Cohort Effects

The majority of older people spent fewer years in formal education than their younger counterparts. They have lived through massive technological change, and have survived a world war. The development of "psychological mindedness" within the general population has been facilitated by education and greater availability of resources to be spent on such higher order motivational needs, now that for most people the basics of food and shelter are taken care of. It is not surprising that some older people find psychological concepts unwieldy, and will demand greater flexibility of the therapist in order to establish a therapeutic relationship than younger people might do.

Most older people will have married during their earlier years. Many became parents, and in their middle years experienced the "empty-nest" phenomenon, when the last child leaves the family home. The role of grandparent is a new status for ageing parents and essentially an unchosen one. There is considerable positive potential in the role of grandparenting, and would seem to link in with the generativity theme of Erikson's seventh stage of development. Increasingly those in advanced old age are becoming great grandparents.

Retirement

Unlike unemployment, retirement does not incur social stigma nor is it as unexpected. As retirement is a predictable life transition, it is possible to obtain relevant and necessary information, thereby increasing preparedness. It does not usually involve a major psycho social crisis. In the Erikson framework retirement may trigger the transition between generativity versus stagnation and integrity versus despair. With retirement there is likely to be a shift from a structured routine, with social contact made at work, to unstructured leisure time with much less built in social contact, a reduction in social status, feelings of self worth and the achievement of goals.
Retirement may be perceived either as a timely conclusion to a person's occupational career or as an unwelcome and unwanted permanent state with little chance of re-entering the workforce.

An individual's personality appears to be an important factor in the smoothness of the shift to retirement. Reichard et al (1962) reported, that three personality types were associated with good adjustment to retirement: mature; who appeared to accept themselves realistically, and found satisfaction in their activities and personal relationships. Rocking chair men; who were generally passive, happy to be free of responsibility. Armoured; appeared to avoid their fear of physical decline and ageing by keeping active. There were two types who adjusted poorly: angry men; who blamed others for their disappointments and could not accept the fact that they were growing old. Self haters; who felt their lives were disappointing and that they had failed, but turned their anger inward and blamed themselves and were likely to be depressed. Such data suggest that an individual's style of personality is relatively enduring and that it affects one's ability to adjust to a transition such as retirement.

Bereavement

The elderly are especially likely to face losses. Bereavement brings loss of economic and social status as well as loss of emotional attachment. Social isolation is often increased by the death or disability of friends, siblings and other cohort members, and the relocation of other family members. Physical disability and poor health lead to loss of mobility and independence, while the loss of social roles and status result from stereotyped expectations of the limited ability of older people and age-demanded retirement from employment. These losses mean that the elderly frequently face multiple difficulties of a chronic or acute nature at a time when their resources for dealing with them may be reduced (Goodstein, 1981). Widowhood (loss of one's partner of either sex) more commonly affects women than men. There is some evidence that the impact of the loss depends upon how expected it was. Eisdorfer and
Wilkie (1977) found that the loss was less stressful if the deceased had been ill for some time. Cunningham and Brookbank (1988) describe the situation for widows as being that satisfaction can be obtained from the maintenance of certain role behaviours e.g. mother, housekeeper. However, she is likely to live alone and face financial difficulties. Loneliness is a frequent experience, and some never come to terms with living alone. Evidence shows that elderly widows are in poorer health and have higher suicide rates than their non-widowed peers. MacMahon and Pugh (1965) found that deaths from suicide clustered in the first four years of widowhood, especially among widowers.

Environmental Resources

Physical Resources

Whilst many older people live capably in independent household arrangements it must be recognised that much of the housing is either inappropriate or inadequate. Difficulties arise when living arrangements are no longer compatible with remaining physical ability, so that the housework and garden become too much, or if the bathroom and bedroom are upstairs the person may find the stairs tiring.

Problems are made worse when elderly people live in inadequate conditions. Fox (1981) reported that elderly people are more likely than younger people to live in inadequate housing. The importance of the physical environment should not be underestimated when considering it's potential impact on functional behaviour.

Access to amenities is also an important consideration. Being within walking distance or a short bus ride to the shops is of immense value, as well as being located near to social clubs and other leisure opportunities.
Social Resources
Friendship

Friendships are very important at all ages, but especially in old age, compensating for spouses who have died and providing opportunities for rewarding activity. The role of friend lasts longer than the role of worker, and usually spouse. Arling (1976) found that contact with friends and neighbours did serve to reduce loneliness and increased feelings of usefulness. Having a stable group of friends helps to maintain autonomy and self-worth in later life and friends often provide assistance with daily living and crisis intervention.

Older women tend to have closer friends, whereas elderly men typically have more remote friends and acquaintances with shared interests. Women tend to have both larger social networks and are more likely than men to have intimate same sex friends. Many friendships especially for men, are formed on shared interests at the workplace, and as such may not survive the transition to retirement. In addition the social network available to a man shrinks when his wife dies, while widows are able to maintain a stable network. Lowenthal and Haven (1968) identified the psychological benefits of having at least one confidante with whom to share troubles, fears, as well as happiness. Intimacy is a significant factor in influencing adjustment to the demands of ageing.

Psychological Theories

A number of psychological theories of ageing have been put forward to explain commonly observed behaviours in older adults, and other general theories of human behaviour can be adapted to apply to this population. Disengagement Theory (Cumming and Henry, 1961) proposes that there is a natural tendency to psychologically and socially withdraw from the environment as people reach old age. This is argued to stem from internal processes such as recognition of personal declines in abilities and skills. Others, argue that disengagement is a socially imposed condition,
as society withdraws support, positions of status, social roles, available rewards, and opportunities for meaningful social interactions from the elderly.

Depression is the most common psychiatric disorder in the elderly, and there is a tendency to accept a state of apathy and disinterest in surroundings as an unavoidable part of the ageing process. The disengagement theory allows withdrawal and decreased interaction with others to be seen as normal. Levin (1967) has argued that younger people tend to become disengaged when they become depressed, suggesting that a certain amount of disengagement in the elderly may be a product of depression itself.

Learned helplessness is an useful concept which provides an alternative explanation for depression and apathy in older people. Seligman (1975) proposes that depression arises as a result of believing that life events are beyond control. In a society which places a premium on youth and wealth, it may seem to the less well off older person that there are insurmountable barriers to their achieving happiness. (e.g. poor health, mobility and low income). With a decline in physical strength and vigour, it may not seem worth the energy expenditure for the return on their effort. Feeling helpless and without a sense of control over their lives are likely to lead to feelings of hopelessness and depression. It may also engender dependency on younger relatives and friends, which may further erode self esteem. The locus of control construct of Rotter (1966) may provide us with a valuable insight into later life maladjustment. If a person holds the belief that they can generally control their environment and future destiny it may predispose them to attribute failure to themselves as the cause for their helplessness when life goes wrong. While these expectations may contribute to positive adjustment in old age, it may not be so when confronted with adverse life circumstances.

Lewinsohn (1974) believes that loss of mastery over and pleasure in life's activities, especially those which provide access to social rewards, can be associated with the development and maintenance of depression. A reduction in the availability of social reinforcement in the environment, or reduced activity in later life because of role transitions or failing health, may lead to depressed mood. Depression may result in
social avoidance. Withdrawal from social activity further reduces a person's prospects of being in receipt to positive reinforcement, and mood continues to deteriorate. Role activity theory proposes that our social roles form the basis of our identity and are crucial to the maintenance of positive feelings toward ourselves. As we enter later adulthood, there is a tendency to become removed from those activities or social roles that have been the foundation of self-identity. Feelings of personal worth, value, and meaningfulness may suffer. Conversely, if an elderly person is to maintain positive feelings toward the self, new social roles must be adopted to replace those that have been lost.

Continuity Theory (Covey, 1982) emphasises the continuity of experience, skills and preferences throughout the life span, and the complex interaction between biological, psychological and social influences that lead to stability or change in each individual. It follows from this approach that it is important to examine each person's life course when considering their care. It is not the case that all older people are best adjusted when disengaged from society or that they necessarily need to replace lost roles. Throughout life there is a need to adapt to environmental demands, the successful or unsuccessful negotiation of which may markedly affect personality development.

The psychology of old age requires an appreciation of the current life situation along with an understanding of the life span. Different historical experiences produce different expectations and patterns of behaviour in old age.

Having considered both the general resources and demands made upon older people, it will now be helpful to consider the impact of dementia upon the individual, their family and the wider social system.

**Dementia**

This age related disorder has a major impact upon the needs of older people and their relatives/carers for psychological involvement. It is characterised by a generalised and progressive decline of higher order cognitive functions, based upon neuronal
degeneration processes. In other words people lose the ability to concentrate, remember things, and to form and carry out complex plans of action. This may explain why dementia is such a frightening and debilitating condition. In the early stages, sufferers often recognise that something is wrong and will try to compensate for any difficulties they experience. The progressive nature of the condition gives rise to further and more severe symptoms with time, increasing the level of distress in the individual as well as increasing the demands made upon the "helper system" involved with their care. Working with / through staff and carers is the most likely form of psychological involvement for people suffering from dementia, and creates a distinction between such work and that with younger, independent adults.

Earlier psychological intervention with older adults was based predominantly upon a behavioural model, reflecting a focus upon problems occurring in institutional care. The issues that have occupied the psychologists time have been concerns about helping older people to learn or relearn the skills of everyday living and orientation information, and about the effects of institutional environmental contingencies upon the behaviour of patients and staff. Psychologists have attempted to tackle directly the problem of the confused elderly through the use of reality orientation (Holder and Woods, 1982) and memory training strategies (Zarit et al, 1982).

Environmental psychology places a clear emphasis upon the importance of the physical and social environment. Lindsley (1964) suggested that prosthetic environments should be developed in which compensation could be made for disabilities of the elderly. Social psychologists have helped to explain the behaviour of care staff and relatives. The three factor theory of attitudes, which allows for a loose linkage between the emotional, cognitive and behavioural aspects of an attitude (Eiser, 1980), and attribution theory (Shaver, 1978) may help us to understand the discrepancy sometimes found between what people say about caring for an elderly confused person and what they actually do, and will hopefully also guide the development of approaches to assist care staff to act according to their beliefs.
Recently there has been an interest in psychological approaches to therapy and management. The development of Reminiscence Therapy, which is in part based on the life review concept of Butler (1963) is used widely, as has the development of individual care planning to help dementing people regain skills in specific areas such as self care and toileting. Interest is also being shown in the internal, emotional world of the dementia sufferer (Sinason, 1992).

**Conclusion**

Flexibility and sensitivity are at a premium when working psychologically with older adults, as material from across the life span is potentially available for intervention. The need to work through carers and staff, as well as addressing our own dependency fears can create further complications to the work. However, whilst older people face a variety of unique challenges due to their advanced age, this should not obscure their similarities to younger people. Even in advanced cases of dementia, the sufferer (and their carer/s) continue to have the same emotional needs as other people.
References


Critically discuss the contribution that neuropsychology can make to the assessment of people who have suffered a stroke.

Before appraising the information that neuropsychological assessment obtains, it will be useful to outline what neuropsychology is, and to explain what the terms 'assessment' and 'stroke' refer to.

What is neuropsychology?

Clinical neuropsychology is an applied science concerned with understanding the mind and the brain. It has become established within the last fifteen to twenty years in response to the practical problems of assessment and rehabilitation of brain injured patients.

Human cognitive neuropsychology "can illuminate the processes involved in human perception, language and memory" (Ellis and Young., 1988 p3). It involves the study of how particular brain structures and processes mediate behaviour. Any explanation offered by neuropsychology refers to impairment to psychological operations which are necessary for normal functioning.

Cognitive neuropsychology has two basic aims (Coltheart, 1986) firstly to decipher the unique pattern of test scores a brain injured patient obtains on the particular assessment measures used, by drawing upon theories or models of normal cognitive functioning in order to elucidate both the spared and damaged processes. Secondly, by analysing the patterns of test scores it is possible to draw conclusions about how non-damaged cognitive processes function. Such conclusions can then be experimentally investigated using normal subjects.
What is assessment?

Assessment is a process of collecting information from a variety of sources that are relevant to the particular question being asked. The information gathered often consists of qualitative and quantitative data. It involves the refinement of working hypotheses, influenced by test results and observational data. Incorporated into the assessment is an evaluation of the patient's needs and circumstances from a psychological viewpoint. Such clarification may stimulate new questions to be answered, and may well redirect the focus of assessment to previously undefined areas.

What does the term 'stroke' mean?

Stroke is the outward manifestation of a sudden localised interruption of the blood supply to some part of the brain. As Horn and Reitan (1990, p644) have summarised "the type and severity of the neurologic deficit resulting from stroke depends upon such factors as the location, size, temporal sequence, and mechanism of the stroke. The neurologic sequelae resulting from disruption in blood flow can vary tremendously, from a comatose state and hemiplegia to negligible neurologic symptoms of a transitory duration". Because such a confusing array of symptoms can result from a stroke, a wide variety of techniques may have to be used to define the exact nature of the neuropsychological deficits observed.

So, what are the merits of conducting neuropsychological assessments of stroke patients?

Neuropsychological assessment depends upon the use of reliable and valid tests and other tools in order to investigate such psychological processes as perception, memory,
intelligence, praxis, language and attention. A reliable test is one in which the scores obtained by subjects are known to be consistent, and unlikely to change because of factors which are not connected with the test procedure. A valid test is one which measures what it is supposed to measure, and not something else! There are now a large number of such tests available which allow the examiner to sample a patient's performance in all the major input and output channels. (e.g. auditory and visual receptive modalities and their spoken, written, graphic, and constructional response modalities). Many standardised tests have been developed and validated for detecting the presence and localisation of cerebral lesions. New tests and measures continue to be advanced.

The use of standardised and well researched test materials enables the examiner to observe a patient's behaviour under more or less standard, replicable and manufactured conditions. This 'sameness' enables the examiner to compare behaviour samples between individuals, over time, or with expected performance levels.

The results of testing consist of direct observations (qualitative data) and numerical summary statements about the observed behaviour (quantitative data). The individual's test results can be compared with the norms collected for the test, enabling the examiner to compare the patient to a variety of reference groups to ascertain the severity of any impairment sustained and whether it is commonly found in that particular age group, sex or diagnosis. Test interpretation is based upon quantified differences between scores from repeated testing, or between scores on two different tests or subscales, or subtest profile patterns. In sum, test scores produce "objective, readily replicable data cast in a form that permits reliable interpretation and meaningful comparisons". (Lezak, 1976).

There is evidence that standardised tests of such psychological functions as intelligence, memory and language do have statistically reliable associations with a wide range of behavioural phenomena relevant to clinical practice. As Berger (1986) proposed, when test scores are regarded as an index of performance on a particular set of tasks, they allow the educated test user to make clinical interpretations from them.
In this way the statistical merits of tests are retained, enabling the clinician to report the patients score in relation to his age peers and the average score obtained without reifying the score. It is also possible to go beyond the standard procedure of a test in order to extend the information available on the patient's capabilities. For instance, continuing with a subtest even when the set time allowed for it has been exceeded, in order to discover whether it is speed alone which is causing the difficulty, or whether even with unlimited time available the patient is still unable to complete the test. Testing the limits does not affect the standard test procedures or scoring. It is only done after the test item has been completed according to the standard instructions. Thus, a test can be used as a measuring instrument and as a device for eliciting some aspects of cognitive functioning that do not show up in interviews or in day-to-day observations.

Having considered the general merits of neuropsychological assessment, what are the specific merits in relation to stroke patients? Neuropsychological assessment of a stroke patient will be concerned with one of two tasks: providing further refining information, and describing their spared and damaged cognitive processes. Even with the current sophisticated neuro-imaging techniques available to neurologists, certain conditions such as transient ischaemic attack (the so called 'mild stroke') may produce impairment which is too subtle to be identified by current neurological procedures, but may well be detected by behavioural measures administered during the neuropsychological assessment. Assessment also provides data with which to discriminate between psychiatric and neurological symptoms, or to aid in distinguishing between different neurological conditions.

For patients who have already received a diagnosis of stroke, a thorough assessment of their cognitive functioning provides precise descriptive information which is essential for designing sensitive and appropriate rehabilitation which caters for the patient's needs, strengths, and limitations. By obtaining a detailed history that includes developmental, clinical and social factors and carefully reviewing educational, medical and rehabilitation records an estimate of pre-morbid functioning can be made. Wilson
et al (1978) attempted to make this process more systematic and objective by building regression equations to predict premorbid WAIS IQ from demographic variables. It is also possible to use a test specifically designed to estimate premorbid ability. The most widely used of such tests is the National Adult Reading Test (Nelson, 1982). If visuospatial inattention is suspected this can be investigated by using e.g. cancellation tasks. (Diller and Weinberg, 1977).

The nature of the patients deficits will preclude certain forms of rehabilitation altogether, or will make some methods more desirable than others. Regularly repeated full-scale assessments give information about the rate and extent of recovery or deterioration, and about relative rates of change between functions. Such assessments can also facilitate communication and understanding between the various professionals involved in a rehabilitation programme, which needs to be multidisciplinary in nature if it is to promote gains in the various effected processes. Regular assessments would also identify any cerebral atrophy and global effect on cognitive functioning caused by the cumulative effect of many small lesions. Multiple infarct dementia, vascular stenosis, and arteriovenous malformations are all vascular disorders that give rise to dementia. The onset of symptoms is rarely abrupt and more often subtle and progressive, and is often a very confusing and frightening process for the individual and their family. Information obtained from the assessment may help relatives to understand, and adjust to the nature of the changes occurring in their loved one.

Rehabilitation depends upon the patients motivation to persevere at specified tasks in order for progress to be made. Such motivation, rests upon the degree of insight the patient has into their altered capabilities alongside the emotional impact of such changes upon them. Feeding back factual information from the assessment to the stroke patient may increase his understanding of his current functioning, and improve his ability to set realistic goals. For patients who sustain a mild stroke, such information can also be reassuring, by recognising subtle changes in cognitive functioning as due to their mild stroke, rather than attributing it to going mad. As Lezack (1976) writes "careful reporting and explanation of psychological findings can
do much to allay a patient's anxieties and dispel his confusion". It can also allow the patient to talk about their feelings and to provide reassurance that feeling depressed is a common reaction when people have suffered a stroke. It can also assist family members in the difficult process of adjusting to the changes in their loved one.

Data obtained from a neuropsychological assessment may also be used to evaluate treatment. For instance, Goldstein, Kleinknecht and Gallow (1970) describe changes in the direction of improved performance on the Reitan battery of neurological tests and other measures, in patients who underwent an endarterectomy operation which re-establishes an efficient circulation by clearing accumulated plaque from the lumen of the artery.

When evaluating change it is extremely helpful to have test results available for public scrutiny. Provided that a reliable and valid instrument has been used appropriately, changes in scores will be able to reflect in part some of the changes occurring in the patient's life. Obtaining baseline measures of a patient's performance is critical to the provision of appropriate rehabilitation, for not only can a profile of deficits and strengths inform rehabilitation programmes aimed at maximising functional adaptation but it can also be used to monitor the effectiveness of such programmes and suggest modifications necessary to encourage further gains. Such test scores enable purchasers and providers to discuss rehabilitation efforts using the same information, and as such can facilitate communication between those paying for a relatively costly care package with those who are delivering it. Thus, assessment results may be used to evaluate rehabilitation claims by providing objective evidence of progress.

So, what are the drawbacks of conducting neuropsychological assessments of stroke patients?

Assessment measures need to be reliable and valid in order to be useful. The reliability of measurement depends on the patient, clinician, instrument, and environment. It must be remembered that cognitive function changes in response to a number of internal
states, such as circadian rhythms, medication (Curran et al., 1988) and mood state (Jorm, 1986). Unless carefully administered, scored and double checked, it is possible for the clinician to introduce computational errors into the result. Also, the identification of problems in self-correction and regulation depends upon the sensitivity of the examiner's observations of the patient as he responds in the examination.

The issue of validity rests in part upon the reliability of the test along with the appropriateness of the component subtests to investigate the process under examination.

No test is unidimensional, and successful performance will depend upon a variety of psychological operations, some more obvious than others. The need to regard test scores as an index of performance is helpful when interpreting results in order to provide a valid account of the patient's profile.

Language difficulties are a common finding in stroke patients, particularly when the damage occurred in the left hemisphere. Thus, it is not surprising to find a number of stroke patients will be unable to perform within the standard test instructions, because they will have difficulty comprehending them. Wade et al (1989) found that severely aphasic patients were often unable to complete Ravens Matrices even in the absence of other defects: they appeared not to understand the test despite repeated demonstration.

Other barriers to assessment may include a short attention span, being easily tired and distractible. Some stroke patients may have reduced vision or hearing on the side opposite the lesion, with little awareness that they have such a problem. Most tests have been constructed with the physically able person in mind. When a stroke patient has hemiplegia or hemipareisis it is necessary for the examiner to find alternatives to the standard tests the patient cannot use, even if he has to improvise. Even using tests which have been designed for physically disabled people, has the drawback that the norms are not comparable to a standard test.

With any form of measurement, there is always a degree of error involved. The reliability of a measure is taken as an indicator of error estimation, as it focuses upon the accuracy of the measures as well as their replication potential. The difficulty with
psychological measurement is that people learn how to approach a particular test, or they become less anxious so that repeated measurement can never be identical to the initial investigation. Classical test theory developed a number of mathematically complex equations that allow the calculation of a standard error of measurement. Whilst this is a positive step towards recognising the inherent limitations to measuring human behaviour, it is commonly misunderstood and misinterpreted as being the error for the observed score whereas it is the error of the true score, the latter being a concept in classical test theory.

As Eysenck (1967) has pointed out, for any given test item, the possible outcomes are correct, incorrect, abandoned, or not attempted. If several individuals obtain the same score, it is possible that they have done so using quite different routes. Such individual differences are even more complicated when assessing stroke patients, as any of several ability deficits, alone or in combination, may be sufficient to cause failure in an activity. Whilst diagnostic cut-off points are clinically useful, it is important to remember that they are simply mathematical compromises between acceptable levels of sensitivity and specificity. (Galen and Gambino, 1975). It is also imperative to recognise that statistical significance is not the same as clinical significance. The former simply means that a difference in scores is unlikely to be due to chance, not that they are meaningful in any psychological sense. Such pleas for appropriate use and interpretation of test results highlights the need for extensive training being given before a clinician is deemed qualified to use such measures independently.

The norms of any standardised instrument will become increasingly outdated as levels of educational achievement and increased standards of living within the population as a whole occur. Even though Wechsler's tests have undergone revisions aimed at updating norms and items, they (like most tests) were not developed from an explicit theory of what intelligence or memory actually is. The content of many tests has been arrived at by clinical experience, informed guesswork and factor analysis. Whilst such a pragmatic approach is not an insurmountable problem, it merely focuses the issue of treating a test score as an index of performance obtained form the particular tasks
involved in the test, rather than treating it as a direct measure of intelligence, memory or whatever the test purports to measure.

Whilst the standardised procedures utilised by tests enable a number of useful interpretations to be made from the data, the structured nature of such tests often removes the need for the patient to employ higher order, "executive" functions. The conditions of formal testing may actually compensate or mask many of the patient's functional impairments (Svekeres, Ylvisaker and Holland, 1985; Sbordone, 1988). Only specific cognitive processes are required, and for a short time period. Unpredictability rarely features in neuropsychological tasks and only within limited parameters. Such procedures do not adequately assess the patient's ability to organise, plan, and order his responses. Test items may have little ecological validity in the sense that they may not adequately test the patient in real world settings. However, this limitation has been addressed by various researchers (Shallice and Burgess, 1991) and recently developed tests such as the Behavioural Assessment of the Dysexecutive Syndrome (Alderman et al, 1993) seek to systematically investigate skills previously untouched by traditional tests.

**Summary and Conclusions**

Neuropsychological assessment, with its emphasis upon using standardised tests, provides a snapshot picture of a restricted sample of a patient's present neuropsychological profile. That profile will, in part, depend upon variables such as the internal state of the patient, skill of the clinician and the environmental conditions under which the testing occurred. Thus, it provides an imperfect, picture. However, such a picture can be extremely valuable. The unique and rigorous investigation of psychological operations essential for normal functioning illuminates the stroke patient's profile of strengths and weaknesses and enables comparisons to expected performance levels to be made. Such detailed information can then be fed
back to the patient in order to improve their ability to set realistic goals and to monitor the effectiveness of rehabilitation.

Psychological tests are simply a way of standardising the clinicians observations. If used properly they enable us to accomplish much more with greater speed. When tests are misused as substitutes rather than as a continuation of clinical observation they can get in the way of obtaining an holistic view of the patient. Cognitive impairment is among the more serious of the sequelae of stroke, due to its negative impact upon rehabilitation. Attention, memory and some language deficits may be less obvious than hemiplegia or other physical disabilities, yet often prove to be the factors which are responsible for failure to regain independence. The role of neuropsychological assessment in providing information about such "hidden" deficits is an essential component of a thorough and complete assessment of the stroke patient. It should help both staff and carers to appreciate the impact cognitive impairment can have on functioning. Otherwise they may attribute difficulties exhibited by the patient as deliberate and under their own control. The assessment should also consider the patient's own reaction to their difficulties, for instance if a patient is aphasic how are they coping with the new-found barriers to communication with his environment?

When considering the impact of stroke on a patient's functioning, neuropsychological assessment has a great deal to offer, to the patient, relative, clinician and researcher. When it's limitations are borne in mind the information is essential in order to provide as complete a picture as possible.
References


Cognitive impairment after stroke and decision about the viability of living.

The review title suggests an association between the residual cognitive deficits following a stroke and the impact these have upon the quality of life enjoyed by the individual. It implies that beyond a certain level of impairment the viability of life of the individual is brought into question, possibly by the stroke victim themselves or from those caring for them. In order to examine this association in detail the review will be divided into two parts. (1) cognitive impairment: its impact on daily life (2) viability of living: ethical issues involved in the decision making process. The common issues and themes identified will be interwoven throughout the discussion and any implications for professional practice will be highlighted.

Cognitive impairment

As Horn and Reitan (1990 p644) have summarised "the type and severity of the neurologic deficit resulting from stroke depends upon such factors as the location, size, temporal sequence, and mechanism of the stroke. The neurologic sequelae resulting from disruption in blood flow can vary tremendously, from a comatose state and hemiplegia to negligible neurologic symptoms of a transitory duration. Symptoms of mental confusion, sensorimotor deficits, aphasia, apraxia, seizures, and other dysfunction's are other clinical manifestations of stroke".

For the purposes of this review cognitive impairment will refer to difficulties encountered in the following domains: intelligence, memory and language, as it is upon the intact and sophisticated functioning of these domains that our uniqueness in the animal kingdom lies.
**Intelligence**

In the first study to investigate cognitive deficits in a community sample of patients suffering an acute stroke, Wade et al (1989) measured IQ using Raven's Coloured Progressive Matrices found that those with an IQ below 90 had a poor functional outcome: all 9 patients left with severe disability had a low initial IQ, and only 41 % of the low IQ group regained independence as compared with 71 % of patients with high IQ.

Tatemichi et al (1994) focused on cognitive impairment as a general indicator of intellectual decline following ischaemic stroke, which they defined as failure on any 4 or more neuropsychological test items using a statistical criterion based on normative data from a stroke free sample. Cognitive impairment occurred in 35.2 % of patients with stroke and 3.8 % of controls. Cognitive impairment was most frequently found in the areas of memory, orientation, language and attention, all of which are fundamental to the successful completion of many activities of daily living. Perhaps, not surprisingly, functional impairment was greater with cognitive impairment, and dependent living after discharge either at home or nursing home was more likely (55.0 % with, v 32.7 % without cognitive impairment, p = 0.001).

**Memory**

Complaints of poor memory, by both the stroke patient and their relatives is often heard by professionals working in this area. One survey noted that over half of surviving patients complained of a poor memory (Sorensen et al 1982).

Wade et al (1986) investigated the ability to learn and recall new information at 3 and 6 months post-stroke. The following 3 subtests from the Wechsler Memory Scale were used to assess memory function: digit span, logical memory test and visual memory test. From the 138 patients who had complete memory assessments 3 months after stroke, 14 % completely forgot 2 stories within 30 minutes, and 14 % completely
forgot a drawn shape immediately after seeing it. There was evidence that poor memory improved between 3 and 6 months post-stroke, although some patients did deteriorate. There was also evidence that poor memory was independently associated with poor functional ability in simple everyday tasks such as dressing. In other words, regardless of the degree of motor loss, poor learning was clearly associated with a reduction in level of functioning.

**Language**

Any disturbance of language functioning, be it in the production or reception of speech has implications for the social functioning of an individual. If communicating your needs to others or receiving information is made difficult by a central processing impairment (rather than a physical impairment) the end result is often frustration, anger and isolation.

Using the Functional Communication Profile (FCP) Skilbeck et al (1983) found that 38 patients of the initial 162 had an FCP score of 85 or less, indicating an appreciable disturbance of speech function. Wade et al (1989) found that severely aphasic patients were often unable to complete Ravens Matrices even in the absence of other defects: they appeared not to understand the test despite repeated demonstration.

Often, severe aphasics are excluded from general stroke research studies because of the difficulties involved in obtaining a reliable assessment of neuropsychological function. Specific investigations of aphasia after stroke have found that it was associated with more severe disability (degree of limb weakness, loss of function, loss of IQ), and with a less good recovery of social activities, but did not cause any measurable increase in stress upon carers. (Wade et al, 1986).

Intact cognitive functioning, especially in the domains of thought, memory and language are fundamental to the flexible and creative use of functional skills for the successful completion of everyday tasks such as washing, dressing and eating. Unlike the visible signs which often accompany a physical disability, cognitive impairment is
not easily identified by looking at a person. However, it will also have an impact upon such daily living skills, especially when the impairment is severe. Clinical Psychologists need to help both staff and carers to appreciate the impact cognitive impairment can have on functioning, otherwise they may attribute difficulties exhibited by the patient as deliberate and under their own control. Such an assumption may ultimately lead to verbal or even physical abuse of the older person, when a carer feels they are being uncooperative and difficult on purpose in order to upset the carer.

Lying at the severe end of the cognitive impairment continuum, would be a late stage demented patient. Dementia refers to a \textit{progressive} and usually profound deterioration of \textit{all} the intellectual processes. Multiple infarct dementia, vascular stenosis, and arteriovenous malformations are all vascular disorders that give rise to dementia. The cumulative effect of many small lesions is extensive cerebral atrophy and a global effect on cognitive functioning. The onset of symptoms is rarely abrupt and more often subtle and progressive, and is often a very confusing and frightening process for the individual and their family. The personality changes seen with dementing processes are varied and essentially idiosyncratic. Some may be regarded as the patient's own reaction to the realisation, at some level of the changes they are experiencing in their overall functioning. Other changes such as the loss of control of inhibition may be a more direct result of cerebral damage.

Like the carers of severely head injured people (Rosenbaum and Najenson, 1976) the carers of dementing patients often find coping with the personality changes far more stressful than taking care of any practical concerns as a result of the patients physical disability. Professionals need to acknowledge this with carers and to bear in mind the protection afforded them by their professional relationship and their ability to leave the treatment facility at the end of the day. Perhaps it is when the patient no longer resembles the person they once were, as well as being almost totally dependent upon carers for assistance with many routine tasks, that carers may begin to question the patient's quality of life.
Ethical issues

The quality of a person's life would appear to be inextricably linked to any assessment of the viability of living of an individual. Morison (1971 p 63-64) argues that "as the complexity and richness of the interactions of an individual human being wax and wane, his value can be seen to change in relation to others values .... the life of the dying patient becomes steadily less worth living or preserving. The pain and suffering involved in maintaining what is left are inexorably mounting, while the benefits enjoyed by the patient himself, or that he can in any way confer on those around him, are just as inexorably declining. As the costs mount higher and higher and the benefits become smaller and smaller, one, may well begin to wonder what the point of it all is".

The manifestations and cognitive sequelae of stroke (especially when leading to multiple infarct dementia) raise issues regarding the ethical principles of autonomy, nonmalefience, and beneficence. Autonomy refers to an individual's right to make volitional, proactive, and informed decisions. Nonmalefence reflects an injunction to do no harm, while beneficence implies an active duty to do good and to act in the best interests of the other. It is possible that these principles conflict when considering the care of the demented or severely cognitively impaired stroke patient, as they do for other neurological disorders such as the traumatically brain injured or multiple sclerosis sufferer.

Particularly in the later stages of dementia, the family may function as surrogate decision makers for the patient, which requires mutual and honest information sharing between families and professionals. The issue of confidentiality is raised, as surrogacy will necessitate staff to disclose information to family members they would not do so in a general medical setting. It is important that professionals handle this sensitively and do not patronise the patient. Although their cognitive abilities may have been compromised, they deserve dignity and respect, for they are adults who nonetheless have a lifetime's experience behind them. Surrogacy is closely linked to the principle of autonomy, and as with informed consent relies upon four components: disclosure of
information, comprehension of information, voluntariness, and the competency of the decision maker.

The two standards for surrogate decision making are those of substituted judgement and best interest. The former presumes that the surrogate has some knowledge of the patient's values, goals and wishes and can employ them to preserve the patient's autonomy. The latter requires the surrogate to do that which, from an objective standpoint, would seem to promote the patient's good regardless of the patient's actual or supposed preferences. Of ethical interest in surrogate consent for treatment by carers is whether or not all four elements of consent can be satisfied. For example, the surrogate may be a rational individual to whom information is appropriately disclosed by the professionals. And yet, the surrogate's typical ignorance of the nature of cognitive impairment and/or dementia can compromise both the surrogate's understanding of disclosed information and the voluntariness of consent. Coupled with their anguish and psychological need to either deny the information or to hope for an incorrect diagnosis can influence the decision making process. Another potential issue in surrogacy is deciding who can best serve as surrogate. Any conflict between family members over this can create distress and confusion to the professionals involved.

During the early stages of dementia the patient is likely to demonstrate intermittent competence, and this can lead to ethical dilemmas arising from a struggle between acting beneficiently and fostering the patient's autonomy. It is important to ensure that carers do not believe that the patient is lacking "will power" to improve. Professionals should, wherever possible identify with behavioural specificity, those tasks and skills in which the patient has sufficient competence to function autonomously. This will need regular reviews in order to accommodate any further deterioration in cognitive functioning the patient may sustain.

A carer has rights to autonomy, against which they must balance their self generated expectations of moral duties toward the patient. A family must question how far it can extend beneficence to its severely cognitively impaired family member without excessively violating the autonomy of other family members. These ethical conflicts
over the limitations of obligation are among the most difficult for carers to resolve. Provision of day and respite care facilities play an important role in supporting the carers. However, there may come a time when the carer feels unable to cope with the demands made upon them by a very vulnerable and needy, demented patient. At this point, the patient may well be admitted to a residential nursing home. Whatever arrangements are made, the question of the viability of living remains unanswered. The Voluntary Euthanasia Society's (1992) principle object is to "promote legislation which would allow an adult person, suffering from severe illness for which no relief is known, to receive an immediate painless death if, and only if, that is their expressed wish". The two most important criteria are the intolerable nature of the condition and it's incurability. The voluntary element is fundamental in the case of adult patients who are capable of communication, but in many other cases it can not apply. Much of the debate has centred upon painful terminal illnesses or patients in persistent vegetative state. However, the issue has also arisen in the case of Acquired Immuno Deficiency Syndrome (AIDS). AIDS sufferers in Amsterdam are able to use euthanasia or assisted suicide to end their lives, as doctors are not prosecuted if certain conditions are met (e.g. the patient is incurable, in severe suffering, and repeatedly requests euthanasia). For most of such patients the main reason for choosing euthanasia is not pain but fear of the loss of dignity, the associated fear of dementia and the wish not to become dependant. But what of dementia sufferers?

The British Medical Association Handbook of Medical Ethics (1980) says little that could be applied directly to dementia. "The doctors basic duty is to preserve life and there is no rigid code by which such considerations as quality of life can be considered when deciding appropriate treatment". Thus, the medical profession appears paternalistic in it's assertion that the problems of senility are fundamentally medical, that the decisions are medical and that the patient's prior written opinion is not relevant. The medical profession understandably fears possible legal entanglements and questions the ability of doctors to interpret prior written statements at the time of a senile illness at a particular point in the clinical course. There is also concern that an
elderly person might be easily coerced by a relative into signing a document unwillingly.

It would seem that "as our skill in simulating the physiological processes underlying life continues to increase in disproportion to our capacity to maintain its psychological, emotional, or spiritual quality, the difficulty of regarding death as a single, more or less coherent event, resulting in the instantaneous dissolution of the organism as a whole, is likely to become more and more apparent". (Morison, 1971 p62). However, at the present time the jury is out on the issue of Euthanasia, especially for one of the most "silent" groups; that of the elderly demented patient. It is of small comfort indeed to assume that the patient themselves feels little or no distress at their condition, and that it is the relatives who endure the greatest suffering. Scarcity of financial resources in the National Health Service raises the issues of prioritisation and need. Residential nursing care, especially if registered to take in the elderly mentally ill as patients, is expensive compared to general nursing homes. The number of elderly people is growing, and the pressure placed on funds is consequently greater. Some people may well see beyond the emotional significance of euthanasia, to its potential for financial deliverance for the National Health Service. As the use of advanced directives, which represent the patient's settled wish regarding treatment choices when the patient may no longer be able competently to express a view, increases along with the growing numbers of dementing patients the pressure to address this growing ethical problem will increase. Fundamental to the discussion will be the issues of the quality and the sanctity of life, alongside consideration of the individual's autonomy to determine their own death.
References


Clinical Chapter

Over the course of training I have successfully completed four core placements in adult mental health, learning disabilities, child and adolescent services and older adults. Each core placement involved spending three days a week on placement for six months. I then undertook two specialist placements lasting seven months. Two and a half days a week were spent at a community drug and alcohol team. The other half day was spent doing adult mental health work at the psychology department in Worthing.

For further detailed information of the range of my experience and of my performance on clinical placements, please refer to the log books and placement evaluation forms in the appendix section of this chapter.

Also included in this chapter are copies of my placement contracts and summaries of each of the five clinical reports submitted in full, but not included in this public document.
Mr S, an obese and depressed young man, was referred by a Consultant Psychiatrist in order to establish a psychological approach, involving Mr S in examining his eating habits and exploring his thoughts and feelings about his current difficulties. Throughout his childhood, Mr S alternated between feeling loved and rejected. He internalised his father's absolute, perfectionist standards and often felt a failure as he rarely achieved his own ambitious goals. He described being a sad, lonely little boy who found comfort in food.

The Cognitive-Behavioural Model was used to approach both his severe depression and obesity. This involved explaining Beck's Cognitive Model of depression to him, and getting him to record his negative automatic thoughts. Unfortunately, we were unable to focus on the concept of challenging automatic thoughts, as the individual work had to be suspended once joint therapy sessions with his wife were instituted. Nevertheless, he seemed to have grasped the main thrust of the cognitive approach by then, and was given a number of useful handouts which detailed this approach and he could refer to in the future.

Within the individual sessions we also talked about healthy eating. In particular, we discussed caloric balance, nutrition and the health risks associated with obesity. The importance of self-monitoring and his keeping accurate records of his eating habits was emphasised. In order to provide stimulus control, I talked about behavioural strategies he can use to his advantage: for example, he was advised to always eat his meals at the dining table and not to be distracted by reading or watching the television at the same time as eating. In conjunction with his negative automatic thoughts we looked at what he might say to himself after a 'binge' that would be helpful, and enable him to avoid the abstinence violation effect.
By using his diary entries, Mr S was able to identify unhelpful eating patterns and to introduce gradual, manageable increases in his level of exercise. The aim was to educate and encourage Mr S to aim for slow, gradual and permanent weight loss.

The outcome of the work was that Mr S found the cognitive-behavioural approach helpful and empowering in relation to both his difficulties. He learned the necessary skills and was better equipped to recognise and challenge his negative automatic thoughts. His Beck Depression Inventory score improved from a pre-treatment high of 38 to a post treatment score of 19. He also benefited from the stimulus control teaching, which he said enabled him to discriminate 'boredom \ comfort' eating from physiological hunger.Aside from his individual work, therapy identified the major difficulties in his marriage and relationships with his step children. This resulted in co-joint sessions and referral to family therapy.
Miss X was referred by the Consultant Psychiatrist from the in-patient adolescent unit for individual therapy to address her long standing problems with low mood, self esteem and self-harming behaviours.

Miss X sustained multiple emotional, physical and sexual abuses throughout her childhood and early adolescence. She was used to being treated badly and believed this to have been her own fault. As she said 'I'm so used to people hating me that I can't think why people would like me'. As well as anticipating hatred from others Miss X hated herself. This manifest itself in her negative automatic thoughts, bulimia and self harming behaviours (cutting and overdosing). During childhood she learned to become passive and numb to her pain. Such behaviour had been protective then, but now made her vulnerable to further abuse. It would be important for us to acknowledge the horror of her past but to also look at her present experience on the unit, and what she can do to take care of herself in relationships now.

Because Miss X saw nurse Y to carry out disclosure work, I decided to meet the nurse on a weekly basis to share information and to lessen the likelihood or impact of any splitting by the client into one of us being 'all good' and the other 'all bad'. Miss X was informed about these meetings and was informed that they were necessary for such joint work to be feasible. She agreed to this.

A Personal Construct Therapy Approach was taken and involved Miss X to drawing and talking about the various 'roads of life' that she metaphorically travelled on. When relevant we would talk about specific observable behaviours which can be used by her to decide how much to trust people in the future. Occasionally it was possible to directly challenge some of her negative automatic thoughts by requesting evidence I knew she could not provide.
The sessions achieved a number of positive outcomes. Firstly, Miss X chose the focus of the work and respected the boundaries between the two types of therapy input she received. We established a trusting, collaborative working relationship in which she explored a number of important issues. Through this she developed greater self-awareness, and the ability to ask for help when she needed it. In particular, she could discriminate between when she trusted herself to stay safe and when she did not. This resulted in a reduction in the frequency of her cutting from every day to twice in ten days. She also began to acknowledge the scary side of control, and her use of bulimia and overdosing provide her with a 'manageable' sense of control. Through disagreeing with me and setting the agenda of the sessions, Miss X experienced another form of control. She was also able to identify her part in her difficulties in relating to people. This represents a considerable shift away from closing her eyes and praying for the best to getting angry and standing up for herself on the unit.
Older Adults Clinical Report

J had been seen by two consecutive senior house officers on a monthly basis for supportive psychotherapy since July 1993. The third senior house officer to see him, referred him to psychology because she felt that 'a more structured and focused approach with one therapist would be of more benefit to him.'

Although J presented himself to the outside world as confident and proud, inwardly he felt inadequate and a failure. His self esteem was debilitatingly low. He had spent most of his life working hard and serving the needs of his colleagues. He found it hard to be assertive, and had been taken for granted and underpaid. Now he was retired he spent time ruminating on past mistakes and berated himself mercilessly. Whilst he wanted to do things with his wife, she avoided spending time with him. Essentially the marriage had never been a happy one and they stayed together for financial reasons. J's scores on the Beck Depression Inventory and the Beck Hopelessness Scale (24 and 18 respectively) indicated a severe level of depression and hopelessness.

I tape recorded and transcribed every session in order to focus on the process of therapy. Working within the Client Centred Model, the following three core issues arose and were explored. First, his low self esteem and fear of rejection. By providing a regular time and place for the sessions, and paying close attention to what he talked about, I was able to communicate my regard for him and, the value and importance I placed on our work. I kept strictly to the session time and I avoided giving him reassurance when he spoke poorly of himself. The second issue was that of his preference for being second in command. Once J trusted me and felt able to disclose his fear and sadness, he was able to give up his presentation of the expert solicitor for longer and longer periods of time. However, I thought it important that as well as feeling safe in that role, he was telling himself about his strengths and specialist knowledge.
He seemed to be remembering and working through his adult life to make sense of his post retirement life. If he was no longer a solicitor who was he? I tried to facilitate his awareness of his other skills and qualities in relation to his grandchildren in particular. It was also important to avoid colluding with his desire to relate to me as an expert who could give him the answers. I explained my facilitative role several times, and his comments on ending reveal that he had understood my part in the therapy process. The third issue was that of coping with negative emotions. One formulation of J's difficulties was that he would not express his anger directly for fear of rejection, so instead he turned his anger inwards and felt depressed and guilty. He denied ever feeling angry. With time he was able to disagree with me, either directly with words or indirectly by inaction between sessions.

Although his post therapy scores on the Beck Depression Inventory and the Beck Hopelessness Scale (24 and 17 respectively) have not altered in quantitative terms, there has been a shift of emphasis. For instance, after therapy he recorded feeling less guilty and no longer feels he may be punished. He also felt that he could look forward to more good times than bad times. He was able to acknowledge his own hard work and achievement from the sessions and did appear more at peace with himself.
Neuropsychological Report

The counsellor who had been seeing this depressed lady for four months referred her for a cognitive assessment because of her client's confusing and inconsistent reporting of events. The counsellor wanted her suspicion that there was an organic dysfunction underlying her client's difficulties investigated systematically.

From the copies of correspondence sent to and from the counsellor and G.P., which were included with the referral letter, I identified a number of issues that would need to be investigated during the assessment. These were:

1) Her relationship with her husband.
2) The role of clinical depression in her presentation, in particular the possible impact of several important losses she sustained a year earlier.
3) The role of any organic dysfunction in her presentation, in particular discriminating between depression and dementia.

I drew upon neuropsychological knowledge and tests and used the following measures in order to investigate her current level of functioning. The Wechsler Adult Intelligence Scale - Revised., The National Adult Reading Test., Raven's Coloured Progressive Matrices., Visual Cancellation Tasks., The Rivermead Behavioural Memory Test., Recognition Memory Test., Middlesex Early Assessment of Mental State., and the Wisconsin Card Sorting Test.
The outcome of the assessment revealed that her neuropsychological functioning is impaired. In particular her memory is severely impaired. The global difficulties found across verbal and visual tests suggests diffuse brain damage rather than a focal difficulty in one of the hemispheres. A number of hypotheses were proposed to explain her results. The emotional component hypothesis suggested that her performance anxiety and her feelings of inadequacy contributed to her depressed scores. The interactional component hypothesis proposed that the type of relationship that she and her husband have reinforces her feelings of inadequacy and helplessness. Because of her husband's tendency to take charge, this makes it difficult to ascertain precisely what areas of competency she exercises fully and those she surrenders to her husband because she can not do them or because she recognises he needs to be busy and in charge. The third and final hypothesis identifies her consistently low scores as evidence of an organic impairment, which may have been exacerbated by her recent losses. In order to gain insight into the course of her difficulties, it was recommended that a repeat investigation is given in a year's time. Comparison between the scores would then elucidate whether her condition is progressive or not.
Specialist Placement Clinical Report

P referred himself to the community drug team for help with his drug problem. He had a long standing (15 years) addiction to opiates, and a history of numerous detoxification's and relapse. Underlying his drug problem were the following issues:

1) poor responsibility awareness
2) low self-esteem and poor assertiveness skills
3) incomplete awareness of internal and external triggers to his drug use

A non-directive Client Centred Model was adopted. This allowed P to assume greater responsibility within the sessions. The therapist stance of neutral, helpful curiosity enabled P to explore some of the reasons surrounding his drug use. He learned to look at himself and reflect upon his actions. From this process, a number of potential triggers were identified and P learned to discriminate between his feelings. Ultimately, his self-esteem and feelings of self-efficacy increased. He became more assertive and assumed greater responsibility awareness. Possibly for the first time he became aware of what he wanted for himself.
Clinical Chapter Appendix
PLACEMENT CONTRACT

Placement
Adult Mental Health
First year (core) placement

Duration
15 October 1993 - 31 March 1994 inclusive

Trainee
Roberta Fry

Supervisor
Elspeth Bawtree

Aims of the placement -
To provide a range of experience of services to adults with psychological problems sufficient to allow the trainee to develop competencies for dealing with this group.

Objectives -

Assessment :

Trainee -

1. To be able to conduct an assessment interview, selecting appropriate measures, and to produce a formulation based on this.

2. To be able to conduct formal psychometric assessments, using a range of agreed tests, and to score and interpret these.

3. To be able to write up an assessment in the appropriate form depending on the purpose of it and the person to whom the results are being communicated.

Supervisor -

1. To ensure that the trainee is provided with a suitable number and range of individuals to achieve 1 - 3 above.

Contd/-.
Therapy -

Trainee -

1. To be able to establish rapport and use appropriate skills, both verbal and non-verbal, to facilitate the therapeutic relationship.

2. To be able to formulate the individual's problems in psychological terms and select the appropriate intervention.

3. To be able to explain the proposed intervention in easily understood terms and obtain the individual's active participation in the therapeutic process.

4. To be able to monitor and evaluate the progress of the individual in therapy.

5. To be familiar with cognitive-behavioural approaches to problems.

Supervisor -

1. To ensure that the trainee is provided with a suitable range and number of individuals to meet the University's requirements and achieve the above.

2. To provide a grounding in a cognitive-behavioural approach.

Teaching/Training:

Trainee -

1. To be able to present a case or paper at a Departmental meeting.

2. To be able to explain a therapeutic approach to a member of another profession/provide basic training in a behavioural approach.

Supervisor

1. To ensure that the trainee is provided with the opportunity to achieve the above.

2. To provide regular supervision or ensure such supervision in speciality areas to meet the requirements of the University.

3. To ensure that the trainee has study time allocated.
Research -

Trainee -
1. To undertake any research projects required by the University.

Supervisor -
1. To facilitate the achievement of the above.

Professional -

Trainee -
1. To read and adhere to the B.P.S. guidelines for professional practice; Departmental policies and procedures; and Trust policies and procedures.
2. To attend Departmental meetings and Trust-wide psychology meetings.
3. To attend relevant other meetings or special interest group meetings.

Supervisor -
1. To ensure easy access to policies and procedures.
2. To inform the trainee of relevant meetings.

Administrative:

Trainee -
1. To carry out routine administrative duties connected with the provision of a clinical psychology service in line with Departmental and Trust policies and procedures - for example, note-keeping, completing Korner returns, writing up diaries, etc.

Supervisor -
1. To provide appropriate facilities e.g. secretarial assistance to achieve the above.

Ref: EB/EI Roberta Fry 24/11/93
(d dictated 12.11.1993)

22 November, 1993
(d dictated 12.11.1993)
EVALUATION OF THE TRAINEE ON PLACEMENT

TRAINEE NAME: ROBERTA FRY.

PLACEMENT TITLE: ADULT MENTAL HEALTH

PLACEMENT DATES: 15/10/93 → 22/04/94  No. of DAYS 81

SUPERVISOR NAME: MRS. ELSPEITH BOWTREE

PLACEMENT ADDRESS:
- HOMEOOOD NHS TRUST
- HOMEOOOD HOUSE
- GUILFORD ROAD
- CHERTSEY
- KT16 0QA

OVERALL RATING FOR THE PLACEMENT

In the supervisor's opinion, has the trainee reached the standard expected to pass the placement?

<table>
<thead>
<tr>
<th>RATING</th>
<th>COMMENT</th>
<th>TICK</th>
</tr>
</thead>
<tbody>
<tr>
<td>3</td>
<td>YES - PASS</td>
<td>✓</td>
</tr>
<tr>
<td>2</td>
<td>YES - CONDITIONAL PASS: The trainee has gaps in experience that need to be addressed later in training</td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>YES - CONDITIONAL PASS: The trainee needs to focus on specified areas of clinical skills in subsequent placements</td>
<td></td>
</tr>
<tr>
<td>0</td>
<td>NO - The trainee has not reached the standard expected</td>
<td></td>
</tr>
</tbody>
</table>

General Comments from Supervisor:
A good first placement. Roberta has worked hard and developed good core skills on which to build in the future. She has been an active member of the department, bringing ideas which have contributed to our knowledge and practice as well as learning from this experience.

Signed __________________________ (Supervisor) Date 29/4/94

Comments from the trainee: I have acquired a good grounding in the application of the cognitive-behavioural approach to psychological problems, along with increasing my knowledge and understanding of adult mental health problems. It was an excellent placement.

Signed __________________________ (Trainee) Date 29/4/94
<table>
<thead>
<tr>
<th>SUPERVISOR - TRAINEE RELATIONSHIP</th>
<th>RATING</th>
<th>Explanation/Expansion of Rating/Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>The supervisor may raise questions or present options for the trainee to consider, but usually the trainee can present plans and make decisions on how to proceed which they have devised independently.</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>The trainee does not usually require observation, monitoring or detailed questioning to maintain the standard of work, but this is used to 'fine tune' skills. The trainee self monitors and identifies the need for assistance in normal circumstances.</td>
<td>3</td>
<td>/Rosa has proved herself extremely good at monitoring his work and asking for support for advice as appropriate. She functions with a high level of autonomy.</td>
</tr>
<tr>
<td>The trainee shows a balance between autonomy and the use of support and advice which is appropriate to their level of skills, the client and the service setting.</td>
<td>3</td>
<td></td>
</tr>
</tbody>
</table>

In your opinion, does the trainee reach the standard expected:

- 3 YES - Above expected level - please expand
- 2 YES - At expected level - please expand
- 1 NO - Borderline - please expand
- 0 NO - Please explain
- N/A Not applicable
<table>
<thead>
<tr>
<th>THE DEVELOPMENT OF COMPETENCY IN THE USE OF SCIENTIFIC METHOD</th>
<th>RATING</th>
<th>Explanation/Expansion of Rating/Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.1 The trainee can convert presenting problems into questions that can be delineated within a psychological perspective and with measurable solutions.</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>1.2 The trainee has good knowledge of the range of assessment procedures available and is able to choose the appropriate one to use in straightforward situations.</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>1.3 to 1.6 The trainee carries out procedures and collects information in an objective way, yet retains a sensitive stance with clients and is able to recognize factors that limit the reliability and validity of assessment.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.3 Psychometric measurement</td>
<td>3</td>
<td>Roberta had a good grounding in psychometric assessment from her degree with a was able to utilise that to underpin the assessments later.</td>
</tr>
<tr>
<td>1.4 Other formal psychological assessments</td>
<td>2</td>
<td>No experience available</td>
</tr>
<tr>
<td>1.5 Behavioural/observational assessments &amp; functional analysis</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>1.6 Other assessments</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>1.7 The trainee separates fact from interpretation, can integrate information from a variety of perspectives, compares and contrasts models; devises a formulation independently that encompasses multifactorial elements.</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>1.8 The trainee can devise a realistic and appropriate intervention plan based on an appropriate therapeutic model.</td>
<td>2</td>
<td></td>
</tr>
</tbody>
</table>
1.9 The trainee can plan an overall intervention strategy, evaluate progress, re-formulate and modify the intervention plan.

1.10 Evaluation of clinical interventions: the trainee understands the importance of evaluation in clinical work; chooses and uses appropriately common methods and can modify measures for a new situation.

<table>
<thead>
<tr>
<th>In your opinion does the trainee reach the standard expected:</th>
</tr>
</thead>
<tbody>
<tr>
<td>3 YES - Above expected level - please expand</td>
</tr>
<tr>
<td>2 YES - At expected level - please expand</td>
</tr>
<tr>
<td>1 NO - Borderline - please explain</td>
</tr>
<tr>
<td>0 NO - Please explain</td>
</tr>
<tr>
<td>N/A Not applicable</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>THERAPY AND INTERVENTION SKILLS</th>
<th>RATING</th>
<th>Explanation/Expansion of Rating/Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.1 The trainee takes overall responsibility for action in relation to routine client matters such as making appointments, setting up meetings with colleagues etc.</td>
<td>3</td>
<td>Roberto is well organised and very quickly took responsibility for organising his clinical and other activities without the need for checking or monitoring.</td>
</tr>
<tr>
<td>2.2 The trainee can handle unplanned and unexpected events in a therapy session in an effective and controlled way to the benefit of the client, referring back to the supervisor subsequently.</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>2.3 The trainee engages the client, communicates appropriately to them, demonstrates awareness of what is clinically relevant and is sensitive and flexible in applying techniques. This particularly applies to clients from different cultural or ethnic backgrounds, or at different levels of intellectual ability.</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>2.4 Communication of psychological information or opinion. The trainee can present psychological information or opinion to clients, relatives and/or carers and staff effectively, modifying language appropriately, using the appropriate style and addressing concerns raised in a facilitative manner.</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>2.5 Interviewing: The trainee interviews clients effectively and appropriately, keeps control of the session, keeps to a structure yet allows the client to express their own issues.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>---</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.6 to 2.10 The trainee demonstrates effective therapy skills both at a general level and in the use of particular models; the supervisor gives feedback primarily to 'fine tune' their skills.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.6 Individual therapy work:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.7 Therapy work with couples:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.8 Therapy work with families</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.9 Directive/behavioural groups:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.10 Non-directive/psychotherapeutic groups:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.11 Indirect client work: The trainee demonstrates effective skills both at a general level and in relation to the particular requirements of the setting; the supervisor gives feedback primarily to 'fine tune' their skills.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.12 Client work within a formal system (such as ipp): The trainee demonstrates effective skills both at a general level and in relation to the particular requirements of the system; the supervisor gives feedback primarily to 'fine tune' their skills.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

In your opinion does the trainee reach the standard expected:

- 3 YES - Above expected level - please expand
- 2 YES - At expected level - please expand
- 1 NO - Borderline - please explain
- 0 NO - Please explain
- N/A Not applicable
<table>
<thead>
<tr>
<th><strong>THE DEVELOPMENT OF PROFESSIONALISM</strong></th>
<th><strong>RATING</strong></th>
<th><strong>Explanation/ Expansion of Rating/Comments</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>3.1 The trainee knows the background, structure and future trends of the profession that underlie the work of clinical psychologists sufficient to relate it appropriately to the placement.</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>3.2 The trainee understands the history, philosophy, structure, working rules and procedures that relate to the particular placement.</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>3.3 The trainee demonstrates effective work management skills (time management, record keeping, reliability and administrative independence).</td>
<td>3</td>
<td>Restated has good organisational and self-monitoring skills but was able to demonstrate both these attributes.</td>
</tr>
<tr>
<td>3.4 The trainee demonstrates self management skills (awareness of skill limitations when overworked, stressed or needing personal support).</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>3.5 The trainee presents in a professional way to the client and maintains a proper and effective therapeutic relationship, maintaining an over-riding concern for the client’s interests, an awareness of the boundaries of competence and of ethical and procedural guidelines that apply.</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>3.6 Equal opportunities/equality of access: The trainee understands the importance of these factors in service provision within the health and social services and addresses them within their work, particularly in relation to attitudes and skills in client work.</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>3.7 The trainee presents well and relates effectively to colleagues both in psychology and elsewhere within the NHS and other agencies.</td>
<td>3</td>
<td>Restated shows excellent interpersonal skills and related well to others within the organisation, both within and outside the psychology service.</td>
</tr>
<tr>
<td>3.8 The trainee makes a positive contribution in verbal communication, presents material clearly, concisely and well structured, can separate fact from interpretation, incorporate information and opinions from others, can argue effectively and negotiate to a satisfactory outcome in normal circumstances within the placement.</td>
<td>2</td>
<td></td>
</tr>
</tbody>
</table>
3.9 The trainee presents material clearly and concisely in written communication, and makes good use of structure; separates fact from interpretation and relevant from irrelevant material; has a flexible style depending on the needs of the recipient.

<table>
<thead>
<tr>
<th>RATING</th>
<th>Explanation/Expansion of Rating/Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td></td>
</tr>
</tbody>
</table>

3.10 The trainee demonstrates an understanding of the range of roles that psychologists might undertake, such as teaching, supervision, consultancy, research project work and service development.

<table>
<thead>
<tr>
<th>RATING</th>
<th>Explanation/Expansion of Rating/Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td></td>
</tr>
</tbody>
</table>

In your opinion does the trainee reach the standard expected:

3 YES - Above expected level - please expand
2 YES - At expected level - please expand
1 NO - Borderline - please explain
0 NO - Please explain
N/A Not applicable

<table>
<thead>
<tr>
<th>THE DEVELOPMENT OF AWARENESS AND COMPETENCE IN SERVICE AND ORGANISATIONAL ISSUES</th>
<th>RATING</th>
<th>Explanation/Expansion of Rating/Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>4.1 The trainee demonstrates a balanced and realistic awareness of how organisational factors impinge on client work both directly and through staff practices.</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>4.2 The trainee works appropriately and effectively within the boundaries and constraints of organisations and settings.</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>4.3 The trainee works appropriately and effectively within the boundaries and constraints of a multi-disciplinary team.</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>4.4 The trainee understands, and is knowledgeable, in relation to the skills and work practices of other professions and other staff groups.</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>4.5 The trainee is able to analyse and describe, with some independence, some psychological processes active within groups, settings or organisations.</td>
<td>2</td>
<td></td>
</tr>
</tbody>
</table>
4.6 The trainee is able to describe, with some level of independence, the psychological skills and methods required to produce change within groups, settings or organisations.  

4.7 Presentation: The trainee prepares the material in terms of structure and content, relevant to the needs of the audience; displays effective verbal and non-verbal skills; shows effective use of time; chooses appropriate style (didactic or facilitative) relevant to the audience.  

4.8 Teaching: The trainee prepares the material in terms of structure and content, relevant to the needs of the audience; displays effective verbal and non-verbal skills; shows effective use of time; chooses appropriate style (didactic or facilitative) relevant to the audience. The trainee chooses assessment and evaluation materials.  

4.9 If the trainee has undertaken work in any of the following areas, please tick and briefly describe the work, and comment on the skills used and level of expertise displayed:  

- consultancy

- supervision  

- project work  

- service development work  

In your opinion does the trainee reach the standard expected:  

3 YES - Above expected level - please expand  

2 YES - At expected level - please expand  

1 NO - Borderline - please explain  

0 NO - Please explain  

N/A Not applicable
<table>
<thead>
<tr>
<th>THE SHIFT TO WORK BEING GROUNDED IN PSYCHOLOGICAL PRINCIPLES FROM BEING ORIENTATED IN RELATION TO SPECIFIC TECHNIQUES</th>
<th>RATING</th>
<th>Explanation/Expansion of Rating/Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>5.1 The trainee is able to perceive issues from different perspectives; draws information from a variety of sources and develops it into an individualised framework; can see how facts can be conceptualised in different ways - using supervisor primarily as a sounding board for own thinking processes.</td>
<td>3</td>
<td>Rasha is good at utilising information from different sources to understand his formulation and treatment approaches.</td>
</tr>
<tr>
<td>5.2 The trainee approaches work from a theoretical stance with a broad vision of the general applicability of principles of practice, integrating theories from general psychology and those specific to settings or client groups.</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>5.3 Generic skills: The trainee draws on therapeutic skills techniques and methods from the range of client groups, and uses them with appropriate modifications for the individual client.</td>
<td>2</td>
<td></td>
</tr>
</tbody>
</table>

In your opinion does the trainee reach the standard expected:

- 3 YES - Above expected level - please expand
- 2 YES - At expected level - please expand
- 1 NO - Borderline - please explain
- 0 NO - Please explain
- N/A Not applicable
Supervision Contract for Learning Disability Placement at Homewood NHS Trust

Psychologist in Clinical Training: Roberta Fry
Supervisor: Rosamund Roach

1. Introduction to services available to people with learning disabilities.

: Time spent observing the work of the following professionals.
Speech Therapy, Occupational therapy, Physiotherapy, Music Therapy, Consultant Psychiatrist, Community Nurse, Social Worker.

: Experience of observational shift working in different residential settings.
Home for people with severe LDs and physical handicaps.
Home for people with mild learning disabilities.
Behavioural Unit.

: Visit to a Day Centre for people with LDs/ and Adult Education service for people with LDs.

2. Assessment of clients with learning disabilities.

2.1 Intellectual Assessment

: To be introduced to a range of ways of assessing cognitive functioning

: To assess clients using at least two tests, WAIS-R, Leiter

2.2 Assessment of Adaptive Skills

: To be introduced to a range of different assessment tools

: To assess client using at least two different tests, Hampshire Assessment of Living with Others (HALO) and Adaptive Behaviour Scale ABS Part (i)
2.3 Assessment of Behavioural Problems

: To be introduced to a range of different assessment tools

: To carry out assessments using Computer Observation Packages, Record Charts and Scale of Behavioural Problems ABS Part (ii)

: Conduct an Analogue Assessment

2.4 Assessment through clinical interview

Use of questionnaires, videotaped role plays etc.

3. Exposure to work with clients.

3.1 Different ages and/or stages of the life cycle

adolescents

young adults

middle age

older people

3.2 Different cultural and/or ethnic background

3.3 Different levels of functioning

mild

moderate

severe

profound & multiple handicap

3.4 Different problem areas

Intervention to include

Assertiveness Training

Anger Management
Skills Training

Behavioural Problem Management

Issues of residential placement

Roberta will work with at least two clients on 1-1 basis, and one family and jointly run a group in addition to indirect work with carers.

4. Teaching

Roberta will prepare a seminar for the department.

5. Supervision

5.1 Roberta will have a minimum of 1½ hour supervision each week with her main supervisor and a minimum of 3 hours contact with supervisor each week.

5.2 It is expected that supervision will cover discussion of the following:

- clinical work
- academic issues
- organisational issues
- emotional impact of the work

5.3 Method of supervision

- presentation of work
- direct observation of trainee
- possible use of videotape and audiotape material

ROBERTA FRY
CLINICAL PSYCHOLOGIST IN TRAINING

ROSAMUND ROACH
CHARTERED CLINICAL PSYCHOLOGIST

Date 25.05.94
UNIVERSITY OF SURREY / S W T R H A

M Sc in Clinical Psychology

Trainee's name: Robert Fry

Placement Type: People with Learning Disabilities

Date: 29th April - 28th Oct '94

Supervisors Name: Rosamund Reach

Placement District: North West Surrey

Summary of Clinical Activity

Please indicate at the end of your placement what you have covered under the following seven categories:

(1) Clinical activity with individual clients, couples & families (use attached sheet C)

(2) Group work - use attached sheet B

(3) Teaching/Skills transmission/Presentations

Outline each experience of teaching, indicating what, to whom how organised, the extent of your role and its degree of success.

15th Aug '94: I presented the main findings of the joint HANS assessment I carried out at a case plan review meeting. Those present were the 2 clients, their parents, case managers, home leader, social worker and representatives from the council.

13th Sept '94: I described and explained a behavioural programme to nursing staff. Considerable time was spent obtaining their views in order to provide evidence as to why the programme should be implemented.

(4) Organisational Work (eg: developing IPP system, staff support, assessing case recording system). Outline each piece of work, indicating the extent of your role and outcome.

6th Oct '94: I described and explained a behavioural programme to nursing staff; and organised for the occupa Therapist to attend so that she could demonstrate how to work with the client on activities. I ran this "workshop approach" twice.

11th Oct '94: I gave the following presentation to the Psychology Department: "Gentle Teaching: A critical review", with producing handouts and evaluation forms. The presentation was designed to facilitate discussion.
5. RESEARCH

Outline any projects which you initiated or with which you were involved and indicate the extent of your involvement.

6. MEETINGS, VISITS, OBSERVATIONS

Outline briefly each experience and the extent of your involvement.

21st April 1994: Attended Community Team meeting; which included presentations by Nursing, Psychiatry, Social work, Occupational Therapy, Speech and Language therapy, Physiotherapy and Clinical Psychology.

1st May 1994: Visited a home for people with mild learning disabilities and helped out during part of an evening shift. (4:30 → 8pm)

12th May 1994: Observed “Rebound Therapy”. (A treatment offered jointly between Physiotherapy and Occupational Therapy).

13th May 1994: Went out with a Social Worker for the morning to see their work and learn about their role in a team.


17th May 1994: Observed my supervisor interview a member of staff about a client referred for temper tantrums.

18th May 1994: Visited a home for people with severe learning disabilities (all aged 65 years and over) and helped out during part of a morning shift. (7:30am → 10am)

19th May 1994: Went out with Community Nurse to see their work and learn about their role in a team. (visited a number of Asian families to gain further experience of working with people from ethnic minorities)

25th May 1994: Observed a “Talk About” group facilitated by a Speech Therapist. (A group of 16 mildly ID clients discussing issues associated with their worry to move to a small group home for the 4 of them. They currently live in a 2 bedded unit)

26th May 1994: Observed a “Self Advocacy” Group facilitated by Occupational
Learning disabled male, his mother and sister at their home. Included discussion of confidentiality, what a clinical psychologist does and issues to do with sexual abuse.

9th June 1994: Attended a review meeting for a community client. Rosamund Peach acted as chair.

10th June 1994: Observed Kieran, Hodges interview the teacher of the 16 year old male mentioned above.

16th June 1994: Observed Kieran and participated in the session with the 16 year old client.

16th June 1994: Discussed assessment measures used by speech therapists. Also observed a “Talkabout” group with several learning disabled clients.

17th June 1994: Observed Kieran interview a member of the 16 year old CIU.

For summary of ongoing contact with this family see Appendix C3.

28th June 1994: Visited Cranstock Day Centre.

28th June 1994: Observed Rosamund conduct an interview with a client and her keyworker. Client is mild learning disability as well as suffering from manic-depressive illness.

25th July 1994: Observed a Psychiatrist interview a learning disabled client who also suffers from a psychiatric disorder. (Manic depression).

15th Aug 1994: Attended a case conference/review of care plan for the couple. Assessed using the HAT0. Presented the main findings to those present. (Clients', Home header, Parents, Social Worker, Case Manager).

15th Aug 1994: Observed a Psychiatrist interview a client. Also discussed the role.

16th Aug 1994: Observed a Psychiatrist interview a client. Also observed the role of the Team.

1st Sept 1994: Discussed the range of work carried out by Speech Therapists, or their role in a multidisciplinary Team for people with learning disabilities.

7th Sept 1994: Attended a marathon training session where I practised sign words and simple phrases (Stages 1-3).

8th Sept 1994: Observed Rosamund Peach talk about bereavement with a client and his carer. Also discussed the care plan being drawn up, as a proactive plan prior to the actual loss of his mother.

13th Sept 1994: Discussed the issue of working with parents of clients. The often long and protracted, if not indefinite process of coming to terms with their offsprings disability and its impact on their lives as a family.
26th Sept 1994: Visited the "Snoozeland Centre" and observed for myself how it works. Discussed with staff its applications with both children and adults with learning difficulties.

23rd Sept 1994: Attended a Makaton workshop (No. 4). Learnt stages 1 and 2. Practical use of signs, including those related to feeling such as happy, sad. (Stage 5).


30th Sept 1994: Discussed the cases of 2 elderly clients whom Elaine Al has worked with. Issues pertinent to both their age and learning disability were raised and discussed.

16th Oct 1994: Discussed Advocacy with Jane Cobb, Advocate from the Advocacy Centre. I also arranged for her to give a presentation to the Psychology Department.

23rd Oct 1994: Visited a group home for severely learning disabled clients, which is equipped with Snoezelen sensory equipment. Discussed the staff training programme with the Assistant Psychologist involved in the project.

21st Oct 1994: Attended and participated in a hydrotherapy session. Discussed the role of physiotherapists working in the area of learning disabilities.

7. COURSES AND TRAINING EVENTS ATTENDED AS PART OF PLACEMENT

Please list and outline each one.

Attended "Working with Chronic Populations" training day (20/05/94)
Lecture by Professor Max Birchwood.

Attended a lecture given by Dr. Rachel Perkins. (3/06/94) about Service provision for long-term mentally ill clients in USA.

Watched BBC 'Inside Story': False memory video with members of the 'Adult Psychology Services' and discussed the issues raised. (13/07/94).

Attended workshop run by Clive Skilbeck about Tracing agencies. (29/06/94)
Attended Seminar "Ethnic Differences in Anorexia Nervosa" by Dr. Mazzon Soomee, Senior Registrar, ACU. on the 30th Sept 1994.

8. OTHER

Please outline any other experience on placement.

Visited and "helped out" for a weekend at Lord Mayor Treloar College (residential Special School for up to 290 young people with any kind of physical disability (except totally blind). This often includes Learning Disabilities.

Attended one day workshop of Gestalt Theory. Included Self-aware exercises and Experiential group work. Run by Jenny Stolzenberg an Linda Martin (4/06/94)

Attended Special Interest Group for Psychologists working with People with Learning Disabilities (6/07/94)

Signed. Roberta Fry  Trainee    Date  28th October 1994

Signed. Rosamund Road  Supervisor  Date  28th October 1994
### APPENDIX B - WORK WITH GROUPS

<table>
<thead>
<tr>
<th>Therapists</th>
<th>Your Role (Active/Obsidian)</th>
<th>Membership (Ages &amp; Sexes)</th>
<th>Selection of Members</th>
<th>Nature of Group Work</th>
<th>Number of Sessions</th>
<th>Outcome Evaluation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Robert Fry</td>
<td>Active</td>
<td>55 M</td>
<td>Structured interview confirmed clinical Psychologists speculation that members needed to develop assertiveness skills</td>
<td>Cognitive - Behavioural</td>
<td>10</td>
<td>Good. 3 out of the 5 members acquired new skills in the art of &quot;being assertive&quot;. They also described situations outside the group, when they used them. The other 2 members appeared to enjoy the group, but did not demonstrate assertive behaviour either within or beyond the group.</td>
</tr>
<tr>
<td>Tim Cromwell</td>
<td></td>
<td>26 F</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>47 F</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>46 F</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>39 M</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Supervised by</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rosamund Roach</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
**Appendix C3**

**Clinical Activity with Individual Clients, Couples, and Families - Placement Summary**

<table>
<thead>
<tr>
<th>Ex</th>
<th>Age</th>
<th>Assessment</th>
<th>Intervention</th>
<th>Type of Contact</th>
<th>Presenting Need</th>
<th>Model of Therapy</th>
<th>No of Hours</th>
<th>Outcome/Evaluation</th>
<th>Additional Info/Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>39</td>
<td>Interview</td>
<td>FI</td>
<td>S</td>
<td>Assessment of Cognitive Abilities</td>
<td>-</td>
<td>3</td>
<td></td>
<td>I also liaised with the key worker to set up a training programme with objective, measurable goals.</td>
</tr>
<tr>
<td>2</td>
<td>26</td>
<td>Interview and HALO</td>
<td>FI</td>
<td>S</td>
<td>Assessment of living skills to inform teaching needs. Semi-structured interview re: assessment.</td>
<td>-</td>
<td>5</td>
<td></td>
<td>Excellent. I produced separate reports giving information and recommendations for both partners. As well as a joint report indicating their overall strengths and areas needing further training.</td>
</tr>
<tr>
<td>3</td>
<td>46</td>
<td>Interview and WAIS-R</td>
<td>FI</td>
<td>S</td>
<td>Assessment of Cognitive Abilities</td>
<td>-</td>
<td>2½</td>
<td>Good. Report written giving information and recommendations.</td>
<td>Also interviewed a care worker with client present. I presented findings at a joint care plan review meeting.</td>
</tr>
<tr>
<td>4</td>
<td>33</td>
<td>Assessment (levier International Performance Scale, Digit span, visual and verbal power assessment; auditory verbal learning test.)</td>
<td>FI</td>
<td>S</td>
<td>Produce a report from HALO.</td>
<td>-</td>
<td>16</td>
<td>Good. Client learned self-control skills and gained independence.</td>
<td>A great deal of S's self-esteem was aimed at enabling his mother to begin managing situations by herself. I also gave feedback to her about the findings and implications of the assessment. Interviewed mother to gain background.</td>
</tr>
<tr>
<td>No</td>
<td>Age</td>
<td>Assessment</td>
<td>Intervention</td>
<td>Type of Contact</td>
<td>Presenting Need</td>
<td>Model of Therapy</td>
<td>No of Hours</td>
<td>Outcome/Evaluation</td>
<td>Additional Info/Comments</td>
</tr>
<tr>
<td>----</td>
<td>-----</td>
<td>----------------------------------------------------------------------------</td>
<td>--------------</td>
<td>----------------</td>
<td>-------------------------------------------------------------------------------</td>
<td>------------------------------------------</td>
<td>-------------</td>
<td>----------------------------------------------------------------------------------</td>
<td>--------------------------</td>
</tr>
<tr>
<td>31</td>
<td>31</td>
<td>Interviewed a member of staff who worked extremely well with this client (who has since moved to another unit) interviewed 2 members of staff who work currently with this client. Produced a recording form for staff to note any instances of inappropriate behaviour. Conducted an Analogue Assessment and used the Motivation Assessment Questionnaire. Observation of client's turn taking skills, along with an interview.</td>
<td>FI: IC</td>
<td>S</td>
<td>To devise a programme for staff to manage her inappropriate behaviour. Over time, the consistent application of the programme should reduce the frequency and intensity of the inappropriate behaviour.</td>
<td>Behavioural model drawing on principles of Positive Programming</td>
<td>7</td>
<td>Good. Guidelines were produced which included activity scheduling and the rationale behind this, along with management guidelines for the inappropriate behaviour.</td>
<td>Considerable time was spent “hand over” the guidelines to staff. I worked with an OT who arranged to demonstrate how to do activities with the client.</td>
</tr>
<tr>
<td>46</td>
<td>46</td>
<td>Administered Beck Anxiety Inventory and conducted an assessment interview.</td>
<td>FI: IC</td>
<td>J (with Assistant Psychologist)</td>
<td>To develop clients turn taking skills.</td>
<td>Behavioural</td>
<td>8</td>
<td>Good. Client appeared to enjoy the sessions and started to take turns more readily.</td>
<td></td>
</tr>
<tr>
<td>47</td>
<td>47</td>
<td>Administered Beck Anxiety Inventory and conducted an assessment interview.</td>
<td>FI</td>
<td>S</td>
<td>Provide anxiety management and relaxation training</td>
<td>Cognitive-Behavioural</td>
<td>7</td>
<td>Good. Client's confidence increased and she acknowledged the need for further work into relaxation.</td>
<td></td>
</tr>
</tbody>
</table>
### Clinical Activity with Individual Clients, Couples, and Families - Placement Summary

<table>
<thead>
<tr>
<th>No.</th>
<th>Age</th>
<th>Assessment</th>
<th>Intervention</th>
<th>Type of Contact</th>
<th>Presenting Need</th>
<th>Model of Therapy</th>
<th>No of Hours</th>
<th>Outcome/Evaluation</th>
<th>Additional Info/Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>49</td>
<td>Interview, CAPE ; Ravens Progressive Matrices</td>
<td>FI</td>
<td>S</td>
<td>To establish his current level of cognitive functioning in order to compare it to results obtained 20 years ago.</td>
<td>Cognitive</td>
<td>2</td>
<td>Good. Report written giving the information that there was no evidence of deterioration.</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>37</td>
<td>Read notes and interview staff to obtain background information (e.g. any recent losses) ; Ecological Analysis of his environment ; Observational analysis of behavior using momentary time sampling with MTS programme on a hand held PDA ; Analysis of % time spent engaging in a variety of behaviors to elucidate antecedents and consequences and the possible functions of the behavior.</td>
<td>IC, FI</td>
<td>S</td>
<td>To establish the antecedents and consequences of his stripping behavior. Also to provide recommendations/guidelines for how to reduce, eliminate or even replace this behavior.</td>
<td>Behavioral (utilizing a Positive Programming Approach)</td>
<td>5</td>
<td>Good. A positive programme was devised which included both activity scheduling and management guidelines. A follow up observation suggested that the guidelines were being implemented.</td>
<td></td>
</tr>
</tbody>
</table>
### UNIVERSITY OF SURREY/SWTRHA

**Psych D/MSc IN CLINICAL PSYCHOLOGY**

**EVALUATION OF THE TRAINEE ON PLACEMENT**

**LEARNING DISABILITIES**

<table>
<thead>
<tr>
<th>TRAINEE NAME</th>
<th>ROBERTA FRY</th>
</tr>
</thead>
<tbody>
<tr>
<td>PLACEMENT TITLE</td>
<td>PEOPLE WITH LEARNING DISABILITIES</td>
</tr>
<tr>
<td>PLACEMENT DATES</td>
<td>29th APRIL → 28th Oct 94</td>
</tr>
<tr>
<td>SUPERVISOR NAME</td>
<td>ROSAMUND ROACH</td>
</tr>
<tr>
<td>PLACEMENT ADDRESS</td>
<td>HOMEWOOD RESOURCE CENTRE, GUILDFORD ROAD, CHERTSEY, SURREY, KT16 0QA</td>
</tr>
<tr>
<td></td>
<td>Tel: 0932 872010 ext 2253</td>
</tr>
</tbody>
</table>

#### OVERALL RATING FOR THE PLACEMENT

In the supervisor’s opinion, has the trainee reached the standard expected to pass the placement?

<table>
<thead>
<tr>
<th>COMMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>PASS</td>
</tr>
<tr>
<td>PASS: The trainee has gaps in experience that need to be addressed later in training</td>
</tr>
<tr>
<td>PASS: The trainee needs to focus on specified areas of clinical skills in subsequent placements</td>
</tr>
<tr>
<td>FAIL: The trainee has not reached the standard expected</td>
</tr>
</tbody>
</table>

#### General Comments from Supervisor:

Roberta has been hardworking and enthusiastic whilst on placement and her work has generally been of a very high standard. In particular her work on setting up a funnished analysis, and also some of her reports were excellent. She has missed out on close working part of a multidisciplinary team, due to lack of opportunities.

Signed **Rosamund Roach** (Supervisor) Date 28/10/94

#### Comments from the trainee:

A well organised and productive placement. I have gained experience of working with a wide range of clients in a variety of settings and have extended my clinical skills in order to work effectively with both clients and staff/careers.

Signed **Roberta Fry** (Trainee) Date 28/10/94
**SUPERVISOR - TRAINEE RELATIONSHIP**

<table>
<thead>
<tr>
<th>The supervisor may raise questions or present options for the trainee to consider, but usually the trainee can present plans and make decisions on how to proceed which they have devised independently.</th>
<th>RATING</th>
<th>Explanation/Expansion of Rating/Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2</td>
<td>Roberta has developed throughout the placement &amp; reached a good degree of independence.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>The trainee does not usually require observation, monitoring or detailed questioning to maintain the standard of work, but this is used to ‘fine tune’ skills. The trainee self monitors and identifies the need for assistance in normal circumstances.</th>
<th>RATING</th>
<th>Explanation/Expansion of Rating/Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>3</td>
<td>Roberta’s standard of work has always been high and has not needed prompting to ensure work is done on time or to a suitable standard.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>The trainee shows a balance between autonomy and the use of support and advice which is appropriate to their level of skills, the client and the service setting.</th>
<th>RATING</th>
<th>Explanation/Expansion of Rating/Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>3</td>
<td>Roberta has always sought an appropriate level of support.</td>
</tr>
</tbody>
</table>

In your opinion, does the trainee reach the standard expected:

<p>| 3 | YES - Above expected level - please expand |
| 2 | YES - At expected level - please expand |
| 1 | NO - Borderline - please expand |
| 0 | NO - Please explain |
| N/A | Not applicable |</p>
<table>
<thead>
<tr>
<th>THE DEVELOPMENT OF COMPETENCY IN THE USE OF SCIENTIFIC METHOD</th>
<th>RATING</th>
<th>Explanation/Expansion of Rating/Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.1 The trainee can convert presenting problems into questions that can be delineated within a psychological perspective and with measurable solutions.</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>1.2 The trainee has good knowledge of the range of assessment procedures available and is able to choose the appropriate one to use in straightforward situations.</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>1.3 to 1.6 The trainee carries out procedures and collects information in an objective way, yet retains a sensitive stance with clients and is able to recognize factors that limit the reliability and validity of assessment.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.3 Psychometric measurement</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>1.4 Other formal psychological assessments</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>1.5 Behavioural/observational assessments &amp; functional analysis</td>
<td>3</td>
<td>Roberta's functional analysis was excellent.</td>
</tr>
<tr>
<td>1.6 Other assessments</td>
<td>na</td>
<td></td>
</tr>
<tr>
<td>1.7 The trainee separates fact from interpretation, can integrate information from a variety of perspectives, compares and contrasts models; devises a formulation independently that encompasses multifactorial elements.</td>
<td>2</td>
<td>At a level appropriate for level of training</td>
</tr>
<tr>
<td>1.8 The trainee can devise a realistic and appropriate intervention plan based on an appropriate therapeutic model.</td>
<td>2</td>
<td>as above.</td>
</tr>
</tbody>
</table>
1.9 The trainee can plan an overall intervention strategy, evaluate progress, reformulate and modify the intervention plan.

1.10 Evaluation of clinical interventions: the trainee understands the importance of evaluation in clinical work; chooses and uses appropriately common methods and can modify measures for a new situation.

<table>
<thead>
<tr>
<th>THERAPY AND INTERVENTION SKILLS</th>
<th>RATING</th>
<th>Explanation/Expansion of Rating/Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.1 The trainee takes overall responsibility for action in relation to routine client matters such as making appointments, setting up meetings with colleagues etc.</td>
<td>2</td>
<td>Very high standard - as would be expected</td>
</tr>
<tr>
<td>2.2 The trainee can handle unplanned and unexpected events in a therapy session in an effective and controlled way to the benefit of the client, referring back to the supervisor subsequently.</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>2.3 The trainee engages the client, communicates appropriately to them, demonstrates awareness of what is clinically relevant and is sensitive and flexible in applying techniques. This particularly applies to clients from different cultural or ethnic backgrounds, or at different levels of intellectual ability.</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>2.4 Communication of psychological information or opinion. The trainee can present psychological information or opinion to clients, relatives and/or carers and staff effectively, modifying language appropriately, using the appropriate style and addressing concerns raised in a facilitative manner.</td>
<td>2</td>
<td>I have received good feedback from people who have worked with Roberta.</td>
</tr>
<tr>
<td>2.5 Interviewing: The trainee interviews clients effectively and appropriately, keeps control of the session, keeps to a structure yet allows the client to express their own issues.</td>
<td>2</td>
<td></td>
</tr>
</tbody>
</table>
2.6 to 2.10 The trainee demonstrates effective therapy skills both at a general level and in the use of particular models; the supervisor gives feedback primarily to 'fine tune' their skills.

<table>
<thead>
<tr>
<th>2.6 Individual therapy work:</th>
<th>2</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.7 Therapy work with couples:</td>
<td>1</td>
</tr>
<tr>
<td>I have seen Roberta's group work skills improve over her placement. U. good.</td>
<td></td>
</tr>
<tr>
<td>2.8 Therapy work with families</td>
<td>n/a</td>
</tr>
<tr>
<td>2.9 Directive/behavioural groups:</td>
<td>2</td>
</tr>
<tr>
<td>2.10 Non-directive/psychotherapeutic groups:</td>
<td></td>
</tr>
<tr>
<td>2.11 Indirect client work: The trainee demonstrates effective skills both at a general level and in relation to the particular requirements of the setting; the supervisor gives feedback primarily to 'fine tune' their skills.</td>
<td>2</td>
</tr>
<tr>
<td>Roberta has demonstrated she can present information in a way appropriate to the setting.</td>
<td></td>
</tr>
<tr>
<td>2.12 Client work within a formal system (such as IPP): The trainee demonstrates effective skills both at a general level and in relation to the particular requirements of the system; the supervisor gives feedback primarily to 'fine tune' their skills.</td>
<td>1</td>
</tr>
<tr>
<td>Roberta has not had the opportunity.</td>
<td></td>
</tr>
</tbody>
</table>

3. THE DEVELOPMENT OF PROFESSIONALISM

<table>
<thead>
<tr>
<th>THE DEVELOPMENT OF PROFESSIONALISM</th>
<th>RATING</th>
<th>Explanation/ Expansion of Rating/Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.1 The trainee knows the background, structure and future trends of the profession that underlie the work of clinical psychologists sufficient to relate it appropriately to the placement.</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>3.2 The trainee understands the history, philosophy, structure, working rules and procedures that relate to the particular placement.</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>3.3 The trainee demonstrates effective work management skills (time management, record keeping, reliability and administrative independence).</td>
<td>3</td>
<td>Roberta has very high standard.</td>
</tr>
<tr>
<td>3.4 The trainee demonstrates self management skills (awareness of skill limitations when overworked, stressed or needing personal support).</td>
<td>2/N.a.</td>
<td>Roberta has not faced any particular personal problems during the placement which have impacted on her work.</td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>3.5 The trainee presents in a professional way to the client and maintains a proper and effective therapeutic relationship, maintaining an over-riding concern for the client’s interests, an awareness of the boundaries of competence and of ethical and procedural guidelines that apply.</td>
<td>2</td>
<td>Roberta has a caring and sensitive approach to work with clients.</td>
</tr>
<tr>
<td>3.6 Equal opportunities/equality of access: The trainee understands the importance of these factors in service provision within the health and social services and addresses them within their work, particularly in relation to attitudes and skills in client work.</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>3.7 The trainee presents well and relates effectively to colleagues both in psychology and elsewhere within the NHS and other agencies.</td>
<td>3</td>
<td>Roberta presents herself very well.</td>
</tr>
<tr>
<td>3.8 The trainee makes a positive contribution in verbal communication, presents material clearly, concisely and well structured, can separate fact from interpretation, incorporate information and opinions from others, can argue effectively and negotiate to a satisfactory outcome in normal circumstances within the placement.</td>
<td>3</td>
<td>Roberta's presentation is clear and thoughtful. She expresses herself well.</td>
</tr>
<tr>
<td>3.9 The trainee presents material clearly and concisely in written communication, and makes good use of structure; separates fact from interpretation and relevant from irrelevant material; has a flexible style depending on the needs of the recipient.</td>
<td>3</td>
<td>Sure &amp; Roberta's reports have been excellent. A slight tendency to be over-inclusive.</td>
</tr>
<tr>
<td>3.10 The trainee demonstrates an understanding of the range of roles that psychologists might undertake, such as teaching, supervision, consultancy, research project work and service development.</td>
<td>2</td>
<td>Appropriate level of training.</td>
</tr>
<tr>
<td>THE DEVELOPMENT OF AWARENESS AND COMPETENCE IN SERVICE AND ORGANISATIONAL ISSUES</td>
<td>RATING</td>
<td>Explanation/Expansion of Rating/Comments</td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>4.1 The trainee demonstrates a balanced and realistic awareness of how organisational factors impinge on client work both directly and through staff practices.</td>
<td>3</td>
<td>Roberta has demonstrated good understanding</td>
</tr>
<tr>
<td>4.2 The trainee works appropriately and effectively within the boundaries and constraints of organisations and settings.</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>4.3 The trainee works appropriately and effectively within the boundaries and constraints of a multi-disciplinary team.</td>
<td>1/a</td>
<td>Roberta has not had the opportunity to chair a multi-disciplinary meeting</td>
</tr>
<tr>
<td>4.4 The trainee understands, and is knowledgeable, in relation to the skills and work practices of other professions and other staff groups.</td>
<td>2</td>
<td>Appropriate</td>
</tr>
<tr>
<td>4.5 The trainee is able to analyse and describe, with some independence, some psychological processes active within groups, settings or organisations.</td>
<td>2</td>
<td>Appropriate to level of training</td>
</tr>
<tr>
<td>4.6 The trainee is able to describe, with some level of independence, the psychological skills and methods required to produce change within groups, settings or organisations.</td>
<td>2</td>
<td>Appropriate to level of training</td>
</tr>
<tr>
<td>4.7 Presentation: The trainee prepares the material in terms of structure and content, relevant to the needs of the audience; displays effective verbal and non-verbal skills; shows effective use of time; chooses appropriate style (didactic or facilitative) relevant to the audience.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.8 Teaching: The trainee prepares the material in terms of structure and content, relevant to the needs of the audience; displays effective verbal and non-verbal skills; shows effective use of time; chooses appropriate style (didactic or facilitative) relevant to the audience. The trainee chooses assessment and evaluation materials.</td>
<td>3</td>
<td>Roberta’s Seminar to be the department’s ‘top’ one of the year. Well researched &amp; presented.</td>
</tr>
</tbody>
</table>
4.9 If the trainee has undertaken work in any of the following areas, please tick and briefly describe the work, and comment on the skills used and level of expertise displayed:

- consultancy
- supervision
- project work
- service development work

<table>
<thead>
<tr>
<th>THE SHIFT TO WORK BEING GROUNDED IN</th>
<th>RATING</th>
<th>Explanation/Expansion of Rating/Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>PSYCHOLOGICAL PRINCIPLES FROM BEING ORIENTATED IN RELATION TO SPECIFIC TECHNIQUES</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5.1 The trainee is able to perceive issues from different perspectives; draws information from a variety of sources and develops it into an individualised framework; can see how facts can be conceptualised in different ways - using supervisor primarily as a sounding board for own thinking processes.</td>
<td>2</td>
<td>Appropriate to level of training</td>
</tr>
<tr>
<td>5.2 The trainee approaches work from a theoretical stance with a broad vision of the general applicability of principles of practice, integrating theories from general psychology and those specific to settings or client groups.</td>
<td>2</td>
<td>Appropriate to level of training</td>
</tr>
<tr>
<td>5.3 Generic skills: The trainee draws on therapeutic skills techniques and methods from the range of client groups, and uses them with appropriate modifications for the individual client.</td>
<td>2</td>
<td>Appropriate to level of training</td>
</tr>
</tbody>
</table>
This contract is designed to set parameters for Roberta Fry in the Child and Adolescent Psychology Department with Nick Kirby-Turner in the Mid-Downs Health Authority

Induction Processes

for Roberta Fry to gain an understanding of the relationship of Child Psychology to services in Child Mental Health, and also in Child Health and Child Protection Services. Specifically:

1. Observe Clinical Child Psychologists working in different settings
2. Observe an Educational Psychologist at work
3. Observe a Clinical Medical Officer conducting a developmental assessment
4. Observe a Juvenile Court
5. Attend a session in a play group
6. Attend a session in a primary school
7. Visit Larchwood Children's Unit
8. Visit the Family Therapy Clinic
9. Become familiar with issues surrounding Child Protection Assessment
10. Endeavour to observe children with Pervasive Developmental Delay

Clinical Work

for Roberta Fry to familiarise herself with the range of assessment procedures and therapeutic techniques by:

- Outpatient work at Larchwood Lodge. A variety of cases, reflecting the full age range, to illustrate the breadth of the specialty in terms of reasons for referral and therapeutic approaches applicable. Opportunities for individual and family centred work. Some joint work with Nick Kirby-Turner and Dr. J. Alvarez.

- Inpatient work at Colwood Adolescent Unit. Participating in individual work specifically. Some opportunity to work with children who have been abused.

- Teaching: Presentation in the Child Seminar Series to other Child Psychologists. Also, as opportunities arise, formal teaching of other professionals, possibly through case-based teaching.

- Research: Use of the theoretical framework and research methodology of Personal Construct Psychology.
  To investigate the treatment planning process of a sample of staff from an Adolescent Unit
  To discuss on-going research issues in Child work.
Professional Development

for Roberta Fry to endeavour to gain a perspective of service delivery issues through clinical work and to explore issues of service development by some attendance at Departmental Meetings and discussing issues as they arise.

Supervision

At least one formal hour per week. Further supervision through informal meetings and via weekly Child Seminars. Some direct observation of Roberta Fry's work through joint sessions and the use of the VCR.
UNIVERSITY OF SURREY / S W T R H A

M Sc in Clinical Psychology

Trainee's name: Roberta Fry
Placement Type: Child + Adolescent
Date: 2nd Nov 94 → 11th May 95
Supervisors Name: Nick Kirby-Turner
Placement District: MID. SUSSEX

Summary of Clinical Activity

Please indicate at the end of your placement what you have covered under the following seven categories:

(1) Clinical activity with individual clients, couples & families
   (use attached sheet C)

(2) Group work - use attached sheet B

(3) Teaching/Skills transmission/Presentations
   Outline each experience of teaching, indicating what, to whom
   how organised, the extent of your role and its degree of success.

6/10/95: Presented a discussion, along with a handout about
the Consent to Psychological Treatment for the Psychology Dept.
Successfully promoted discussion and was extended to 2 sessions.
3/10/95: Discussed the roles of a clinical psychologist to a
student nurse visiting the adolescent unit.
3/10/95: Gave a joint presentation with Nick Kirby Turner to the Dept
* about personal construct theory and Pep Grids.

(4) Organisational Work (eg: developing IPP system, staff support,
   assessing case recording system). Outline each piece of work,
   indicating the extent of your role and outcome.

*11/05/95: gave a presentation to 'A' level psychology students at
the local college. (eg, what is clinical? what does it mean?
   discussed cases to demonstrate links between theory & practice -
5. RESEARCH

Outline any projects which you initiated or with which you were involved and indicate the extent of your involvement.

I initiated, planned and conducted a piece of exploratory research entitled "First steps in treatment planning on an adolescent unit: A personal construct analysis." which involved extensive interviewing and completion of Rep Grids along with analysis and interpretation. I led to the construction of a questionnaire sensitive to the relevant issues for the adolescent unit. The information from which the "possible next step" for the unit could be decided.

6. MEETINGS, VISITS, OBSERVATIONS

Outline briefly each experience and the extent of your involvement.

11/94 Observed Nick Kirby-Turner at a meeting involving a social worker, head teacher and foster parent.

11/94 Attended a ward round at the adolescent inpatient unit.

11/94 Observed Nick Kirby-Turner at a meeting held at a School, involving parent, teacher, deputy head teacher, educational psychologist.

11/94 Observed Nick Kirby Turner at a meeting with a Guardian ad litem.

11/94 Observed Dr. Jenny Alcante interview a family.

11/94 Worked a day shift at Colwood Adolescent Unit "Sat-in" school lessons, preparation and the "community meeting" (where the students give support and feedback to each other; staff also comment and ensure the "self selected grades" are appropriate to the effort exerted by members.

12/94 Spent the morning at a pre-school nursery, observing the children playing and interacting.

01/95 Spent the morning observing the children (5-11 years) at a small primary school.

3/95 Discussed the role and responsibilities of the social worker with Jo Brody, Social Worker to the Adolescent unit.

6/95 Joined multidisciplinary team meeting at Horsham Clinic

10/95 Observed a Consultant Child and Adolescent Psychiatrist
20/04/95. Observed a developmental assessment conducted on a 3 year old by Dr. Isobel Jones, Consultant Paediatrician.

11/04/95. Sat in on a variety of cases at the Family Court.

21/4/95. Discussed Angela Tompkins experience of observing a speech therapist run a group for children with speech and language difficulties.

20/4/95. Observed J. Almaraz conduct an assessment interview with a family with a child with developmental delay.

7. COURSES AND TRAINING EVENTS ATTENDED AS PART OF PLACEMENT

Please list and outline each one.

Attended weekly child seminars at the Department.

8th March 1995: Attended talk about Ritalin by Dr.

9th March 1995: Participated at the Supervisor training workshop (eg devised a role play exercise + facilitated discussion).

7th April 1995: Attended a case discussion by Veronica Bradley (eg test interpretation and report writing).

8. OTHER

Please outline any other experience on placement.

I met weekly with a nurse and social work trainee (separately) in order to exchange information about the client that we were both working with on separate issues. (eg social worker provided dynamic psychotherapy whilst I focused on anger management techniques).

Whilst for the other client, the nurse provided disclosure work and I offered supportive psychotherapy.
<table>
<thead>
<tr>
<th>Sex</th>
<th>Age</th>
<th>Assessment</th>
<th>Intervention</th>
<th>Type of Contact</th>
<th>Presenting Need</th>
<th>Model of Therapy</th>
<th>No of Hours</th>
<th>Outcome, Evaluation</th>
</tr>
</thead>
<tbody>
<tr>
<td>M</td>
<td>11yr</td>
<td>Assessment for treatment interview (family + individual)</td>
<td>FE</td>
<td>S</td>
<td>Assess impact of Short stature on him; Is therapy appropriate?</td>
<td>assessment only</td>
<td>4</td>
<td>Good</td>
</tr>
<tr>
<td>M</td>
<td>5yr 2 months</td>
<td>Assessment for treatment interview (family + individual)</td>
<td>FE</td>
<td>S</td>
<td>Has suffered from chronic constipation for 2 years; withdrawal; extremely shy</td>
<td>Systemic and Behavioural</td>
<td>20</td>
<td>Excellent</td>
</tr>
<tr>
<td>M</td>
<td>15yr 6 months</td>
<td>Assessment for treatment interview</td>
<td>FE</td>
<td>J</td>
<td>Mr Nick Kirby-Turner</td>
<td>Anxiety; Poor school attendance; Fearsitting</td>
<td>Time spent trying to engage client</td>
<td>5</td>
</tr>
<tr>
<td>M</td>
<td>3yr 2 months</td>
<td>Assessment for treatment interview</td>
<td>IF</td>
<td>S</td>
<td>Temper Tantrums</td>
<td>Behavioural</td>
<td>7</td>
<td>Excellent</td>
</tr>
<tr>
<td>F</td>
<td>15yr 8 months</td>
<td>Assessment for treatment interview</td>
<td>FI</td>
<td>S</td>
<td>Depression; Then lavoro on explored bereavement issues</td>
<td>Cognitive-behavioural, non-directive counselling</td>
<td>5</td>
<td>Good</td>
</tr>
</tbody>
</table>

Note: The table includes various assessments and interventions for clients, including assessments for treatment interviews, and different types of contact such as S (Session) and J (Joint). The presenting needs vary from physical to mental health issues, and the model of therapy ranges from assessment only to systemic and behavioural approaches. The number of hours varies, and outcomes range from Good to Excellent.
<table>
<thead>
<tr>
<th>Assessment</th>
<th>Intervention</th>
<th>Type of Contact</th>
<th>Presenting Need</th>
<th>Model of Therapy</th>
<th>No of Hours</th>
<th>Outcome/Evaluation</th>
<th>Additional Info/Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Assessment for Treatment Interview. = 17 yrs.</td>
<td>FI</td>
<td>S</td>
<td>Self-hate and belief that others hate her.</td>
<td>Focused Psychotherapy</td>
<td>15</td>
<td>Excellent</td>
<td>Established trust and supportive relationship which became internalised.</td>
</tr>
<tr>
<td>Cognitive Assessment (WISC-R, Rep Gm'd) Interview. m. 3 yrs 1 mo.</td>
<td>FI</td>
<td>S</td>
<td>Major Conduct Disorder - Cognitive Assessment</td>
<td>Assessment of personal constructs</td>
<td>5</td>
<td>Good</td>
<td>Provided groundwork for further therapeutic input.</td>
</tr>
<tr>
<td>Assessment for Treatment Interview. F. 6 yrs 1 mo.</td>
<td>FF</td>
<td>S</td>
<td>Sleep difficulties</td>
<td>Behavioural</td>
<td>1</td>
<td>Satisfactory - Child now sleeps through the night</td>
<td>Seemed mom did not want to implement beh. prog. But some resolution achieved by attending the assessment.</td>
</tr>
<tr>
<td>Assessment for Treatment Interview. 1. 9 yrs 8 mo.</td>
<td>FF</td>
<td>S</td>
<td>Marked facial tic</td>
<td>Cognitive - Behavioural</td>
<td>2</td>
<td>Good</td>
<td></td>
</tr>
<tr>
<td>Assessment Interview with ch. parent; paralely. 1.3 yrs 1 mo.</td>
<td>FF + IF</td>
<td>S</td>
<td>Temper Tantrums</td>
<td>Assessment only</td>
<td>4</td>
<td>No change</td>
<td>&quot;Real issue&quot; was parents' abusiveness separation and unresolved residuals order.</td>
</tr>
</tbody>
</table>
### EVALUATION OF THE TRAINEE ON PLACEMENT

<table>
<thead>
<tr>
<th>TRAINEE NAME</th>
<th>ROBERTA FRY</th>
</tr>
</thead>
<tbody>
<tr>
<td>PLACEMENT TITLE</td>
<td>CHILD + ADOLESCENT SERVICES</td>
</tr>
<tr>
<td>PLACEMENT DATES</td>
<td>2nd Nov 94 until 11th May 1995</td>
</tr>
<tr>
<td></td>
<td>No. of DAYS: YR 1: 72</td>
</tr>
<tr>
<td>SUPERVISOR NAME</td>
<td>MR. NICK KIRBY-TURNER</td>
</tr>
<tr>
<td>PLACEMENT ADDRESS</td>
<td>LARCHWOOD LODGE, PRINCESS ROYAL HOSPITAL, LEWES ROAD, MAYWARDS HEATH, W. SUSSEX, RH16 4EX</td>
</tr>
<tr>
<td></td>
<td>0444 441851 ext 4994</td>
</tr>
</tbody>
</table>

### OVERALL RATING FOR THE PLACEMENT

In the supervisor's opinion, has the trainee reached the standard expected to pass the placement?

<table>
<thead>
<tr>
<th>COMMENT</th>
<th>TICK</th>
</tr>
</thead>
<tbody>
<tr>
<td>PASS</td>
<td>✓</td>
</tr>
<tr>
<td>PASS: The trainee has gaps in experience that need to be addressed later in training</td>
<td></td>
</tr>
<tr>
<td>PASS: The trainee needs to focus on specified areas of clinical skills in subsequent placements</td>
<td></td>
</tr>
<tr>
<td>FAIL: The trainee has not reached the standard expected</td>
<td></td>
</tr>
</tbody>
</table>

**General Comments from Supervisor:**

I have applied a realistic evaluation, taking into account Roberta's stage in training as an already highly competent psychologist. Her skills well developed - thus "expected level" is already very high. Sound knowledge base - well applied - developing a very good therapeutic personal style... Signed __________________ (Supervisor) Date __________

**Comments from the trainee:**

I feel that I have made considerable progress in both my therapeutic and research skills during this placement. I am more able to leverage uncertainty and to listen to a client's pain and distress. My aim of developing my "process skills" has been met and created further avenues for me to explore later.

Signed Roberta Fry (Trainee) Date 11th May 1995

*PTO*
The supervisor may raise questions or present options for the trainee to consider, but usually the trainee can present plans and make decisions on how to proceed which they have devised independently.

<table>
<thead>
<tr>
<th>SUPERVISOR - TRAINEE RELATIONSHIP</th>
<th>RATING</th>
<th>Explanation/Expansion of Rating/Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>The trainee does not usually require observation, monitoring or detailed questioning to maintain the standard of work, but this is used to ‘fine tune’ skills. The trainee self monitors and identifies the need for assistance in normal circumstances.</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>The trainee shows a balance between autonomy and the use of support and advice which is appropriate to their level of skills, the client and the service setting.</td>
<td>2</td>
<td>Roberts able to identify specific areas of need especially early on in placement Good self monitoring</td>
</tr>
</tbody>
</table>

In your opinion, does the trainee reach the standard expected:

- 3 YES - Above expected level - please expand
- 2 YES - At expected level - please expand
- 1 NO - Borderline - please expand
- 0 NO - Please explain
- N/A Not applicable
<table>
<thead>
<tr>
<th>ASSESSMENT, FORMULATION, CLINICAL EVALUATION</th>
<th>RATING</th>
<th>Explanation/Expansion of Rating/Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.1 The trainee can convert presenting problems into questions that can be delineated within a psychological perspective and with measurable solutions.</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>1.2 The trainee has good knowledge of the range of assessment procedures available and is able to choose the appropriate one to use in straightforward situations.</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>1.3 to 1.6 The trainee carries out procedures and collects information in an objective way, yet retains a sensitive stance with clients and is able to recognize factors that limit the reliability and validity of assessment.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.3 Psychometric measurement</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>1.4 Other formal psychological assessments</td>
<td>2</td>
<td>use of BDI</td>
</tr>
<tr>
<td>1.5 Behavioural/observational assessments &amp; functional analysis</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>1.6 Other assessments</td>
<td>2</td>
<td>assessing FTC assessment and use in assessment for therapy cases</td>
</tr>
<tr>
<td>1.7 The trainee separates fact from interpretation, can integrate information from a variety of perspectives, compares and contrasts models; devises a formulation independently that encompasses multifactorial elements.</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>1.8 The trainee can devise a realistic and appropriate intervention plan based on an appropriate therapeutic model.</td>
<td>2</td>
<td></td>
</tr>
</tbody>
</table>
1.9 The trainee can plan an overall intervention strategy, evaluate progress, re-formulate and modify the intervention plan.

1.10 Evaluation of clinical interventions: the trainee understands the importance of evaluation in clinical work; chooses and uses appropriately common methods and can modify measures for a new situation.

<table>
<thead>
<tr>
<th>THERAPY AND INTERVENTION SKILLS</th>
<th>RATING</th>
<th>Explanation/Expansion of Rating/Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.1 The trainee takes overall responsibility for action in relation to routine client matters such as making appointments, setting up meetings with colleagues etc.</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>2.2 The trainee can handle unplanned and unexpected events in a therapy session in an effective and controlled way to the benefit of the client, referring back to the supervisor.</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>2.3 The trainee engages the client, communicates appropriately to them, demonstrates awareness of what is clinically relevant and is sensitive and flexible in applying techniques. This particularly applies to clients from different cultural or ethnic backgrounds, or at different levels of intellectual and linguistic ability.</td>
<td>2</td>
<td>(Ben). managing trust/autonomy/modeling in therapy eg men, child and hospital, paediatric war majors shift in ingrained pattern of secrecy.</td>
</tr>
<tr>
<td>2.4 Communication of psychological information or opinion. The trainee can present psychological information or opinion to clients, relatives and/or carers and staff effectively, modifying language appropriately, using the appropriate style and addressing concerns raised in a facilitative manner.</td>
<td>2</td>
<td>Development of range of communication eg analogy as facilitative device</td>
</tr>
<tr>
<td>2.5 Interviewing: The trainee interviews clients effectively and appropriately, keeps control of the session, keeps to a structure yet allows the client to express their own issues.</td>
<td>2</td>
<td></td>
</tr>
</tbody>
</table>
2.6 to 2.10 The trainee demonstrates effective therapy skills both at a general level and in the use of particular models; the supervisor gives feedback primarily to ‘fine tune’ their skills.

<table>
<thead>
<tr>
<th>2.6 Individual therapy work:</th>
<th>2</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.7 Therapy work with couples:</td>
<td>NA</td>
</tr>
<tr>
<td>2.8 Therapy work with families</td>
<td>2</td>
</tr>
<tr>
<td>2.9 Directive/behavioural groups:</td>
<td>NA</td>
</tr>
<tr>
<td>2.10 Non-directive/psychotherapeutic groups:</td>
<td>3.2</td>
</tr>
</tbody>
</table>

2.11 Indirect client work: The trainee demonstrates effective skills both at a general level and in relation to the particular requirements of the setting; the supervisor gives feedback primarily to ‘fine tune’ their skills.

2.12 Client work within a formal system (such as IPP): The trainee demonstrates effective skills both at a general level and in relation to the particular requirements of the system; the supervisor gives feedback primarily to ‘fine tune’ their skills.

2.13 Trainee handles termination of client contract effectively (either end of treatment or end of placement), dealing with both practical issues and the emotional aspect.

| 2.13 Trainee handles termination of client contract | 2 |

3. THE DEVELOPMENT OF PROFESSIONALISM

<table>
<thead>
<tr>
<th>RATING</th>
<th>Explanation/Expansion of Rating/Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.1</td>
<td>The trainee knows the background, structure and future trends of the profession that underlie the work of clinical psychologists sufficient to relate it appropriately to the placement.</td>
</tr>
<tr>
<td>3.2</td>
<td>The trainee understands the history, philosophy, structure, working rules and procedures that relate to the particular placement.</td>
</tr>
<tr>
<td>3.3 The trainee demonstrates effective work management skills (time management, record keeping, reliability and administrative independence).</td>
<td>2</td>
</tr>
<tr>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>3.4 The trainee demonstrates self management skills (awareness of skill limitations when overworked, stressed or needing personal support).</td>
<td>2</td>
</tr>
<tr>
<td>3.5 The trainee presents in a professional way to the client and maintains a proper and effective therapeutic relationship, maintaining an over-riding concern for the client’s interests, an awareness of the boundaries of competence and of ethical and procedural guidelines that apply.</td>
<td>2</td>
</tr>
<tr>
<td>3.6 Equal opportunities/equality of access: The trainee understands the importance of these factors in service provision within the health and social services and addresses them within their work, particularly in relation to attitudes and skills in client work.</td>
<td>2</td>
</tr>
<tr>
<td>3.7 The trainee presents well and relates effectively to colleagues both in psychology and elsewhere within the NHS and other agencies.</td>
<td>2</td>
</tr>
<tr>
<td>3.8 The trainee makes a positive contribution in verbal communication, presents material clearly, concisely and well structured, can separate fact from interpretation, incorporate information and opinions from others, can argue effectively and negotiate to a satisfactory outcome in normal circumstances within the placement.</td>
<td>2</td>
</tr>
<tr>
<td>3.9 The trainee presents material clearly and concisely in written communication, and makes good use of structure; separates fact from interpretation and relevant from irrelevant material; has a</td>
<td>2</td>
</tr>
<tr>
<td>4.1</td>
<td></td>
</tr>
</tbody>
</table>
3.10 The trainee demonstrates an understanding of the range of roles that psychologists might undertake, such as teaching, supervision, consultancy, research project work and service development.

<table>
<thead>
<tr>
<th>THE DEVELOPMENT OF AWARENESS AND COMPETENCE IN SERVICE AND ORGANISATIONAL ISSUES</th>
<th>RATING</th>
<th>Explanation/Expansion of Rating/Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>4.1 The trainee demonstrates a balanced and realistic awareness of how organisational factors impinge on client work both directly and through staff practices.</td>
<td>2</td>
<td>None</td>
</tr>
<tr>
<td>4.2 The trainee works appropriately and effectively within the boundaries and constraints of organisations and settings.</td>
<td>2</td>
<td>None</td>
</tr>
<tr>
<td>4.3 The trainee works appropriately and effectively within the boundaries and constraints of a multi-disciplinary team.</td>
<td>2</td>
<td>None</td>
</tr>
<tr>
<td>4.4 The trainee understands, and is knowledgeable, in relation to the skills and work practices of other professions and other staff groups.</td>
<td>2</td>
<td>None</td>
</tr>
<tr>
<td>4.5 The trainee is able to analyse and describe, with some independence, some psychological processes active within groups, settings or organisations.</td>
<td>2</td>
<td>None</td>
</tr>
<tr>
<td>4.6 The trainee is able to describe, with some level of independence, the psychological skills and methods required to produce change within groups, settings or organisations.</td>
<td>2</td>
<td>None</td>
</tr>
<tr>
<td>4.7 Presentation: The trainee prepares the material in terms of structure and content, relevant to the needs of the audience; displays effective verbal and non-verbal skills; shows effective use of time; chooses appropriate style (didactic or facilitative) relevant to the audience.</td>
<td>2</td>
<td>None</td>
</tr>
</tbody>
</table>
### 4.8 Teaching:
The trainee prepares the material in terms of structure and content, relevant to the needs of the audience; displays effective verbal and non-verbal skills; shows effective use of time; chooses appropriate style (didactic or facilitative) relevant to the audience. The trainee chooses assessment and evaluation materials.

<table>
<thead>
<tr>
<th>4.9 If the trainee has undertaken work in any of the following areas, please tick and briefly describe the work, and comment on the skills used and level of expertise displayed:</th>
</tr>
</thead>
<tbody>
<tr>
<td>- consultancy</td>
</tr>
<tr>
<td>- supervision</td>
</tr>
<tr>
<td>- project work</td>
</tr>
<tr>
<td>- service development work</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Consultation/Support to nurse in helping setting therapeutic boundaries.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Live supervision of nurse in assessment interview of family.</td>
</tr>
<tr>
<td>Introducing a behavioural model to (older) unit - an evaluation of staff knowledge + attitudes.</td>
</tr>
</tbody>
</table>

### 5.

#### THE SHIFT TO WORK BEING GROUNDED IN PSYCHOLOGICAL PRINCIPLES FROM BEING ORIENTATED IN RELATION TO SPECIFIC TECHNIQUES

<table>
<thead>
<tr>
<th>RATING</th>
<th>Explanation/Expansion of Rating/Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>5.1 The trainee is able to perceive issues from different perspectives; draws information from a variety of sources and develops it into an individualised framework; can see how facts can be conceptualised in different ways - using supervisor primarily as a sounding board for own thinking processes.</td>
<td>2</td>
</tr>
<tr>
<td>5.2 The trainee approaches work from a theoretical stance with a broad vision of the general applicability of principles of practice, integrating theories from general psychology and those specific to settings or client groups.</td>
<td>2</td>
</tr>
</tbody>
</table>
APPENDICES

APPENDIX 1

CHECKLIST - ENGAGING AND WORKING WITH A CHILD

By mid-placement the trainee would be expected:

- To use skills to keep a child in the room
- To use language appropriate to the child's developmental level
- To have a reasonable knowledge of child development
- To be comfortable with silence
- To select the use of toys appropriately
- To explain to a child about levels of confidentiality
- To establish the child's preconceptions
- To achieve a balance between eliciting information and making therapeutic suggestions
- To maintain an appropriate level of identification with the child
- To be able to set limits of what is acceptable within a session
- To engage a child/parent enough that they come back
- To be aware of separation anxiety in negotiating the length of the session
- To maintain a balance between structure and play
- To plan the session
- To plan endings

The trainee would not be expected to work independently with:

- Bereavement
- Suicidal thoughts
- Long term problems
- Sexual abuse/disclosure
- Work with legal implications

APPENDIX 2

CHECKLIST - WORKING WITH A FAMILY

By mid-placement the trainee would be expected:
CLINICAL PSYCHOLOGY

with OLDER ADULTS

PLACEMENT CONTRACT

May - November 1995

Worthing Priority Care Trust, Directorate of Clinical Psychology
Introduction

In this placement we aim to give an introduction to working with older adults with mental health problems as a clinical psychologist.

This contract is drawn up between

Ms Roberta Fry, trainee clinical psychologist (=the trainee)

and

Drs. C.A.J. Meesters, clinical psychologist (=the supervisor)

The placement is from 18-5 to 18-11-1995

Aims of placement

The main aim of the placement is to offer the trainee the opportunity to gain experience in all aspects of clinical psychology applied to an EMI setting: direct and indirect work with clients, clinical and educational work with carers and relatives, structural and supportive work with staff members and involvement in ongoing clinical research.

We also hope to introduce the trainee to the challenge of working in this specialism and the implications of multidisciplinary work.
Operationalisation

Setting

Worthing Priority Care Trust has a service for elderly people with mental health problems. The service emphasises that it aims to serve elderly people with mental health problems, both 'functional' and with a background of organic brain damage. The service has a strong commitment to multidisciplinary approach to client treatment, and this commitment is visible in all parts of the service:

- three community teams
- two in-patient units
- a day hospital
- a respite facility for people with dementia

The assessment units specialise in short term assessment of the client's problems resulting in extensive care plans. One unit is specialised in assessment and short term treatment with emphasis on clients with 'functional' problems, the other giving more attention to clients with problems based on organic brain damage.

Placement content

The trainee will be based in a shared office with the supervisor and from that position be introduced to the community teams, the assessment units and the day hospital.

All settings will provide opportunities for familiarisation with specialist assessment methods, treatment and research. Seeing the time limitations of the placement the trainee will be expected to concentrate on direct client work in the assessment unit and the community. In addition there is space for short term projects of structural work, either client-related or staff-related in any setting.

Techniques

The trainee will gain experience in:
performing and interpreting specialist assessments (neuropsychological, functional analysis, structural interviews)
  • applying and evaluating a range of treatment methods (client-centred counselling, cognitive techniques, memory training, behavioural programmes)
  • contributing to multidisciplinary client reviews and treatment planning
  • setting up and conducting a group, possibly co-working with another facilitator

Teaching

Staff training and support is an inherent part of the clinical psychologist’s work in an EMI service. The trainee will have the opportunity to participate in a pilot project, aiming at integrating general nursing approach in a training course, based on psychological principles. She will also have the opportunity to observe and/or assist the supervisor in ongoing training and support activities aimed at staff and clients’ relatives.

Working arrangements

The trainee will be introduced to the service through an induction period, in which she will meet the most relevant workers in the service components. After this induction period she will be expected to bear increasing responsibility for the organisation and time management of her workload, in close consultation with the supervisor.

Two hours per week has been set aside for formal supervision in a fixed arrangement. In addition the trainee will know at all times where and how to reach the supervisor for emergencies or informal supervision.

The psychologists in the Trust have a monthly business meeting, followed by a clinical presentation, to which the trainee is very welcome. These professional meetings will serve as an opportunity to compare EMI work with work aimed at other client groups and as a means to meet other psychologists.

Outcome expectations
The trainee is expected to gain an understanding of all aspects of EMI psychology as a specialism from this placement. Growing insight and expertise in technical aspects of the placement should become apparent in her progress through reports and correspondence; growing understanding of the specialist role of the clinical psychologist in an EMI service is expected to be demonstrated via feedback on diverse exposure experiences.

Finally the placement should be a challenging and positive experience, encouraging and guiding the trainee towards conscious choices for her future career development.

Worthing, 18 May 1995

Roberta Fry
Trainee Clinical Psychologist

Ms. Roberta Fry
Trainee Clinical Psychologist

Drs. C.A.J. Meesters
Clinical Psychologist
APPENDIX 7
Log Book

UNIVERSITY OF SURREY /S W T R H A
M Sc in Clinical Psychology

nee's name: ROBERTA FRY
Placement Type: ADULT / REHAB

15th OCTOBER -> 22nd APRIL 1993
Placement Type: ADULT / REHAB
Supervisors Name: ELSPETH BAUSTREE
NORTH WEST SURREY

Summary of Clinical Activity

ase indicate at the end of your placement what you have covered under following seven categories:

Clinical activity with individual clients, couples & families (use attached sheet C)

Group work – use attached sheet B

Teaching/Skills transmission/Presentations

Outline each experience of teaching, indicating what, to whom how organised, the extent of your role and its degree of success.

9.2.94 Gave a Case presentation to the Psychology Department.
20.4.94 Presented the literature review on "measures of insight"
9.2.94 Gave a Case presentation to the Psychology Department.
20.4.94 Presented the literature review on "measures of insight"

Developed and produced handouts for individual clients and organisational work (eg: developing IRR system, staff support, assessing case recording system). Outline each piece of work, indicating the extent of your role and outcome.
RESEARCH

Outline any projects which you initiated or with which you were involved and indicate the extent of your involvement.

MEETINGS, VISITS, OBSERVATIONS

Outline briefly each experience and the extent of your involvement.

93. Non-Participant Observation of 1 Session of Relapse Prevention Group.
    
    Attended Drug and Alcohol Team Ward Round: non-participant observation.

93. Observed a Clinical Psychologist working within GP Setting.
    Observed the use of the Cognitive-Behavioural Model with a depressed young man. A "Second" interview with the husband of a depressed elderly woman (she was present too). The Second meeting of a young woman seeking fertility treatment.
    Finally, a woman discussing attendance at a group for sexual abuse survivors.

93. Observed a Clinical Psychologist working within a Continuing Care home for people with long term mental health needs.

3. Attended Departmental Meeting.
    Observed Supervisor with 2 initial assessments, and 2 clients already in therapy.

3. Attended Day Hospital Business Meeting.
    Participant Observer in a relaxation training session.
    Participant Observer in a current affairs group.
    Meeting with the Day Hospital Sister discussing the Day Hospital.
    Observation of a Sports/Activities Session.
    Meeting with Occupational Therapist to learn of or's role within the day hospital.
    Observed Supervisor during a final session with a client.
93. Visit + observation of in patient ward (Acute).
93. Observed a CPN conduct an assessment interview with a lady suffering from claustrophobia, during the mornings "drop in" session.
93. Spent the afternoon with CPN's doing home visits to a range of client groups. (E. Learning disabled, chronic schizophrinie, Depression, Support to the wife of a dementia patient).
93. Visit to 'Project 18' Employment Development Scheme for people with mental health problems who want to work. Discussions with Sylvia Smith who is head of the team.
93. Observed supervisor with clients (whose problems were: Depression, mood swings and burping (aerophagist)).
93. Observed supervisor with anger management clients (3rd session) (I previously observed this clients initial assessment as well).
93. Observed an experienced clinical psychologist administer the WMS-R with a 71 year old, possibly dementia lady from the acute ward.
93. Met with senior register (Dr. Rachel Hennessey, Psychiatric) to discuss the medical, medical used, and role of the Psychiatrist. Time was also spent discussing the Psychiatric interview, present state Examination and mental state interviews.
93. Observed an experienced clinical psychologist administer the WMS-R with an elderly lady from the acute ward.
93. Observed "anxiety management" techniques discussed with a young man diagnosed as Schizoaffective.
93. Attended ward round for 2 of the Acute Admissions wards.
93. Observed a mental state examination conducted by Dr. Rachel Hennessey, senior register. (Chronic Schizophrenic patient).
93. Observed a Psychiatric interview with a depressed man at a Psychiatric Clinic.
93. Attended Bridgewell Horse Team Meeting. (A Community Mental Health Resource Centre).
93. Attended Group Link Team meeting (Imputed Rehabilitation House).
6. Meetings, visits, observations. (continued).

93. Attended Residents meeting at Green lane. (12 bedded Rehabilitation House for clients who need high levels of staff support to live in the community).

94. Spent a morning observing the work of an approved social worker.

94. Observed a marital therapist conduct an initial assessment with a couple.

94. Observed supervisor work with an anger management client. (Same client that I observed on initial assessment and 3rd session appointment).

94. I conducted an assessment interview of a patient suffering from residual positive psychotic symptoms, role-played by the Clinical Psychologist working with patients suffering from long term disabilities.

394. Observed Mel Banyan conduct an assessment interview of a patient suffering from residual positive psychotic symptoms.

694. Observed supervisor work with a bulimic woman.

494. Attended follow-up session of the couple attending for marital therapy. They did not attend, so the marital therapist showed me some of the materials she would have shown to the couple and talked through the approach she would have used.
7. COURSES AND TRAINING EVENTS ATTENDED AS PART OF PLACEMENT

Please list and outline each one.

- Attended an Art Therapy workshop, and learned about its history and application, as well as working through a very useful experiential exercise.
- Attended "Violence and Addictions" discussion held by the Forensic and Addictions Forum.

8. OTHER

Please outline any other experience on placement.

- Attended Academic meetings within the Abraham Cowley Uni which were open for all staff to attend. (List of topics available upon request).
- Attended a weekly Balint Group to discuss the Psychodynamic aspects of particular cases.

Signed: [Signature] Trainee. Date: 29/4/94

Signed: [Signature] Supervisor. Date: 29/4/94
<table>
<thead>
<tr>
<th>Therapists</th>
<th>Your Role (Active/Observer)</th>
<th>Membership (Ages &amp; Sexes)</th>
<th>Selection of Members</th>
<th>Nature of Group Work</th>
<th>Number of Sessions</th>
<th>Outcome Evaluation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anna and Rebecca (Clinical Psychologist)</td>
<td>Active. Preparing handouts and discussing the cognitive-behavioural approach to depression</td>
<td>4 men, 2 women</td>
<td>All Severely Depressed</td>
<td>Cognitive-Behavioural</td>
<td>7 x 2 Hour Sessions</td>
<td>3 out of 4 remaining members wish to continue cognitive therapy in a group, the other would like individual therapy. Post Treatment Scores:</td>
</tr>
<tr>
<td></td>
<td>24</td>
<td>male</td>
<td>41</td>
<td>19</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>29</td>
<td>Female</td>
<td>35</td>
<td>20</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>30</td>
<td>Male</td>
<td>31</td>
<td>18</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>38</td>
<td>Female</td>
<td>28</td>
<td>20</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>42</td>
<td>Male</td>
<td>39</td>
<td>17</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>60</td>
<td>Male</td>
<td>38</td>
<td>20</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Age</th>
<th>Sex</th>
<th>BDI</th>
<th>BHS</th>
</tr>
</thead>
<tbody>
<tr>
<td>24</td>
<td>M</td>
<td>41</td>
<td>17</td>
</tr>
<tr>
<td>29</td>
<td>F</td>
<td>30</td>
<td>20</td>
</tr>
<tr>
<td>30</td>
<td>M</td>
<td>30</td>
<td>19</td>
</tr>
<tr>
<td>38</td>
<td>F</td>
<td>13</td>
<td>14</td>
</tr>
<tr>
<td>42</td>
<td>M</td>
<td>Did not complete</td>
<td></td>
</tr>
<tr>
<td>60</td>
<td>M</td>
<td>Course of therapy</td>
<td></td>
</tr>
</tbody>
</table>
**APPENDIX C3**

* = indicates client from an ethnic minority / different cultural background.

**CLINICAL ACTIVITY WITH INDIVIDUAL CLIENTS, COUPLES, AND FAMILIES - PLACEMENT SUMMARY**

<table>
<thead>
<tr>
<th>Case</th>
<th>Age</th>
<th>Assessment</th>
<th>Intervention</th>
<th>Type of Contact</th>
<th>Presenting Need</th>
<th>Model of Therapy</th>
<th>No of Hours</th>
<th>Outcome/Evaluation</th>
<th>Additional Info/Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>F</td>
<td>25y</td>
<td>Assessment interview, involving devising a graded hierarchy and using ratings of severity coping etc.</td>
<td>FI</td>
<td>S</td>
<td>Severe fear of driving, relationship issues</td>
<td>cog-beh</td>
<td>17</td>
<td>Good Outcome</td>
<td>No longer fears driving. Feels better able to cope with indecision.</td>
</tr>
<tr>
<td>F</td>
<td>27y</td>
<td>Assessment interview (use of &quot;key questions&quot; and &quot;objective&quot; techniques for dream analysis)</td>
<td>FI</td>
<td>S</td>
<td>Nightmares.</td>
<td>Cognitive-behavioural</td>
<td>6</td>
<td>Good outcome. - no longer has the nightmares and feels able to cope better if they return.</td>
<td></td>
</tr>
<tr>
<td>F</td>
<td>46y</td>
<td>Assessment interviews. (Horowitz impact of Event Scale, Trauma Bond Inventory, Holmes-Rahe Social Readjustment Rating Scale, BDI, EMS)</td>
<td>FI</td>
<td>S</td>
<td>Post Traumatic Stress Disorder with concurrent depression.</td>
<td>Cognitive-behavioural</td>
<td>15</td>
<td>Good Outcome. Reduction in symptoms along with a greater recognition of further work needed.</td>
<td>Will be seen by my supervisor for a few more sessions.</td>
</tr>
<tr>
<td>F</td>
<td>52y</td>
<td>Assessment interview</td>
<td>FI</td>
<td>S</td>
<td>Tinnitus and marital issues.</td>
<td>Cognitive-behavioural for Tinnitus. non-directive approach for marital issues</td>
<td>4</td>
<td>Satisfactory/Goal.</td>
<td>Relaxation training was helpful for the tinnitus. Along with an opportunity to tour through the marital difficulties which alleviated the tinnitus.</td>
</tr>
<tr>
<td>Age</td>
<td>Assessment</td>
<td>Intervention</td>
<td>Type of Contact</td>
<td>Presenting Need</td>
<td>Model of Therapy</td>
<td>No of Hours</td>
<td>Outcome/Evaluation</td>
<td>Additional Info/Comment</td>
<td></td>
</tr>
<tr>
<td>-----</td>
<td>------------</td>
<td>--------------</td>
<td>-----------------</td>
<td>-----------------</td>
<td>------------------</td>
<td>-------------</td>
<td>--------------------</td>
<td>------------------------</td>
<td></td>
</tr>
<tr>
<td>5ys</td>
<td>Assessment for Treatment Interviews (including devising a graded hierarchy)</td>
<td>FO</td>
<td>S</td>
<td>Severe Spider Phobia</td>
<td>Behavioural</td>
<td>2</td>
<td>Little or no change</td>
<td>Client terminated Therapy.</td>
<td></td>
</tr>
<tr>
<td>44ys</td>
<td>Assessment interview</td>
<td>FO</td>
<td>S</td>
<td>Claustrophobia - but only for 1 particular room, nowhere else</td>
<td>Cognitive</td>
<td>1</td>
<td>No change</td>
<td>Described imaginal desensitization. Client did not want to pursue it because no present need to go to the particular room. Interviewed wife and nursing staff</td>
<td></td>
</tr>
<tr>
<td>36ys</td>
<td>Assessment interview. BDI, BHS, WAIS-R; WMS-R; RBMT; Nait.</td>
<td>FO</td>
<td>S (but observed by clinical psychologist)</td>
<td>Assessment of Emotional and Neuropsychological Status after a craniotomy</td>
<td>Psychometric Assessments</td>
<td>14</td>
<td>No change</td>
<td></td>
<td></td>
</tr>
<tr>
<td>47ys</td>
<td>Assessment for Treatment (BDI; BFI; BHS; Panic Diary)</td>
<td>FO</td>
<td>S</td>
<td>Panic Attacks</td>
<td>Cog-Beh</td>
<td>4</td>
<td>No change</td>
<td>Client DNA Gap. Wanted to work out the &quot;real problem&quot; on his own. Assessed his girlfriend prior to Couple Therapy. Unfortunately, his real job made attendance impossible.</td>
<td></td>
</tr>
<tr>
<td>36ys</td>
<td>Assessment Interview (Anger Inventory)</td>
<td>FO</td>
<td>S</td>
<td>Anger Management; Assertiveness</td>
<td>Cog-Beh</td>
<td>4</td>
<td>Good Outcome. (No longer uses violence to try to solve problems. Furthermore, possible if Couple Therapy undertaken.)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ex</td>
<td>Age</td>
<td>Assessment</td>
<td>Intervention</td>
<td>Type of Contact</td>
<td>Presenting Need</td>
<td>Model of Therapy</td>
<td>No of Hours</td>
<td>Outcome/Evaluation</td>
<td>Additional Info/Comment</td>
</tr>
<tr>
<td>----</td>
<td>-----</td>
<td>------------</td>
<td>--------------</td>
<td>----------------</td>
<td>-----------------</td>
<td>-----------------</td>
<td>-------------</td>
<td>-------------------</td>
<td>-------------------------</td>
</tr>
<tr>
<td>1</td>
<td>4yr</td>
<td>Assessment Interview</td>
<td>FI</td>
<td>S</td>
<td>Panic Attacks; and fear of negative Social evaluation</td>
<td>Cognitive - Behavioural</td>
<td>6</td>
<td>Good Outcome</td>
<td>Will be seen for a couple of sessions by my supervisor, as my placement came to an end.</td>
</tr>
<tr>
<td>2</td>
<td>33yr</td>
<td>Assessment Interview (Weiss; Harrington Recognition Memory Test; WAIS-R; NART)</td>
<td>FI</td>
<td>S</td>
<td>Memory Assessment</td>
<td>Psychometric Assessment</td>
<td>3</td>
<td>No change</td>
<td>A very interesting case, requiring information from his Psychiatric and Neuropsychological file along with details of a psychotherapy group he attended prior to his need for help.</td>
</tr>
<tr>
<td>3</td>
<td>23yr</td>
<td>Assessment Interviews, BDI; BHS; Eating Inventory</td>
<td>FI</td>
<td>S</td>
<td>Obesity and severe Depression</td>
<td>Cognitive - Behavioural</td>
<td>8</td>
<td>Individual work revealed the need for marital therapy</td>
<td>I had to report an incident he disclosed to Social Services. His wife attended the next session and agreed to joint therapy.</td>
</tr>
<tr>
<td>F</td>
<td>32yr</td>
<td>Assessment interview and assertiveness inventory</td>
<td>FI</td>
<td>S</td>
<td>To obtain wife's history before joint therapy.</td>
<td>Cognitive - Behavioural</td>
<td>1</td>
<td>Obtained sufficient information to proceed with joint sessions.</td>
<td>Good outcome. Resolved marital difficulties at the suggestion of the partner.</td>
</tr>
<tr>
<td>M</td>
<td>23yr+</td>
<td>Assessment interview of marital difficulties, D.A.S. (Psychiatric Adjustment Scale)</td>
<td>FC</td>
<td>S</td>
<td>Communication difficulties, and lack of trust in another</td>
<td>Cognitive - Behavioural</td>
<td>6</td>
<td>Resolved marital difficulties at the suggestion of the partner.</td>
<td>Social worker referred them for family therapy.</td>
</tr>
</tbody>
</table>
Trainee's name: Roberta Fry
Placement Type: Older Adult
Date: 18.05.96 - 30.11.96
Supervisors Name: Conrie Meesters
Placement District: WEST SUSSEK

Summary of Clinical Activity

Please indicate at the end of your placement what you have covered under the following seven categories:

(1) Clinical activity with individual clients, couples & families (use attached sheet C)

(2) Group work - use attached sheet B

(3) Teaching/Skills transmission/Presentations

Outline each experience of teaching, indicating what, to whom how organised, the extent of your role and its degree of success.

21-09-96 House Adams (1st year trainee) and myself (2nd year trainee) gave a joint presentation entitled "Current issues for trainees at Surrey" to the Psychology Dept.

7-10-95 I was involved in presenting clinical psychology services to the general public at the public service presentation.

(4) Organisational Work (eg: developing IPP system, staff support, assessing case recording system). Outline each piece of work, indicating the extent of your role and outcome.

1-11-95 Explained and handed over a behavioura recording form to a physiotherapist and nursing staff.

8-11-95 Explained, answered questions and handed over a behavioural programme to a physiotherapist and nursing staff.

11-10-95 Worked in directly for a patient at an in-patient assessment ward. This involved co-working with O and nurses, handling acute pressure, moving goal posts as to referred request, and integrating treatment approaches (eg reality orientation, validation) into the report.
5. RESEARCH

Outline any projects which you initiated or with which you were involved and indicate the extent of your involvement.

6. MEETINGS, VISITS, OBSERVATIONS

Outline briefly each experience and the extent of your involvement.

19/05/95 Met Steve Brooks, Senior O.T. for the Birchfield Unit.
19/05/95 Attended and participated in 'Quality Update' meet at Trust Headquarters.
19/05/95 Met John Beave, Head of Psychology Dept.
23/05/95 Met with CPN to discuss his role & contribution to CMHT older adults.

24/05/95 Met ward manager of the Ridings Day Centre.
24/05/95 Met Clinical Nurse Manager of the Ridings Day Centre.
7/06/95 Discussed O.T. input to both in and day patients at Ridings (7/06/95). Participant observer of reminiscence group at the Ridings.
13/06/95 Met unit manager to discuss the Birchfield Unit.
14/06/95 Attended Glebelands Day Centre.
15/06/95 Visited Alzheimer's Disease Society Information Unit in Worthing.

11/07/95 Attended a lunch held for carers.
25/07/95 Discussed 2 of Corr's cases: 1 a lady with physical disability (severe arthritis) and the other an racist gentleman, whose answers on picture arrangement were influenced by his views. Received copies of reports (anonymous).
7. COURSES AND TRAINING EVENTS ATTENDED AS PART OF PLACEMENT

Please list and outline each one.

8. OTHER

Please outline any other experience on placement.

25/05/95. Attended Risk Awareness Seminar conducted by Dr. J. Purdy.
6106/95. Attended "Memory for Health Professionals" by Prof. John Aggleton.
25/01/95. Attended Team building away day.


<table>
<thead>
<tr>
<th>Practitioners</th>
<th>Your Role (Active/Observer)</th>
<th>Membership (Ages &amp; Sexes)</th>
<th>Selection of Members</th>
<th>Nature of Group Work</th>
<th>Number of Sessions</th>
<th>Outcome Evaluation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jason Underen, Jr., OT</td>
<td>Active and Facilitatory</td>
<td>67 yrs Female</td>
<td>Explanation of Cognitive Model along with administration of Beck Anxiety Inventory and a Group Expectations Questionnaire.</td>
<td>1/2 hour Session Initial 45 minutes led by facilitators to work within a Cognitive Framework. This part was Structured and task orientated. The latter 45 minutes were spent sharing experiences over tea, as well as facilitating group members to &quot;own&quot; the group and feel able to offer suggestions and encouragement to other members.</td>
<td>8 Sessions Then 4 weeks later 1 Session follow up. Total = 9</td>
<td>Pre-Beck</td>
</tr>
<tr>
<td></td>
<td></td>
<td>69 yrs Female</td>
<td></td>
<td></td>
<td></td>
<td>27</td>
</tr>
<tr>
<td></td>
<td></td>
<td>74 yrs Female</td>
<td></td>
<td></td>
<td></td>
<td>30</td>
</tr>
<tr>
<td></td>
<td></td>
<td>72 yrs Female</td>
<td></td>
<td></td>
<td></td>
<td>26</td>
</tr>
<tr>
<td></td>
<td></td>
<td>80 yrs Male</td>
<td>Did not wish to attend after Cognitive Model outlined.</td>
<td></td>
<td></td>
<td>25</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>(All moderate – severe rating)</td>
</tr>
</tbody>
</table>

(First session was within normal range of the latter too falls within severe range)
<table>
<thead>
<tr>
<th>Age</th>
<th>Assessment</th>
<th>Intervention</th>
<th>Type of Contact</th>
<th>Presenting Need</th>
<th>Model of Therapy</th>
<th>No of Hours</th>
<th>Outcome/ Evaluation</th>
</tr>
</thead>
<tbody>
<tr>
<td>75yrs</td>
<td>Initial Interview, plus BD1 and BHS.</td>
<td>FI</td>
<td>S</td>
<td>Depression and low self esteem.</td>
<td>Client-Centred Therapy</td>
<td>10</td>
<td>Good outcome. Able to feedback to client and her husband the results of testing. Facilitated recognition of difficulties and possible future needs. Held feedback meeting to discuss report with counselor. Then another feedback meeting with the couple (cousin and my supervisor also present).</td>
</tr>
<tr>
<td>61yrs</td>
<td>Interview; Subjective memory questionnaire: WAIS-R; NART; Ravens Coloured Progressive Matrices; visual cancellation tasks; REMT, RMFT; NEAMS: Wisconsin Card Sorting Test.</td>
<td>FI and Small amount FC</td>
<td>S</td>
<td>Cognitive Assessment; particularly memory. Need to differentiate organic impairment from depression.</td>
<td>Cognitive for Assessment - Cognitive and systemic for intervention</td>
<td>10</td>
<td></td>
</tr>
<tr>
<td>69yrs</td>
<td>Initial Interview</td>
<td>FI</td>
<td>S</td>
<td>Depression and low self esteem.</td>
<td>Cognitive - Behavioural</td>
<td></td>
<td></td>
</tr>
<tr>
<td>69yrs</td>
<td>Initial Interview</td>
<td>FI</td>
<td>S</td>
<td>Depression and low self esteem.</td>
<td>Client-Centred Therapy</td>
<td>6</td>
<td>Excellent.</td>
</tr>
<tr>
<td>91</td>
<td>Interview: Physiotherapy: Read medical notes. Conduct behavioural observation and analysis. Create baseline measures chart for physio to complete.</td>
<td>FI and IT</td>
<td>S</td>
<td>Panic behaviour and verbal outbursts interfere to such an extent his active rehabilitation is compromised or avoided.</td>
<td>Behavioural</td>
<td></td>
<td></td>
</tr>
<tr>
<td>80yrs</td>
<td>Initial interview, BAI and expectations questionnaire and</td>
<td>FC</td>
<td>S</td>
<td>Anxiety.</td>
<td>Cognitive - Behavioural</td>
<td>1</td>
<td>He chose not to attend group as</td>
</tr>
<tr>
<td>Sex</td>
<td>Age</td>
<td>Assessment</td>
<td>Intervention</td>
<td>Type of Contact</td>
<td>Presenting Need</td>
<td>Model of Therapy</td>
<td>No of Hours</td>
</tr>
<tr>
<td>-----</td>
<td>-----</td>
<td>----------------------------------------------------------------------------</td>
<td>--------------</td>
<td>-----------------</td>
<td>-----------------------------------------------------</td>
<td>------------------</td>
<td>-------------</td>
</tr>
<tr>
<td>F</td>
<td>85</td>
<td>Initial interview, phone call to Son and OT involved when she was an inpatient: Administered: Nart; Raven, coloured Progressive Matrices (Block Design Subtest); MEAMS; RBMT.</td>
<td>FI</td>
<td>S</td>
<td>Memory Assessment</td>
<td>Cognitive Assessment</td>
<td>5</td>
</tr>
<tr>
<td>F</td>
<td>77</td>
<td>Initial interview</td>
<td>FI</td>
<td>S</td>
<td>Depression</td>
<td>Crisis intervention</td>
<td>1</td>
</tr>
<tr>
<td>M</td>
<td>71</td>
<td>Initial interview; Beck Anxiety Inventory Diaries</td>
<td>FI</td>
<td>S</td>
<td>Anxiety and Fear of growing old.</td>
<td>Cognitive-Behavioral</td>
<td>7</td>
</tr>
<tr>
<td>E</td>
<td>67</td>
<td>Initial interview; BAI and expectations questionnaire and screening interview; Anxiety management</td>
<td>FI</td>
<td>S</td>
<td>Anxiety and Loneliness</td>
<td>Cognitive-Behavioral</td>
<td>2</td>
</tr>
<tr>
<td>E</td>
<td>69</td>
<td>Behaviour observation recording and analysis; Create data records</td>
<td>FI</td>
<td>S</td>
<td>Memory and Intellectual Assessment</td>
<td>Behavioural</td>
<td>7</td>
</tr>
<tr>
<td>Age</td>
<td>Assessment</td>
<td>Intervention</td>
<td>Type of Contact</td>
<td>Presenting Need</td>
<td>Model of Therapy</td>
<td>No of Hours</td>
<td>Outcome/Evaluation</td>
</tr>
<tr>
<td>-----</td>
<td>------------</td>
<td>--------------</td>
<td>-----------------</td>
<td>----------------</td>
<td>-----------------</td>
<td>-------------</td>
<td>-------------------</td>
</tr>
<tr>
<td>69</td>
<td>Anxiety assessed by BAI and interview, also gave group satisfaction questionnaire</td>
<td>FI</td>
<td>S</td>
<td>Re-administer measures to follow up group members</td>
<td>Cognitive-Behavioural</td>
<td></td>
<td></td>
</tr>
<tr>
<td>74</td>
<td>&quot; &quot;</td>
<td>FI</td>
<td>S</td>
<td>&quot; &quot;</td>
<td>&quot; &quot;</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>TRAINEE NAME</strong></td>
<td>Roberta Fry</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>------------------</td>
<td>-------------</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>PLACEMENT TITLE</strong></td>
<td>Older Adults</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>PLACEMENT DATES</strong></td>
<td>18th May 95 – 30 Nov 95</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>No. of DAYS</strong></td>
<td>68</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>SUPERVISOR NAME</strong></td>
<td>Corrie Meesters</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>PLACEMENT ADDRESS</strong></td>
<td>Birchfield Unit, Southlands Hospital, Upper Shoreham Road, Shoreham-by-Sea, West Sussex, BN43 6TQ</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**OVERALL RATING FOR THE PLACEMENT**

In the supervisor’s opinion, has the trainee reached the standard expected to pass the placement?

<table>
<thead>
<tr>
<th><strong>COMMENT</strong></th>
<th><strong>TICK</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>PASS</td>
<td>✓</td>
</tr>
<tr>
<td>PASS: The trainee has gaps in experience that need to be addressed later in training</td>
<td></td>
</tr>
<tr>
<td>PASS: The trainee needs to focus on specified areas of clinical skills in subsequent placements</td>
<td></td>
</tr>
<tr>
<td>FAIL: The trainee has not reached the standard expected</td>
<td></td>
</tr>
</tbody>
</table>

General Comments from Supervisor:

Roberta has made great progress and I feel she has developed visibly as a clinical psychologist.

Signed Corrie Meesters (Supervisor) Date 30-11-1995

Comments from the trainee: I was a member of a Community Mental Health Team for over 6 months and this increased my awareness of the issues that can arise from multidisciplinary team work. In my role as a member of the team, I felt supported, and if necessary, protected by my supervisor. This resulted in greater awareness and confidence in my professional identity as a clinical psychologist.

Signed Roberta Fry (Trainee) Date 30-11-1995
<table>
<thead>
<tr>
<th>SUPERVISOR-TRAINEE RELATIONSHIP</th>
<th>RATING</th>
<th>Explanation/Expansion of Rating/Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>The supervisor may raise questions or present options for the trainee to consider, but usually the trainee can present plans and make decisions on how to proceed which they have devised independently.</td>
<td>2</td>
<td>I expect a trainee at this level to initiate and present plans. Robert met this expectation. She could also correctly identify when she needed for advice and support.</td>
</tr>
<tr>
<td>The trainee does not usually require observation, monitoring or detailed questioning to maintain the standard of work, but this is used to “fine tune” skills. The trainee self monitors and identifies the need for assistance in normal circumstances.</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>The trainee shows a balance between autonomy and the use of support and advice which is appropriate to their level of skills, the client and the service setting.</td>
<td>3</td>
<td>Most appropriate were Robert’s needs for ‘specialist’ assistance. As expected these needs decreased in the course of the placement. Most impressive was her handling of an absence during holiday. (including handling a ‘crisis’ referral.</td>
</tr>
</tbody>
</table>

In your opinion, does the trainee reach the standard expected:

- 3 YES - Above expected level - please expand
- 2 YES - At expected level - please expand
- 1 NO - Borderline - please expand
- 0 NO - Please explain
- N/A Not applicable
<table>
<thead>
<tr>
<th>THE DEVELOPMENT OF COMPETENCY IN THE USE OF SCIENTIFIC METHOD</th>
<th>RATING</th>
<th>EXPLANATION/EXPANSION OF RATING/COMMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.1 The trainee can convert presenting problems into questions that can be delineated within a psychological perspective and with measurable solutions.</td>
<td>2</td>
<td>Initially a bit 'nervous', but very good development in 'taking the flow' with time.</td>
</tr>
<tr>
<td>1.2 The trainee has good knowledge of the range of assessment procedures available and is able to choose the appropriate one to use in straightforward situations.</td>
<td>3</td>
<td>Robust, was most impressive in situ; respect and needed minimal supervision here.</td>
</tr>
<tr>
<td>1.3 to 1.6 The trainee carries out procedures and collects information in an objective way, yet retains a sensitive stance with clients and is able to recognize factors that limit the reliability and validity of assessment.</td>
<td>1.3 Psychometric measurement</td>
<td>3</td>
</tr>
<tr>
<td>1.4 Other formal psychological assessments</td>
<td>2</td>
<td>No further comment.</td>
</tr>
<tr>
<td>1.5 Behavioural/observational assessments &amp; functional analysis</td>
<td>3</td>
<td>Very well handled in extremely difficult cases.</td>
</tr>
<tr>
<td>1.6 Other assessments</td>
<td>3</td>
<td>Included in 1.5. Also demonstrated as part of complicated neuropsychological assessment (in my opinion, excellent demonstration of skill integration).</td>
</tr>
<tr>
<td>1.7 The trainee separates fact from interpretation, can integrate information from a variety of perspectives, compares and contrasts models; devises a formulation independently that encompasses multifactorial elements.</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>1.8 The trainee can devise a realistic and appropriate intervention plan based on an appropriate therapeutic model.</td>
<td>3</td>
<td>Especially against a background of 'multiple pathology', impressive performance in balancing patient's relevant needs against realistic options.</td>
</tr>
</tbody>
</table>
### 1.9 The trainee can plan an overall intervention strategy, evaluate progress, reformulate and modify the intervention plan.

<table>
<thead>
<tr>
<th>Rating</th>
<th>Explanation/Expansion of Rating/Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>3</td>
<td>Self-evident</td>
</tr>
</tbody>
</table>

### 1.10 Evaluation of clinical interventions: the trainee understands the importance of evaluation in clinical work; chooses and uses appropriately common methods and can modify measures for a new situation.

<table>
<thead>
<tr>
<th>Rating</th>
<th>Explanation/Expansion of Rating/Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>Fully adequate in terms of 'classical' patient-centred needs, room for improved/protection in terms of administrative/organisational needs.</td>
</tr>
</tbody>
</table>

**In your opinion does the trainee reach the standard expected:**

- 3 YES - Above expected level - please expand
- 2 YES - At expected level - please expand
- 1 NO - Borderline - please explain
- 0 NO - Please explain
- N/A Not applicable

### 2. Therapy and Intervention Skills

<table>
<thead>
<tr>
<th>Therapy and Intervention Skills</th>
<th>Rating</th>
<th>Explanation/Expansion of Rating/Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.1 The trainee takes overall responsibility for action in relation to routine client matters such as making appointments, setting up meetings with colleagues etc.</td>
<td>2</td>
<td>Self-evident</td>
</tr>
<tr>
<td>2.2 The trainee can handle unplanned and unexpected events in a therapy session in an effective and controlled way to the benefit of the client, referring back to the supervisor (subsequently.)</td>
<td>3</td>
<td>Likely to happen already, not way therapists this has to accentuate strategy.</td>
</tr>
<tr>
<td>2.3 The trainee engages the client, communicates appropriately to them, demonstrates awareness of what is clinically relevant and is sensitive and flexible in applying techniques. This particularly applies to clients from different cultural or ethnic backgrounds, or at different levels of intellectual ability.</td>
<td>3</td>
<td>I feel Roberta especially handled age + cultural issues very well, both in her contact with clients as in relation to colleagues &amp; myself. N.B. Supervisor had di culture background</td>
</tr>
<tr>
<td>2.4 Communication of psychological information or opinion. The trainee can present psychological information or opinion to clients, relatives and/or carers and staff effectively, modifying language appropriately, using the appropriate style and addressing concerns raised in a facilitative manner.</td>
<td>2</td>
<td>Letter still a bit &quot;clunky&quot; but very adequate and fairly free of jargon. Roberta was very good in her b.f.f. in personal contact with clients. At this point I'd like to raise bar to a 3.</td>
</tr>
<tr>
<td>Section</td>
<td>Description</td>
<td>Rating</td>
</tr>
<tr>
<td>---------</td>
<td>-------------</td>
<td>--------</td>
</tr>
<tr>
<td>2.5</td>
<td>Interviewing: The trainee interviews clients effectively and appropriately, keeps control of the session, keeps to a structure yet allows the client to express their own issues.</td>
<td>3</td>
</tr>
<tr>
<td>2.6</td>
<td>Individual therapy work:</td>
<td>3</td>
</tr>
<tr>
<td>2.7</td>
<td>Therapy work with couples:</td>
<td>N/A</td>
</tr>
<tr>
<td>2.8</td>
<td>Therapy work with families</td>
<td>N/A</td>
</tr>
<tr>
<td>2.9</td>
<td>Directive/behavioural groups:</td>
<td>3</td>
</tr>
<tr>
<td>2.10</td>
<td>Non-directive/psychotherapeutic groups:</td>
<td>3</td>
</tr>
<tr>
<td>2.11</td>
<td>Indirect client work: The trainee demonstrates effective skills both at a general level and in relation to the particular requirements of the setting; the supervisor gives feedback primarily to ‘fine tune’ their skills.</td>
<td>2</td>
</tr>
<tr>
<td>2.12</td>
<td>Client work within a formal system (such as IPP): The trainee demonstrates effective skills both at a general level and in relation to the particular requirements of the system; the supervisor gives feedback primarily to ‘fine tune’ their skills.</td>
<td>2</td>
</tr>
</tbody>
</table>

In your opinion does the trainee reach the standard expected:

3 YES - Above expected level - please expand
2 YES - At expected level - please expand
1 NO - Borderline - please explain
0 NO - Please explain
N/A Not applicable
<table>
<thead>
<tr>
<th>THE DEVELOPMENT OF PROFESSIONALISM</th>
<th>RATING</th>
<th>Explanation/Expansion of Result/Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.1 The trainee knows the background, structure and future trends of the profession that underlie the work of clinical psychologists sufficient to relate it appropriately to the placement.</td>
<td>3</td>
<td>kept boundaries very well in relation with non-clinical backgrounds.</td>
</tr>
<tr>
<td>3.2 The trainee understands the history, philosophy, structure, working rules and procedures that relate to the particular placement.</td>
<td>2</td>
<td>Placement was hectic at times and at some points I feel I should have spent more time explaining backgrounds.</td>
</tr>
<tr>
<td>3.3 The trainee demonstrates effective work management skills (time management, record keeping, reliability and administrative independence).</td>
<td>3</td>
<td>Very difficult in hectic setting + division of workplaces. Excellent handled.</td>
</tr>
<tr>
<td>3.4 The trainee demonstrates self management skills (awareness of skill limitations when overworked, stressed or needing personal support).</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>3.5 The trainee presents in a professional way to the client and maintains a proper and effective therapeutic relationship, maintaining an over-riding concern for the client's interests, an awareness of the boundaries of competence and of ethical and procedural guidelines that apply.</td>
<td>3</td>
<td>See remarks in section 1.</td>
</tr>
<tr>
<td>3.6 Equal opportunities/equality of access: The trainee understands the importance of these factors in service provision within the health and social services and addresses them within their work, particularly in relation to attitudes and skills in client work.</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>3.7 The trainee presents well and relates effectively to colleagues both in psychology and elsewhere within the NHS and other agencies.</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>3.8 The trainee makes a positive contribution in verbal communication, presents material clearly, concisely and well structured, can separate fact from interpretation, incorporate information and opinions from others, can argue effectively and negotiate to a satisfactory outcome in normal circumstances within the placement.</td>
<td>3</td>
<td></td>
</tr>
</tbody>
</table>
3.9 The trainee presents material clearly and concisely in written communication, and makes good use of structure; separates fact from interpretation and relevant from irrelevant material; has a flexible style depending on the needs of the recipient.  

3.10 The trainee demonstrates an understanding of the range of roles that psychologists might undertake, such as teaching, supervision, consultancy, research project work and service development.

<table>
<thead>
<tr>
<th>RATING</th>
<th>Explanation/Expansion of Rating/Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>a bit &quot;wishy-washy&quot;, but very adequate, possibly simply a matter of style</td>
</tr>
<tr>
<td>3</td>
<td>well demonstrated and improved upon towards end of placement work with less felt very much as &quot;colleague&quot; rather than &quot;struggling learning student&quot;</td>
</tr>
</tbody>
</table>

In your opinion does the trainee reach the standard expected:

3 YES - Above expected level - please expand
2 YES - At expected level - please expand
1 NO - Borderline - please explain
0 NO - Please explain
N/A Not applicable

### The Development of Awareness and Competence in Service and Organisational Issues

<table>
<thead>
<tr>
<th>THE DEVELOPMENT OF AWARENESS AND COMPETENCE IN SERVICE AND ORGANISATIONAL ISSUES</th>
<th>RATING</th>
<th>EXPLANATION/EXPANSION OF RATING/COMMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>4.1 The trainee demonstrates a balanced and realistic awareness of how organisational factors impinge on client work both directly and through staff practices.</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>4.2 The trainee works appropriately and effectively within the boundaries and constraints of organisations and settings.</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>4.3 The trainee works appropriately and effectively within the boundaries and constraints of a multi-disciplinary team.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.4 The trainee understands, and is knowledgeable, in relation to the skills and work practices of other professions and other staff groups.</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>4.5 The trainee is able to analyse and describe, with some independence, some psychological processes active within groups, settings or organisations.</td>
<td>2</td>
<td>Good insight demonstrated, especially in excellent use of supervision</td>
</tr>
<tr>
<td>4.6 The trainee is able to describe, with some level of independence, the psychological skills and methods required to produce change within groups, settings or organisations.</td>
<td>2</td>
<td>See 4.5</td>
</tr>
<tr>
<td>---------------------------------------------------------------</td>
<td>---</td>
<td>---------------------------------------------------------</td>
</tr>
</tbody>
</table>

**4.7 Presentation:** The trainee prepares the material in terms of structure and content, relevant to the needs of the audience; displays effective verbal and non-verbal skills; shows effective use of time; chooses appropriate style (didactic or facilitative) relevant to the audience.

| 4.7 Presentation | 3 | *Excellently demonstrated in co-work with GP practice staff; excellent feedback from peers - excellent examples of group work.* |

**4.8 Teaching:** The trainee prepares the material in terms of structure and content, relevant to the needs of the audience; displays effective verbal and non-verbal skills; shows effective use of time; chooses appropriate style (didactic or facilitative) relevant to the audience. The trainee chooses assessment and evaluation materials.

| 4.8 Teaching | 2 | *Well demonstrated in presentation to psychology department. Excellent handling of hitches regarding co-work.* |

**4.9 If the trainee has undertaken work in any of the following areas, please tick and briefly describe the work, and comment on the skills used and level of expertise displayed:**

| - consultancy | 3 | *Excellent work in terms of engagement, boundary-keeping & disengagement. See also 4.7. Combination of direct work with indirect very good.* |
| - supervision | 2 | |
| - project work | 3 | |
| - service development work | | |

In your opinion does the trainee reach the standard expected:

- 3 YES - Above expected level - please expand
- 2 YES - At expected level - please expand
- 1 NO - Borderline - please explain
- 0 NO - Please explain
- N/A Not applicable
### 5.1 The trainee is able to perceive issues from different perspectives; draws information from a variety of sources and develops it into an individualised framework; can see how facts can be conceptualised in different ways - using supervisor primarily as a sounding board for own thinking processes.

<table>
<thead>
<tr>
<th>RATING</th>
<th>Explanation/Expansion of Rating/Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>Very well demonstrated in supervision. Robert's progress was plainly visible as the week along. At end of placement she felt strong enough to handle referral on independent basis (approximately!!!)</td>
</tr>
</tbody>
</table>

### 5.2 The trainee approaches work from a theoretical stance with a broad vision of the general applicability of principles of practice, integrating theories from general psychology and those specific to settings or client groups.

| RATING | |
|--------| |
| 2      |  |

### 5.3 Generic skills: The trainee draws on therapeutic skills techniques and methods from the range of client groups, and uses them with appropriate modifications for the individual client.

<table>
<thead>
<tr>
<th>RATING</th>
<th>Explanation/Expansion of Rating/Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>Very well demonstrated in ten direct therapeutic contacts. Excellent boundary keeping. Not just in terms of the relationship, but in terms of adhering (or adjusting) therapeutic model.</td>
</tr>
</tbody>
</table>

---

**In your opinion does the trainee reach the standard expected:**

- 3 **YES** - Above expected level - please expand
- 2 **YES** - At expected level - please expand
- 1 **NO** - Borderline - please explain
- 0 **NO** - Please explain
- N/A **NO** - Not applicable
SPECIALIST PLACEMENT CONTRACT FOR ROBERTA FRY

Options 50-5 days 5th December 1995 - 12th June 1996

This contract outlines requirements and opportunities while working in the speciality of addictive behaviour.

Client Contact

Individual client work from both the alcohol and drug teams.

Places to Visit

1. Crawley Substance Misuse Service
2. Herbert Hone Clinic, Brighton
3. Drug and Alcohol Information Service, Brighton
4. Rowan Detox Ward at Springfield Hospital, Tooting
5. A rehabilitation unit eg one or two of the following: Brighton Recovery, Phoenix House Family Project, Arch House, Ravenscourt, St. Josephs, Phoenix House, Bexhill on Sea, Roma Programme or Eden House.

Therapy Skills

Further develop my skills using the cognitive behavioural model through in-depth client work. Obtain skills in the use of motivational interviewing and relapse prevention.

Scientific Method

Clear emphasis on formulation skills and the process of therapy. Where possible, link this to relapse prevention work.

This will be facilitated by the trainee spending

- more time for the assessment and planning of an intervention
- more use of process record of treatment sessions
- more use of written records to develop structure and conceptual skills
Professional Issues

• Further develop own style of working
• Reflect upon role of Clinical Psychologist in a multi-disciplinary team
• Be aware of issues of personal safety
• Be aware of ethical issues involved in the work

Organisational Issues

• Learn about the development and history of Options
• Develop greater understanding of multi-disciplinary work
• Develop awareness of similarities and differences between the specialist services and mental health divisions within the Trust
• Attend a variety of multi-professional meetings concerning service development.

Agreed Focus of the Placement

In depth work with selected client group with primary drug and alcohol service needs. Coupled with an opportunity to develop experience and understanding of organisational issues within Substance Misuse Service Delivery.

Roberta Fry
Clinical Psychologist in Training

Michael George
Chartered Clinical Psychologist
LOG BOOK
UNIVERSITY OF SURREY / S T R H A
PsychD in Clinical Psychology

Trainee's Name: Roberta Fry
Placement Type: Specialist
Supervisor's Name: Mike George
Date: 5th Dec 95 - 12th June 96
Placement District: Worthing
West Sussex

Summary of Clinical Activity

Please indicate at the end of your placement what you have covered under the following seven categories:

1) Clinical activity with individual clients, couples and families - use attached sheet C
2) Group work - use attached sheet B
3) Teaching/Skills transmission/presentations
   Outline each experience of teaching, indicating what, to whom, how organised, the extent of your role and its degree of success:
   24-1-96 Presented research proposal to the options team during a peer review session.
   18-4-96 Presented research design at the Psychology Department.
   22-5-96 Presented and facilitated a peer review discussion about therapeutic endings.
4) Organisational Work (e.g. developing IPP system, staff support, assessing case recording system). Outline each piece of work, indicating the extent of your role and outcome:
   30-5-96 Presented my research and preliminary findings to the Clinical Psychology Special Interest Group in Addictions at Surrey University.
   11-6-96 Presented my research to the CATCH (Chichester Alcohol Team).
   27/6/96 Presented my research to the Brighton Community Alcohol Team, to enlist their help in recruiting subjects.
5) RESEARCH

Outline any projects which you initiated or with which you were involved and indicate the extent of your involvement:

I conducted my final piece of research for my Clinical Doctorate at Options.
I was responsible for the design, data collection, analysis and report writing.
I applied Self Concept Discrepancy Theory to a sample of alcohol clients attending local alcohol services.

The team were very supportive of my research efforts.

6) MEETINGS, VISITS, OBSERVATIONS

Outline briefly each experience and the extent of your involvement:

- 12-95 Attended weekly peer review meetings.
- 12-95 Observed supervisor at a meeting with a teacher and a youth worker to discuss the possibility of groups run by peer tutors at the youth centre.
- 12-95 Attended between Drug and Alcohol Team meetings on a weekly basis.
- 12-95 Discussed the role of the Clinical Nurse Specialist for the drug team with them.
- 12-95 Discussed the role of the Clinical Nurse Specialist for the alcohol team.
- 12-95 Observed a local G.P. run a methadone prescribing clinic and discussed his role in the team.
- 12-95 Attended a prescribing meeting.
- 12-95 Observed supervisor work with two clients. Discussed both cases in detail using the framework of motivational interviewing to "dissect" the clinical sessions.
- 1-96 Attended Adul Drug Group meeting.
- 1-96 Discussed the role of the social worker for the Alcohol Team.
- 1-96 Observed an assessment interview and discussed
7/3/96. Attended and participated in South Thames (West) Region Wide Substance Misuse Quality Assurance and Audit Forum.

14/3/96. Attended West Sussex Drugs and Alcohol Advisory Committee meeting.

24/4/96. Spoke to Steve Byrne, Research Nurse from St. George about his work there.

30/4/96. Asked Christine Daniels (Clinical Nurse Specialist in Psychological Counselling) about her work at Options.

4/5/96. Sat in a session with the social worker for the alcohol team, completing the Community Care forms.

10/5/96. Discussed some of the issues involved in methadone prescribing with the Programme Manager and found out about her role within the team.

8/5/96. Visited Rowan and Sycamore wards at the Regional Drug Dependence Treatment and Research Unit, Springfield University Hospital, London.


23/5/96. Observed a joint meeting of Optim staff with Social Services Counterparts.

30/5/96. Visited and observed the Crawley Drug Team.

14/6/96. Visited the HOPE FAMILY PROJECT (6 month rehabilitation unit for drug clients and their family).

19/6/96. Visited the Her Majesty's Prison, Brighton.

27/6/96. Visited Wendy Stevens, Clinical Psychologist to the Alcohol team in Brighton.
7) COURSES AND TRAINING EVENTS ATTENDED AS PART OF PLACEMENT

Please list and outline each one:

5-12-95 watched the "managing Drink" Training Video

13 - 12 -95 Attended and participated in a motivational interviewing workshop.

24- 2-96. Listened to an audio tape recording of a lecture given by Dr. Scott Gliba about "Brief Solution Focused Therapy".

12-6-96. Attended Recent Developments in the Psychology of Addictive Behaviours Conference - (PSI6A).

8) OTHER

Please outline any other experience on placement:

5-12-95 Attended Susie Orbach lecture. The False Body: Reflections on the physical counter - transference

7-3-96. Attended Gianna Williams. The no - entry system: Reflections on the assessment of adolescents with eating disorders.

25-3-96 Attended Introductory Course in Psychodynamic Concepts for Clinical Psychologists at the Tavistock.

29-3-96 Clinic.

Signed ___________________________ Trainee ___________________________ Date 28/6/96

Signed ___________________________ Supervisor ___________________________ Date 28/6/96
<table>
<thead>
<tr>
<th>Sex</th>
<th>Age</th>
<th>Assessment</th>
<th>Intervention</th>
<th>Type of Contact</th>
<th>Presenting Needs</th>
<th>Model of Therapy</th>
<th>No. of Hours</th>
<th>Outcome/ Evaluation</th>
<th>Additional Info/Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>M</td>
<td>32</td>
<td>Clinical interview</td>
<td>FI</td>
<td>S</td>
<td>Requested rehab. issues around release prevention and his feelings</td>
<td>Client Centred/ Reflective</td>
<td>12</td>
<td>Good Outcome.Client able to take responsibility for decision making.</td>
<td>Therapeutic contact had been useful but insufficient to see the length of sessions for him.</td>
</tr>
<tr>
<td>M</td>
<td>23</td>
<td>Clinical interview</td>
<td>FI</td>
<td>S</td>
<td>Concern for his mental health after large close of ecstasy.</td>
<td>Motivational interviewing and relapse prevention</td>
<td>9</td>
<td>Good Outcome. Matched expectations for therapy enhanced their usefulness.</td>
<td></td>
</tr>
<tr>
<td>F</td>
<td>46</td>
<td>Clinical interview</td>
<td>FI</td>
<td>S</td>
<td>Fear of Relapse</td>
<td>Client Centred/ Reflective</td>
<td>5</td>
<td>Good Outcome. He found sessions helpful and knows he can re-frame his resourcefulness and assess memory.</td>
<td></td>
</tr>
<tr>
<td>M</td>
<td>38</td>
<td>Clinical interview</td>
<td>FI</td>
<td>S</td>
<td>Assessment / motivational interview.</td>
<td>Motivational interviewing used for assessment</td>
<td>2</td>
<td>Good Outcome.</td>
<td>He found sessions helpful and knows he can re-frame his resourcefulness and assess memory.</td>
</tr>
<tr>
<td>M</td>
<td>46</td>
<td>Memory Assessment</td>
<td>FI</td>
<td>IT</td>
<td>Request for rehab. Team query about short term memory ability.</td>
<td>Cognitive</td>
<td>1.5</td>
<td>Good. Able to re-frame his resourcefulness and assess memory.</td>
<td>Basically a community care assessment by social worker, with a brief assessment of his memory.</td>
</tr>
</tbody>
</table>
EVALUATION OF THE TRAINEE ON PLACEMENT

<table>
<thead>
<tr>
<th>TRAINEE NAME</th>
<th>Roberta Koste Fry</th>
</tr>
</thead>
<tbody>
<tr>
<td>PLACEMENT TITLE</td>
<td>Specialist Placement in Substance Misuse</td>
</tr>
<tr>
<td>PLACEMENT DATES</td>
<td>5-12-95 → 12-6-95</td>
</tr>
<tr>
<td>No. of DAYS-YR 1</td>
<td></td>
</tr>
<tr>
<td>No. of DAYS-YR 2</td>
<td>50-5</td>
</tr>
<tr>
<td>SUPERVISOR NAME</td>
<td>Mike George</td>
</tr>
<tr>
<td>PLACEMENT ADDRESS</td>
<td>24, Grafton Road (OPTIONS)</td>
</tr>
<tr>
<td></td>
<td>WORTHING</td>
</tr>
<tr>
<td></td>
<td>W. SUSSEX</td>
</tr>
<tr>
<td></td>
<td>BN11 1QP</td>
</tr>
<tr>
<td></td>
<td>01903 204539</td>
</tr>
</tbody>
</table>

OVERALL RATING FOR THE PLACEMENT

In the supervisor’s opinion, has the trainee reached the standard expected to pass the placement?

<table>
<thead>
<tr>
<th>COMMENT</th>
<th>TICK</th>
</tr>
</thead>
<tbody>
<tr>
<td>PASS</td>
<td>✓</td>
</tr>
<tr>
<td>PASS: The trainee has gaps in experience that need to be addressed later in training</td>
<td></td>
</tr>
<tr>
<td>PASS: The trainee needs to focus on specified areas of clinical skills in subsequent placements</td>
<td></td>
</tr>
<tr>
<td>FAIL: The trainee has not reached the standard expected</td>
<td></td>
</tr>
</tbody>
</table>

General Comments from Supervisor: Roberta has had ample opportunity in this placement to demonstrate the professionalism, empathy and maturity which she brings to her clinical work.

Signed: Michael George (Supervisor) Date 17-5-96

Comments from the trainee: I have thoroughly enjoyed my time at options. I have further developed my confidence, professional identity and felt well respected on both teams. I learned from all of my colleagues and felt safe enough to disagree with them at times!

Signed: Roberta Fry (Trainee) Date 17-5-96
The supervisor may raise questions or present options for the trainee to consider, but usually the trainee can present plans and make decisions on how to proceed which they have devised independently.

<table>
<thead>
<tr>
<th>SUPERVISOR - TRAINEE RELATIONSHIP</th>
<th>RATING</th>
<th>Explanation/Expansion of Rating/Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>3</td>
<td></td>
</tr>
</tbody>
</table>

The trainee does not usually require observation, monitoring or detailed questioning to maintain the standard of work, but this is used to 'fine tune' skills. The trainee self-monitors and identifies the need for assistance in normal circumstances.

|                                   | 3      |                                          |

The trainee shows a balance between autonomy and the use of support and advice which is appropriate to their level of skills, the client and the service setting.

|                                   | 3      |                                          |

In your opinion, does the trainee reach the standard expected:

- 3 YES - Above expected level - please expand
- 2 YES - At expected level - please expand
- 1 NO  - Borderline - please expand
- 0 NO  - Please explain
- N/A Not applicable
<table>
<thead>
<tr>
<th>ASSESSMENT, FORMULATION, CLINICAL EVALUATION</th>
<th>RATING</th>
<th>Explanation/Expansion of Rating/Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.1 The trainee can convert presenting problems into questions that can be delineated within a psychological perspective and with measurable solutions.</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>1.2 The trainee has good knowledge of the range of assessment procedures available and is able to choose the appropriate one to use in straightforward situations.</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>1.3 to 1.6 The trainee carries out procedures and collects information in an objective way, yet retains a sensitive stance with clients and is able to recognize factors that limit the reliability and validity of assessment.</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>1.3 Psychometric measurement</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.4 Other formal psychological assessments</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>1.5 Behavioural/observational assessments &amp; functional analysis</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>1.6 Other assessments</td>
<td>2</td>
<td>level of addiction/quantity of substance misuse</td>
</tr>
<tr>
<td>1.7 The trainee separates fact from interpretation, can integrate information from a variety of perspectives, compares and contrasts models; devises a formulation independently that encompasses multifactorial elements.</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>1.8 The trainee can devise a realistic and appropriate intervention plan based on an appropriate therapeutic model.</td>
<td>3</td>
<td></td>
</tr>
</tbody>
</table>
1. The trainee can plan an overall intervention strategy, evaluate progress, re-formulate and modify the intervention plan.

2. Evaluation of clinical interventions: the trainee understands the importance of evaluation in clinical work; chooses and uses appropriately common methods and can modify measures for a new situation.

<table>
<thead>
<tr>
<th>THERAPY AND INTERVENTION SKILLS</th>
<th>RATING</th>
<th>Explanation/Expansion of Rating/Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.1 The trainee takes overall responsibility for action in relation to routine client matters such as making appointments, setting up meetings with colleagues etc.</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>2.2 The trainee can handle unplanned and unexpected events in a therapy session in an effective and controlled way to the benefit of the client, referring back to the supervisor.</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>2.3 The trainee engages the client, communicates appropriately to them, demonstrates awareness of what is clinically relevant and is sensitive and flexible in applying techniques. This particularly applies to clients from different cultural or ethnic backgrounds, or at different levels of intellectual and linguistic ability.</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>2.4 Communication of psychological information or opinion. The trainee can present psychological information or opinion to clients, relatives and/or carers and staff effectively, modifying language appropriately, using the appropriate style and addressing concerns raised in a facilitative manner.</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>2.5 Interviewing: The trainee interviews clients effectively and appropriately, keeps control of the session, keeps to a structure yet allows the client to express their own issues.</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>2.6 to 2.10 The trainee demonstrates effective therapy skills both at a general level and in the use of particular models; the supervisor gives feedback primarily to 'fine tune' their skills.</td>
<td>2.6 Individual therapy work:</td>
<td>3</td>
</tr>
<tr>
<td>2.7 Therapy work with couples:</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>2.8 Therapy work with families</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>2.9 Directive/behavioural groups:</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>2.10 Non-directive/psychotherapeutic groups:</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>2.11 Indirect client work: The trainee demonstrates effective skills both at a general level and in relation to the particular requirements of the setting; the supervisor gives feedback primarily to 'fine tune' their skills.</td>
<td></td>
<td>N/A</td>
</tr>
<tr>
<td>2.12 Client work within a formal system (such as IPP): The trainee demonstrates effective skills both at a general level and in relation to the particular requirements of the system; the supervisor gives feedback primarily to 'fine tune' their skills.</td>
<td></td>
<td>?</td>
</tr>
<tr>
<td>2.13 Trainee handles termination of client contract effectively (either end of treatment or end of placement), dealing with both practical issues and the emotional aspect.</td>
<td>3</td>
<td>particular sensitivity to the issue of closure.</td>
</tr>
</tbody>
</table>

### THE DEVELOPMENT OF PROFESSIONALISM

<table>
<thead>
<tr>
<th>RATING</th>
<th>Explanation/ Expansion of Rating/Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.1 The trainee knows the background, structure and future trends of the profession that underlie the work of clinical psychologists sufficient to relate it appropriately to the placement.</td>
<td>2</td>
</tr>
<tr>
<td>3.2 The trainee understands the history, philosophy, structure, working rules and procedures that relate to the particular placement.</td>
<td>2</td>
</tr>
<tr>
<td>3.3</td>
<td>The trainee demonstrates effective work management skills (time management, record keeping, reliability and administrative independence).</td>
</tr>
<tr>
<td>3.4</td>
<td>The trainee demonstrates self management skills (awareness of skill limitations when overworked, stressed or needing personal support).</td>
</tr>
<tr>
<td>3.5</td>
<td>The trainee presents in a professional way to the client and maintains a proper and effective therapeutic relationship, maintaining an over-riding concern for the client's interests, an awareness of the boundaries of competence and of ethical and procedural guidelines that apply.</td>
</tr>
<tr>
<td>3.6</td>
<td>Equal opportunities/equality of access: The trainee understands the importance of these factors in service provision within the health and social services and addresses them within their work, particularly in relation to attitudes and skills in client work.</td>
</tr>
<tr>
<td>3.7</td>
<td>The trainee presents well and relates effectively to colleagues both in psychology and elsewhere within the NHS and other agencies.</td>
</tr>
<tr>
<td>3.8</td>
<td>The trainee makes a positive contribution in verbal communication, presents material clearly, concisely and well structured, can separate fact from interpretation, incorporate information and opinions from others, can argue effectively and negotiate to a satisfactory outcome in normal circumstances within the placement.</td>
</tr>
<tr>
<td>3.9</td>
<td>The trainee presents material clearly and concisely in written communication, and makes good use of structure; separates fact from interpretation and relevant from irrelevant material; has a flexible style depending on the needs of the recipient.</td>
</tr>
</tbody>
</table>

Robert showed a high level of professionalism and clarity in all her communication with colleagues.
3.10 The trainee demonstrates an understanding of the range of roles that psychologists might undertake, such as teaching, supervision, consultancy, research project work and service development.

<table>
<thead>
<tr>
<th>THE DEVELOPMENT OF AWARENESS AND COMPETENCE IN SERVICE AND ORGANISATIONAL ISSUES</th>
<th>RATING</th>
<th>Explanation/Expansion of Rating/Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>4.1 The trainee demonstrates a balanced and realistic awareness of how organisational factors impinge on client work both directly and through staff practices.</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>4.2 The trainee works appropriately and effectively within the boundaries and constraints of organisations and settings.</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>4.3 The trainee works appropriately and effectively within the boundaries and constraints of a multi-disciplinary team.</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>4.4 The trainee understands, and is knowledgeable, in relation to the skills and work practices of other professions and other staff groups.</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>4.5 The trainee is able to analyse and describe, with some independence, some psychological processes active within groups, settings or organisations.</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>4.6 The trainee is able to describe, with some level of independence, the psychological skills and methods required to produce change within groups, settings or organisations.</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>4.7 Presentation: The trainee prepares the material in terms of structure and content, relevant to the needs of the audience; displays effective verbal and non-verbal skills; shows effective use of time; chooses appropriate style (didactic or facilitative) relevant to the audience.</td>
<td>3</td>
<td>I observed presentations by Robertah! The Options Team (x2) and to the psychology dept. all well prepared and delivered.</td>
</tr>
</tbody>
</table>
### 4.8 Teaching
The trainee prepares the material in terms of structure and content, relevant to the needs of the audience; displays effective verbal and non-verbal skills; shows effective use of time; chooses appropriate style (didactic or facilitative) relevant to the audience. The trainee chooses assessment and evaluation materials.

### 4.9 If the trainee has undertaken work in any of the following areas, please tick and briefly describe the work, and comment on the skills used and level of expertise displayed:
- consultancy
- supervision
- project work
- service development work

### 5. The Shift to Work Being Grounded in Psychological Principles from Being Orientated in Relation to Specific Techniques

<table>
<thead>
<tr>
<th>RATING</th>
<th>Explanation/Expansion of Rating/Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>3</td>
<td></td>
</tr>
</tbody>
</table>

5.1 The trainee is able to perceive issues from different perspectives; draws information from a variety of sources and develops it into an individualised framework; can see how facts can be conceptualised in different ways - using supervisor primarily as a sounding board for own thinking processes.

5.2 The trainee approaches work from a theoretical stance with a broad vision of the general applicability of principles of practice, integrating theories from general psychology and those specific to settings or client groups.
| 5.3 Generic skills: The trainee draws on therapeutic skills techniques and methods from the range of client groups, and uses them with appropriate modifications for the individual client. | 3 |
ADULT SPECIALIST PLACEMENT

5 December 1995 → 11 June 1996 (19 clinical days)

AIMS

1. To further develop core therapeutic skills.

2. To facilitate the integration of the themes and issues encountered during the four core placements, in order to enable the trainee to fully appreciate developmental and life span issues across Specialty work.

THERAPY SKILLS

Develop greater awareness of the process of establishing the therapeutic alliance, e.g., through interpersonal contact; accurate empathy and unconditional positive regard.

SCIENTIFIC METHOD

Provide a clear emphasis upon formulation and the process of therapy by:

1. Spending more time for the assessment and planning of an intervention.

2. Making more use of a process record of sessions.

3. Making more use of written records to develop structure and conceptual skills.

PROFESSIONAL ISSUES

Develop and refine trainee's own style of working therapeutically.

AGREED FOCUS OF THE PLACEMENT

To develop understanding of the Cognitive-Behavioural Model and learn how to apply it to client work.

[Signature]

Rebecca Fry
Trainee's Name: Roberta Fry
Placement Type: Specialist
Supervisor's Name: John 
Date: 5.12.95 - 11.06.96
Placement District: Worthing

Summary of Clinical Activity

Please indicate at the end of your placement what you have covered under the following seven categories:

1) Clinical activity with individual clients, couples and families - use attached sheet C
2) Group work - use attached sheet B
3) Teaching/Skills transmission/presentations
   Outline each experience of teaching, indicating what, to whom, how organised, the extent of your role and its degree of success:
   18-4-96. Presented my Psych D Research Proposal to the Psychology Department.
4) Organisational Work (e.g. developing IPP system, staff support, assessing case recording system). Outline each piece of work, indicating the extent of your role and outcome:
5) RESEARCH

Outline any projects which you initiated or with which you were involved and indicate the extent of your involvement:

6) MEETINGS, VISITS, OBSERVATIONS

Outline briefly each experience and the extent of your involvement:
7) COURSES AND TRAINING EVENTS ATTENDED AS PART OF PLACEMENT

Please list and outline each one:

8) OTHER

Please outline any other experience on placement:

- 24.2.96. Listened to an audio tape recording of a lecture given by Dr. Scott-Gliba about "Brief Solution Focused Therapy".
- 25-3-96 Attended Introductory Course in Psychodynamic Concepts for Clinical Psychologists at the Tavistock Clinic.
- Signed: Roberta Fry. Trainee. Date: 26/6/1996.

Signed: Name. Supervisor. Date: 9/7/96.

12-7-96 Attended "Creating a Secure Family Base: Implications of Attachment Theory of Family Therapy" by Dr. John Byng-Hall.
<table>
<thead>
<tr>
<th>Sex</th>
<th>Age</th>
<th>Assessment</th>
<th>Intervention</th>
<th>Type of Contact</th>
<th>Presenting Needs</th>
<th>Model of Therapy</th>
<th>No. of Hours</th>
<th>Outcome/ Evaluation</th>
<th>Additional Info/Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>M</td>
<td>26</td>
<td>Clinical Interview and Diaries</td>
<td>FI</td>
<td>S</td>
<td>Obsessive-Compulsive Disorder</td>
<td>Cognitive-Behavioural</td>
<td>8</td>
<td>Good Outcome. No longer worries about hearing obsessive thoughts and able to cope.</td>
<td></td>
</tr>
<tr>
<td>F</td>
<td>21</td>
<td>Clinical Interview and Diaries</td>
<td>FI</td>
<td>S</td>
<td>Bulimia</td>
<td>Cognitive-Behavioural</td>
<td>13</td>
<td>Excellent outcome for eating disorder and relationship difficulties</td>
<td></td>
</tr>
</tbody>
</table>

* = Born in France, moved to UK age 19.
EVALUATION OF THE TRAINEE ON PLACEMENT

<table>
<thead>
<tr>
<th>TRAINEE NAME</th>
<th>Roberta Fry</th>
</tr>
</thead>
<tbody>
<tr>
<td>PLACEMENT TITLE</td>
<td>Specialist Adult Placement</td>
</tr>
<tr>
<td>PLACEMENT DATES</td>
<td>5/12/95 - 11/6/96 1 session a week</td>
</tr>
<tr>
<td>No. of DAYS-YR 1</td>
<td>19</td>
</tr>
<tr>
<td></td>
<td>YR 2</td>
</tr>
<tr>
<td>SUPERVISOR NAME</td>
<td>Mr. John Le Lievre</td>
</tr>
<tr>
<td>PLACEMENT ADDRESS</td>
<td>16, Liverpool Gardens, Worthing, West Sussex, BN11 1RJ, Tel: 01903 820672</td>
</tr>
</tbody>
</table>

OVERALL RATING FOR THE PLACEMENT

In the supervisor's opinion, has the trainee reached the standard expected to pass the placement?

<table>
<thead>
<tr>
<th>COMMENT</th>
<th>TICK</th>
</tr>
</thead>
<tbody>
<tr>
<td>PASS</td>
<td>✓</td>
</tr>
<tr>
<td>PASS: The trainee has gaps in experience that need to be addressed later in training</td>
<td></td>
</tr>
<tr>
<td>PASS: The trainee needs to focus on specified areas of clinical skills in subsequent placements</td>
<td></td>
</tr>
<tr>
<td>FAIL: The trainee has not reached the standard expected</td>
<td></td>
</tr>
</tbody>
</table>

General Comments from Supervisor:

Roberta came to the placement with a basic grounding in Cognitive-Behavioural work and was able to develop this by working in a more cognitive framework.

Signed John Le Lievre (Supervisor) Date 9/7/96

Comments from the trainee:

An excellent grounding in the Cognitive-Behavioural model. It has been helpful to use the model again with adult clients and to focus on both my formulation and information giving skills.

Signed Roberta Fry (Trainee) Date 26/6/96
### SUPERVISOR - TRAINEE RELATIONSHIP

<table>
<thead>
<tr>
<th>Rating</th>
<th>Explanation/Expansion of Rating/Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>The supervisor may raise questions or present options for the trainee to consider, but usually the trainee can present plans and make decisions on how to proceed which they have devised independently.</td>
</tr>
<tr>
<td></td>
<td>The trainee does not usually require observation, monitoring or detailed questioning to maintain the standard of work, but this is used to &quot;fine tune&quot; skills. The trainee self monitors and identifies the need for assistance in normal circumstances.</td>
</tr>
<tr>
<td></td>
<td>The trainee shows a balance between autonomy and the use of support and advice which is appropriate to their level of skills, the client and the service setting.</td>
</tr>
</tbody>
</table>

**In your opinion, does the trainee reach the standard expected:**

- 3  YES - Above expected level - please expand
- 2  YES - At expected level - please expand
- 1  NO - Borderline - please expand
- 0  NO - Please explain
- N/A Not applicable
1.9 The trainee can plan an overall intervention strategy, evaluate progress, re-formulate and modify the intervention plan.

1.10 Evaluation of clinical interventions: the trainee understands the importance of evaluation in clinical work; chooses and uses appropriately common methods and can modify measures for a new situation.

<table>
<thead>
<tr>
<th>THERAPY AND INTERVENTION SKILLS</th>
<th>RATING</th>
<th>Explanation/Expansion of Rating/Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.1 The trainee takes overall responsibility for action in relation to routine client matters such as making appointments, setting up meetings with colleagues etc.</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>2.2 The trainee can handle unplanned and unexpected events in a therapy session in an effective and controlled way to the benefit of the client, referring back to the supervisor.</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>2.3 The trainee engages the client, communicates appropriately to them, demonstrates awareness of what is clinically relevant and is sensitive and flexible in applying techniques. This particularly applies to clients from different cultural or ethnic backgrounds, or at different levels of intellectual and linguistic ability.</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>2.4 Communication of psychological information or opinion. The trainee can present psychological information or opinion to clients, relatives and/or carers and staff effectively, modifying language appropriately, using the appropriate style and addressing concerns raised in a facilitative manner.</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>2.5 Interviewing: The trainee interviews clients effectively and appropriately, keeps control of the session, keeps to a structure yet allows the client to express their own issues.</td>
<td>2</td>
<td></td>
</tr>
</tbody>
</table>
### 3.3 The trainee demonstrates effective work management skills (time management, record keeping, reliability and administrative independence).

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2</td>
</tr>
</tbody>
</table>

### 3.4 The trainee demonstrates self management skills (awareness of skill limitations when overworked, stressed or needing personal support).

<table>
<thead>
<tr>
<th></th>
<th>2</th>
</tr>
</thead>
</table>

### 3.5 The trainee presents in a professional way to the client and maintains a proper and effective therapeutic relationship, maintaining an over-riding concern for the client's interests, an awareness of the boundaries of competence and of ethical and procedural guidelines that apply.

<table>
<thead>
<tr>
<th></th>
<th>2</th>
</tr>
</thead>
</table>

### 3.6 Equal opportunities/equality of access: The trainee understands the importance of these factors in service provision within the health and social services and addresses them within their work, particularly in relation to attitudes and skills in client work.

<table>
<thead>
<tr>
<th></th>
<th>NA</th>
</tr>
</thead>
</table>

### 3.7 The trainee presents well and relates effectively to colleagues both in psychology and elsewhere within the NHS and other agencies.

<table>
<thead>
<tr>
<th></th>
<th>2</th>
</tr>
</thead>
</table>

### 3.8 The trainee makes a positive contribution in verbal communication, presents material clearly, concisely and well structured, can separate fact from interpretation, incorporate information and opinions from others, can argue effectively and negotiate to a satisfactory outcome in normal circumstances within the placement.

<table>
<thead>
<tr>
<th></th>
<th>2</th>
</tr>
</thead>
</table>

### 3.9 The trainee presents material clearly and concisely in written communication, and makes good use of structure; separates fact from interpretation and relevant from irrelevant material; has a flexible style depending on the needs of the recipient.

<table>
<thead>
<tr>
<th></th>
<th>2</th>
</tr>
</thead>
</table>
The trainee demonstrates an understanding of the range of roles that psychologists might undertake, such as teaching, supervision, consultancy, research project work and service development.

<table>
<thead>
<tr>
<th>THE DEVELOPMENT OF AWARENESS AND COMPETENCE IN SERVICE AND ORGANISATIONAL ISSUES</th>
<th>RATING</th>
<th>Explanation/Expansion of Rating/Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>4.1 The trainee demonstrates a balanced and realistic awareness of how organisational factors impinge on client work both directly and through staff practices.</td>
<td>NA</td>
<td></td>
</tr>
<tr>
<td>4.2 The trainee works appropriately and effectively within the boundaries and constraints of organisations and settings.</td>
<td>NA</td>
<td></td>
</tr>
<tr>
<td>4.3 The trainee works appropriately and effectively within the boundaries and constraints of a multi-disciplinary team.</td>
<td>NA</td>
<td></td>
</tr>
<tr>
<td>4.4 The trainee understands, and is knowledgeable, in relation to the skills and work practices of other professions and other staff groups.</td>
<td>NA</td>
<td></td>
</tr>
<tr>
<td>4.5 The trainee is able to analyse and describe, with some independence, some psychological processes active within groups, settings or organisations.</td>
<td>NA</td>
<td></td>
</tr>
<tr>
<td>4.6 The trainee is able to describe, with some level of independence, the psychological skills and methods required to produce change within groups, settings or organisations.</td>
<td>NA</td>
<td></td>
</tr>
<tr>
<td>4.7 Presentation: The trainee prepares the material in terms of structure and content, relevant to the needs of the audience; displays effective verbal and non-verbal skills; shows effective use of time; chooses appropriate style (didactic or facilitative) relevant to the audience.</td>
<td>NA</td>
<td></td>
</tr>
</tbody>
</table>
4. Teaching: The trainee prepares the material in terms of structure and content, relevant to the needs of the audience; displays effective verbal and non-verbal skills; shows effective use of time; chooses appropriate style (didactic or facilitative) relevant to the audience. The trainee chooses assessment and evaluation materials.

4.9 If the trainee has undertaken work in any of the following areas, please tick and briefly describe the work, and comment on the skills used and level of expertise displayed:

- consultancy
- supervision
- project work
- service development work

5. THE SHIFT TO WORK BEING GROUNDED IN PSYCHOLOGICAL PRINCIPLES FROM BEING ORIENTATED IN RELATION TO SPECIFIC TECHNIQUES

<table>
<thead>
<tr>
<th>RATING</th>
<th>Explanation/Expansion of Rating/Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

5.1 The trainee is able to perceive issues from different perspectives; draws information from a variety of sources and develops it into an individualised framework; can see how facts can be conceptualised in different ways - using supervisor primarily as a sounding board for own thinking processes.

5.2 The trainee approaches work from a theoretical stance with a broad vision of the general applicability of principles of practice, integrating theories from general psychology and those specific to settings or client groups.
Generic skills: The trainee draws on therapeutic skills techniques and methods from the range of client groups, and uses them with appropriate modifications for the individual client.
Research Chapter

The research chapter of the portfolio consists of three pieces of work. The first, 'Measuring awareness of deficit after head injury : A review' was a literature review carried out during the first year.

The second piece 'First steps in treatment planning on an adolescent unit : A personal construct analysis' was the second year piece of research conducted on placement during my time with a child and adolescent service.

The third and final piece 'Examining the relationships between conflicting self-beliefs, emotional distress and severity of alcohol dependence in both relapsing and abstinent alcoholics.' represents the third year research project.
MEASURING AWARENESS OF DEFICIT AFTER HEAD INJURY: A REVIEW

INTRODUCTION

Investigation into impaired awareness of deficits sustained after head injury has potentially important theoretical and clinical consequences. First, data collected from controlled, clinical trials designed to elucidate the underlying neural mechanisms, should provide an empirical basis for advancing neuropsychological models of the brain systems involved. Second, research concerning unawareness of deficits is likely to produce findings which existing cognitive theories of awareness and consciousness should be able to explain. Such evidence represents a potentially rich source of material for cognitive theorists. Third, the identification and monitoring of unawareness has considerable implications for the rehabilitation of brain injured patients, by clarifying the effects of awareness, or lack of it, upon progress in rehabilitation. (Prigatano et al, 1986; Ben-Yishay and Prigatano, 1990). Fourthly, by systematically studying the subset of brain damaged patients who exhibit defensive denial, clinicians will be able to develop a neuropsychological approach to defensive denial, which will provide an alternative to the psychiatric framework currently employed.

Since the turn of the century, experimental and clinical observations have been made into the nature of impaired human awareness. However, systematic, rigorous research into unawareness of deficits has only just begun, and the findings remain poorly understood. A number of key questions remain unanswered. For instance, what is the 'course' of unawareness in different patient groups? and can clinicians develop effective therapeutic interventions to remedy unawareness which is interfering in everyday functioning? In order to answer these questions an adequate measure of unawareness is required. The construction of such a measure has been delayed because of the initial assumption that awareness is an all or nothing, monolithic entity.
Fortunately, there is growing acceptance of the need for a model of unawareness which postulates that it can take many forms. This review is based upon that assumption.

The purpose of this review is to consider the properties of measures specifically developed to investigate awareness after head injury. In order to make meaningful comparisons I will consider them in relation to four of the five forms of unawareness described by Schachter and Prigatano (1991). The fifth, "neural bases of unawareness" will not be used as the measures investigated do not provide data relevant to such a label. Therefore the following forms were considered the most appropriate with which to evaluate the measures.

1) Level of unawareness

A distinction can be made between unawareness of the existence of a neurological deficit itself and unawareness of some of the consequences of the deficit. This can be detected when a discrepancy occurs between verbal acknowledgement of a deficit alongside difficulties with on-line monitoring of performance effected by the deficit. For example aphasic patients who recognise the existence of their deficit but fail to notice when they make a linguistic error.

2) Specificity of unawareness

Different measures may tap different processes, which in turn can support either "aware" or "unaware" performance, depending on the level of functioning of the specific processes that are tapped in particular patients. Because of the specific nature of the different measures used it would seem appropriate to use multiple measures in order to obtain a comprehensive "awareness profile" for each individual studied (Germino and McCorkle, 1985)
3) Partial / implicit knowledge of deficits
A discrepancy can be seen between verbal denial of a deficit itself with certain aspects of behaviour or linguistic expressions which betray some knowledge of it.

4) Defensive denial
Refers to the ego protecting mechanism observed in non-head injured people, which is believed to play a part in some brain injured people's unawareness of deficits. The difficulty lies in determining the extent of it's contribution along side neurological bases of unawareness.

In addition, a number of researchers used existing measures to further our knowledge in this area. But did not provide sufficiently extensive information to be included in the review. These studies were:


REVIEW OF TESTS
The review will be divided into three sections depending on the type of measure: patient's self report only; relatives and / or staff ratings only; both patient and relative / staff ratings.
MEASURES USING SELF REPORT ALONE


Content: assesses patients' self ratings of cognitive functioning on 29 seven point likelihood scales ranging from severe problem to definite strength.

Reliability: Factor analysis yielded six factors. Sensorimotor, attention, language, arithmetic, learning and memory and logical thinking. Six corresponding neuropsychological measures were selected in order to compare the factors against test performances.

Validity: Correlations calculated between self ratings and neuropsychological performance showed that patients did not relate their cognitive functions in correspondence with test performance. Accuracy was not uniform across groups and functional areas. Also normal controls were not consistently more realistic than clinical samples.

Levels of unawareness: May acknowledge difficulties on the SDQ but not notice them during test performance.

Specificity of unawareness: Use of corresponding neuropsychological measures allows a degree of specificity.

Partial / implicit knowledge of deficits: Possibility during test performance that language or behaviour may reveal some previously unacknowledged difficulty.

Defensive / motivated denial: No.

Inform treatment: Identifies patients beliefs about their cognitive functioning which because of their influence on behaviour, could be a useful target for intervention.


Contents: assesses the short and long term behavioural and social adjustment problems of mild head injured patients (e.g. loss of consciousness < 24 hours). Inventory includes 24 questions about temperament and emotionality (severity determined by observation); activities and social behaviour and physical capabilities. PAI scores may be based on reports by patients and family members as well as trained
observers. Situational data determine some scores. Data collected at regularly scheduled cognitive examinations, conducted by neuropsychological technician.

**Reliability:** No.

**Validity:** No.

**Levels of unawareness:** No.

**Specificity of unawareness:** Could compare subjects performance on cognitive tests with their self report on the PAL.

**Partial/ implicit knowledge of deficits:** Language or behaviour during testing may belie some knowledge of deficits not captured by the PAI.

**Defensive/ motivated denial:** Familiar pattern of increasing difficulties with anxiety, depression and significant relationships during first 12 - 24 months post injury. Then improvement seen through third or fourth year. Possibly due to "increased awareness of their altered status may be accompanied by emotional distress." Whether increased awareness is due to improvement in neurological functioning or weakening of defensive denial is still not apparent.

**Inform treatment:** Identified emotional, social and physical difficulties in mild head injured adults 5 years post injury with no signs to suggest they would get better without professional help.

3) **Tyerman and Humphrey (1984) Semantic differential technique.**

**Contents:** 20 item semantic differential scale completed in respect to present self, past self, future self, typical head injured person and typical person of their own sex and age.

**Reliability:** No.

**Validity:** The proportion of the current group (72%) reporting some subjective personality change is comparable to that reported by relatives in a number of other studies (Thomsen, 1974; Weddell et al., 1980; McKinlay et al, 1981).

**Levels of unawareness:** No.

**Specificity of unawareness:** No.
Partial/ implicit knowledge of deficits: No.

Defensive/ motivated denial: Patients at seven months post injury stage rate themselves slightly more positively than a typical head injured person and not dissimilar from a typical person, seemingly to retain self esteem. Although as Deaton (1986) has noted denial may be an inappropriate term because "the similarity of ratings may instead reflect the difficulty with which our self concept changes" and be more closely linked to unawareness rather than denial.

Inform treatment: Authors suggest that the technique proved to be of "immediate cathartic value" and provides a "framework for future therapy". Re-administration of the technique could inform clinical judgement as to when to confront a patient's lack of realism.

RELATIVES AND / OR STAFF MEASURES ALONE


Contents: included 90 items related to objective burden for carers (e.g. patients physical and mental state, behaviour and self-care ability). Subjective burden was assessed using a seven point rating scale (see McKinlay et al (1981)).

Reliability: Likely to be high as the interview is structured and does not require specialised training to administer it.

Validity: Choice of questions was dictated by an examination of the relevant literature and by the author's clinical experience.

Levels of unawareness: No.

Specificity of unawareness: No.

Partial / implicit knowledge of deficits: No.

Defensive / motivated denial: Not investigated directly, however the late increase in behaviour disturbance reported by relatives maybe as a result of "increasing experience of interacting with the injured patient" so that relatives come to "identify problems that had been brushed aside or considered to be insignificant or denied earlier after injury."
Inform treatment: Need to be aware of the burden and its course on relatives and ways of ameliorating it supported.

Contents: Wide ranging interview designed to assess many aspects of psycho-social recovery, including personality and behavioural change. Also used "personality" checklist containing bipolar adjectives.
Reliability: as for 4
Validity: as for 4
Levels of unawareness: No.
Specificity of unawareness: No.
Partial / implicit knowledge of deficits: No.
Defensive / motivated denial: No.
Inform treatment: Relatives who perceive a "high burden," have a greater likelihood of reporting that the patient's personality has changed (92 %) than those in the "low-medium" burden category (50 %). The authors suggest that after the first six months of injury during which physical recovery is at its maximum, rehabilitation efforts should be directed towards the patient and their family. "Teaching the family members to recognise, and to manage personality and behaviour change in the patient may be a crucial aspect of rehabilitation for this group of patients."

Contents: 41 questions divided into 4 main categories: Remote memory; Recent memory; questions that could be answered by using cues in the room and finally questions which frequently drew an appropriate "I don't know" reply from a non-neurological control group. After completing the standard interview, the patient was asked to re-answer 3 questions to which they had previously replied "I don't know". The author hypothesised that "a tendency to confabulate on re answering would reflect
individual personality characteristics rather than degree of amnestic disorder. "Responses, including latencies, comments and expressive reactions were recorded. Responses were scored as "correct," "wrong," "I don't know" or "confabulation." The correct answer to each question was obtained from the patient's hospital record or family.

Reliability: No.
Validity: No.

Levels of unawareness: No.
Specificity of unawareness: No.
Partial / implicit knowledge of deficits: No.
Defensive denial: No.

Inform treatment: Confabulation is likely to occur when the following factors are present: the patient believes a response is required; accurate memory of the answer is lacking; an over learned and affectively significant response is available and the ability to monitor or self-correct is defective.

7) Oddy, Humphrey and Uttley (1978) Interview and other measures.

Contents: within a month of the injury relatives were asked to complete the Wakefield Scale (Snaith et al, 1971) and the Katz Adjustment Scale (Katz and Lyerly, 1963). Then at six months post injury relatives were also asked questions regarding the nature of any stresses or anxieties they were experiencing. Any physical or emotional illnesses the relative had suffered during the previous six months, and whether the relative was satisfied with the supportive services provided.

Reliability: No.
Validity: Demonstrates face validity.

Levels of unawareness: No.
Specificity of unawareness: No.
Partial/ implicit knowledge of deficits: No.
Defensive/ motivated denial: No.
Inform treatment: Findings "underline the importance of helping patients to readjust
to family and social life as well as work." and that "marital and parental counselling
should form part of the routine after-care of brain-damaged patients."

8) Starkstein, Federoff, Price and Robinson (1993): Hamilton Depression and
Anxiety Scales (HDS, HAS); Present State Examination (PSE); Mini Mental
State Examination; John Hopkins Functioning Inventory (JHFI); Social Ties
Checklist (STC); Neuropsychological examination and Denial of Illness Scale
(DIS).

10 items scored on the presence of either motor or visual deficits only. Severity was
assessed using a 0-1 or 0-2 scale. It was scored by the interviewer after the completion
of a standardised interview to obtain date and cause of head injury, demographic data,
mood changes, deficits in activities of daily living and cognitive impairment.

Reliability: Inter-rater reliability was high. DIS showed a high degree of internal
consistency.

Validity: Patients were interviewed by a second interviewer using the Anosognosia
Questionnaire (AQ) to provide external validation of DIS. Their replies enabled the
examiners to classify them into four groups (no denial, mild, moderate or severe denial
of illness). One way ANOVA showed significant different DIS scores between the
four groups. Planned comparisons using a Fischer PLSD test showed significant
differences in DIS scores between patients in the different groups. There were also
significant differences between patients with mild versus severe anosognosia, and
patients with moderate versus severe anosognosia. Multiple regression using DIS score
as dependent variable and the scores of visual and auditory extinction on double-
simultaneous stimulation, motor impersistence, personal neglect, and hemispatial
neglect on drawing as independent variables was significant, with neglect variables
accounting for 46 % of the variance in DIS score. Also found a significant positive
correlation between DIS scores and the total number of anosognosic phenomena (e.g. phantom limb).

Levels of unawareness: The anosognosia questionnaire presents questions moving from the general to the specific and can be used to establish a patient's overall level of awareness.

Specificity of unawareness: No.

Partial/ implicit knowledge of deficits: Language or behaviour during anosognosia questionnaire may reveal partial awareness of deficits.

Defensive denial: Found significantly higher DIS scores in patient's with right temporoparietal or thalamic lesions (traditionally linked with the denial of illness phenomenon) than patients with lesions in other brain areas, offering evidence against the concept of motivated denial in favour of the neurological hypothesis.

Inform treatment: DIS may provide a useful measure to establish the presence and severity of unawareness of visual and motor deficits in stroke victims. Would be easy to re-administer and useful for monitoring the course of awareness in these patients.

BOTH PATIENT AND STAFF / RELATIVES RATINGS USED


Contents: a 30 item 5-point rating scale asking the informant to judge the competency with which the patient is able to perform a variety of everyday activities.

Reliability: Interstaff ratings calculated before staff discussion show high reliability, and patient test-retest consistency appears adequate over 1-2 weeks.

Validity: No.

Levels of unawareness: No.

Specificity of unawareness: Comparison of staff-patient ratings on PCRS identified 3 groups of patients. The first rated their dysfunction at the same level as staff, both
before and after rehabilitation. Group 2 and 3 patients greatly underestimated their initial levels of dysfunction, but group 2 patient's ratings moved closer to staff ratings after rehabilitation whilst group 3 patients perceptions moved further away.

**Partial / implicit knowledge of deficits:** Language or behaviour may reveal implicit knowledge of deficits.

**Defensive denial:** "Increase in group three's PCRS ratings and the associated increased emotional distress may have reflected a defensive reaction to repeated confrontation with the realities of their injury."

**Inform treatment:** No.


**Contents:** Head Injury Behaviour Scale (HIBS) contains twenty four items describing behavioural problems commonly associated with head injury (e.g. impulsivity) Each item is rated on a seven point likert scale. It was administered to both the patients (HIBS-SELF) and the close others (HIBS-OTHER). Two scores were computed from HIBS-self data: number of problems and a distress score. Number of problems was also computed from the HIBS-other data. Also administered the Neuropsychological Impairment Scale (NIS; O Donnell, Reynolds, and De Soto, 1984) which contains 45 items describing neuropsychological symptoms, which are rated on a three point scale. The NIS was completed by the patient (NIS-SELF) and their close other (NIS-OTHER).Patients also undertook a video-recorded Social Skill Assessment in which they spent 15 minutes getting to know a female interactor "just like you would if you had met elsewhere for the first time". Afterwards they were asked to rate how socially skilled they thought they had appeared during the conversation. Ratings were made on a 7 point rating scale. Three graduate psychology students were trained to rate the patients social skill level during the conversation on a scale identical to that used for the patient self ratings. Finally, patients completed the Zung Self Rating Depression Scale (SDS; Zung 1964); the Anxiety Trait Scale of Spielberger State-Trait Anxiety
Inventory, Form Y (STAI-Y; Spielberger, Gorsuch, Lushene, Vagg and Jacobs, 1983); and the Rosenberg Self-Esteem Inventory (RSE; Rosenberg 1965).

**Reliability:** The HIBS has high internal consistency. The HIBS-other number of problems score correlates significantly with clinician ratings of the severity of patients problem behaviour on the Social Behaviour Assessment Schedule. For the video-recorded Social Skill Assessment, interrater reliability was high.

**Validity:** Demonstrates face validity.

**Levels of unawareness:** Potentially revealed by differences between HIBS-self and HIBS-other scores and NIS-self and NIS-other scores. Also, potential for a difference in self rated social skills performance from that agreed upon by trained raters.

**Specificity of unawareness:** If the 24 items on the HIBS were used in the Social Skills rating by judges then specificity could be demonstrated e.g. patient may acknowledge impulsivity on a rating scale but not spontaneously mention it in an overall behavioural rating. Specificity may also be revealed by any discrepancy between the patients self rating of social skills and that reached by trained judges. However the rating task was not the same for patients and judges and in future both patients and judges should rate videotaped social behaviour (in the current study patients judged their performance retrospectively whereas judges rated "on-line" video performance).

**Partial/ implicit knowledge of deficits:** Possibility during social skills task that language or behaviour may reveal some previously unacknowledged difficulty.

**Defensive/ motivated denial:** No.

**Inform treatment:** The social skills assessment if extended to include other situations could provide a baseline measure prior to introducing social skills training. The use of video taped scenarios would provide useful feedback which the patient can consider and discuss. Then the original scenarios could be used to measure any changes in the patients performance, and highlight those areas requiring further attention.

Contents: using a 5 point rating scale to rate changes for 3 areas of functioning: physical, emotional and cognitive. Administered to 20 closed head injured adults with moderate to good recovery (Glasgow Coma Outcome Scale) 20 controls and 13 family members.

Reliability: No.

Validity: No.

Levels of unawareness: Head injured subjects agreed with relatives ratings as far a physical change was concerned but differed in the areas of cognitive and emotional change.

Specificity of unawareness: No.

Partial / implicit knowledge of deficits: No.

Defensive / motivated denial: Possibility raised by the author that less severely injured patients may experience and recognise a greater loss in cognitive abilities than more damaged patients, and therefore use denial as a coping response.

Inform treatment: Head injured people may require counselling to "cope with perceived and real physical and psychosocial limitations resulting from head injury." Questionnaire measures could provide "substantiating evidence" of counsellor's hypotheses about familial patterns of viewing outcome after trauma.


Contents: Adapted the 32 item Stages-of-Change Questionnaire (SCQ) by McConnaughty, Prochaska and Velicer (1983) by excluding the Maintenance Scale and specified head injury problems in memory, attention, concentration and learning. Thus, the Change Assessment Questionnaire (CAQ) has a 5 point Likert format measuring each of the 3 remaining stages (Pre-Contemplation; Contemplation and Action). The Treatment Performance Scale (TPS) uses a 5 point likert scale for staff to
measure the client's performance in compliance to treatment, treatment progress, awareness of one's strengths and weaknesses and motivation for treatment.

Reliability: High internal consistency reliability coefficients of the CAQ were obtained for each of the three 8 item scales. Inter-rater reliability between 2 members of staff using the TPS was 0.83, p < 0.001

Validity: Demonstrates face validity.

Levels of unawareness: Three distinct groups were obtained from the cluster analysis of the CAQ data. "Pre-Contemplative cluster" (9 patients were well above average on the pre-contemplative scale and well below average on the contemplative and action scales). "Ambivalent cluster" (17 clients were above average on pre-contemplative and about average on the contemplation and action scales). "Participation cluster" (19 clients with below average scores on the pre-contemplative and above average scores on the contemplation and action scales). A one way ANOVA compared the groups on treatment performance and found significant differences between TPS scores among the 3 groups. Post-hoc comparisons using the Scheffe procedure indicate that the 3 groups differ in their TPS scores. Such differences suggest that clients who are aware of their difficulties and are ready to change achieve better outcomes from rehabilitation efforts than do their unaware counterparts. This study identifies inter-client levels of unawareness rather than intra-client levels.

Specificity of unawareness: The CAQ is specific on it's focus on cognitive problems following a head injury whereas the TPS measures broader issues such as "motivation for treatment". As long as the broader issues depend on the specifics tapped by the CAQ the two measures should be complimentary and may suggest specificity of unawareness eg. client may acknowledge a head injury problem on a questionnaire (contemplation scale) but not recognise the need to engage in treatment when requested to by staff.

Partial / implicit knowledge of deficits: Possibility that response latency to a question or a chance remark in response to a question may reveal implicit knowledge.
Defensive / motivated denial: Possibility that when treatment is matched appropriately to those in the Pre-Contemplative stage that over time, those manifesting defensive denial (rather than unawareness through neurological causes) will move towards the Contemplative and finally Action stages and be able to admit to their difficulties rather than deny them.

Inform treatment: The CAQ appears to be a useful measure for assessing the client's stage of change for treatment matching purposes.

Contents: scored 1-5, covering physical, cognitive, executive and psychosocial skills.
Each skill is behaviourally defined.
Reliability: Cronbach's alpha scores were high, ranging from 0.91 to 0.97, indicating good reliability.
Validity: Demonstrates face validity.
Levels of unawareness: No.
Specificity of unawareness: No.
Partial / implicit knowledge of deficits: No.
Defensive denial: No.
Inform treatment: No.

14) Newton and Johnson (1985): Katz Adjustment Scale (KAS-R) (Katz and Lyerly, 1963); Questionnaire of Social and Evaluative Anxiety (Watson and Friend, 1969); Rosenberg Self-Esteem Scale (RSE) (Rosenberg, 1965); Neurophysical Scale (Bond, 1976) and Wechsler Adult Intelligence Scale (WAIS); Observational measure of social performance.
Contents: 5 minute video taped conversation between the subject and a stranger (confederate). Performance rated blindly by 2 observers on 12 aspects of verbal and non-verbal social behaviour, adapted from Trower et al (1978) and Bellack (1979). Items were rated 0-3 with each being behaviourally defined, and summated to produce
a total performance score. Overall impressions of performance, anxiety and
assertiveness were rated on a 0-5 scale.

Reliability: No.
Validity: No.

Levels of unawareness: Possibility of disclosure of difficulties on questionnaires
which may then not be identified by subjects during performance on the WAIS or
social skill measure.

Specificity of unawareness: Comparison with out patient referrals with social
interaction difficulties revealed that head injured subjects scores on the social
performance measure was significantly lower indicating the "extreme difficulties
experienced by the head injured in social performance". The KAS-R results are similar
to a psychiatric population. Except for the head injured being reported as significantly
more confused, less anxious, less nervous and less hyperactive, they also showed less
general psychopathology. When compared to with the general population data
(Hogarty and Katz, 1971) they showed more belligerence, negativism, helplessness,
suspiciousness, withdrawal, confusion and less stability.

Partial/ implicit knowledge of deficits: 72 % reported high social anxiety and low
self-esteem. Possibility that language or behaviour during observational measure may
have indicated partial awareness.

Defensive denial: No.

Inform treatment: Need to research the efficacy of broad-based group therapy aimed
at improving social performance.

15) Oddy, Coughlan, Tyerman and Jenkins (1985): Bond Neuropsychological
Scale (Bond, 1975); Ravens Progressive Matrices and the Synonyms section of
the Mill Hill Vocabulary Scale. Interview, symptom checklist and Wimbledon
Self Report Scale.

Contents: ask patient about behavioural, cognitive and social sequelae and relatives
about social adjustment and his/her memory and behaviour. Checklist covers recent
physical, cognitive and behavioural symptoms. Wimbledon Self Report Scale (unpublished adjective checklist designed to detect emotional disturbance regardless of presence of physical disability or illness).

Reliability: Test-retest reliability of intellectual tests for a 7 year time period is not known.

Validity: Demonstrates face validity.

Levels of unawareness: Although broadly similar symptoms were reported by both relatives and patients, the latter were less likely to report childish behaviour.

Specificity of unawareness: No.

Partial / implicit knowledge of deficits: Behaviour during the 2 intellectual tests may potentially reveal partial awareness.

Defensive / motivated denial: No.

Inform treatment: None of the patients who were unemployed at 2 years post injury had managed to return to work by 7 years and the difficulties of being unemployed were compounded by difficulties in maintaining established friendships. The authors highlight the need for continued availability of expert professional guidance and support for the patient and family who "are clearly struggling in their efforts to provide for as many of the needs as possible."


Contents: asked a close relative to assess the patient's social adjustment.

Reliability: No.

Validity: No.

Levels of unawareness: No.

Specificity of unawareness: Compare performance on cognitive tests to the list of symptoms acknowledged by the patient on the checklist.

Partial / implicit knowledge of deficits: Behaviour or language during testing may reveal implicit knowledge of deficits.
Defensive denial: No.

Inform treatment: Focus on social isolation and family relationships by rehabilitation professionals may stimulate patient's motivation to engage in therapy.

17) Prigatano, Altman, and O' Brien (1990): Patient Competency Rating Scale (PCRS) and Neuropsychological Measures.

Contents: Patients and relatives independently rate 30 items on a 5 point scale. All items involve specified observable behaviour. A rating of 1 means the patient cannot do the behavioural items described, whereas a rating of 5 means they can do it with ease. After both patient and relative's ratings are obtained, they were then compared by subtracting the relative's rating from the patient's rating. A positive value indicates "that the patient sees himself as being more competent in carrying out the task than the relative perceives the patient." The scale that includes self care, domestic and emotional processing skills. The Neuropsychological measures used were the Scaled Scores of the Block Design and Digit Symbol subtests of the WAIS-R; the Halstead Finger Tapping, right-and left-hand scores; the raw score of the Visual Reproduction of card C from the Wechsler Memory Scale -Revised (WMS-R); the total number of "hard" paired associates learned from WMS-R over three trials, and the Scaled Score of the Information Subtest of the WAIS-R.

Reliability: No.

Validity: No.

Levels of unawareness: May acknowledge a deficit, but not notice errors made during formal testing.

Specificity of unawareness: Patients ratings tended to be in agreement with relatives ratings when related to activities of daily living, but discrepancies occurred when patients underestimated their abilities in handling emotional and social interactions. The authors suggest that "this finding emphasises the importance of assessing a variety of behavioural skills when assessing impaired awareness of behavioural limitations after..."
traumatic brain injury." Judgements of complex social behaviour were not related to Neuropsychological test scores.

**Partial / implicit knowledge of deficits:** Possibility that language or behaviour during formal testing may reveal some otherwise unacknowledged knowledge of deficits.

**Defensive / motivated denial:** If re-administered after a specified period of rehabilitation, any changes in scores to a more realistic appraisal suggests previously defensive denial.

**Inform treatment:** Measures used can facilitate patient appreciating that they may not be able to drive a car safely.


**Contents:** Investigate the incidence of 28 types of memory failure in everyday life after head injury using a 9 point frequency rating scale. Also asked whether memory and concentration difficulties were "a serious nuisance, a moderate nuisance, a slight nuisance or no nuisance at all" and to what, if anything the difficulties prevent them from doing.

**Reliability:** No.

**Validity:** Questionnaire showed face validity, but only 70% of patients contacted returned completed questionnaires and this raises questions of how representative this group is of the larger head injured population.

**Levels of unawareness:** Seven out of eight patients in the severe group who admitted that they were disabled by memory and concentration difficulties still reported lower total scores than their relatives.

**Specificity of unawareness:** No.

**Partial / implicit knowledge of deficits:** No.

**Defensive / motivated denial:** Authors felt that motivated denial was unlikely to be operating during completion of the questionnaires as 7 out of 8 severe head injured patients admitted they were disabled by memory and concentration problems. More
likely that patients with impaired memory can only recall a small proportion of their memory failures.

**Inform treatment:** Authors suggest the use of checklists or questionnaire measures with simple rating scales which lessen the demand on memory and may allow patients to give more valid self reports.


**Contents:** A close relative or staff member were asked questions about the patient's physical and mental state, behaviour and self care ability. Patient's "were interviewed by a similar, but not identical questionnaire. When the two statements did not agree, the relative's or staff's answers were preferred."

**Reliability:** No.

**Validity:** No.

**Levels of unawareness:** No.

**Specificity of unawareness:** No.

**Partial / implicit knowledge of deficit:** No.

**Defensive / motivated denial:** Using clinical observation as an anchor point Thomsen found that compared to the spouse's of head injured patients, the parents gave unrealistic views of patients behaviour.

**Inform treatment:** Findings at 10-15 year follow up indicate that improvement in psychosocial functions can continue for several years.


**Contents:** Patients and relatives were asked to judge their present state in relation to their functioning in 17 areas prior to the injury. The questionnaire was filled out by the investigator while interviewing the patient. Each answer was scored as either 0 or 1 depending upon whether the complaint was absent or present. A 5 point scale with graded answers formed the Return to Work Scale (RTW).
Reliability: No.

Validity: Demonstrates face validity.

Levels of unawareness: Forgetfulness was the most frequent residual complaint whereas questions relating to emotional changes that may occur after head injury were less likely to be confirmed, although relatives did report the same general structure with respect to the severity factor.

Specificity of unawareness: No.

Partial / implicit knowledge of deficits: No.

Defensive / motivated denial: No.

Inform treatment: Gives recognition that 84% of patients who sustained a severe closed head injury, reported some residual deficit in their psychological functioning after 2 years.

SUMMARY AND CONCLUSIONS

So far this review has limited itself to describing each of the measures in isolation. It would now seem profitable to provide a critical appraisal of the measures as a whole, structured according to the themes which became apparent to the author in the process of writing the review. The following were identified: source(s) of information; functional area(s) investigated and method(s) of assessment. There will then follow a recommendations section in which suggestions for future research will be made which build upon the advances already made through the use of the measures reviewed here.

Source(s) of information.

Obtaining information from only one source could possibly enable a greater length of time and analysis to be invested in such a single subject approach, compared to using other sources as well. Indeed the studies listed in the first section demonstrate some of the advantages of this approach. For instance Allen and Ruff (1990) focused upon the cognitive functioning of patients, using the San Diego Questionnaire alongside corresponding test performances. Lezack and O'Brien (1988) by including the Portland
Adaptability Inventory into regularly scheduled cognitive examinations were able to compare subjects performance on cognitive tests with their self report on the PAI over the five years posttrauma period. Tyerman and Humphrey (1984) investigated the very idiographic and personal realm of self-concept change using the Semantic Differential Technique which renders information from relatives incongruous in this instance. However, whilst bearing these considerable strengths in mind, it is nonetheless worth pointing out the advantages of obtaining information from both the patient and a close relative. As Brooks (1991) cogently argues "failing to do so will result in an inadequate analysis of change in the patient; inadequate analysis of the patient's perception of the current situation; an inadequate analysis of the functional consequences of the changes for the family; and an inappropriate and inefficient treatment plan." For the majority of research designs encountered in this review, there certainly appear to be more advantages to eliciting information from both the patient and a close relative or staff member in daily contact with the patient, than relying entirely on the patient's self report alone.

Functional area(s) investigated.

Unawareness of deficit has been found in a variety of functional domains. The following seven appear to represent those of most interest to researchers: physical state, cognitive abilities, behaviour, emotional state, social skills, self care and domestic skills. In order to succinctly represent the functional areas investigated by the new measures Table 1 was constructed. (See next two pages) It does not consider the potentially relevant information obtained from existing measures such as the MMPI or Katz Adjustment Scales used by some of the studies, but focuses exclusively on the "unawareness measures".

As can be seen from the final row in table 1, the most frequently investigated functional area is that of cognitive abilities, closely followed by emotional state, then behaviour and social skills, then physical state, self care and finally domestic skills. The frequency distribution of the number of functional areas investigated forms the following pattern:
Six studies investigated either 1 or 4 functional areas. Two studies either did not investigate any of the areas listed, or focused upon either 2, 3 or 6 functional areas. None of the studies considered 5 or all 7 functional areas.

When the design of the studies investigating one functional area is considered, they were no more likely than studies looking at two or more areas to report the psychometric properties of the measure, or to use more than one measure to assess unawareness. I will comment on this finding in the recommendations section. (See 5 "awareness profile"
Table 1: Functional Areas investigated by the "Unawareness Measures".

<table>
<thead>
<tr>
<th>Study</th>
<th>Physical State</th>
<th>Cognitive Abilities</th>
<th>Behaviour State</th>
<th>Emotional State</th>
<th>Social Skills</th>
<th>Self Care</th>
<th>Domestic Skills</th>
<th>Functions Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allen and Ruff (1990)</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>1</td>
</tr>
<tr>
<td>Lezack and O'Brien (1988)</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>4</td>
</tr>
<tr>
<td>Tyerman and Humphrey (1984)</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>0</td>
</tr>
<tr>
<td>Relatives / staff ratings</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Brooks et al (1986)</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>4</td>
</tr>
<tr>
<td>Brooks and McKinlay (1983)</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>2</td>
</tr>
<tr>
<td>Mercer et al (1977)</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>1</td>
</tr>
<tr>
<td>Oddy et al (1978)</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>0</td>
</tr>
<tr>
<td>Starkstein et al (1993)</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>4</td>
</tr>
<tr>
<td>Patient and staff / relatives ratings</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fordyce and Roueche (1986)</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>6</td>
</tr>
<tr>
<td>Godfrey et al (1993)</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>2</td>
</tr>
<tr>
<td>Hendryx (1989)</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>3</td>
</tr>
<tr>
<td>Lam et al (1988)</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>1</td>
</tr>
<tr>
<td>Malia and Powell (1993)</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>4</td>
</tr>
<tr>
<td>Newton and Johnson (1985)</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>1</td>
</tr>
<tr>
<td>Oddy et al (1985)</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>4</td>
</tr>
<tr>
<td>Oddy and Humphrey (1980)</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>1</td>
</tr>
<tr>
<td>Prigatano et al (1990)</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>6</td>
</tr>
</tbody>
</table>
Method(s) of Assessment.

The most frequently used assessment instruments were those of a questionnaire and / or a structured interview. Five of the studies incorporated the interviewers observations made during the assessment as determining some scores. (Lezack and O'Brien, 1988; Mercer et al, 1977; Starkstein et al, 1993; Godfrey et al, 1993; and Newton and Johnson, 1985). Two studies made use of video taped conversation between the subject and a stranger (confederate) (Godfrey et al, 1993; Newton and Johnson, 1985). Only the study by Sunderland et al (1984) made use of a postal questionnaire.

Examination of the relevant literature and the researcher's clinical experience tended to dictate the choice of questions used. Such a pragmatic approach is often appropriate in the area of clinical research, however a major criticism of over half the studies was their lack of investigation into the psychometric properties of a measure. Without information about the reliability and validity of a measure, full confidence in it's utility can not be given, and will always need to be borne in mind when drawing conclusions from the data.

RECOMMENDATIONS

1) In order to obtain as comprehensive an assessment as possible it is useful to question either a close relative or member of staff, as well as the patients themselves. In order for a comparison of the replies to be valid, it is essential that all informants are asked identical questions in the same sequence.
2) Opening the assessment with a global, non-specific question requiring the informant to rate in global terms the particular functional area under scrutiny prior to more specific questions being asked may provide useful information as to the level of unawareness disclosed by the interviewee.

3) If the assumption is made that unawareness can take many forms and is not a monolithic entity, it would be useful to limit measures to investigating one functional area in greater detail than would otherwise be possible. This would enable greater use to be made of collaborative performance measures, alongside the more traditional verbal report format. Several researchers have brought into question the accuracy of relatives reports (Brooks et al, 1986; Romano, 1974) making the collection of observable demonstrations by patients all the more valuable.

4) By recording such behaviour onto video tape (especially profitable for social / interactional tasks) patients could self rate their performance using the same criteria as trained raters. For some tasks it may be possible to elicit a pre-performance estimate of their aptitude, which would serve a similar function to the "feeling of knowing" ratings given in metamemory experiments, namely to indicate the level of accuracy of their awareness.

This could facilitate the development of behaviourally specified scoring criteria which the investigator can use to rate the patient's behaviour during the assessment. The work of Starkstein et al (1993) with stroke patients is a promising development in the area of observable motor or visual deficits. If a valid unawareness measure can be constructed for such phenomenon, it could possibly inform the development of measures designed to investigate the more cognitive / verbal forms of unawareness.

5) Such use of multiple measures to investigate a particular area will enable an "awareness profile" to be built up, providing detailed and useful data. Such a profile if
established prior to any treatment efforts would provide a baseline measure against which treatment efficacy could be ascertained through repeated administration of the measures used originally, along with possibly suggesting the basis of the unawareness. Langer and Padrone (1992) proposed that any changes in awareness after psychotherapeutic treatment for this purpose would suggest that the unawareness stemmed from defensive denial rather than from neurological causes.

Bearing such information in mind, what are the qualities of the measures which could inform three or more of the forms of unawareness along with contributing to treatment planning? (See studies marked with * on Table 2 page 218). They all used multiple assessment measures to obtain as much information as possible on one functional area. Some used video tape to record the patient's performance and others used specific observable behaviour to be the item to be rated.

**CONCLUSIONS**

The development of an agreed measure/s of unawareness would facilitate communication between researchers and would enable useful comparisons to be made across studies. It could also generate appropriate information to develop a data bank of "unawareness profiles" which would accelerate the collection of normative data. Such a measure would play a significant role in developing the empirical foundation for neuropsychological models of awareness and consciousness, along with assisting clinicians to develop effective therapeutic interventions by standardising the evaluation process.

In conclusion, future research should focus on one functional area at a time, assessing it thoroughly using a variety of techniques and utilising information from both the patient and a close relative or staff member. If possible, interviews and performance on tests and/or social skills type tasks should be recorded and rated by trained observers as well as by the informants themselves, using identical rating scales. Information obtained in this way could then inform the content of any therapeutic intervention, and act as a baseline to which any later scores could then be compared.
Table 2: Summary of the Measures Reviewed.

<table>
<thead>
<tr>
<th>Study</th>
<th>Level of unawareness</th>
<th>Specificity of unawareness</th>
<th>Partial knowledge of deficits</th>
<th>Motivated denial</th>
<th>Inform treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allen and Ruff (1990) *</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Lezack and O'Brien (1988) *</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Tyerman and Humphrey (1984)</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Allen and Ruff (1990) *</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Lezack and O'Brien (1988) *</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Tyerman and Humphrey (1984)</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Brooks et al (1986)</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Brooks and McKinlay (1983)</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Mercer et al (1977)</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Oddy et al (1978)</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Starkstein et al (1993) *</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Fordyce and Roueche (1986)</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Godfrey et al (1993) *</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Hendryx (1989)</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Lam et al (1988) *</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Malia and Powell (1993)</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Newton and Johnson (1985)</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Oddy et al (1985)</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Oddy and Humphrey (1980)</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Prigatano et al (1990) *</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Sunderland et al (1984)</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Tomhson (1984)</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Van Zomeran and Van den Burg (1985)</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
</tr>
</tbody>
</table>
REFERENCES


First Steps in Treatment Planning on an Adolescent Unit: A Personal Construct Analysis

Abstract

Various members of staff working at an in-patient adolescent unit approached the Clinical Psychologist involved in the team and requested training in behavioural approaches. This study examined staff views about behaviourally based approaches with adolescents. Since a similar request was made by several members of staff at approximately the same time, I began to speculate as to some of the reasons for such a phenomenon. Three possible motivations for the requests were explored: 1) Behavioural approaches are regarded as an appropriate and clinically sensitive tool. 2) Staff would like a Clinical Psychologist to oversee behavioural programmes on a full time basis. 3) Behavioural approaches are regarded as a punitive, last attempt to help very difficult patients.

It was carried out in two stages using the theoretical framework and research methodology of Personal Construct Psychology. The first involved seven participants completing a "self characterisation" of themselves as a treatment planner on the unit, from which a pool of bipolar constructs were identified, nine of which were selected and used in a traditional repertory grid format, with professions from the multidisciplinary team as elements to be rated. The process of analysing the data generated a number of interesting questions which led to the construction of an eleven item semi-structured questionnaire, posted to all twenty six members of staff. Twelve questionnaires were returned.

Conduct disorders, phobias and anorexia were regarded as suitable for behavioural interventions whereas psychotic and depressive disorders were not. Behavioural approaches were regarded as tending to focus on the target individual without paying adequate attention to other family members.
Although punishment was viewed as only moderately or not important at all within such an approach, the majority felt that behavioural approaches did have dangers associated with them. Whilst most did not regard them as only concerned with getting rid of undesirable behaviour there was agreement that such approaches are sometimes only concerned with superficial change. There was a general consensus that it would not be desirable to widely introduce behavioural approaches as the sole therapeutic approach on the unit, instead it should be used in conjunction with other therapies.

**Introduction**

This study was conducted at an in-patient adolescent unit run along the lines of a therapeutic community (although admissions and final decisions are made by staff). It arose from staff requests for information or training in behavioural approaches in relation to more difficult patients on the unit (meaning they did not respond to the therapeutic milieu fast enough or with enough positive change). Rather than accepting such requests at face value I decided to **explore** three possible motivations driving such demands, using the reflexive and dynamic approach of personal construct psychology.

**Motivation 1**

Staff view some adolescents as needing a high degree of structure and routine built into their lives, and behavioural approaches are seen as suited to this purpose.

**Motivation 2**

If behavioural approaches were to be implemented as routine treatment on the unit considerable involvement by a Chartered Clinical Psychologist would be required. This would alter his existing role from that of an individual therapist and consultant to that of a behaviour modification programmer.
Motivation 3

Many of the adolescents exhibit behaviour staff find difficult to deal with and rather than stay with feelings of hopelessness and despair which often characterise these "difficult" patients, staff ask for a "quick fix" in the form of a behaviour modification programme.

The underlying philosophy of personal construct theory is that every person is his / her own scientist, and as such is compatible with the aims of this project. Namely to elicit how staff think about or construe behavioural approaches, rather than forging ahead with constructing a knowledge based questionnaire based upon the authors pre-conceived notion of their existing level of understanding. Although such a questionnaire is a valuable tool for identifying practical training needs, it would be limited to explicit technical replies, and would not enable us to reach the complex sometimes contradictory views and attendant emotions people may hold about the use of behavioural approaches. The fragmentation corollary of personal construct theory explicitly recognises that a person may successively employ a variety of subsystems which are inferentially incompatible with each other.

Kelly (1955) called his philosophy "constructive alternatism" meaning that we have alternatives available to us with which we try to make sense of ourselves, each other and the world around us. Each of us invents and re-invents an implicit theoretical framework which, be it well or badly designed, is our personal construct system. Repertory grid technique is, in its multitudes of forms, a way of exploring the structure and content of such implicit theories. It is perhaps best looked on as a particular form of structured interview. Our usual way of exploring another person's construct system is by conversation. The grid formalises this process and assigns mathematical values to the relationships between a person's constructs. Kelly's argument is that we make sense out of our world by simultaneously noting likenesses and differences. It is in the contrast that the usefulness of the bipolar construct subsists, as it enables us to arrive at some kind of matrix of the pattern of interrelationships between constructs.
Method

In order to elicit people's constructs, each of the initial seven participants (Child and Adolescent Psychiatrist, Clinical Assistant, four Nurses and a Clinical Psychologist) completed a "self characterisation" of themselves as a treatment planner who is able to identify when to use a behavioural approach on the adolescent unit, following Kelly's original format (Kelly, 1955) in relation to three clinical cases provided (see Appendix 1). A list of bipolar constructs were then identified for each participant, and after this stage had been completed for all seven participants I selected nine of the constructs from across the sample, aiming to cover the identified themes of assessment, treatment and outcome. (see Appendix 2a). Participants were asked whether the constructs made sense to them prior to completing the grid to ascertain that the labels were meaningful to them. Each participant acknowledged understanding the constructs and were happy to use them. These were then used in a traditional repertory grid format, with various professions from the multidisciplinary team, along with self and ideal self as the elements to be rated. Thus, the elements were representative of the area of construing under consideration and fell within the range of convenience of the constructs which were applied (see Appendix 2b). Each of them were asked to rank those elements most readily subsumed under the emergent pole of the construct (e.g. slow and careful process of analysis) to those most readily subsumed under the contrast pole (e.g. sloppy thinking). Participants therefore judged their own profession and all other relevant professions on a series of pertinent criteria. The individuality corollary states that persons differ from each other in their construction of events, and so each individual grid was analysed independently and no comparisons were made across them.

The grids were analysed using the Circumgrid programme, and interpretations for each of the plots were made by the investigator (see Appendices 3-9). The process of interpretation involves considering the percent Eigenvalues for a particular grid, as this indicates how much variance is encompassed by a particular dimension. The greater the percent variance the more important the construct is within that person's construct
system. The overall distribution of variance across the three dimensions of a grid indicates the nature or complexity of a person's construing of the topic under question. From the various locations of constructs on the plot and the numbers arrived at by the computer analysis, it is possible to group together those constructs that cluster together. It was then a matter for the investigator to think of various explanations as to why a particular construct stood alone or clustered with other constructs. The explanations I arrived at led to the construction of an eleven item anonymous semi-structured questionnaire which was sent to all the members of staff, including the original seven participants (see Appendix 10). Data from the grids and questionnaire results were used to examine the appropriateness of the proposed motivations.

Results: Part one: Output

The computer analysis allows for numerous correlations between each pair of rankings to be made. The two constructs accounting for most of the variance are extracted to form the main dimensions. The second axis is taken to be that accounting for most of the common variance after the first has been taken out, but which is statistically independent of it, and so on for the third axis. Basically it is a process of condensing information in a way that incorporates as much of the variance as possible in two or three dimensions. The percent variances of the Eigenvalues listed for each of the grids (see Appendices 3-9) is a measure of how much variance is encompassed by a particular dimension.

Plot interpretation

The grid data and each of the plots are located from Appendices 3-9. This section will report upon the interpretations of the plots. The following framework was adopted to facilitate interpretation of the plots:
Motivation 1 was corroborated by the following being positively rated:
A slow and careful process of analysis
Formulate the problem
Incentive based, positive approach
Built in evaluation
Real change.

Motivation 2 was corroborated by the following being positively rated:
Competent in behavioural approach
Behavioural approach as treatment of choice

Motivation 3 was corroborated by the following being positively rated:
Considers family factors
Various methods
Reactive, knee-jerk
Manipulation, punishment
Behavioural approach as treatment of last resort
Superficial change

Person 1
Person One's emphasis upon the rigorous nature of the behavioural approach in regard to analysis and formulation of a problem and the use of built in evaluation leading to real change, suggests that they would favour the use of behavioural approaches on the unit.
Such emphasis on the fundamentals of the behavioural approach lend credence to motivation one, that staff view some adolescents as needing a high degree of structure
and routine built into their lives. Although competency in behavioural approaches is seen as desirable, person one's plot suggests that such skills should exist throughout the staff, and not reside solely in the Clinical Psychologist. Although he should oversee individual programmes, his role as an individual therapist would essentially remain unchanged. Nor did the plot suggest the desire to use behavioural approaches as a "quick fix", but rather to incorporate its systematic, research based techniques into the range of approaches on the unit.

**Person 2**
A slow and careful process of analysis, formulation of the problem coupled with competency in the behavioural approach and an incentive based positive approach are associated with real change. And real change is facilitated by built in evaluation. As with person one they emphasise the fundamentals of the behavioural approach, which fits well with motivation one, as they focus on the long term nature of behavioural approaches if they are to produce real change. Mention of competency in behavioural approaches suggests a level of support for motivation two, but this is not very high as the other construct is not given prominence.

**Person 3**
Although favouring a positive, incentive based approach person three possibly regards behaviourists as satisfied with superficial change, and therefore appears not to corroborate any of the proposed motivations; except possibly motivation three. It may be that they appreciate the utility of certain behavioural methods but would want them to be one of the various methods available to staff.

**Person 4**
A slow and careful process of analysis and real change are regarded positively, but person four appears to associate behavioural approaches with manipulation and punishment and sees the behavioural approach as the treatment of last resort. Once
again, not a clear cut advocate for the proposed motivations, but a possibility that motivation three's theme of "difficult patients" requiring behavioural approaches is identifiable.

**Person 5**

A slow and careful process of analysis, linked to an incentive based positive approach are associated with real change. Competency in behavioural approaches is positively regarded, and would seem to authenticate motivation one. However, due to the apparent connection between behavioural approaches considering individual factors alone, this could imply indirect support for motivation two e.g. Clinical Psychologist considers individual factors whilst other members of the team consider family factors.

**Person 6**

A slow and careful process of analysis along with formulation of the problem, competency in the behavioural approach and built in evaluation are positively regarded, and would lend credence to motivation one. Once again, real change is associated with an individual rather than for a family, and this association with only an individual's success may lead person six to uphold the use of behavioural approaches alongside other approaches. In some cases, it may be that behavioural approaches are then used as construed in motivation three, as a last resort for "difficult" patient when all else has failed.

**Person 7**

Behavioural approaches are seen as the treatment of choice for person seven, and incentive based positive approaches are associated with real change. Once again, behavioural approaches are seen as most beneficial to an individual rather than a family. Overall, such an interpretation would substantiate motivation one.
Results: Part Two: Questionnaire results

The main focus of the questionnaire was to explore some of the questions raised by the plot interpretations, and as such it appears sensitive to the issues raised in motivation three. Although question one, two, four and ten (see Appendix 10) are non-specific, all the others can be associated with motivation three.

Twelve out of the twenty six anonymous questionnaires were returned, giving a response rate of 46%.

The results will be presented as replies, frequencies or percentages to each of the questions contained in the questionnaire.

1) The following problems are seen as most likely to benefit from a behavioural approach:

(Two subjects did not answer this. N = 10)

<table>
<thead>
<tr>
<th>Problem</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conduct Disorder</td>
<td>6</td>
<td>60%</td>
</tr>
<tr>
<td>Phobias</td>
<td>6</td>
<td>60%</td>
</tr>
<tr>
<td>Anorexia</td>
<td>5</td>
<td>50%</td>
</tr>
<tr>
<td>Bulimia</td>
<td>3</td>
<td>30%</td>
</tr>
<tr>
<td>Anxiety Based Problems</td>
<td>3</td>
<td>30%</td>
</tr>
<tr>
<td>Obsessive Compulsive</td>
<td>3</td>
<td>30%</td>
</tr>
<tr>
<td>School Refusal</td>
<td>3</td>
<td>30%</td>
</tr>
<tr>
<td>Physical Abuse</td>
<td>1</td>
<td>10%</td>
</tr>
<tr>
<td>Drug Addiction</td>
<td>1</td>
<td>10%</td>
</tr>
<tr>
<td>Depression</td>
<td>1</td>
<td>10%</td>
</tr>
<tr>
<td>Learning Disability</td>
<td>1</td>
<td>10%</td>
</tr>
</tbody>
</table>
2) The following problems are seen as least likely to benefit from a behavioural approach:

(Two subjects did not answer this. N = 10).

<table>
<thead>
<tr>
<th>Problem</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychotic Disorder</td>
<td>6</td>
<td>60 %</td>
</tr>
<tr>
<td>Depression</td>
<td>5</td>
<td>50 %</td>
</tr>
<tr>
<td>Eating Disorders</td>
<td>1</td>
<td>10 %</td>
</tr>
<tr>
<td>Abuse Victims</td>
<td>1</td>
<td>10 %</td>
</tr>
<tr>
<td>Poor Motivation</td>
<td>1</td>
<td>10 %</td>
</tr>
</tbody>
</table>

3) Ten respondents (83 %) agreed with "behavioural approaches are compatible with consideration of family factors". One disagreed (8 %) and one did not know (8 %).

4) Nine respondents (75 %) disagreed with "behavioural approaches are the treatment of choice for the unit". Two agreed (16 %) and one did not know (8 %).

5) Nine respondents (75 %) agreed with "behavioural approaches have dangers associated with them". Two disagreed (16 %) and one did not know (8 %).

6) Eight respondents (66 %) agreed with "behavioural approaches focus on the target individual without paying adequate attention to other family members". Three disagreed (25 %) and one did not know (8 %).

7) Five respondents (41 %) replied moderately or not at all (41 %) to the question "how important is punishment in behavioural approaches?" The remaining two (16 %) saw punishment as very important.
8) Eight respondents (66 %) disagreed with "behavioural approaches are only concerned with stamping out behaviour". Two (16 %) agreed and two (16 %) did not know.

9) Twelve respondents (100% ) replied sometimes to "behavioural approaches are only concerned with superficial change".

10) Nine respondents (75 %) did not want "the widespread introduction of behavioural approaches as the main type of therapeutic input at the unit" whilst two did not know (16 %) and one (8 %) said yes.

11) One person mentioned the need to apply behavioural approaches in conjunction with other therapies.

**Discussion of survey results**

There appeared to be a general consensus that whilst people suffering from depression or psychotic disorders were unsuitable for behavioural treatment, those with conduct disorders, phobias or anorexia nervosa were more amenable to such an approach, and therefore most likely to benefit. What, if anything does this tell us about the three proposed motivations?

It could be that staff regard conduct disordered, phobic or anorexic adolescents as requiring structure and routine. The difficulty with this argument is that, apart from obsessive compulsive disorders the remaining problems could also be in want of structure and routine.

A fair number of the referrals to the unit do have conduct disorders, whereas phobias and anorexia are relatively less common. This selection of " behaviourally" amenable disorders does not suggest that staff are seeking to constrict the role of the Psychologist on the unit. Indeed, the majority did not feel that behavioural approaches were the treatment of choice for the unit, nor did they want to see the widespread
introduction of behavioural approaches as the main type of therapeutic input at the unit.

It could be that conduct disorders, phobias or anorexics are perceived as less rewarding to work with or possibly do not respond as quickly to the therapeutic environment as the other disorders listed. But, it would be unhelpful to reach such a hasty conclusion. A more moderate view would be to regard the possibility of motivation three on a case by case basis, when last ditch attempts are readily apparent. A brief summary of the remaining results will now be presented. The majority of respondents saw behavioural approaches as compatible with consideration with family factors, although they felt that there is a tendency to focus on the target individual without paying adequate attention to other family members. Whist most did not regard behavioural approaches as only concerned with stamping out behaviour, there was unanimous agreement that such approaches are sometimes only concerned with superficial change.

What of any dangers? The majority did believe that behavioural approaches have dangers associated with them. However, the majority also saw punishment as either moderately or not at all important in such treatment. It would have been useful to ask people to specify the dangers they had thought of. In conclusion, it would seem that the staff are fairly well informed about behavioural approaches, and see them as just one of many therapies appropriate to the unit. It would seem that overall the results accord with motivation one, that some adolescents need a high degree of structure and routine built into their lives. However there may be considerable profit to outlining the principles of behavioural approaches (i.e. the distinction between classical and operant conditioning and the attendant treatments of behaviour modification and behaviour therapy) and there possible application to a wide variety of problems, including poor motivation!

A number of points need to be raised in relation to the research approach chosen. Firstly, although personal construct psychology seeks not to impose structure onto respondents replies, there were several points during the methodology that required the
investigator to look beyond the given information and to speculate as to the significance of it. For instance, it was the investigator who selected the range of bipolar constructs to be used with the original seven participants in the repertory grid. It was also the role of the investigator to analyse the patterns in the resultant grids and to identify recurrent themes and to provide explanations about the significance of them. These explanations then created interesting questions to ask of the wider population. However, the methodology provided a systematic, yet flexible approach to explore in quantitative terms, areas of personal conceptualisation that are difficult to examine by conventional methods. Additionally it enabled the investigator to consider a politically sensitive question in an indirect way. Furthermore, it suggested the next step to be that of informing staff as to the principles of behavioural approaches, their strengths and limitations and how and when they can be best applied, in conjunction with other therapies at a specialist in-patient adolescent unit.
Appendix 1

Self Characterisation Instructions

Please describe yourself as a "treatment planner" at the unit in relation to identifying a behavioural approach to the following cases. There are only three guidelines: 1, write in the third person; 2, make this a frank and intimate character sketch and 3, be sympathetic in your observations. How would you identify a behavioural approach to the following:

Client AB

Is a 15 year old male. He has one older half sister who is 25 years old, married and has a baby. His natural father left home when he was two years old. Mother had a series of boyfriends who were often violent towards her. AB witnessed such violence but was never himself physically attacked. Mother started courting her present partner when AB was 10 years old. He moved in when they got married in June 1991, when AB was 12 years old.

Presenting Problems: School non-attendance
Withdrawn
Lacking in self confidence
Difficulty forming social relationships with peers
Angry / rude (especially towards mother)
Client CD

Is a 15 year old girl who has a younger sister (aged 13 years) and brother (aged 11).
Her father died in a car accident when she was 7 years old. Her mother does not have a current boyfriend. CD has not been getting on with her mother for about a year or so.

Presenting Problems: Eating Disorder (Bulimia Nervosa)
- Depression
- Wants to die; taken 3 overdoses
- Self mutilation
- Unresolved grief

Client DR

DR is the second of three daughters; the eldest is 18, then DR is 16 and her younger sister is 13 years old. Her father is an Anglican clergyman, and she is very close to her mother. Since having to change school she left a small close circle of friends behind and never replaced them. She felt unwanted, isolated and was teased and bullied at her new school.

Presenting Problems: Eating disorder (Anorexia Nervosa)
- Low mood and withdrawal
- Thoughts of self harm
- Took an overdose in 1993
Appendix 2

2a) List of Bipolar Constructs used in grids

A : Slow and careful process of analysis — Sloppy thinking
B : Formulate the problem — Reactive, knee jerk
C : Considers family factors — Considers individuals factors
D : Competent in behavioural approach — Incompetent in behavioural approach
E : Incentive based, positive approach — Manipulation, punishment
F : Various methods — Single approach
G : Behavioural approaches as treatment of choice — Behavioural treatment as last resort of choice
H : Built in evaluation — Not checking feedback
I : Real change — Superficial change

2b) Personal Construct Theory

a) *Fundamental Postulate*: A person's processes are psychologically channelized by the ways in which he anticipates events.

b) *Construction Corollary*: A person anticipates events by construing their replications.

c) *Individuality Corollary*: Persons differ from each other in their construction of events.

d) *Organisation Corollary*: Each person characteristically evolves, for his convenience in anticipating events, a construction system embracing ordinal relationships between constructs.

e) *Dichotomy Corollary*: A person's construction system is composed of a finite number of dichotomous constructs.

f) *Choice Corollary*: A person chooses for himself that alternative in a dichotomised construct through which he anticipates the greater possibility for extension and definition of his system.

239
g) **Range Corollary:** A construct is convenient for the anticipation of a finite range of events only.

h) **Experience Corollary:** A person's construction system varies as he successively construes the replication of events.

i) **Modulation Corollary:** The variation in a person's construction system is limited by the permeability of the constructs within whose ranges of convenience the variants lie.

j) **Fragmentation Corollary:** A person may successively employ a variety of construction subsystems which are inferentially incompatible with each other.

k) **Commonality Corollary:** To the extent that one person employs a construction of experience which is similar to that employed by another, his psychological processes are similar to those of the other person.

l) **Sociality Corollary:** To the extent that one person construes the construction processes of another he may play a role in a social process involving the other person.

---

**Formal Aspects of Constructs**

*Range of Convenience:* A construct's range of convenience comprises all those things to which the user would find its application useful.

*Focus of Convenience:* A construct's focus of convenience comprises those particular things to which the user would find its application maximally useful. These are the elements upon which the construct is likely to have been formed originally.

*Elements:* The things or events which are abstracted by a person's use of a construct are called elements. In some systems these are called objects.

*Context:* The context of a construct comprises those elements among which the user ordinarily discriminates by means of the construct. It is somewhat more restricted than the range of convenience, since it refers to the circumstances in which the construct emerges for practical use, and not necessarily to all the circumstances in which a person might eventually use the construct. It is somewhat more extensive than the focus of convenience, since the construct may often appear in circumstances where its application is not optimal.

*Pole:* Each construct discriminates between two poles, one at each end of its dichotomy. The elements abstracted are like each other at each pole with respect to the construct and are unlike the elements at the other pole.

*Contrast:* The relationship between the two poles of a construct is one of contrast.
Likeness End: When referring specifically to elements at one pole of a construct, one may use the term "likeness end" to designate that pole.

Contrast End: When referring specifically to elements at one pole of a construct, one may use the term "contrast end" to designate the opposite pole.

Emergence: The emergent pole of a construct is that one which embraces most of the immediately perceive context.

Implicitness: The implicit pole of a construct is that one which embraces constrating context. It contrasts with the emergent pole. Frequently the person has no available symbol or name for it; it is symbolised only implicitly by the emergent term.

Symbol: An element in the context of a construct which represent not only itself but also the construct by which it is abstracted by the user is called the construct's symbol.

Permeability: A construct is permeable if it admits newly perceived elements to its context. It is impermeable if it rejects elements on the basis of their newness.
<table>
<thead>
<tr>
<th></th>
<th>self</th>
<th>ideal self</th>
<th>child psychiatrist</th>
<th>creative therapist</th>
<th>nurse</th>
<th>paediatrician</th>
<th>psychologist</th>
<th>social worker</th>
<th>teacher</th>
</tr>
</thead>
<tbody>
<tr>
<td>slow + careful</td>
<td>4</td>
<td>2</td>
<td>9</td>
<td>5</td>
<td>6</td>
<td>7</td>
<td>1</td>
<td>3</td>
<td>8</td>
</tr>
<tr>
<td>process of analysis</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>formulate the problem</td>
<td>4</td>
<td>1</td>
<td>8</td>
<td>5</td>
<td>6</td>
<td>9</td>
<td>2</td>
<td>3</td>
<td>7</td>
</tr>
<tr>
<td>considers family factors</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>9</td>
<td>2</td>
<td>7</td>
<td>3</td>
<td>1</td>
<td>8</td>
</tr>
<tr>
<td>incompetent in</td>
<td>5</td>
<td>2</td>
<td>6</td>
<td>3</td>
<td>4</td>
<td>9</td>
<td>1</td>
<td>7</td>
<td>8</td>
</tr>
<tr>
<td>behavioural approach</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>incentive based,</td>
<td>4</td>
<td>2</td>
<td>8</td>
<td>3</td>
<td>7</td>
<td>6</td>
<td>1</td>
<td>5</td>
<td>9</td>
</tr>
<tr>
<td>positive approach</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>various methods</td>
<td>4</td>
<td>3</td>
<td>1</td>
<td>8</td>
<td>7</td>
<td>5</td>
<td>2</td>
<td>6</td>
<td>9</td>
</tr>
<tr>
<td>behavioural approach as</td>
<td>6</td>
<td>5</td>
<td>4</td>
<td>8</td>
<td>3</td>
<td>9</td>
<td>1</td>
<td>7</td>
<td>2</td>
</tr>
<tr>
<td>treatment of choice</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>built in evaluation</td>
<td>5</td>
<td>1</td>
<td>9</td>
<td>4</td>
<td>6</td>
<td>7</td>
<td>2</td>
<td>3</td>
<td>8</td>
</tr>
<tr>
<td>real change</td>
<td>3</td>
<td>1</td>
<td>7</td>
<td>5</td>
<td>6</td>
<td>8</td>
<td>2</td>
<td>4</td>
<td>9</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Appendix 3 Person 1 Grid Data**

Percent Variances of the Eigenvalues: 62.20 14.06 9.14

- Slow and careful process of analysis: 0.96 -0.11 -0.14
- Built in evaluation: 0.94 -0.25 -0.08
- Real change: 0.98 -0.02 -0.01
- Formulate the problem: 0.95 0.00 -0.07
- Considers family factors: 0.50 0.44 -0.70
- Competent in behavioural approach: 0.82 0.16 0.43
- Various methods: 0.39 0.39 0.16
- Behavioural approach as treatment of choice: 0.15 0.86 0.23
- Incentive based, positive approach: 0.91 -0.29 0.20

242
Person 1 plot.

\[ \begin{array}{cccccccccc}
.9 & G & .8 & .7 & .6 & .5 & .4 & F & C & .3 \\
.2 & D & .1 & .9 & .8 & .7 & .6 & .5 & .4 & .3 & .2 & .1 & + & .1 & .2 & .3 & .4 & .5 & .6 & .7 & .8 & .9 & B & I \\
.1 & A & .2 & H & .3 & E & .4 & .5 & .6 & .7 & .8 & .9
\end{array} \]

Key: Bipolar constructs represented by letters in plot.

A: Slow and careful process of analysis
   ----- Sloppy thinking.
B: Formulate the problem
   ----- Reactive, knee jerk
C: Considers family factors
   ----- Considers individuals factors
D: Competent in behavioural approach
   ----- Incompetent in behavioural approach
E: Incentive based, positive approach
   ----- Manipulation, punishment
F: Various methods
   ----- Single approach
G: Behavioural approach as treatment of choice
   ----- BA as treatment of last resort
H: Built in evaluation
   ----- Not checking feedback
I: Real change
   ----- Superficial change

Results and plot Interpretation

The % Eigenvalues suggest a higher order 'good-bad' construct, with behavioural approaches being positively regarded.
In particular the aspects of analysis, formulation, competency in the behavioural approach, built in evaluation and real change are linked with being 'good.'
A slow and careful process of analysis along with built in evaluation are seen as closely associated with real rather than superficial change. Person one's grid would seem to fit with motivation one.
<table>
<thead>
<tr>
<th>self</th>
<th>ideal self</th>
<th>child psychiatrist</th>
<th>creative therapist</th>
<th>nurse</th>
<th>paediatrician</th>
<th>psychologist</th>
<th>social worker</th>
<th>teacher</th>
</tr>
</thead>
<tbody>
<tr>
<td>5</td>
<td>1</td>
<td>3</td>
<td>6</td>
<td>4</td>
<td>9</td>
<td>2</td>
<td>7</td>
<td>8</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Sloppy thinking

<table>
<thead>
<tr>
<th>formulate the problem</th>
<th>5</th>
<th>1</th>
<th>3</th>
<th>6</th>
<th>2</th>
<th>9</th>
<th>4</th>
<th>2</th>
<th>7</th>
<th>8</th>
</tr>
</thead>
</table>

Reactive, knee jerk

<table>
<thead>
<tr>
<th>considers family factors</th>
<th>4</th>
<th>1</th>
<th>3</th>
<th>9</th>
<th>2</th>
<th>7</th>
<th>5</th>
<th>6</th>
<th>8</th>
</tr>
</thead>
</table>

Considers individual factors

<table>
<thead>
<tr>
<th>competent in behavioural approach</th>
<th>5</th>
<th>1</th>
<th>4</th>
<th>6</th>
<th>3</th>
<th>9</th>
<th>2</th>
<th>8</th>
<th>7</th>
<th>8</th>
</tr>
</thead>
</table>

Incompetent in behavioural approach

<table>
<thead>
<tr>
<th>incentive based, positive approach</th>
<th>5</th>
<th>1</th>
<th>4</th>
<th>7</th>
<th>2</th>
<th>8</th>
<th>3</th>
<th>6</th>
<th>9</th>
</tr>
</thead>
</table>

Manipulative punishment

<table>
<thead>
<tr>
<th>various methods</th>
<th>5</th>
<th>1</th>
<th>4</th>
<th>2</th>
<th>3</th>
<th>9</th>
<th>7</th>
<th>6</th>
<th>8</th>
</tr>
</thead>
</table>

Single approach

<table>
<thead>
<tr>
<th>behavioural approach as treatment of choice</th>
<th>5</th>
<th>3</th>
<th>2</th>
<th>7</th>
<th>4</th>
<th>9</th>
<th>1</th>
<th>6</th>
<th>8</th>
</tr>
</thead>
</table>

Behavioural approach as treatment of last resort

<table>
<thead>
<tr>
<th>built in evaluation</th>
<th>4</th>
<th>1</th>
<th>7</th>
<th>6</th>
<th>3</th>
<th>8</th>
<th>2</th>
<th>5</th>
<th>9</th>
</tr>
</thead>
</table>

Not checking feedback

<table>
<thead>
<tr>
<th>real change</th>
<th>4</th>
<th>1</th>
<th>5</th>
<th>7</th>
<th>3</th>
<th>8</th>
<th>2</th>
<th>6</th>
<th>9</th>
</tr>
</thead>
</table>

Superficial change

---

**Appendix 4 Person 2 Grid Data**

Percent Variances of the Eigenvalues: 83.37 7.29 4.04

Slow and careful process of analysis: 0.97 -0.04 -0.10

Considers family factors: 0.86 -0.08 -0.21

Behavioural approach as treatment of choice: 0.88 -0.08 -0.20

Formulate the problem: 0.97 0.16 -0.16

Competent in behavioural approach: 0.98 -0.03 0.01

Incentive based, positive approach: 0.98 -0.04 0.02

Various methods: 0.68 0.72 0.02

Built in evaluation: 0.88 -0.08 0.46

Real change: 0.97 -0.15 0.18

---

244
Person 2 plot.

<p>| | | | | | | | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>.9</td>
<td>.8</td>
<td>.7</td>
<td>F</td>
<td>.6</td>
<td>.5</td>
<td>.4</td>
<td>.3</td>
<td>.2</td>
<td>.1</td>
</tr>
<tr>
<td>.1</td>
<td>.2</td>
<td>.3</td>
<td>.4</td>
<td>.5</td>
<td>.6</td>
<td>.7</td>
<td>.8</td>
<td>.9</td>
<td>E</td>
</tr>
<tr>
<td>-.1</td>
<td>-.2</td>
<td>-.3</td>
<td>-.4</td>
<td>-.5</td>
<td>-.6</td>
<td>-.7</td>
<td>-.8</td>
<td>-.9</td>
<td></td>
</tr>
</tbody>
</table>

Key: Bipolar constructs represented by letters in plot.

A: Slow and careful process of analysis
B: Formulate the problem
C: Considers family factors
D: Competent in behavioural approach
E: Incentive based, positive approach
F: Various methods
G: Behavioural approach as treatment of choice
H: Built in evaluation
I: Real change

Results and plot Interpretation

The % Eigenvalues suggest a higher order 'good-bad' construct. An incentive based positive approach, competency in behavioural methods, real change, formulation, and a slow and careful process of analysis are all seen as desirable.

Formulation of the problem appears to stand alone as does the use of various methods. They are furthest from the three item cluster of considering family factors, the use of the behavioural approach as the treatment of choice and a slow and careful process of analysis.
It may be that whilst recognising the rigorous nature of behavioural analysis of a problem which often includes consideration of family factors that person two does not believe that such a process really influences the formulation stage, nor is it compatible with other approaches.

The use of an incentive based positive approach is linked to people's competency in the behavioural approach. And real change is facilitated by built in evaluation in a system.

Such an interpretation lends credibility to motivation one, possibly for motivation two and does not do so for motivation three.
Appendix 5 Person 3 Grid Data

Percent Variances of Eigenvalues: 58.93 18.10 10.05

Slow and careful process of analysis 0.85 -.16 -.40
Formulate the problem 0.81 -.32 -.32
Considers family factors 0.31 0.86 -0.35
Competent in behavioural approach 0.80 0.54 -0.02
Incentive based, positive approach 0.92 -0.05 0.11
Built in evaluation 0.66 -0.23 0.43
Various methods 0.97 0.09 0.09
Behavioural approach as treatment of choice 0.55 0.40 0.55
Real change 0.82 -0.50 -0.06
Person 3 plot.

Key: Bipolar constructs represented by letters in plot.

A: Slow and careful process of analysis       ----- Sloppy thinking.
B: Formulate the problem                    ----- Reactive, knee jerk
C: Considers family factors                 ----- Considers individuals factors
D: Competent in behavioural approach        ----- Incompetent in behavioural approach
E: Incentive based, positive approach       ----- Manipulation, punishment
F: Various methods                          ----- Single approach
G: Behavioural approach as treatment of choice ----- BA as treatment of last resort
H: Built in evaluation                      ----- Not checking feedback
I: Real change                              ----- Superficial change

Results and plot Interpretation

The % variances of Eigenvalues suggests a higher order 'good-bad' construct, with various methods, and an incentive based positive approach being regarded as particularly good.

A slow and careful process of analysis and formulation of the problem appear closely linked and separate from all other constructs.
Competency in the behavioural approach is negatively correlated with real change. Possibly this person feels that the behaviourists are satisfied with directly observable change, which they themselves may feel is not always real but a temporary, superficial change.

Such an interpretation does not readily corroborate any of the proposed motivations, but could be regarded as tentative support for motivation three.
Appendix 6 Person 4 Grid Data

Percent Variances of Eigenvalues: 40.24 21.21 19.67

Slow and careful process of analysis 0.90 -0.05 0.29

Incentive based, positive approach 0.22 -0.48 0.51

Formulate the problem 0.40 0.62 0.67

Considers family factors 0.71 0.07 0.45

Competent in behavioural approach 0.68 0.46 -0.36

Various methods 0.72 -0.01 -0.30

Built in evaluation 0.55 -0.08 -0.72

Real change 0.90 -0.37 -0.13

Behavioural approach as treatment of choice -0.08 0.97 -0.13
Person 4 plot.

Key: Bipolar constructs represented by letters in plot.

A : Slow and careful process of analysis
----- Sloppy thinking.
B : Formulate the problem
----- Reactive, knee jerk
C : Considers family factors
----- Considers individuals factors
D : Competent in behavioural approach
----- Incompetent in behavioural approach
E : Incentive based, positive approach
----- Manipulation, punishment
F : Various methods
----- Single approach
G : Behavioural approach as treatment of choice
----- BA as treatment of last resort
H : Built in evaluation
----- Not checking feedback
I : Real change
----- Superficial change

Results and plot Interpretation

More evenly distributed % variances in Eigenvalues suggests a rich construct system, although a wider 'good-bad' dimension is evident on the plot.

A slow and careful process of analysis and real change are viewed as particularly desirable. Whereas the behavioural approach as treatment of choice is a much less attractive option.
An incentive based, positive approach is negatively correlated with the statement behavioural approach as treatment of choice. It would seem that person four associates behavioural approaches with manipulation and punishment, and a positive approach may be adopted without having to limit therapeutic input to the behavioural model alone. Such a stance would fit well with motivation three.

It would seem that a slow and careful process of analysis using various methods and including built in evaluation alongside consideration of family factors are regarded by this respondent as particularly relevant to the unit.
<table>
<thead>
<tr>
<th></th>
<th>self</th>
<th>ideal self</th>
<th>child psychiatrist</th>
<th>creative therapist</th>
<th>nurse</th>
<th>psychologist</th>
<th>social worker</th>
<th>teacher</th>
</tr>
</thead>
<tbody>
<tr>
<td>slow + careful process of analysis</td>
<td>3</td>
<td>2</td>
<td>4</td>
<td>8</td>
<td>7</td>
<td>5</td>
<td>1</td>
<td>9</td>
</tr>
<tr>
<td>formulated the problem</td>
<td>3</td>
<td>1</td>
<td>5</td>
<td>7</td>
<td>9</td>
<td>6</td>
<td>2</td>
<td>8</td>
</tr>
<tr>
<td>considers family factors</td>
<td>3</td>
<td>4</td>
<td>2</td>
<td>9</td>
<td>6</td>
<td>7</td>
<td>5</td>
<td>1</td>
</tr>
<tr>
<td>considers in behavioural approach</td>
<td>3</td>
<td>2</td>
<td>4</td>
<td>9</td>
<td>7</td>
<td>5</td>
<td>1</td>
<td>8</td>
</tr>
<tr>
<td>incentive based, positive approach</td>
<td>1</td>
<td>3</td>
<td>5</td>
<td>9</td>
<td>7</td>
<td>6</td>
<td>2</td>
<td>8</td>
</tr>
<tr>
<td>various methods</td>
<td>4</td>
<td>3</td>
<td>1</td>
<td>9</td>
<td>5</td>
<td>7</td>
<td>2</td>
<td>6</td>
</tr>
<tr>
<td>behavioural approach as treatment of choice</td>
<td>7</td>
<td>6</td>
<td>4</td>
<td>9</td>
<td>6</td>
<td>2</td>
<td>3</td>
<td>8</td>
</tr>
<tr>
<td>built in evaluation</td>
<td>3</td>
<td>2</td>
<td>6</td>
<td>5</td>
<td>8</td>
<td>9</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>real change</td>
<td>3</td>
<td>2</td>
<td>5</td>
<td>9</td>
<td>6</td>
<td>8</td>
<td>1</td>
<td>7</td>
</tr>
</tbody>
</table>

**Appendix 7 Person 5 Grid Data**

Percent Variances of Eigenvalues: 63.01 18.35 9.97

Slow and careful process of analysis 0.95 -0.19 -0.02

Incentive based, positive approach 0.92 -0.18 -0.06

Formulate the problem 0.89 -0.17 -0.31

Considers family factors 0.40 0.74 0.47

Competent in behavioural approach 0.97 -0.12 0.07

Various methods 0.78 0.32 0.45

Behavioural approach as treatment of choice 0.28 -0.80 0.40

Built in evaluation 0.66 0.50 -0.45

Real change 0.94 -0.04 -0.07
Results and plot Interpretation

The % variances of Eigenvalues suggests a higher order 'good-bad' construct, with behavioural approaches being positively regarded. In particular, competency in the behavioural approach, a slow and careful process of analysis, real change and an incentive based positive approach are associated with the 'good' end of the superordinate construct.
Adopting the behavioural approach as treatment of choice would seem to be associated with consideration of an individual's factors alone and is not connected with consideration of family factors.

Consideration of family factors may occur during a slow and careful process of analysis and at the formulation stage, but it would seem that person five regards built-in evaluation of family factors to be difficult to achieve in practice.

A slow and careful process of analysis is associated with an incentive-based, positive approach. It would seem that, rather than adopting a behavioural approach in its entirety, person five would favor incorporation of an incentive-based positive approach into the unit and as such lends credibility to motivation two.
Appendix 8 Person 6 Grid Data

Percent Variances of Eigenvalues:
- Formulate the problem: 0.85
- Incentive based, positive approach: 0.78
- Slow and careful process of analysis: 0.84
- Considers family factors: 0.27
- Competent in behavioural approach: 0.86
- Various methods: 0.92
- Behavioural approach as treatment of choice: 0.42
- Built in evaluation: 0.85
- Real change: 0.20
Person 6 plot.

.9
.8
.7
.6 I
.5 G
.4 H
.3
.2
.1 E B
.9 .8 .7 .6 .5 .4 .3 .2 .1 + .1 .2 .3 .4 .5 .6 .7 .8 .9
-.1 A
-.2 F
-.3
-.4 D
-.5
-.6
-.7
-.8
-.9 C

Key: Bipolar constructs represented by letters in plot.

A: Slow and careful process of analysis —— Sloppy thinking.
B: Formulate the problem —— Reactive, knee jerk
C: Considers family factors —— Considers individuals factors
D: Competent in behavioural approach —— Incompetent in behavioural approach
E: Incentive based, positive approach —— Manipulation, punishment
F: Various methods —— Single approach
G: Behavioural approach as treatment of choice —— BA as treatment of last resort
H: Built in evaluation —— Not checking feedback
I: Real change —— Superficial change

Results and plot Interpretation

The % variances of Eigenvalues suggests a rich construct system. Again the construct 'good-bad' dominates, and the following are seen as good: the use of various methods, formulation of the problem, a slow and careful process of analysis, competency in the behavioural approach and in built evaluation, thus authenticating motivation one.
A second construct appears to be 'productive-unproductive', this may explain the negative correlation between consideration of family factors and real change. It is possible that person six finds real change possible for an individual but sees only superficial change for that individual's family.

Formulation of the problem is closely linked to an incentive based, positive approach which suggests that person six regards most of the adolescents on the unit as in need of structure, support and encouragement. The emphasis seems to be that of working towards a goal in order to build self esteem.

A third construct may be 'intrapsychic change-observable change' which could then account for the negative correlation between behavioural approach as treatment of choice and real change. However, person six rated the use of various methods as most desirable for their ideal self, so it may be that they would not support the widespread introduction of behavioural approaches to the unit, but would value using various behavioural methods when approapriate. Thus, they would prefer a sensitive and appropriate use of behavioural methods alongside other approaches. Such a stance would advocate motivation one and possibly motivation three.
<table>
<thead>
<tr>
<th>self</th>
<th>ideal self</th>
<th>child</th>
<th>Psychiatrist</th>
<th>creative therapist</th>
<th>nurse</th>
<th>paediatrician</th>
<th>psychologist</th>
<th>social worker</th>
<th>teacher</th>
</tr>
</thead>
<tbody>
<tr>
<td>7</td>
<td>4</td>
<td>6</td>
<td>2</td>
<td>1</td>
<td>9</td>
<td>5</td>
<td>8</td>
<td>3</td>
<td>sloppy</td>
</tr>
<tr>
<td>6</td>
<td>4</td>
<td>5</td>
<td>3</td>
<td>1</td>
<td>8</td>
<td>2</td>
<td>9</td>
<td>7</td>
<td>reactive, knee jerk</td>
</tr>
<tr>
<td>1</td>
<td>8</td>
<td>6</td>
<td>3</td>
<td>2</td>
<td>9</td>
<td>5</td>
<td>7</td>
<td>4</td>
<td>considers individual factors</td>
</tr>
<tr>
<td>8</td>
<td>7</td>
<td>1</td>
<td>6</td>
<td>5</td>
<td>9</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>incompetent in behavioural approach</td>
</tr>
<tr>
<td>9</td>
<td>7</td>
<td>1</td>
<td>3</td>
<td>2</td>
<td>8</td>
<td>5</td>
<td>6</td>
<td>4</td>
<td>manipulates punishment</td>
</tr>
<tr>
<td>8</td>
<td>7</td>
<td>2</td>
<td>5</td>
<td>3</td>
<td>6</td>
<td>1</td>
<td>9</td>
<td>4</td>
<td>single approach</td>
</tr>
<tr>
<td>7</td>
<td>9</td>
<td>6</td>
<td>3</td>
<td>1</td>
<td>8</td>
<td>2</td>
<td>4</td>
<td>5</td>
<td>behavioural approach as treatment of last resort</td>
</tr>
<tr>
<td>8</td>
<td>9</td>
<td>6</td>
<td>5</td>
<td>1</td>
<td>7</td>
<td>4</td>
<td>2</td>
<td>3</td>
<td>not checking feedback</td>
</tr>
<tr>
<td>8</td>
<td>9</td>
<td>5</td>
<td>3</td>
<td>1</td>
<td>7</td>
<td>2</td>
<td>6</td>
<td>4</td>
<td>superficial change</td>
</tr>
</tbody>
</table>

**Appendix 9 Person 7 Grid Data**

Percent Variances of Eigenvalues: 

- 57.54
- 16.17
- 12.06

Slow and careful process of analysis: 
- 0.74
- 0.50
- -0.08

Formulate the problem: 
- 0.70
- 0.53
- -0.35

Considers family factors: 
- 0.51
- 0.57
- 0.42

Competent in behavioural approach: 
- 0.62
- -0.63
- -0.17

Incentive based, positive approach: 
- 0.84
- -0.21
- -0.26

Various methods: 
- 0.76
- -0.09
- -0.53

Behavioural approach as treatment of choice: 
- 0.89
- -0.07
- 0.36

Real change: 
- 0.96
- -0.06
- 0.11

Built in evaluation: 
- 0.73
- -0.38
- 0.52

259
Key: Bipolar constructs represented by letters in plot.

A: Slow and careful process of analysis  ----- Sloppy thinking.
B: Formulate the problem  ----- Reactive, knee jerk
C: Considers family factors  ----- Considers individuals factors
D: Competent in behavioural approach  ----- Incompetent in behavioural approach
E: Incentive based, positive approach  ----- Manipulation, punishment
F: Various methods  ----- Single approach
G: Behavioural approach as treatment of choice  ----- BA as treatment of last resort
H: Built in evaluation  ----- Not checking feedback
I: Real change  ----- Superficial change

**Results and plot Interpretation**

The % variances of Eigenvalues suggests a superordinate construct 'good-bad' with the following as being positively regarded: real change, behavioural approach as treatment of choice and an incentive based, positive approach.

Person seven associates a slow and careful process of analysis with facilitating formulation of the problem.
Behavioural approach as treatment of choice is linked with real change in direct contrast to person five.

Competency in the behavioural approach is negatively correlated with consideration of family factors, which suggests that such an approach is more suited to consideration of an individual, perhaps in relation to their stay at the unit rather than, for instance how they behave with their family.

The use of various methods within a treatment package for an individual is used on the unit, but person seven seems to think that built in evaluation does not occur, so that discriminating between what worked for an individual and what did not is a difficult task at the end of treatment.

The overall impression gained from their plot is that person seven is in favour of the use of the behavioural approach and as such would seem to recognise motivation one as influencing the request for training in behavioural approaches.
Appendix 10

Behavioural Approaches and The Unit

Whilst working at the unit I interviewed various members of the team to find out how they regarded behavioural approaches in relation to a sample of cases. This process generated a number of interesting questions which I would like to "throw open" to a wider audience.

I would be most grateful if you would complete this short anonymous questionnaire for me. Many thanks for your time, Roberta Fry, Clinical Psychologist in Training.

1) What types of problems do you think are most likely to benefit from a behavioural approach?

2) What types of problems do you think are least likely to benefit from a behavioural approach?

3) "Behavioural approaches are compatible with consideration of family factors".
   Agree? Disagree?

4) "Behavioural approaches are the treatment of choice for Colwood".
   Agree? Disagree?

5) "Behavioural approaches have dangers associated with them".
   Agree? Disagree?

6) "Behavioural approaches focus on the target individual without paying adequate attention to other family members".
   Agree? Disagree?

7) How important is punishment in behavioural approaches?
   Not at all Moderately important Very important

8) "Behavioural approaches are only concerned with stamping out behaviour".
   Agree? Disagree?

9) "Behavioural approaches are only concerned with superficial change".
   Never Sometimes Always

10) Would you like to see the widespread introduction of behavioural approaches as the main type of therapeutic input at Colwood?
    Yes No Don't Know

11) If there are other aspects of behavioural approaches that have not been tapped in this questionnaire, and you think are important please write about them here:

262
References


Examining the relationships between conflicting self beliefs, emotional distress and severity of alcohol dependence in both relapsing and abstinent alcoholics.

Abstract

Self-discrepancy theory (Higgins, 1987) proposes that conflicting self beliefs can produce emotional distress. In particular it relates specific kinds of self-discrepancies to specific kinds of affective consequences. 47 participants all with a history of seriously dependent problem drinking (27 relapsing and 20 abstinent alcoholics) completed a measure of psychological conflict designed to identify self-concept discrepancies, along with a variety of standard measures of emotional distress. Three predictions derived from Self discrepancy theory (Higgins, 1987) were tested: (1) the greater the magnitude of self-concept discrepancy the greater the magnitude of emotional distress exhibited; (2) predominant actual-ideal discrepancies will be associated with dejection-related emotions; (3) predominant actual-ought discrepancies will be associated with agitation-related emotions. The results did not support any of the predictions.

The commonly held belief that female alcoholics have greater psychopathology and emotional distress than their male counterparts was also investigated. The findings suggested that relapsing female alcoholics scored significantly higher on the Beck Depression Inventory than relapsing male alcoholics. Finally, differences between abstinent and relapsing participants were examined. As predicted, abstinent participants demonstrated significantly lower scores on the BDI and various subscales of the SCL-90-R.

It was concluded that the instrument used to measure psychological conflict was insufficiently sensitive and a number of improvements were recommended.
1 Introduction

1.1 Self Discrepancy Theory

How we see ourselves influences how we feel about ourselves. Self discrepancy theory explores this complex relationship by distinguishing between an individual's self concept, or \textit{actual self} and their \textit{self guides}. According to the theory there are two self guides which we use to monitor our behaviour: \textit{ideal self-guides}, which consist of an individual's hopes, wishes or aspirations for themselves. And \textit{ought self-guides}, which consist of beliefs about their duties, obligations, and responsibilities. A classic literary example of the difference between the ideal self and the ought self is the conflict between a hero's 'personal wishes' and his or her 'sense of duty.'

Running through both self-guides are two dimensions, the \textit{domains of the self} and \textit{standpoints on the self}. Domains of the self refers to whether a person is considering who they are, who they would like to be or who they feel they ought to be (the actual, ideal or ought selves). Standpoints on the self refers to whether a person is working from their own viewpoint or looking at themselves as they imagine someone else would see them. Thus, each individual can have multiple \textit{ideal} and \textit{ought guides} for behaviour, which vary in accessibility in different contexts or situations. Combining each of the domains of the self with each of the standpoints on the self gives six basic types of self-state representations (see Table 1.0)
Table 1.0: Standpoint by domain combinations and the resulting self-state representations

<table>
<thead>
<tr>
<th>Standpoints on the self</th>
<th>Actual Self</th>
<th>Ideal Self</th>
<th>Ought Self</th>
</tr>
</thead>
<tbody>
<tr>
<td>Own</td>
<td>Actual Own</td>
<td>Ideal Own</td>
<td>Ought Own</td>
</tr>
<tr>
<td>Other</td>
<td>Actual Other</td>
<td>Ideal Other</td>
<td>Ought Other</td>
</tr>
<tr>
<td>Actual-Self (Self-Concept)</td>
<td>Ideal Self Guide</td>
<td>Ought Self Guide</td>
<td></td>
</tr>
</tbody>
</table>
Table 1.1: Self-discrepancies and motivational predisposition's

<table>
<thead>
<tr>
<th>Type of Discrepancy</th>
<th>Motivational Predisposition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Actual-Ideal discrepancy</td>
<td>Motivated to meet ideal guide. Behaviour is aimed at maximising the presence of positive outcomes and minimising the absence of positive outcomes</td>
</tr>
<tr>
<td>Actual-Ought discrepancy</td>
<td>Motivated to meet ought guide. Behaviour is aimed at maximising the absence of negative outcomes and minimising the presence of negative outcomes</td>
</tr>
</tbody>
</table>

Individuals who possess an actual-ideal discrepancy are motivated to meet their ideal guide in order to maximise the presence of positive outcomes and minimise the absence of positive outcomes. In contrast, individuals who possess an actual-ought discrepancy are motivated to meet their ought guide in order to maximise the absence of negative outcomes and minimise the presence of negative outcomes.

Table 1.2: Types of self-discrepancies and their affective consequences

<table>
<thead>
<tr>
<th>Ideal Own</th>
<th>Ideal Other</th>
<th>Ought Own</th>
<th>Ought Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Absence of positive outcomes. Vulnerable to dejection related emotions</td>
<td>Absence of positive outcomes. Vulnerable to dejection related emotions</td>
<td>Presence of negative outcomes. Vulnerable to agitation related emotions</td>
<td>Presence of negative outcomes. Vulnerable to agitation related emotions</td>
</tr>
</tbody>
</table>

It is neither the actual-self alone nor self-guides alone that underlie emotional vulnerabilities. Rather, it is the relation between the actual-self and self-guides that is critical. It is to such relations that we shall now turn.
1.2 Types of self-discrepancies and their emotional counterparts

1.2.1 Actual \ own versus ideal \ own
If a person possesses this discrepancy, they do not believe that their actual-self attributes match those ideal-self attributes he or she wants or hopes to attain. This discrepancy represents the absence of positive outcomes and the person is predicted to be vulnerable to dejection-related emotions, in particular disappointment and dissatisfaction.

1.2.2 Actual \ own versus ideal \ other
If a person possesses this discrepancy, they do not believe that their actual-self attributes match those ideal-self attributes that some significant other person hopes or wishes that he or she would attain. This discrepancy again represents the absence of positive outcomes and the person is predicted to be vulnerable to dejection-related emotions, in particular shame, embarrassment or feeling downcast.

1.2.3 Actual \ own versus ought \ own
If a person possesses this discrepancy, they do not believe that their actual-self attributes match those ought-self attributes that they believe it is their duty to attain. This discrepancy represents the presence of negative outcomes (e.g., a readiness for self-punishment) and thus, self-discrepancy theory predicts that the person is vulnerable to agitation-related emotions, in particular guilt, self-contempt and uneasiness.

1.2.4 Actual \ own versus ought \ other
If a person possesses this discrepancy, they do not believe that their actual-self attributes match the ought-self attributes that they believe some significant other person considers to be his or her duty to attain. This discrepancy represents the presence of negative outcomes (e.g., expectation of punishment) and the person is
predicted to be vulnerable to *agitation-related emotions* in particular feeling fearful and threatened.

1.2.5 Conflicting Self-Guides
As well as such self-concept mismatches with self-guides, it is also possible to have conflicting self-guides. Although not of direct concern in the present study, it is worth mentioning the findings of Van Hook and Higgins (1988) in this regard. Undergraduates who possessed a self-guide self-guide discrepancy were significantly more likely to suffer from indecision, muddledness, identity confusion, distractibility, and rebelliousness than undergraduates who did not possess such a discrepancy.

1.3 Availability and Accessibility of Self-discrepancies
The likelihood of a particular event accessing a self-discrepancy is determined by when it was last activated, how often it is activated, and it's being relevant to the event.

1.4 Motivation to reduce discomfort
The theory assumes that the greater the discrepancy between *actual self beliefs* with various self guides, then, the greater will be the resulting discomfort. Zanna, Higgins and Taves (1976) examined whether dissonance is a phenomenologically aversive state by asking students to write counter attitudinal essays. They all took a pill, which they had just taken in the context of another experiment, and all were then given one of the following side effects explanations. (1) they would feel excited (2) they would feel tense (3) given no information (4) told there were no side effects. Subjects in the first three conditions, aroused by writing an essay dissonant with their personal views, were able to attribute their arousal to the pill and therefore did not alter from their original attitudes. Subjects in the last condition were unable to attribute their discomfort to the pill, and so stated attitudes more congruent with the essay in an attempt to reduce their dissonance and discomfort. These results are consistent with the notion that dissonance
is an aversive state and that subjects will seize, when possible, an external attribution for their discomfort.

1.5 Self discrepancy theory and emotional distress - an empirical basis for the proposed link.

Higgins, Klein and Strauman (1985) had 52 psychology undergraduates fill out a questionnaire designed to measure their self discrepancies as well as a variety of standard measures of depression and anxiety. (e.g., Beck Depression Inventory, Hopkins Symptom Checklist).

The hypothesis that the greater the magnitude of self concept discrepancy the greater the intensity of discomfort induced by the discrepancy was strongly confirmed. On each of the measures, there was a significant, positive relation between the magnitude of total self discrepancy score and the intensity of general discomfort.

As predicted, partial correlational analyses revealed that discrepancies between individual's self-concepts and their ideal self-guides (e.g. actual \ own: ideal \ own and actual \ own : ideal \ other discrepancies) were more closely associated with dejection-related emotions than with agitation related emotions, whereas the opposite was true for discrepancies between individuals self-concepts and their ought self-guides.

Higgins, Bond, Klein and Strauman (1986) tested whether the kind of discomfort that resulted from focusing on a negative event would vary depending on the type of self-discrepancy that was predominant for an individual. As predicted, when they were exposed to a positive event there was no difference between predominately actual-ideal discrepancy subjects and predominately actual-ought discrepancy subjects in their dejection-related and agitation-related mood scores but when they were exposed to a negative event, predominate actual-ideal discrepancy subjects felt significantly more dejected than did predominate actual-ought discrepancy subjects, whereas the latter tended to be more agitated than their counterparts. This study demonstrates that people with both types of discrepancies can experience either an increase in dejection
or an increase in agitation depending on which type of discrepancy is temporarily made more accessible by the momentary context.

Higgins and Tykocinski (1992) examined whether persons who possess different types of self-discrepancies are sensitive to different types of psychological situations, as shown in their memory for another person's experiences. All subjects read the same essay in which a target person experienced events reflecting both the presence of a positive outcome and the absence of a negative outcome. The target person's experiences were circumstantial and not personality related (e.g., finding money on the street; escaping an unpleasant school day because of an election). Half the subjects were predominant actual-ideal discrepancy persons, who had better recall for the events that reflected the presence and absence of positive outcomes. The other half, the actual-ought discrepant individuals, had better recall for the events that reflected the absence or presence of negative outcomes. Such results suggest that a chronic pattern of self-beliefs sensitises a person to attend to and remember events that accord with their self-beliefs, rather than to those events that do not.

Higgins et al. (1994) found that the distinction between ideal and ought self-regulatory systems extends to differences in predilections for different regulatory forms, with the ideal system being concerned with approach (particularly approaching matches to desired end states) and the ought system concerned with avoidance (avoiding mismatches to desired end states and avoiding matches to undesired end states). Two studies using different paradigms activated either ideal self-guides or ought self-guides and measured subjects concern with different forms of self-regulation. A third study asked ideal versus ought discrepant subjects to select among alternative strategies for friendship. The results suggested that a concern with approach is greater for ideal than ought self-regulation, whereas a concern with avoidance is greater for ought than ideal self-regulation.
1.6 Miskimins

The work by Miskimins and his colleagues has identified that there are many and varied aspects of the self-concept (Berry and Miskimins, 1969, Berry, Wilson and Miskimins, 1972, Braught, 1971, Miskimins and Braught, 1971, and Wilson, Miskimins and Berry, 1971). The Miskimins Self-Goal-Other Discrepancy Scale (MSGO) (Miskimins and Braught, 1971) measures the discrepancies in a person's alignment of (a) his self-concept (where you are), (b) his goal self-concept (where you want to be), and (c) his perception of how others evaluate him (where other see you). These three variables are rated on 9 point scales for 15 pairs of constructs (e.g., happy and sad). Again, it is not the absolute ratings that are of interest, instead it is the differences between the self-concept rating and the other two. Miskimins and Braught (1971) have emphasised that the measurement of the incongruencies among self, goal, and others reflects internal tension. Specifically, there are two kinds of discrepancy scores available: self-goal and self-other. Each of these may be positive or negative. Thus, although similar to the selves measure, the MSGO would not allow exploration of the ought self, nor did it encompass the division between domains and standpoints on the self. However, the use of nomothetic constructs was appealing. Five of the constructs used in the Miskimins scale were selected, and people asked to rate themselves as they actually are, as they want to be and as they feel they ought to be along each of these descriptions. It would then be possible to examine if there was any relationship between these nomothetic descriptors and those supplied by each participant. Thus, participants were asked to rate themselves from their own standpoint, and then from another person's viewpoint across the actual, ideal and ought selves firstly according to the following descriptors: smart/intelligent; a good person; caring (about other people's feelings) friendly and good looking. They were then asked to do the same again, only this time they were to supply more relevant and meaningful descriptors of themselves. I did not expect to find a relationship between the supplied and the self nominated descriptors. It was more likely that the self nominated
descriptors would be more sensitive to a person's internal conflict of the moment, rather than general socially approved of labels. Moretti and Higgins (1990) sought to establish the size of the unique proportion of the variance accounted for by actual-ideal discrepancy scores independently of actual-self ratings in a person's self-esteem. Subjects completed a nomothetically based measure that assessed actual-ideal discrepancy on a set of personality characteristics and an idiographically based measure that assessed actual-ideal discrepancy between subject's self-nominated actual-self and ideal-self attributes. The results indicated that the discrepancy scores derived from an idiographic measure of the actual-self and ideal-self are significant predictors of global self esteem. Discrepancy scores from the selves questionnaire correlate significantly with self-esteem on the Rosenberg Self-Esteem Scale and on the Coopersmith Self-Esteem Inventory, independent of the relation between discrepancy scores and the actual-self. In contrast, discrepancy scores derived from a nomothetic measure of the actual-self and ideal-self are neither strongly nor uniquely associated with self-esteem. Such results highlight the value of idiographic measures of discrepancy between the actual-self and the ideal-self. Moretti and Higgins (1990) argued that such idiographic measures are more reliable than discrepancy scores from a nomothetic measure and, therefore more predictive of self-esteem. The test-retest reliability of the discrepancy scores on the selves questionnaire, over a 4 to 6 week period ranged from .39, \( p < .05 \) (actual-ideal discrepancy), to .53, \( p < .01 \) (actual-ought discrepancy). Hoge and McCarthy (1983) reported that the test-retest reliability of real-ideal discrepancy scores derived from a nomothetic measure of the actual-self and ideal-self was \( r = .27 \) over a period of one year. Although these results are from different samples and different test-retest periods, they are consistent with the notion that discrepancy scores derived from an idiographic measure of the actual-self and ideal-self are more reliable than are discrepancy scores based on a nomothetic measure.
1.7 Why Alcohol Clients?

Alcoholics exhibit lower self esteem ratings than social drinkers (Berg, 1971) and non-alcoholics (Carrol and Fuller, 1969) and generally poorer self concepts than students (Quereshi and Soat, 1976). The link between low self esteem and depression is well established, and low self esteem has long been recognised as being associated with alcoholism (McCord and McCord, 1960).

Quereshi and Soat (1976) examined the person perception of alcoholics compared to non-alcoholics after controlling for age, sex and ability level. They found that alcoholics rated themselves less positively on extroversion and self-assertiveness and also judged their parents and partner less positively on unhappiness, extroversion and productive persistence. There were no significant differences between the two groups in judging famous people or in the degree of differentiation that was evident in rating across all the 16 people used, including the self. Thus, the process of self and other perception was similar between alcoholics and non-alcoholics. The main difference was the negative evaluation alcoholics applied to themselves and their closest family members.

Armstrong and Wertheimer (1959) and Armstrong and Hoyt (1963) have suggested that the alcoholic perceives himself as being significantly different from what he would like to be. It has been reported that drinking behaviour may temporarily lead to a reduction of the discrepancy. McGuire et al (1966) studied four chronic male alcoholics before, during and after they underwent experimentally induced intoxication, and argued that they achieved a 'more integrated ego system' while they were intoxicated than when they were sober. While intoxicated, the alcoholics interpreted women's avoidance of them as evidence of their fantasies of being 'masculine, sexually powerful and special'. The authors believed that the intoxicated alcoholics used 'their relationships in the service of ego-syntonic fantasy fulfilment and falsification of reality'. McClelland et al (1972) argue that the alcoholic is motivated by the need for greater personalised power, which manifests in manipulative and exploitative behaviour designed to boost his self-image. However, whether it is the need for a
feeling of power, sexual prowess or nurturance that leads to dependence upon alcohol for some people, the core issue would seem to be dissatisfaction with themselves. Who they currently are is at uncomfortable odds with who they want to be or who they feel they should be.

1.8 Alcohol Dependence and Psychiatric Disorders

Seriously dependent problem drinkers who are relapsing are likely to exhibit a range of difficulties. Alcohol has a direct action on the central nervous system (CNS) and is capable of producing symptoms similar to those observed in major psychiatric disorders. (Schuckit, 1983). A cross-sectional, population-based American study found that an increasing level of alcohol consumption was associated with increasing psychiatric distress, starting at moderate consumption levels for women, and at heavy consumption levels for men (Dryman et al, 1989)

1.8.1 Anxiety

The prevalence of anxiety disorders in alcoholics has been reported to range from 16 to 37 %, as compared with a much lower incidence rate of 4-5 % in the general population (Welte, 1985). Western epidemiological findings suggest particular groups of drinkers may be using alcohol to reduce chronic anxiety (Welte, 1985).

1.8.2 Tension reduction hypothesis

The original tension reduction hypothesis (Conger, 1951, 1956) proposed that alcohol reduces tension or anxiety by way of it’s depressant effects upon the central nervous system. Later revisions (Cappell and Greeley, 1987) contextualise the theory by recognising the importance of situational, biological, expectancy and gender-related factors which govern a person’s embodiment of alcohol’s effects. Powers and Kutash (1985) consider that alcohol can reduce a number of negative affective states including tension, low self-esteem and anger. Extending the tension reduction hypothesis to alcoholics would suggest that alcoholics might consume large amounts of alcohol to
cope with severe anxiety problems (Bibb and Chambliss, 1986, Blane and Leonard, 1987). However, most studies indicate that even modest doses of alcohol are associated with increases, not decreases, in physiological measures associated with tension as well as with subjective feelings of anxiety (Williams, 1966, Logue et al, 1978, Schuckit, 1985).

However, the danger is that a number of problem drinkers, who started out drinking to self medicate their anxiety state then enter a vicious cycle of relief drinking that escalates and is maintained by alcohol's secondary anxiety effects. Stockwell et al (1984) found that phobic alcoholics generally considered alcohol could reduce their phobic anxiety, but problems related to heavy drinking eventually exacerbated their anxiety problems. Stockwell and Bolderston (1987) have reviewed a number of studies suggesting that heavy alcohol use is often associated with an increase in anxiety leading to tension induction rather than the expected tension reduction. Higher anxiety levels are associated with more severe alcoholism (Donovan et al, 1978, Whitelock et al, 1971).

After the development of physical dependence to any brain depressant, the acute abstinence syndrome, lasting for 4-5 days or more, is likely to include tremors, feelings of tension, restlessness, and insomnia. All symptoms found in severe anxiety states. This is often followed by a secondary abstinence syndrome lasting for months and characterised by anxiety, emotional instability, autonomic overreactivity, restlessness, and sleep impairment (DeSoto et al, 1985)

1.8.3 Depression

A close relationship between alcoholism and depression has been found (Winokur et al, 1971, Pottenger et al, 1978, Powell et al, 1982, Weissmam et al, 1980). Within his investigation of the relationship between alcohol dependence and alcohol-related problems, Drummond (1990) found that 55 % of his sample of people presenting to an alcohol treatment unit (n = 103) reported feeling depressed for more than a week and 49 % had suicidal thoughts. There is evidence of people diagnosed as suffering from
alcoholism are much more likely than the average person to commit suicide (e.g. Kessel, 1965).

Alcohol is a CNS depressant which is capable of inducing feelings of sadness. This is especially likely to be observed at falling blood alcohol concentrations. While the intensity of affect is likely to be different for different people, it is probable that it will be longer lasting and more profound following higher blood alcohol concentrations and longer periods of drinking. Seriously dependent problem drinkers are most vulnerable to such mood altering effects of alcohol, due to their severe and sustained levels of drinking. Several studies have reported that alcoholics experience increased dysphoria and anxiety as a result of alcohol consumption (Mendelson, 1974, Nathan and Lisman, 1976, Freed, 1978) The Chronic ingestion of alcohol can lead to profound changes in affect that can mimic a depressive episode. (Mayfield and Coleman, 1968).

Overall, the rate of severe depression in the course of alcohol abuse or dependence is at least 30-40 %, and when less stringent criteria are applied the figure may be 70 % or higher (Schuckit, 1983, Cadoret and Winokur, 1974). As is true in the general population, depressive symptoms are more likely to be reported by female alcoholics than by male alcoholics (Schuckit and Winokur, 1972, Hatsukami and Pickens, 1982). Hatsukami and Pickens (1982) found that amongst relapse subjects the rate and severity of depressive symptoms were higher than those found in the general population.

Regardless of gender, the quality of depression seen in the course of heavy drinking can be similar to the symptom profile noted during primary affective episodes (Schuckit, 1979, Schuckit, 1983, Weissman et al, 1977).

However, not only the physiological effects of alcohol are involved in the mood state of the alcoholic. Life problems (financial, interpersonal and medical) inherent in the course of alcoholism are also expected to induce affective disturbances.
1.8.4 Female alcoholics

Since excessive drinking is regarded as more of a social taboo among women, there is an argument that only greater psychopathology would enable a woman to reach alcoholic status. Several studies suggest that women alcoholics have a poor, inadequate or distorted self-image, low self-esteem or poor self-concept (Kinsey, 1966., Kinsey, 1968., Wood and Duffy, 1966), and that about 20 % start seriously misusing alcohol at the time of a middle age identity crisis brought about by some situational event (Curlee, 1970).

Curlee (1970) found that women alcoholics were more likely to be admitted to hospitals as psychiatric patients, were admitted more often and for longer periods, and were more often divorced than were men alcoholics. Braiker (1984) cites studies showing the greater amount of psychiatric treatment among women with alcohol problems; more frequent reports by these women than alcoholic men of depressed or sad mood, feelings of inadequacy, low self-esteem, and anxiety; and an elevated rate of suicide attempts relative to men.

It is difficult to separate serious psychological damage caused by a woman's alcoholism from pre alcoholic predisposing factors (Curlee, 1967). Although both men and women alcoholics have experienced a high incidence of disruptive emotional behaviour and deprivation as children ( De lint, 1964., Kinsey, 1966., Koller and Castanos, 1969., Oltman and Friedman, 1967., Rathod and Thomson, 1971) women have experienced more damaging experiences, such as loss of a parent through divorce, desertion or death (Curlee, 1970., De Lint, 1964., Linsansky, 1957). and had more emotional trauma (Podolsky, 1963).

Pemberton (1967) found that some women drank heavily because they could not adequately fulfil a satisfying role within the family unit. Many studies have documented sex differences in reported depressive symptomatology, and there is general agreement that females are at higher risk for depression than males (Weissman and Klerman, 1977., Goldman and Ravid, 1980., Amenson and Lewinsohn, 1981., Midanik, 1983., Myers et al, 1984., Caetano, 1987., Parker et al., 1987., Weissman, 1987). Hatsukami
and Pickens (1982) found that, even among women who abstained, there was a significantly higher rate of depressive symptoms than among men who abstained.

1.8.5 Abstinent alcoholics

Although the intensity of depressive symptoms during the course of dependent drinking can be severe, the affective disturbances are likely to be transitory, showing great improvement or disappearance of symptoms within several days or weeks of abstinence (Liskow et al, 1982., Schuckit and Winokur, 1972., Schuckit, 1985., Powell et al, 1987). Hatsukami and Pickens (1982) found that the rate and severity of depressive symptoms for subjects who did not relapse were no higher than those found among the general population. Several longer term follow-ups of alcoholics who were able to maintain abstinence showed little evidence of severe or prolonged depression during the follow-up periods (Schuckit et al, 1985., Pettinati et al, 1982) Evaluation of 312 abstinent alcoholics (163 men and 149 women) with the Symptom Check-List 90 revealed a progressive decline in symptomatology with prolonged abstinence. The scores approximated levels found in the general population after ten years of abstinence or more. The levels were similar for men and women. A particularly interesting finding was that feelings of guilt persisted at high levels, even after many years of sobriety. For instance, 87 % of subjects reported 'feelings of guilt' during the first six months of abstinence, this figure is above the 68 % obtained for psychiatric outpatients (Derogatis, 1977). The percentage drops to 56 % for the greater than 10 years group, but even this figure is far above the 17 % obtained in the general population (DeSoto et al, 1985).

1.8.6 Probable conflicting self beliefs of the relapsing alcoholic

The persistently high level of guilt found by DeSoto et al, (1985) would be explained by self-discrepancy theory as the result of a discrepancy between the person's actual self from their own ought-self. Thus, such feelings occur because they believe they have transgressed a personally accepted moral standard.
Because of the social, domestic, professional and medical problems incurred through dependent drinking, relapsing alcoholics are likely to show evidence of several conflicts between who they are and who they would like to be, and with who others expect them to be. Marital difficulties are often evident when one or both partners have a drinking problem (Orford and Edwards, 1977). Alcoholics often speak of how their body 'demands' alcohol even when they want to abstain. It is as if their drinking is beyond their will. Such internal conflict could be captured in the distinction between the ideal self and the actual self. Whilst the relapsing alcoholic wishes to become abstinent, he seems unable to make this become reality. As well as intrapsychic conflict, alcoholics experience interpersonal conflict because of their secrecy and growing involvement in deceit. Such conflict could be represented in the distinction between the ought self and the actual self. Whilst the relapsing alcoholic believes that he should stop drinking, he seems unable to make this actually happen. Thus, the concept of addiction rests upon the distinction between a person's desire and their will. Such a distinction easily lends itself to self concept discrepancy theory, with it's assumption of separate hopes, aspirations and wishes in one self guide (ideal self) from a person's feelings of duty or obligation (the ought self guide). The hypothesis that alcohol consumption results in reduced self awareness and less regulation of behaviour by internalised social standards (Hull, 1987) could also be describing the temporarily reduced role of the self-guides when people are drunk. This claim is similar to the description of alcohol as the 'solvent' of the super-ego!

2.0 Summary

The literature indicates that relapsing alcoholics will display several conflicting self beliefs because of the CNS depressant effects of alcohol, associated life problems and general dissatisfaction with themselves. Further evidence suggests that female alcoholics are likely to feel at odds with the traditional sex role stereotype, resulting in additional gender specific conflict, which creates greater emotional distress than their male counterparts experience.
In order to examine the relationships between conflicting self-beliefs, emotional distress and severity of alcohol dependence, two groups of drinkers were recruited to the present study. Those that had been abstinent for six months or more and those who were still currently drinking. Both men and women were invited to participate, in order to examine any possible sex differences.

2.1 Aims of the study

1) To investigate the relationship between the five nomothetic descriptors supplied with the subjects' self-nominated actual-self, ideal-self and ought-self attributes.

2) To investigate the relationship between type and severity of self discrepancy and emotional distress.

3) To investigate the relationship between type and severity of emotional distress and severity of alcohol dependence in relapsing participants.

4) To investigate whether female alcoholics (both abstinent and relapsing) report greater self discrepancies and consequently experience greater emotional distress than male alcoholics.

5) To investigate whether relapsing alcoholics report greater self discrepancies and consequently experience greater emotional distress than abstinent participants.

2.2 Hypotheses

1. There will be no relationship between the five nomothetic descriptors supplied with the participants self-nominated actual-self, ideal-self and ought-self attributes.

2. Participants with larger self-concept discrepancies will show greater emotional distress than participants with smaller self-concept discrepancies.

3. Participants displaying a predominantly actual-ideal discrepancy will be associated with dejection-related emotions.

4. Participants displaying a predominantly actual-ought discrepancy will be associated with agitation related emotions.
5. The greater the intensity of emotions experienced the greater the likelihood of severity of alcohol dependence in relapsing participants.

6. Female participants will exhibit greater self concept discrepancies associated with greater intensity of emotions than male participants.

7. Abstinent participants will have smaller self concept discrepancies associated with less intense emotions than those relapsing.

3.0 Method

3.1 Design

A cross sectional, two group between subjects design was utilised for this study, to examine individual subject's profiles as well as between-group factors. Groups consisted of male and female relapsed seriously dependent problem drinkers and those who had been abstinent for 6 months or more.

3.2 Participants

The relapse sample consisted of 27 participants. 17 men (X age = 47.29 (SD = 13.26) years, range = 23-68) and 10 women (X age = 43.60 (SD = 8.45) years, range = 31-56). They were drawn from client caseloads of mental health professionals working for community alcohol teams. The study gained ethical approval from both the Worthing and Brighton ethical committees (see Appendix 1 and 2). Participants were invited to take part in the research, by a letter given to them by their key worker (see Appendix 3). The abstinent sample consisted of 20 subjects. 12 men (X age = 42.58 (SD = 9.33) years, range = 28-59) and 8 women (X age = 44.63 (SD = 11.45) years, range = 29-65). 13 of these were recruited from local Alcoholics Anonymous Groups. Participants were excluded if they were intoxicated or showed evidence of organic impairment.

All of the participants had a history of drinking in excess of the harmful dose of alcohol per week. (50 units for men, 35 units for women). Thus, the sample consists of people with a history of seriously dependent problem drinking. The relapse sample have had a
lapse in the previous 3 months, but are working towards their goal of abstinence. The abstinent participants will not have consumed any alcohol for six months or more.

3.3 Measures

The following measures were administered during a one off clinical interview with the researcher. They were presented in a counterbalanced order.

3.3.1 The Background Information Questionnaire

Participants were asked their age, sex, current drinking pattern, how long they have either been in treatment or attending AA meetings and how many in-patient detoxifications they have had. From the information given the number of units consumed per week was calculated. (See Appendix 4).

3.3.2 The Beck Depression Inventory (BDI) (Beck et al., 1961)

This self-report inventory contains 21 items relating to depressive emotions and symptoms. For each item subjects select one of four or five statements that increase in severity (scored from 0 to 3, with higher numbers indicating more severe depression). (See Appendix 5) The clinical cut offs are as follows: 0-9 normal, 10-18 mild moderate, 19-29 moderate severe and 30-63 severe extremely depressed.

The BDI has high internal consistency in both clinical and nonclinical populations. Internal consistency estimates based upon Cronbach's coefficient alpha for 105 alcohol patients was .90 (Steer, Beck and Shaw, 1985) A meta-analysis with 9 psychiatric samples obtained .86 and for 15 nonpsychiatric samples, .81 Test re-test reliability for nine studies of nonpsychiatric samples ranged from .60 to .90

As for construct validity, hopelessness is hypothesised to be associated with depression. Beck, Weissman, Lester and Trexler (1974) found that scores on the hopelessness scale were positively related to the BDI scores in all six normative samples.
3.3.3 The Hopkins Symptom Check List Revised (SCL-90-R) (Derogatis et al., 1973)

This is a modern, well standardised measure with good coverage of important areas of symptomatology and psychopathology (Derogatis, 1977). The 90 item scale provides measures in each of nine areas; somatization, obsessive-compulsive, interpersonal sensitivity, depression, anxiety, hostility, phobic anxiety, paranoid ideation and psychoticism. Each item is rated on a 5 point scale, with higher numbers indicating more severe symptoms. (See Appendix 6) This scale was chosen to measure emotional distress because it contains the following subscales that were used in the analysis: depression, anxiety and hostility as well as three global indices of distress. Such specificity will enable the predictions of self discrepancy theory to be tested, as Higgins, Klein and Strauman did in their (1985) study.

Two studies investigated the internal consistency reliability using coefficient alpha and found satisfactory coefficients, ranging from a low of .77 for psychotisism to a high of .90 for depression in the Derogatis, Rickels and Rock (1976) study, and from a low of .79 for paranoid ideation to a high of .90 for depression in the Horowitz et al (1988) study. Test-retest reliability were also conducted. Derogatis, Rickels and Rock (1976) found that the majority of coefficients lie between .80 and .90, which is an appropriate level for measures of symptom constructs. In the Horowitz et al (1988) report, test-retest coefficients ranged from .68 for somatization to .83 for paranoid ideation, even though the time elapsed between assessments was 10 weeks.

Derogatis and Cleary (1977) completed a construct-oriented study of the SCL-90-R and the empirical analysis matched the theoretical structure quite well on most of the dimensions. There was some overlap between the anxiety and phobic anxiety dimensions, and some splitting between items on the psychoticism dimension. However, on the whole the empirical-theoretical match was confirmed.
3.3.4 The Selves Questionnaire

This questionnaire was created to measure self-concept discrepancy. Unlike Higgins (1985) written questionnaire which was used with undergraduates, and requested ten self nominated attributes, I reduced this number to five in order to make it more feasible for an interview format. I also needed to consider that the current sample were older, probably with fewer years of education and possibly less verbally able than the sample used by Higgins (1985).

The adapted selves questionnaire asked participants to consider themselves against five supplied nomothetic descriptions and to then to provide a further five idiographic descriptions associated with different self-concepts (the actual, ideal and ought selves). It consisted of two sections, the first working from their own perspective, and the second concerned with the viewpoint of somebody important to them. (See Appendix 7)

Participants were asked to rate themselves on a 5 point scale (ranging from 1, not at all true of me to 5 extremely true of me) according to the extent to which they or their significant other believed they actually possessed, ideally would like to possess, or ought to possess a list of 5 supplied attributes (smart \ intelligent, good person, caring, friendly, and good looking). They were asked to do the same for the 5 attributes they supplied. Such experimenter-selected set of positive, socially desirable attributes may not be important or relevant to individual participants.

Having both the nomothetic and idiographic sections meant that there would need to be two scores for each self guide, rather than the one possible using Higgins (1985) questionnaire format. Thus, in total this measure yielded the following four totals:

- actual \ ideal discrepancy for the nomothetic descriptors (AI-n)
- actual \ ideal discrepancy for the idiographic descriptors (AI-i)
- actual \ ought discrepancy for the nomothetic descriptors (AO-n)
- actual \ ought discrepancy for the idiographic descriptors (AO-i)
Actual \ ideal (AI-n) discrepancy scores for the nomothetic descriptors were calculated by comparing the scores on the ratings scale. If the scores were within two scale points this was considered a match, anything greater was considered a mismatch. The same applied to the actual \ ought discrepancy scores (AO-n)

Actual \ ideal (AI-i) discrepancy scores for the idiographic descriptors were calculated by comparing each attribute in the actual-self list with the attributes listed for ideal \ own and ideal \ other. Actual \ ought discrepancy scores were calculated by comparing the actual-self attributes with those listed for ought \ own and ought \ other. Attributes on the lists were considered discrepant if they were antonymous or if they were synonymous but had extent ratings differing by 2 or more scale points. Discrepancy scores for each guide were aggregated across own and other standpoints.

3.3.5 The Severity of Alcohol Dependence Questionnaire (SADQ) (Stockwell et al., 1979)

This measure elicits information on the frequency with which various alcohol-related experiences occurred in a typical month of heavy drinking. It contains 20 questions dealing with physical withdrawal symptoms, affective symptoms of withdrawal, relief drinking, level of alcohol consumption and rapidity of reinstatement after withdrawal. Each item has it's own frequency scale ranging from 'almost never' to 'nearly always.' (See Appendix 8). Each constituent item can be scored from 0 to 3. Thus a total score for each section can be obtained as well as a total SADQ score of 60. Scores greater than 30 have been found to correspond to Edward's' own ratings of 'severe alcohol dependence' (Stockwell et al., 1979). Stockwell et al, (1983) found an overall reliability of 0.85 when the SADQ was given to 45 participants after a two week interval. Concurrent validation was explored by Stockwell et al, (1979) who demonstrated that the SADQ gave a biserial correlation of 0.84 with clinical ratings of intensity. Meehan et al, (1985) has also found an agreement between the SADQ and clinical ratings. Studies of the validity of alcoholics self-reports through correlation's with external criteria such as collatoral reports, arrest and hospitalisations records, and blood alcohol
tests all indicate that alcoholics provide reliable reports of their drinking. (Hesselbrock et al, 1982., Polich, 1982)

4.0 Procedure

After subjects had provided written consent to participate in the study they were asked to attend a one off, individual interview with the researcher, during which five questionnaires were administered. At interview subjects were told that the purpose of the research was 'to understand more about the relationships between your own views of yourself, how you think people who are important see you, and how you feel.' They were also assured that all information gathered would be kept in the strictest confidence. Either the researcher or the participant read aloud the instructions and each of the questions in turn. The researcher wrote down all the replies given by the participants, to ensure completeness and to provide an opportunity to check out whether the participants intended meaning had been received by the researcher.
5.0 Results

5.1 Data Analysis

Non-parametric tests were used throughout the analysis, because assessment of the data revealed that it was not normally distributed, and therefore did not meet one of the main requirements for parametric tests.

In order to examine the relations between the different kinds of discrepancies and various emotions and symptoms associated with depression and anxiety, Spearman's rho and Kendall's tau-b correlations were calculated. The former is a non-parametric test which measures the amount and significance of a correlation between people's scores on two variables. The latter is a nonparametric measure of correlation for ordinal variables that takes ties into account.

Investigation of group differences (between either men and women and abstinent and relapsed participants) involved using the Mann-Whitney U Test, a nonparametric test used to examine differences between the scores within the different groups. Two-tailed tests were used throughout.

Because it was found that abstinent participants had significantly lower scores on the measures of emotional distress, all the relevant correlations were calculated on the total sample, as well as the two subgroups of relapsing and abstinent participants. This was done to ensure that significant relationships were not being masked when only the total sample was analysed.
5.2 Results

**Hypothesis One**: There will be no relationship between the five nomothetic descriptors supplied with the participants' self-nominated actual-self, ideal-self and ought self attributes

<table>
<thead>
<tr>
<th>Table One: Inter-correlations between self-concepts using the total sample.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>AI-n</strong></td>
</tr>
<tr>
<td>AI-i</td>
</tr>
<tr>
<td>AO-i</td>
</tr>
<tr>
<td>AO-n</td>
</tr>
</tbody>
</table>

Using Spearman’s rho, two-tailed test, p <.05

**Key for the abbreviations used in the table:**
- actual \ ideal discrepancy for the nomothetic descriptors (AI-n)
- actual \ ideal discrepancy for the idiographic descriptors (AI-i)
- actual \ ought discrepancy for the nomothetic descriptors (AO-n)
- actual \ ought discrepancy for the idiographic descriptors (AO-i)

As can be seen from Table One there was no relationship between the scores obtained from the five nomothetic descriptors and the five self-nominated descriptors across the actual, ideal and ought self domains. Therefore the null hypothesis was accepted when the total sample was considered.

However, there was a strong positive correlation between the ideal and ought domains when both refer to the five nomothetic descriptors. (.6094, p < .05) In other words, people tended to rate themselves similarly across both ideal and ought self guides on the nomothetic descriptors. Likewise, there was a strong positive correlation between the self-nominated descriptors given by participants for the ideal and ought selves.
(.5574, p < .05). Thus the self-discrepancy measure was distinct in terms of the nomothetic \ idiographic split but not according to the ideal \ ought selves split. In other words, participants regarded the five nomothetic descriptors as distinct from their own supplied descriptors. But when participants supplied the descriptors they tended to choose the same words for both their ideal and ought selves, suggesting that they did not perceive ideal and ought selves as different from each other.

Table Two: Inter-correlations between self-concepts for relapse participants only

<table>
<thead>
<tr>
<th></th>
<th>AI-n</th>
<th></th>
<th>AO-n</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>AI-i</td>
<td>.0815</td>
<td>n = 27</td>
<td>-.0934</td>
<td>n = 27</td>
</tr>
<tr>
<td></td>
<td>sig = .686</td>
<td></td>
<td>sig = .643</td>
<td></td>
</tr>
<tr>
<td>AO-i</td>
<td>-.2096</td>
<td>n = 27</td>
<td>-.0574</td>
<td>n = 27</td>
</tr>
<tr>
<td></td>
<td>sig = .294</td>
<td></td>
<td>sig = .776</td>
<td></td>
</tr>
<tr>
<td>AO-n</td>
<td>.4448</td>
<td>n = 27</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>sig = .020</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Using Spearmans rho, two tailed test. p<.05

Key for the abbreviations used in the table:
- actual \ ideal discrepancy for the nomothetic descriptors (AI-n)
- actual \ ideal discrepancy for the idiographic descriptors (AI-i)
- actual \ ought discrepancy for the nomothetic descriptors (AO-n)
- actual \ ought discrepancy for the idiographic descriptors (AO-i)

The null hypothesis was also accepted when considering the sub-groups. The same pattern was seen when inter-correlations were conducted between the self-concepts of relapsing participants (see Table Two) and abstinent participants (see Table Three). It would seem that abstinent participants rate themselves most similarly across the five nomothetic descriptors (.8380 p <.05) and across the idiographic descriptors (.5906 p < .05).
Table Three: Inter-correlations between self-concepts for abstinent participants only

<table>
<thead>
<tr>
<th></th>
<th>AI-n</th>
<th>AO-n</th>
<th>AO-i</th>
</tr>
</thead>
<tbody>
<tr>
<td>AI-i</td>
<td>.0976 n = 20</td>
<td>-.0212 n = 20</td>
<td>.5906 n = 20</td>
</tr>
<tr>
<td></td>
<td>sig = .682</td>
<td>sig = .929</td>
<td>sig = .006</td>
</tr>
<tr>
<td>AO-i</td>
<td>.0365 n = 20</td>
<td>.1019 n = 20</td>
<td></td>
</tr>
<tr>
<td></td>
<td>sig = .878</td>
<td>sig = .669</td>
<td></td>
</tr>
<tr>
<td>AO-n</td>
<td>.8380 n = 20</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>sig = .000</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Using spearmans rho, two tailed test. p < .05

Key for the abbreviations used in the table:

- actual \ ideal discrepancy for the nomothetic descriptors (AI-n)
- actual \ ideal discrepancy for the idiographic descriptors (AI-i)
- actual \ ought discrepancy for the nomothetic descriptors (AO-n)
- actual \ ought discrepancy for the idiographic descriptors (AO-i)
Hypothesis Two: Participants with larger self-concept discrepancies will show greater emotional distress than participants with smaller self-concept discrepancies.

Table Four: Correlations between self-concept discrepancies and emotional distress for the total sample

<table>
<thead>
<tr>
<th></th>
<th>Beck Depression Inventory</th>
<th>Depression subscale</th>
<th>Anxiety subscale</th>
<th>Hostility subscale</th>
<th>Global severity index</th>
<th>Positive symptom total</th>
<th>Positive symptom distress</th>
</tr>
</thead>
<tbody>
<tr>
<td>AI-n</td>
<td>.2051 n = 47 sig = .167</td>
<td>.0234 n = 47 sig = .867</td>
<td>.1269 n = 47 sig = .395</td>
<td>.2715 n = 47 sig = .065</td>
<td>.1078 n = 47 sig = .471</td>
<td>.0495 n = 47 sig = .741</td>
<td>.2239 n = 47 sig = .130</td>
</tr>
<tr>
<td>AI-i</td>
<td>.1989 n = 47 sig = .180</td>
<td>.2233 n = 47 sig = .131</td>
<td>.3451 n = 47 sig = .018</td>
<td>.0905 n = 47 sig = .545</td>
<td>.2389 n = 47 sig = .106</td>
<td>.2292 n = 47 sig = .121</td>
<td>.1976 n = 47 sig = .183</td>
</tr>
<tr>
<td>AO-n</td>
<td>-.0703 n = 47 sig = .639</td>
<td>-.1745 n = 47 sig = .241</td>
<td>-.1317 n = 47 sig = .378</td>
<td>.1061 n = 47 sig = .478</td>
<td>-.0975 n = 47 sig = .514</td>
<td>-.1406 n = 47 sig = .346</td>
<td>-.0275 n = 47 sig = .854</td>
</tr>
<tr>
<td>AO-i</td>
<td>.0507 n = 47 sig = .735</td>
<td>-.0123 n = 47 sig = .935</td>
<td>.0610 n = 47 sig = .684</td>
<td>-.1431 n = 47 sig = .337</td>
<td>-.0284 n = 47 sig = .850</td>
<td>-.0504 n = 47 sig = .736</td>
<td>.0645 n = 47 sig = .667</td>
</tr>
</tbody>
</table>

Using Spearman's rho, two tailed test, p < .05

Key for the abbreviations used in the table:
- actual \ ideal discrepancy for the nomothetic descriptors (AI-n)
- actual \ ideal discrepancy for the idiographic descriptors (AI-i)
- actual \ ought discrepancy for the nomothetic descriptors (AO-n)
- actual \ ought discrepancy for the idiographic descriptors (AO-i)

As can be seen from Table Four, none of the Spearman's rho correlations between the various self-concept discrepancies and measures of emotional distress scales were significant at the .05 level of significance, using a two tailed test when the total sample scores were used. Thus, the null hypothesis that there is no relationship between the size of self-concept discrepancy with the size of emotional distress was accepted for the total sample.
Table Five: Correlations between self-concept discrepancies and emotional distress in relapsing participants only

<table>
<thead>
<tr>
<th></th>
<th>Beck Depression Inventory</th>
<th>Depression subscale</th>
<th>Anxiety subscale</th>
<th>Hostility subscale</th>
<th>Global severity index</th>
<th>Positive symptom total</th>
<th>Positive symptom distress</th>
</tr>
</thead>
<tbody>
<tr>
<td>AI-n</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>.1909</td>
<td>.0350</td>
<td>.0862</td>
<td>.2975</td>
<td>.1176</td>
<td>.0430</td>
<td>.1507</td>
</tr>
<tr>
<td></td>
<td>n = 27</td>
<td>n = 27</td>
<td>n = 27</td>
<td>n = 27</td>
<td>n = 27</td>
<td>n = 27</td>
<td>n = 27</td>
</tr>
<tr>
<td></td>
<td>sig = .340</td>
<td>sig = .863</td>
<td>sig = .669</td>
<td>sig = .132</td>
<td>sig = .559</td>
<td>sig = .831</td>
<td>sig = .453</td>
</tr>
<tr>
<td>AI-i</td>
<td>.1765</td>
<td>.3196</td>
<td>.4368</td>
<td>.3657</td>
<td>.3966</td>
<td>.4236</td>
<td>.3100</td>
</tr>
<tr>
<td></td>
<td>n = 27</td>
<td>n = 27</td>
<td>n = 27</td>
<td>n = 27</td>
<td>n = 27</td>
<td>n = 27</td>
<td>n = 27</td>
</tr>
<tr>
<td></td>
<td>sig = .379</td>
<td>sig = .104</td>
<td>sig = .023</td>
<td>sig = .061</td>
<td>sig = .041</td>
<td>sig = .028</td>
<td>sig = .116</td>
</tr>
<tr>
<td>AO-n</td>
<td>-.1197</td>
<td>-.1326</td>
<td>-.1927</td>
<td>.1658</td>
<td>-.1067</td>
<td>-.1944</td>
<td>-.0652</td>
</tr>
<tr>
<td></td>
<td>n = 27</td>
<td>n = 27</td>
<td>n = 27</td>
<td>n = 27</td>
<td>n = 27</td>
<td>n = 27</td>
<td>n = 27</td>
</tr>
<tr>
<td></td>
<td>sig = .552</td>
<td>sig = .510</td>
<td>sig = .335</td>
<td>sig = .409</td>
<td>sig = .596</td>
<td>sig = .331</td>
<td>sig = .747</td>
</tr>
<tr>
<td>AO-i</td>
<td>-.1136</td>
<td>-.1149</td>
<td>-.0244</td>
<td>-.0031</td>
<td>-.0681</td>
<td>-.0723</td>
<td>-.0147</td>
</tr>
<tr>
<td></td>
<td>n = 27</td>
<td>n = 27</td>
<td>n = 27</td>
<td>n = 27</td>
<td>n = 27</td>
<td>n = 27</td>
<td>n = 27</td>
</tr>
<tr>
<td></td>
<td>sig = .573</td>
<td>sig = .568</td>
<td>sig = .904</td>
<td>sig = .988</td>
<td>sig = .736</td>
<td>sig = .720</td>
<td>sig = .942</td>
</tr>
</tbody>
</table>

Using spearman's rho, two tailed test. p < .05

Key for the abbreviations used in the table:

- actual \ ideal discrepancy for the nomothetic descriptors (AI-n)
- actual \ ideal discrepancy for the idiographic descriptors (AI-i)
- actual \ ought discrepancy for the nomothetic descriptors (AO-n)
- actual \ ought discrepancy for the idiographic descriptors (AO-i)

However, when only relapsing participants scores were used three large, positive correlations were revealed. Firstly, between the AI-i and the anxiety subscale (.4368 p < .05) Secondly between the AI-i and the global severity index (.3966 p < .05) Finally, between the AI-i and the positive symptom total (.4236 p < .05). Thus, for these three correlations the null hypothesis was rejected. It is interesting that all three significant results involve the idiographic section of the actual \ ideal discrepancy, demonstrating that the larger this discrepancy is for relapsing participants, the larger is their general anxiety, the greater the depth of the disorder (GSI is the single summary measure of the SCL-90-R) and the greater the symptom breadth of the disorder (PST).
The first finding runs counter to the prediction that actual \ ideal discrepancies are associated with dejection-related emotions, as anxiety is classified as an agitation-related emotion. The other two would seem to support hypothesis two, but only for relapsing participants.

Table Six: Correlations between self-concept discrepancies and emotional distress in abstinent participants only

<table>
<thead>
<tr>
<th></th>
<th>Beck Depression Inventory</th>
<th>Depression subscale</th>
<th>Anxiety subscale</th>
<th>Hostility subscale</th>
<th>Global severity index</th>
<th>Positive symptom total</th>
<th>Positive symptom distress</th>
</tr>
</thead>
<tbody>
<tr>
<td>Al-n</td>
<td>.2594</td>
<td>-.0724</td>
<td>.2212</td>
<td>.1375</td>
<td>.0975</td>
<td>-.0114</td>
<td>.3284</td>
</tr>
<tr>
<td></td>
<td>n = 20</td>
<td>n = 20</td>
<td>n = 20</td>
<td>n = 20</td>
<td>n = 20</td>
<td>n = 20</td>
<td>n = 20</td>
</tr>
<tr>
<td></td>
<td>sig = .269</td>
<td>sig = .762</td>
<td>sig = .349</td>
<td>sig = .563</td>
<td>sig = .683</td>
<td>sig = .962</td>
<td>sig = .157</td>
</tr>
<tr>
<td>Al-i</td>
<td>.0963</td>
<td>.0074</td>
<td>.1709</td>
<td>-.4432</td>
<td>-.1349</td>
<td>-.1462</td>
<td>-.0325</td>
</tr>
<tr>
<td></td>
<td>n = 20</td>
<td>n = 20</td>
<td>n = 20</td>
<td>n = 20</td>
<td>n = 20</td>
<td>n = 20</td>
<td>n = 20</td>
</tr>
<tr>
<td></td>
<td>sig = .686</td>
<td>sig = .975</td>
<td>sig = .471</td>
<td>sig = .050</td>
<td>sig = .571</td>
<td>sig = .539</td>
<td>sig = .892</td>
</tr>
<tr>
<td>AO-n</td>
<td>.1195</td>
<td>-.1101</td>
<td>.0521</td>
<td>.1223</td>
<td>.0256</td>
<td>-.0428</td>
<td>.2998</td>
</tr>
<tr>
<td></td>
<td>n = 20</td>
<td>n = 20</td>
<td>n = 20</td>
<td>n = 20</td>
<td>n = 20</td>
<td>n = 20</td>
<td>n = 20</td>
</tr>
<tr>
<td></td>
<td>sig = .644</td>
<td>sig = .644</td>
<td>sig = .827</td>
<td>sig = .608</td>
<td>sig = .915</td>
<td>sig = .858</td>
<td>sig = .199</td>
</tr>
<tr>
<td>AO-i</td>
<td>.0875</td>
<td>.001</td>
<td>.0382</td>
<td>-.4764</td>
<td>-.1565</td>
<td>-.2058</td>
<td>.0393</td>
</tr>
<tr>
<td></td>
<td>n = 20</td>
<td>n = 20</td>
<td>n = 20</td>
<td>n = 20</td>
<td>n = 20</td>
<td>n = 20</td>
<td>n = 20</td>
</tr>
<tr>
<td></td>
<td>sig = .714</td>
<td>sig = .996</td>
<td>sig = .873</td>
<td>sig = .034</td>
<td>sig = .510</td>
<td>sig = .384</td>
<td>sig = .869</td>
</tr>
</tbody>
</table>

Using spearman's rho, two tailed test. p < .05

Key for the abbreviations used in the table:
- actual \ ideal discrepancy for the nomothetic descriptors (Al-n)
- actual \ ideal discrepancy for the idiographic descriptors (Al-i)
- actual \ ought discrepancy for the nomothetic descriptors (AO-n)
- actual \ ought discrepancy for the idiographic descriptors (AO-i)

When only abstinent participants scores are used, two strong, negative correlations are revealed. Firstly between the AI-i with hostility (-.4432 p < .05) and secondly between the AO-i with hostility (-.4764 p < .05). Thus, for these correlations the null hypothesis was rejected. Again, both significant results involve participants discrepancies using their own supplied descriptors. It would seem that for abstinent participants the greater
their AI-i or AO-i discrepancy the lower their level of hostility. Again, the inverse relationship between AO-i with the hostility subscale is surprising since the theory predicts that this should be a positive relationship.

**Hypothesis Three**: Participants displaying a predominantly actual-ideal discrepancy will be associated with dejection related emotions

**Table Seven**: Correlations between actual-ideal discrepancies with various emotions for the total sample

<table>
<thead>
<tr>
<th></th>
<th>Beck Depression Inventory</th>
<th>Depression subscale</th>
<th>Anxiety subscale</th>
<th>Hostility subscale</th>
<th>Global severity index</th>
<th>Positive symptom total</th>
<th>Positive symptom distress</th>
</tr>
</thead>
<tbody>
<tr>
<td>AI-n</td>
<td>.1429</td>
<td>.0158</td>
<td>.0933</td>
<td>.2050</td>
<td>.0728</td>
<td>.0296</td>
<td>.1443</td>
</tr>
<tr>
<td></td>
<td>n = 47</td>
<td>n = 47</td>
<td>n = 47</td>
<td>n = 47</td>
<td>n = 47</td>
<td>n = 47</td>
<td>n = 47</td>
</tr>
<tr>
<td></td>
<td>sig = .184</td>
<td>sig = .882</td>
<td>sig = .383</td>
<td>sig = .061</td>
<td>sig = .493</td>
<td>sig = .781</td>
<td>sig = .173</td>
</tr>
<tr>
<td>AI-i</td>
<td>.1456</td>
<td>.1553</td>
<td>.2665</td>
<td>.0754</td>
<td>.1628</td>
<td>.1683</td>
<td>.1328</td>
</tr>
<tr>
<td></td>
<td>n = 47</td>
<td>n = 47</td>
<td>n = 47</td>
<td>n = 47</td>
<td>n = 47</td>
<td>n = 47</td>
<td>n = 47</td>
</tr>
<tr>
<td></td>
<td>sig = .187</td>
<td>sig = .155</td>
<td>sig = .015</td>
<td>sig = .501</td>
<td>sig = .134</td>
<td>sig = .123</td>
<td>sig = .221</td>
</tr>
</tbody>
</table>

Using Kendall's tau-b two tailed test. p < .05

**Key for the abbreviations used in the table:**
- actual \ ideal discrepancy for the nomothetic descriptors (AI-n)
- actual \ ideal discrepancy for the idiographic descriptors (AI-i)

The only significant relationship found using the Kendall's tau-b correlation, was between the idiographic form of the actual-ideal discrepancy with the anxiety subscale of the SCL-90-R (.2665 p < .05) Such a relationship runs contrary to the hypothesis, as anxiety is regarded as falling in the agitation-related emotions category rather than the dejection-related one.
Table Eight: Correlations between actual-ideal discrepancies with various emotions for relapsing participants only

<table>
<thead>
<tr>
<th>Beck Depression Inventory</th>
<th>Depression subscale</th>
<th>Anxiety subscale</th>
<th>Hostility subscale</th>
<th>Global severity index</th>
<th>Positive symptom total</th>
<th>Positive symptom distress</th>
</tr>
</thead>
<tbody>
<tr>
<td>AI-n</td>
<td>.1329</td>
<td>.0242</td>
<td>.0638</td>
<td>.2166</td>
<td>.0690</td>
<td>.0181</td>
</tr>
<tr>
<td>n = 27</td>
<td>n = 27</td>
<td>n = 27</td>
<td>n = 27</td>
<td>n = 27</td>
<td>n = 27</td>
<td>n = 27</td>
</tr>
<tr>
<td>sig = .342</td>
<td>sig = .866</td>
<td>sig = .657</td>
<td>sig = .133</td>
<td>sig = .628</td>
<td>sig = .899</td>
<td>sig = .487</td>
</tr>
<tr>
<td>AI-i</td>
<td>.1494</td>
<td>.2340</td>
<td>.3498</td>
<td>.2811</td>
<td>.2829</td>
<td>.3225</td>
</tr>
<tr>
<td>n = 27</td>
<td>n = 27</td>
<td>n = 27</td>
<td>n = 27</td>
<td>n = 27</td>
<td>n = 27</td>
<td>n = 27</td>
</tr>
<tr>
<td>sig = .313</td>
<td>sig = .113</td>
<td>sig = .018</td>
<td>sig = .059</td>
<td>sig = .054</td>
<td>sig = .029</td>
<td>sig = .164</td>
</tr>
</tbody>
</table>

Using Kendall's tau-b two tailed test, p < .05

Key for the abbreviations used in the table:
- actual \ ideal discrepancy for the nomothetic descriptors (AI-n)
- actual \ ideal discrepancy for the idiographic descriptors (AI-i)

When only relapsing participants are considered two significant relationships are identified. The first is between AI-i with the anxiety subscale (.3498 p < .05) and the second between AI-i with the positive symptom total (.3225 p < .05). Again the first finding runs counter to the prediction that actual \ ideal discrepancies are associated with dejection-related emotions. Whilst the second suggests that AI-i is related to the symptom breadth demonstrated by relapsing participants.

Another correlation approached significance (.2829 p = .054) between AI-i and global severity, suggesting that participants supplied descriptors that are discrepant between the actual and ideal selves are associated with the general level of emotional distress suffered by relapsing participants.
Table Nine: Correlations between actual-ideal discrepancies with various emotions for abstinent participants only

<table>
<thead>
<tr>
<th></th>
<th>Beck Depression inventory</th>
<th>Depression subscale</th>
<th>Anxiety subscale</th>
<th>Hostility subscale</th>
<th>Global severity index</th>
<th>Positive symptom total</th>
<th>Positive symptom distress</th>
</tr>
</thead>
<tbody>
<tr>
<td>AI-n</td>
<td>.1653</td>
<td>-.0735</td>
<td>.1681</td>
<td>.1035</td>
<td>.0721</td>
<td>-.0222</td>
<td>.2655</td>
</tr>
<tr>
<td></td>
<td>n = 20</td>
<td>n = 20</td>
<td>n = 20</td>
<td>n = 20</td>
<td>n = 20</td>
<td>n = 20</td>
<td>n = 20</td>
</tr>
<tr>
<td></td>
<td>sig = .338</td>
<td>sig = .668</td>
<td>sig = .324</td>
<td>sig = .562</td>
<td>sig = .670</td>
<td>sig = .895</td>
<td>sig = .115</td>
</tr>
<tr>
<td>AI-i</td>
<td>.0656</td>
<td>-.0118</td>
<td>.1349</td>
<td>-.3121</td>
<td>-.1160</td>
<td>-.0989</td>
<td>-.0231</td>
</tr>
<tr>
<td></td>
<td>n = 20</td>
<td>n = 20</td>
<td>n = 20</td>
<td>n = 20</td>
<td>n = 20</td>
<td>n = 20</td>
<td>n = 20</td>
</tr>
<tr>
<td></td>
<td>sig = .710</td>
<td>sig = .946</td>
<td>sig = .439</td>
<td>sig = .088</td>
<td>sig = .502</td>
<td>sig = .568</td>
<td>sig = .893</td>
</tr>
</tbody>
</table>

Using Kendall's tau-b two tailed test. p < .05

Key for the abbreviations used in the table:

- actual \ ideal discrepancy for the nomothetic descriptors (AI-n)
- actual \ ideal discrepancy for the idiographic descriptors (AI-i)

As can be seen from Table Nine, none of the correlations were significant at the .05 level for the abstinent participants. Thus, for this sub-group the null hypothesis that there is no relationship between actual \ ideal discrepancy and dejection-related emotions was accepted.
Hypothesis Four: Participants displaying a predominantly actual-ought discrepancy will be associated with agitation-related emotions

Table Ten: Correlations between actual-ought discrepancies with various emotions for the total sample

<table>
<thead>
<tr>
<th></th>
<th>Beck Depression Inventory</th>
<th>Depression subscale</th>
<th>Anxiety subscale</th>
<th>Hostility subscale</th>
<th>Global severity index</th>
<th>Positive symptom total</th>
<th>Positive symptom distress</th>
</tr>
</thead>
<tbody>
<tr>
<td>AO-n</td>
<td>-0.0611</td>
<td>-0.1268</td>
<td>-0.1001</td>
<td>0.0769</td>
<td>-0.0721</td>
<td>-0.1105</td>
<td>0.0200</td>
</tr>
<tr>
<td></td>
<td>n = 47</td>
<td>n = 47</td>
<td>n = 47</td>
<td>n = 47</td>
<td>n = 47</td>
<td>n = 47</td>
<td>n = 47</td>
</tr>
<tr>
<td></td>
<td>sig = .575</td>
<td>sig = .239</td>
<td>sig = .355</td>
<td>sig = .487</td>
<td>sig = .502</td>
<td>sig = .305</td>
<td>sig = .852</td>
</tr>
<tr>
<td>AO-i</td>
<td>0.0348</td>
<td>-0.0101</td>
<td>0.0641</td>
<td>-1.025</td>
<td>-0.0111</td>
<td>-0.0202</td>
<td>0.0332</td>
</tr>
<tr>
<td></td>
<td>n = 47</td>
<td>n = 47</td>
<td>n = 47</td>
<td>n = 47</td>
<td>n = 47</td>
<td>n = 47</td>
<td>n = 47</td>
</tr>
<tr>
<td></td>
<td>sig = .750</td>
<td>sig = .925</td>
<td>sig = .555</td>
<td>sig = .356</td>
<td>sig = .918</td>
<td>sig = .852</td>
<td>sig = .758</td>
</tr>
</tbody>
</table>

Using Kendall's tau-b two tailed test, p < .05

Key for the abbreviations used in the table:
- actual \ ought discrepancy for the nomothetic descriptors (AO-n)
- actual \ ought discrepancy for the idiographic descriptors (AO-i)

None of the Kendall's tau-b correlations reached significance at the .05 level when the total sample was used in the analysis. Thus, for the sample as a whole the null hypothesis that there is no relationship between actual \ ought discrepancy and agitation-related emotions was accepted.
Table Eleven: Correlations between actual-ought discrepancies with various emotions for the relapsing participants only

<table>
<thead>
<tr>
<th></th>
<th>Beck depression inventory</th>
<th>Depression subscale</th>
<th>Anxiety subscale</th>
<th>Hostility subscale</th>
<th>Global severity index</th>
<th>Positive symptom total</th>
<th>Positive symptom distress</th>
</tr>
</thead>
<tbody>
<tr>
<td>AO-n</td>
<td>-.1337</td>
<td>-.1142</td>
<td>-.1522</td>
<td>.0873</td>
<td>-.1044</td>
<td>-.1544</td>
<td>-.0830</td>
</tr>
<tr>
<td></td>
<td>n = 27</td>
<td>n = 27</td>
<td>n = 27</td>
<td>n = 27</td>
<td>n = 27</td>
<td>n = 27</td>
<td>n = 27</td>
</tr>
<tr>
<td></td>
<td>sig = .360</td>
<td>sig = .431</td>
<td>sig = .297</td>
<td>sig = .551</td>
<td>sig = .470</td>
<td>sig = .288</td>
<td>sig = .566</td>
</tr>
<tr>
<td>AO-i</td>
<td>-.0861</td>
<td>-.1013</td>
<td>-.0096</td>
<td>.0032</td>
<td>-.0535</td>
<td>-.0665</td>
<td>-.0126</td>
</tr>
<tr>
<td></td>
<td>n = 27</td>
<td>n = 27</td>
<td>n = 27</td>
<td>n = 27</td>
<td>n = 27</td>
<td>n = 27</td>
<td>n = 27</td>
</tr>
<tr>
<td></td>
<td>sig = .561</td>
<td>sig = .491</td>
<td>sig = .948</td>
<td>sig = .983</td>
<td>sig = .715</td>
<td>sig = .651</td>
<td>sig = .931</td>
</tr>
</tbody>
</table>

Using Kendall's tau-b two tailed test. p < .05

Key for the abbreviations used in the table:

- actual \ ought discrepancy for the nomothetic descriptors (AO-n)
- actual \ ought discrepancy for the idiographic descriptors (AO-i)

Again, none of the Kendall's tau-b correlations reached significance at the .05 level for relapsing participants. Thus, for this sub-group the null hypothesis that there was no relationship between actual \ ought discrepancy and agitation-related emotions was accepted.
Table Twelve: Correlations between actual-ought discrepancies with various emotions for the abstinent participants only

<table>
<thead>
<tr>
<th></th>
<th>Beck Depression Inventory</th>
<th>Depression subscale</th>
<th>Anxiety subscale</th>
<th>Hostility subscale</th>
<th>Global severity index</th>
<th>Positive symptom total</th>
<th>Positive symptom distress</th>
</tr>
</thead>
<tbody>
<tr>
<td>AO-n</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>-.0692</td>
<td>.0401</td>
<td>.1119</td>
<td>.0000</td>
<td>-.0511</td>
<td>.2315</td>
</tr>
<tr>
<td></td>
<td>n = 20</td>
<td>n = 20</td>
<td>n = 20</td>
<td>n = 20</td>
<td>n = 20</td>
<td>n = 20</td>
<td></td>
</tr>
<tr>
<td></td>
<td>sig = .594</td>
<td>sig = .690</td>
<td>sig = .816</td>
<td>sig = .536</td>
<td>sig = 1.000</td>
<td>sig = .766</td>
<td></td>
</tr>
<tr>
<td>AO-i</td>
<td></td>
<td>-.0115</td>
<td>.0570</td>
<td>-.3965</td>
<td>-.1072</td>
<td>-.1245</td>
<td>.0113</td>
</tr>
<tr>
<td></td>
<td>n = 20</td>
<td>n = 20</td>
<td>n = 20</td>
<td>n = 20</td>
<td>n = 20</td>
<td>n = 20</td>
<td></td>
</tr>
<tr>
<td></td>
<td>sig = .665</td>
<td>sig = .947</td>
<td>sig = .740</td>
<td>sig = .028</td>
<td>sig = .530</td>
<td>sig = .467</td>
<td></td>
</tr>
</tbody>
</table>

Using Kendall's tau-b two tailed test, p < .05

Key for the abbreviations used in the table:
- actual \ ought discrepancy for the nomothetic descriptors (AO-n)
- actual \ ought discrepancy for the idiographic descriptors (AO-i)

Only one significant finding was found to support the hypothesis when abstinent participants scores were used. This was a strong, negative correlation between the AO-i and the hostility subscale (-.3965 p < .05) Once again participants supplied descriptors are involved in the relationship. But once again, the inverse relationship between actual \ ought discrepancy and hostility does not fit with the prediction that actual \ ought discrepancies are associated with agitation-related emotions.
Hypothesis Five: The greater the intensity of emotions experienced the greater the likelihood of severity of alcohol dependence in relapsing participants.

Table Thirteen: Correlations between various emotions and units consumed per week, the consumption subscale of the SADO and the severity of alcohol dependence total

<table>
<thead>
<tr>
<th></th>
<th>Beck Depression Inventory</th>
<th>Depression subscale</th>
<th>Anxiety subscale</th>
<th>Hostility subscale</th>
<th>Global severity index</th>
<th>Positive symptom total</th>
<th>Positive symptom distress</th>
</tr>
</thead>
<tbody>
<tr>
<td>Units per week</td>
<td>-.1875</td>
<td>-.2295</td>
<td>.0848</td>
<td>-.2039</td>
<td>-.2196</td>
<td>-.0428</td>
<td></td>
</tr>
<tr>
<td></td>
<td>n = 27</td>
<td>n = 27</td>
<td>n = 27</td>
<td>n = 27</td>
<td>n = 27</td>
<td>n = 27</td>
<td></td>
</tr>
<tr>
<td></td>
<td>sig = .349</td>
<td>sig = .250</td>
<td>sig = .674</td>
<td>sig = .308</td>
<td>sig = .271</td>
<td>sig = .832</td>
<td></td>
</tr>
<tr>
<td>Consumption subscale</td>
<td>-.1511</td>
<td>-.0757</td>
<td>.2702</td>
<td>.0232</td>
<td>-.0926</td>
<td>.1357</td>
<td></td>
</tr>
<tr>
<td></td>
<td>n = 27</td>
<td>n = 27</td>
<td>n = 27</td>
<td>n = 27</td>
<td>n = 27</td>
<td>n = 27</td>
<td></td>
</tr>
<tr>
<td></td>
<td>sig = .452</td>
<td>sig = .707</td>
<td>sig = .173</td>
<td>sig = .909</td>
<td>sig = .646</td>
<td>sig = .500</td>
<td></td>
</tr>
<tr>
<td>Severity of alcohol</td>
<td>.1587</td>
<td>.3946</td>
<td>.2884</td>
<td>.2751</td>
<td>.3369</td>
<td>.3777</td>
<td>.3571</td>
</tr>
<tr>
<td>dependence</td>
<td>n = 27</td>
<td>n = 27</td>
<td>n = 27</td>
<td>n = 27</td>
<td>n = 27</td>
<td>n = 27</td>
<td>n = 27</td>
</tr>
<tr>
<td></td>
<td>sig = .429</td>
<td>sig = .145</td>
<td>sig = .165</td>
<td>sig = .086</td>
<td>sig = .052</td>
<td>sig = .067</td>
<td></td>
</tr>
</tbody>
</table>

Using Spearman's rho, two tailed test. p < .05

Two strong, positive correlations were identified. Firstly, between the depression subscale and the severity of alcohol dependence total (.3946, p < .05) and secondly between the overall positive symptom total from the SCL-90-R and the severity of alcohol dependence (.377, p < .05).

It may be that there is a small, positive relationship between emotional distress as measured by the SCL-90-R and severity of drinking in the relapse sample, as the other two correlations to approach significance were the two global indices for the SCL-90-R. Such a relationship would provide support for the tension-reduction hypothesis. However, as only two of the twenty one correlations were statistically significant, it would seem that the null hypothesis should be accepted. This states that there is no relationship between the intensity of emotions experienced and the severity of alcohol dependence in relapsing participants.
Hypothesis Six: Female participants will exhibit greater self-concept discrepancies associated with greater intensity of emotions than male participants

Table Fourteen: Comparisons of male and female self-concept discrepancies for the total sample

<table>
<thead>
<tr>
<th>Actual-ideal (n)</th>
<th>Actual-ideal (i)</th>
<th>Actual-ought (n)</th>
<th>Actual-ought (i)</th>
</tr>
</thead>
<tbody>
<tr>
<td>u = 227.0</td>
<td>z = -.7502</td>
<td>u = 256.0</td>
<td>z = -.1120</td>
</tr>
<tr>
<td>z = .4532</td>
<td>sig = .9108</td>
<td>z = .3444</td>
<td>sig = .7305</td>
</tr>
<tr>
<td>sig = .4532</td>
<td></td>
<td>u = 245.5</td>
<td>z = -.9241</td>
</tr>
<tr>
<td></td>
<td></td>
<td>u = 219.5</td>
<td>sig = .3554</td>
</tr>
</tbody>
</table>

Using the Mann Whitney two tailed test. p < .05

As can be seen from Table Fourteen none of the findings from the two tailed Mann Whitney Test were significant at the .05 level. Therefore, the null hypothesis that women's self-concept discrepancies are no different from men's was accepted when considering the sample as a whole.

Table Fifteen: Comparison of male and female discrepancies for relapsing participants only

<table>
<thead>
<tr>
<th>Actual-ideal (n)</th>
<th>Actual-ideal (i)</th>
<th>Actual-ought (n)</th>
<th>Actual-ought (i)</th>
</tr>
</thead>
<tbody>
<tr>
<td>u = 82.0</td>
<td>z = -.1519</td>
<td>u = 73.0</td>
<td>z = -.6123</td>
</tr>
<tr>
<td>z = .8793</td>
<td>sig = .4255</td>
<td>z = -.7968</td>
<td>sig = .5403</td>
</tr>
<tr>
<td></td>
<td></td>
<td>u = 68.0</td>
<td>z = -.8768</td>
</tr>
<tr>
<td></td>
<td></td>
<td>sig = .3806</td>
<td></td>
</tr>
</tbody>
</table>

Using the Mann Whitney two tailed test. P < .05

As can be seen from Table Fifteen none of the findings from the two tailed Mann Whitney Test were significant at the .05 level. Therefore, the null hypothesis that women's self-concept discrepancies are no different from men's was accepted when considering relapsing participants only.
Table Sixteen: Comparison of male and female discrepancies for abstinent participants only

<table>
<thead>
<tr>
<th>Actual-ideal (n)</th>
<th>Actual-ideal (i)</th>
<th>Actual-ought (n)</th>
<th>Actual-ought (i)</th>
</tr>
</thead>
<tbody>
<tr>
<td>$u = 36.5$</td>
<td>$u = 37.0$</td>
<td>$u = 34.0$</td>
<td>$u = 40.5$</td>
</tr>
<tr>
<td>$z = -.8947$</td>
<td>$z = -.8744$</td>
<td>$z = -1.0967$</td>
<td>$z = -.5871$</td>
</tr>
<tr>
<td>sig = .3710</td>
<td>sig = .3819</td>
<td>sig = .2728</td>
<td>sig = .5571</td>
</tr>
</tbody>
</table>

Using the Mann Whitney two tailed test, $p < .05$

As can be seen from Table Sixteen none of the findings from the two tailed Mann Whitney Test were significant at the .05 level. Therefore, the null hypothesis that women's self-concept discrepancies are no different from men's was accepted when considering abstinent participants only.

Table Seventeen: Comparisons of male and female intensity of emotional distress for the total sample

<table>
<thead>
<tr>
<th>Beck Depression Inventory</th>
<th>Depression subscale</th>
<th>Anxiety subscale</th>
<th>Hostility subscale</th>
<th>Global severity index</th>
<th>Positive symptom total</th>
<th>Positive symptom distress</th>
</tr>
</thead>
<tbody>
<tr>
<td>$u = 209.5$</td>
<td>$u = 236.5$</td>
<td>$u = 235.0$</td>
<td>$u = 255.5$</td>
<td>$u = 231.0$</td>
<td>$u = 242.5$</td>
<td>$u = 205.5$</td>
</tr>
<tr>
<td>$z = -.1295$</td>
<td>$z = -.5366$</td>
<td>$z = -.5697$</td>
<td>$z = -.1212$</td>
<td>$z = -.6568$</td>
<td>$z = -.4051$</td>
<td>$z = -.1248$</td>
</tr>
<tr>
<td>sig = .2587</td>
<td>sig = .5915</td>
<td>sig = .5689</td>
<td>sig = .9035</td>
<td>sig = .5113</td>
<td>sig = .6854</td>
<td>sig = .2244</td>
</tr>
</tbody>
</table>

Using the Mann Whitney, two tailed test, $p < .05$

Again, none of the findings from the comparisons between men and women on the measures of emotional distress reached significance either. Therefore the null hypothesis that there was no difference between the intensity of emotional distress between men and women was accepted when considering the whole sample.
Table Eighteen: Comparisons of male and female intensity of emotional distress in relapsing participants only

<table>
<thead>
<tr>
<th>Beck Depression Inventory</th>
<th>Depression subscale</th>
<th>Anxiety subscale</th>
<th>Hostility subscale</th>
<th>Global severity index</th>
<th>Positive symptom total</th>
<th>Positive symptom distress</th>
</tr>
</thead>
<tbody>
<tr>
<td>u = 42.5</td>
<td>z = -2.1382</td>
<td>u = 57.5</td>
<td>z = -1.3822</td>
<td>u = 82.0</td>
<td>u = 55.5</td>
<td>u = 62.5</td>
</tr>
<tr>
<td>sig = .0325</td>
<td>sig = .1669</td>
<td>z = -1.1070</td>
<td>sig = .2683</td>
<td>z = -.1510</td>
<td>z = -1.4816</td>
<td>z = -1.1309</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>sig = .8799</td>
<td>sig = .1384</td>
<td>sig = .2581</td>
</tr>
</tbody>
</table>

Using the Mann Whitney two tailed test. p < .05

When considering relapsing women compared to relapsing men, the women do score significantly higher than the men on the Beck Depression Inventory (U = 42.5 sig = .0325) The average BDI score for relapsing men was 12.47 whereas it was 22.0 for relapsing females. For all the other measures the null hypothesis was accepted because there was no significant difference between the scores.

Table Nineteen: Comparisons of male and female intensity of emotional distress in abstinent participants only

<table>
<thead>
<tr>
<th>Beck Depression Inventory</th>
<th>Depression subscale</th>
<th>Anxiety subscale</th>
<th>Hostility subscale</th>
<th>Global severity index</th>
<th>Positive symptom total</th>
<th>Positive symptom distress</th>
</tr>
</thead>
<tbody>
<tr>
<td>u = 43.5</td>
<td>z = -.3494</td>
<td>u = 34.5</td>
<td>z = -1.0467</td>
<td>u = 43.5</td>
<td>u = 40.0</td>
<td>u = 35.5</td>
</tr>
<tr>
<td>sig = .7268</td>
<td>sig = .2952</td>
<td>u = 43.5</td>
<td>z = -3.481</td>
<td>z = -.3199</td>
<td>z = -.6177</td>
<td>z = -.9655</td>
</tr>
<tr>
<td></td>
<td></td>
<td>u = 44.0</td>
<td>sig = .7278</td>
<td>sig = .7491</td>
<td>sig = .5368</td>
<td>sig = .3343</td>
</tr>
</tbody>
</table>

Using the Mann Whitney two tailed test. p < .05

None of the correlations reached significance at the .05 level. Therefore, when considering male and female abstinent participants there is no significant difference between their scores on the emotional measures used and the null hypothesis was accepted.
Hypothesis Seven: Abstinent participants will have smaller self-concept discrepancies associated with less intense emotions than those relapsing.

Table Twenty: Comparisons of abstinent and relapsing participants self-concept discrepancies

<table>
<thead>
<tr>
<th>Actual-ideal (n)</th>
<th>Actual-ideal (i)</th>
<th>Actual-ought (n)</th>
<th>Actual-ought (i)</th>
</tr>
</thead>
<tbody>
<tr>
<td>u = 246.5</td>
<td>u = 233.0</td>
<td>u = 246.5</td>
<td>u = 212.5</td>
</tr>
<tr>
<td>z = -.5098</td>
<td>z = -.8152</td>
<td>z = -.5134</td>
<td>z = -1.2589</td>
</tr>
<tr>
<td>sig = .6102</td>
<td>sig = .4150</td>
<td>sig = .6077</td>
<td>sig = .2081</td>
</tr>
</tbody>
</table>

Using the Mann Whitney two tailed test, p < .05

As none of the findings were significant, the null hypothesis that there was no significant difference between the self-concept discrepancies of abstinent participants from those relapsing was accepted.

Table Twenty One: Comparisons of abstinent and relapsing participants intensity of emotional distress

<table>
<thead>
<tr>
<th>Beck Depression Inventory</th>
<th>Depression subscale</th>
<th>Anxiety subscale</th>
<th>Hostility subscale</th>
<th>Global severity index</th>
<th>Positive symptom total</th>
<th>Positive symptom distress</th>
</tr>
</thead>
<tbody>
<tr>
<td>u = 152.5</td>
<td>u = 149.0</td>
<td>u = 167</td>
<td>u = 177.5</td>
<td>u = 166.5</td>
<td>u = 158.5</td>
<td>u = 193.5</td>
</tr>
<tr>
<td>z = -2.5338</td>
<td>z = -2.6058</td>
<td>z = -2.2190</td>
<td>z = -2.0046</td>
<td>z = -2.2278</td>
<td>z = -2.4003</td>
<td>z = -1.6464</td>
</tr>
<tr>
<td>sig = .0113</td>
<td>sig = .0029</td>
<td>sig = .0265</td>
<td>sig = .0450</td>
<td>sig = .0259</td>
<td>sig = .0164</td>
<td>sig = .0997</td>
</tr>
</tbody>
</table>

Using the Mann Whitney two tailed test, p < .05

As can be seen from table nine, all of the findings were significant at the .05 level apart from one. Thus, abstinent participants had significantly lower scores than those relapsing on the following measures: the Beck Depression Inventory, the depression, anxiety and hostility subscales, global severity index and the positive symptom total from the SCL-90-R. For all these measures the null hypothesis was rejected.
It would seem that the first part of the hypothesis seven was rejected, with the finding that there is no difference between the self concept discrepancies of abstinent from relapsing participants. However, the second part was supported. Namely, that abstinent participants do have less intense emotional distress than those relapsing.
6.0 Discussion

The results of the present study did not provide support for the predictions tested arising from Higgins (1987) Self-Concept Discrepancy Theory. Participants with larger self-concept discrepancies did not show greater emotional distress than those with smaller self-concept discrepancies, when the sample as a whole was examined. Only when relapsing and abstinent groups were looked at separately, were five significant results obtained, three of which run counter to the predictions of the theory. However, the correlation between the actual \ ideal discrepancy from idiographic descriptors with the global severity index and the positive symptom total for relapsing participants was significant. Suggesting that for relapsing participants the strength of the idiographic discrepancy was related to the intensity of emotional distress displayed.

There was little support for the notion that specific kinds of self-concept discrepancies relate to specific kinds of affective consequences. Thus, participants displaying a predominant actual-ideal discrepancy did not display higher levels of dejection-related emotions when the abstinent participants were considered. Only three significant results were obtained from the total sample and relapse sample, two of which ran counter to the prediction of the theory. The most direct support for the proposed relationship was found in the relapse sample, between the actual \ ideal discrepancy from idiographic descriptors with the positive symptom total. Likewise, participants displaying a predominant actual-ought discrepancy did not display higher levels of agitation-related emotions when the total sample or relapse group were considered. Only one significant result was found from the abstinent group and that was in the opposite direction to that proposed by the theory. A number of possible reasons for these findings will now be discussed.
6.1 Participants

It may be that the participants did not possess large enough self-concept discrepancies, with which to examine the predictions derived from the theory. Possibly a sample of alcoholics undergoing in-patient treatment may have displayed greater self-concept discrepancies than those attending a Community Alcohol Team. Some such studies will now be reported.

White and Porter (1966) examined the self-concept reports of 35 hospitalised male alcoholics, as measured by the McKinney Sentence Completion Blank for relationships with the length of sobriety in hospital. Although the correlations were low ($r = -.33$ for length of time sober and favourable self-concept) there is a suggestion that the longer the alcoholic remained in the hospital (up to 3 months) and abstained from alcohol, the less favourable self-concept he reported, the more guilt feelings he expressed and the less ego strength he showed in facing up to crises. The authors proposed that such findings may be due to the patients participation in Alcoholics Anonymous (AA) meetings. They point to the demands placed on members by the fellowship, such as making an admission of helplessness. During the early sobriety period (1-3 months) members may feel more self depreciating as the meaning of ego surrender became apparent and group pressure in AA was intensified.

Carroll and Fuller (1969) examined whether alcoholics demonstrated a significant discrepancy between their actual and ideal selves and whether with increasing lengths of sobriety and as the alcoholic participates in Alcoholics Anonymous, this discrepancy will decrease. Five groups, each consisting of 20 participants were compared. Group one consisted of alcoholics with a short period of sobriety (20 days). Group two, three and four were drawn from prison populations. Group two consisted of alcoholics with at least 6 months enforced sobriety within a prison setting and at least 6 months of voluntary participation in AA. Group three consisted of alcoholics with at least 6 months of enforced sobriety within a prison setting. Group four consisted of non-alcoholics who had been in prison for at least 6 months. Group five consisted of non-
alcoholics without alcoholic or criminal records. All the men were white and matched for age, education, intelligence and occupation.

They found that the three groups of alcoholics had greater actual-ideal self discrepancy than did the two groups of non-alcoholics. Alcoholics having a long period of sobriety in prison and who have participated in a voluntary AA programme had a significantly smaller actual-ideal self discrepancy than those alcoholics with only a short period of sobriety. There was no difference in the discrepancies demonstrated by both alcoholics having a long period of sobriety in prison without attending AA, and alcoholics having only a short period of sobriety. The authors concluded that length of sobriety and voluntary participation in AA interact to reduce significantly the alcoholic's actual-ideal self discrepancy. This finding would suggest that discrepancies are more likely to be found in relapsing alcoholics and those who have been abstinent for six months or more if they have not engaged with some form of therapeutic help, whether it be formal or informal. Thus, from the present study it would be expected that relapsing alcoholics should demonstrate greater discrepancies than those abstinent participants attending AA. Although no significant difference in the size of discrepancy between abstinent and relapsing participants was found, the findings which support some of the predictions of self-concept discrepancy theory, were obtained from the relapse group, especially when their actual \ ideal discrepancy for idiographic descriptors was considered.

Heather et al (1975) investigated the outcome of in-patient group therapy utilising the repertory grid technique derived from Kelly's Personal Construct Theory (1955). The assumption was that as an outcome of group therapy, successful patients would begin to interpret their problem with alcohol in new ways. The researchers elicited constructs at both admission and discharge from each patient while providing a standard list of relevant elements representing aspects of self-construction and role constructions of drinking behaviour. These were ideal self, typical alcoholic, future self, average drinker, social self (myself as others see me), recovered alcoholic, past self, teetotaller, actual self (myself as I am) and non benefiting alcoholic.
They found that the actual self showed the largest and most consistent changes relevant to other elements, followed by the social self. These appeared to represent a movement away from socially disapproved drinking roles and toward socially approved drinking roles.

Abstinent patients tended to see all alcoholics as the same, and as very different from other types of drinker. Whereas patients who relapsed distinguished between the typical alcoholic and the non-benefiting alcoholic more readily. They also distinguished less between the average drinker and the two alcoholic roles. The abstinent patients' viewpoint would be encouraged and supported within Alcoholics Anonymous, as they insist the alcoholic is never cured. These results also indicate that patients who do not recover their self respect and a feeling of respectability are likely to relapse.

Rollnick and Heather (1980) further studied the changes in self respect and respectability among alcoholic in-patients. Repertory grids were administered to 34 alcoholics at admission and discharge points, using 12 supplied constructs and a set of elements which included actual self, ideal self and social self. Again they found the movement of the actual self which resulted in an improvement in self esteem was mirrored by a movement of the social self which represented an improvement in respectability. The suggestion is that other people's assessment of the alcoholic, and the alcoholic's own perception of the other person's assessment of them, are just as important as how the alcoholic sees themselves. The implication is that staff attitudes about patients' motivation and response to treatment are critical in the process of successful change. If staff judge the patient favourably they in turn are more likely to internalise such opinions for themselves.

Bailey and Sims (1991) studied fifty male inpatients receiving treatment for alcohol dependence. Using the repertory grid technique three elements were examined: self-when-sober, self-when-drunk and ideal self. The results suggested that they held unrealistically favourable perceptions of sobriety and unrealistically unfavourable perceptions of drunkenness. Most possessed tightly organised construct systems, which are more resistant to change than loosely organised ones. No consistent changes in the
grid measures were found after treatment. Bailey and Sims (1991) recommended that treatment should look at the alcoholics' perception of themselves, and their sober, drunk and ideal selves.

6.2 Interview Format

It may be that people would have revealed greater discrepancies with the anonymity of a postal questionnaire. The concern with this method was peoples' understanding of the task, and their willingness to work through a fairly lengthy and somewhat repetitive questionnaire. On balance it would still seem most appropriate to use an interview format.

However, the context of a research interview may not have readily accessed participants' self-discrepancies. They may have wanted to present themselves in a favourable light. Further than that, it may well be that some of the relapsing alcoholics were in denial or were deceiving themselves about their drinking problem. If this was the case they would be unlikely to discuss any discrepancies between who they are and who they would like to be, even with a researcher.

6.3 The Selves Questionnaire

Since the Selves Questionnaire used in this study appeared insufficiently sensitive to participants discrepancies when the total sample was examined, it is not surprising that the null hypothesis was accepted for hypotheses two, three and four, all testing predictions from the theory. And even the support for the hypotheses was sparse in comparison, and mixed in with contradictory findings. The Selves Questionnaire appeared insensitive to the subtle nature of internal self-conflicts presumably held by the participants. For it is hard to believe that they are all entirely comfortable with themselves and have achieved all that they want to out of life. It may have been that the reduction of the idiographic section to five descriptors reduced the likelihood of finding self-concept discrepancies, as it appeared the most often in the significant results. A more feasible explanation for the lack of evidence of self-concept
discrepancies is that many of the words chosen for the different concepts (e.g., either the actual, ideal or ought selves) were non-matches and therefore did not enter into the discrepancy calculation. The second half of the self-discrepancy measure was only concerned with the amount of matches and mismatches between attributes, that is the *relation between attributes*, independent of the particular content of the attributes. This is because the theory proposes that it is the *pattern of interrelations* among individuals' actual-self and self-guide attributes that is important when considering the likely emotional vulnerability they will suffer. However, such analysis necessarily omits a large proportion of the data gathered, as many of the attributes were non-matches.

Wylie (1974) conducted a review of the research studies which used discrepancy scores and concluded that the variance captured in discrepancy scores reflects primarily actual-self ratings. The major difficulty in developing a good measure of self-esteem that evaluates actual-ideal discrepancy according to Wylie (1974) is the variation between individuals in the nature and standards that they employ during self-evaluation. Even with these drawbacks, such observations suggest that an idiographic measure will assess the role of actual-ideal discrepancy and the importance of actual-self attributes in determining self-esteem.

Hoge and McCarthy (1983) compared a discrepancy measure to both self evaluations (the Rosenberg Scale, the Coopersmith Scale and the question 'how well are you doing in school ?) and teacher evaluations (direct evaluation of students along two seven point semantic differentials, behavioural rating scale and subjective dimensional self esteem). The discrepancy measure was a questionnaire consisting of eight statements of self-rating on specific dimensions (e.g. I am smart, Adults think well of me) with six response categories, scored from 1 to 6. A ninth open ended question was included. Participants were then asked to rate their ideal-self on the same dimensions. They found that real-ideal discrepancy scores were not very valid predictors of global self-esteem. Self-ratings by themselves were superior predictors. Also, the real-self evaluations of the participants were superior to real-ideal discrepancy scores in predicting the appropriate teacher evaluations. Hoge and McCarthy concluded that
real-ideal discrepancy measures include large amounts of error which reduce their reliability and validity. However, it must be remembered that their discrepancy measure was in the main, a nomothetic measure with supplied constructs for participants to rate themselves on.

Another issue is the selection of the significant other by the participant. Many participants spontaneously pointed out that their answers would be very different if they had chosen somebody else that is important to them for this task. The idea for leaving the choice to the individual was so that they would use the most meaningful and salient person of the moment.

At the final analysis, the open ended nature of the idiographic section reduced the likelihood of detecting discrepancies. It may have been useful to force people to rate themselves using the attributes they provided for their actual-self, for both the ideal and ought selves. In this way it would be easier to detect matches, mismatches and genuine non-matches.

A final point to mention is the major omission from this study, of not asking participants whether they also consumed prescribed and illicit drugs. A couple of the relapse sample spontaneously mentioned their use of Prozac. If substantial numbers of relapsing participants are taking anti-depressant medication the lower depression score of the abstinent participants is all the more significant. However, since this information was not sought it was not possible to explore this further.

6.4 Other Findings

It was not only the predictions from self-concept discrepancy theory that were unsupported. Hypothesis four stated that those relapsing alcoholics displaying a greater intensity of emotional distress would be more dependent upon alcohol than those with less emotional distress. This tension reduction hypothesis was unsupported by the current findings, with only two out of twenty one correlations reaching significance. Finally, there was little evidence to support the proposal that female alcoholics were more emotionally distressed than their male colleagues. Only for the relapse sample did
women score significantly higher than their male counterparts on the BDI. Such a result may well reflect the fact that depressive symptoms are more likely to be reported by female alcoholics than male alcoholics (Schuckit and Winokur, 1974, Hatsukami and Pickens, 1982). Or it may well be that female alcoholics are more depressed. Certainly, not all studies have found greater psychopathology in female alcoholics when compared to male alcoholics. The Ross et al (1988) study did not find higher rates of psychiatric disorders among female alcoholics when compared to male alcoholics. What she did find was that females were more likely to have anxiety and psychosexual disorders and bulimia, while men were more likely to be diagnosed as having an antisocial personality disorder, a pathological gambling disorder.

Although finding little evidence to support Self-Concept Discrepancy Theory, three significant results were obtained. Firstly, as predicted there was no relationship between the five nomothetic descriptors supplied with the participants self-nominated actual-self, ideal-self and ought-self attributes whether considering the total sample or each of the sub-groups. Although the scores obtained on the selves questionnaire were distinct when considering either nomothetic or idiographic sections, they were not significantly different across the ideal and ought selves, the conceptual distinction that the self-discrepancy theory rests upon. It would seem that the participants did not distinguish between their ideal and ought guides.

The second finding revealed that even when participants demonstrate similar scores on the selves questionnaire, their scores on measures of emotional distress can be significantly different. This was the case with the female relapse participants who had significantly larger scores on the BDI than relapsing males, even though their self-concept discrepancies were not significantly different. The same was true for the abstinent participants, who had similar profiles to the relapse sample on the selves questionnaires, yet much lower scores on measures of depression, anxiety, hostility, global severity index and positive symptom total. The global severity index on the SCL-90-R combines information concerning the number of symptoms reported with the intensity of the perceived distress, and is regarded as the best single indicator of the
current level or depth of emotional distress. The positive symptom total is simply a reflection of the number of symptoms endorsed by the respondent, regardless of the distress reported. It can be interpreted as a measure of symptom breadth. As the abstinent participants had lower scores on both of these measures, the findings indicate that abstinent participants had a narrower, and less intense range of emotional symptoms than those from the relapse group.

6.5 Outcome studies

Self guides change when a person moves from one social life phase to another, such as the formation of an ought / teacher guide or an ideal / peers guide during a child's school years (Higgins and Parsons, 1983) or an ought / boss guide in later life. It may be that people who benefit from Alcoholics Anonymous (AA) acquire a new ought guide, consisting of many of the 12 step teachings. The medical model espoused by AA requires members to accept that they are alcoholics for life, and will always be vulnerable to returning to drinking heavily. AA is a pragmatic, simplified, spiritual approach to life. Unlike in the wider social drinking context, in AA the norm is not to drink, and the person is helped to accept the need for outside help with his problem. The sharing of problems reduces feelings of isolation, anxiety and guilt, and helping others along the path of recovery strengthens self-esteem. Meeting others who have recovered gives hope and encouragement.

Brown (1985) found tension reduction beliefs powerful predictors of relapse 12 months after treatment. It would seem that increasing client's awareness of their tension and whether it is internally or externally generated, alongside teaching them alternative tension relieving skills, such as assertiveness, expressing their emotions more readily, talking things through etc. would be helpful for clients attending services for help with their alcohol problem.

Ray, Friedlander and Soloman (1984) used the Rational Behaviour Inventory (Shorkey and Whiteman, 1977) which assesses the extent to which individual's endorse specific irrational beliefs, to examine pre- and posttreatment scores. Sixty two male alcoholics
took part in a six week in-patient programme. Patients spent the initial two weeks in a detoxification unit, then two weeks in physical rehabilitation and the final two weeks in an 'intensive psychoeducational programme'. This included group Rational Emotive Therapy, group educational discussions of the health hazards of excessive drinking, individual cognitive-behavioural counselling, and the opportunity to attend AA meetings. Findings suggested that the programme was helpful. The patients changed towards a more rational stance, suggesting they were less prone to disturb themselves on the basis of inaccurate or unfounded internal self-statements or expectations. They also moved towards more active control of their lives.

Some research suggests that both therapy (Ends and Page, 1961) and enforced sobriety (Connor, 1962, Fox, 1965) are effective in reducing the alcoholics actual-ideal self discrepancy. White (1965) in a study of male alcoholics found that members of AA who were sober for three years differed significantly from members one to three months sober in psychometrically assessed personality characteristics and cognitive functioning. The three year sober members had greater ego strength, integration and confidence.

MacAndrew and Garfinkel (1962) using the Q-sort technique obtained the sober-self, drunk-self, and ideal-self descriptions of 62 white males who attended an outpatient clinic. The subject's sober-self and drunk-self portrayals were very dissimilar. However, the gap between actual-self and ideal-self was larger in the drunk-self description. (p < .01) But within this finding were considerable individual differences. For instance, whilst the drunk-self descriptions of 25 subjects decreased self esteem, 8 subjects portrayed a significant increase in self-esteem. It would seem from this finding that only a small number of participants possibly drank to reduce the discrepancy between their actual and ideal selves. Excessive drinking, like many behaviours is likely to be influenced by a multitude of factors, ranging from the individuals biological and psychological make-up to the cultural attitudes towards drinking held in a particular country. Although this study has examined only one small part of an individuals psychological profile which may play a part in their drinking, what relevance do the
findings from this study have for the field of addictive behaviours as well as the wider field of clinical psychology?

6.6 Clinical Implications

Large numbers of people drink alcohol, and 6% of male and 2% of female drinkers responding to the General Household Survey (1996) drink more than 50 and 35 units respectively of alcohol per week. Although such dangerous drinking levels reside in a small population of drinkers, nevertheless the associated social and interpersonal problems of these individuals suggests that most clinical psychologists, regardless of the specialty in which they work, will come across clients who are either personally addicted to alcohol or whose lives have been adversely affected by someone close to them who is an alcoholic. Thus, awareness of alcohol abuse and its effects is relevant to many professionals working in the helping professions, not only those directly involved with alcoholics on a regular basis.

Motivational interviewing is a widely used technique within the field of addictive behaviours. The therapeutic concept of motivational interviewing (Prochaska and DiClemente, 1984., Miller, 1983) suggests that key personal constructs, internal attribution, self-efficacy and self-esteem must be addressed if alcohol abusing behaviour is to be changed. Motivational interviewing is a particular way to help people recognise and do something about their present or potential problems. It is intended to help resolve ambivalence and to get a person moving along the path to change. The therapist is often working actively to create discomfort and discrepancy. The aim is to create, and amplify, in the client's mind, a discrepancy between present behaviour and longer term goals. According to Miller (1985) motivation for change is created when people perceive a discrepancy between their present behaviour and important personal goals. This often involves the therapist in clarifying important goals for the client, and exploring the consequences or potential consequences of his or her present behaviour which conflict with these goals. Asking the client to reflect upon their actual, ideal and ought selves and from a variety of standpoints could prove a
useful addition to this awareness raising approach. By exploring the discrepancies between how a client regards themselves at the moment and how they feel they ought to be or would ideally like to be, may well enable them to address the discrepancy in terms of making changes to reduce the discrepancy in longer term, constructive ways. Self-concept discrepancy theory proposes that people's interpretations and evaluations of important life events, whether past, present or future are affected by their self-beliefs, particularly by the distinct patterns of relationships between them. Thus, the same event can produce different emotional and motivational responses in different people or even in the same person at different times, depending on which particular self-belief pattern is activated by the event. This suggests that it may be fruitful to use the idiographic section of the selves questionnaire with clients during the course of therapy, from the initial interview stage onwards, so that clients could review their actual, ideal and ought self descriptions. It may be then be possible to identify the strength of various self-guides before, during and after an activating event, such as a court appearance to establish custody of a child. Such a longitudinal approach may help clients to identify the influence of their self-guides and whether they need to alter their behaviour or their self-guide in order to reduce their discomfort and emotional distress. In this sense, self-guides appear similar to negative automatic thoughts if the self-guides are absolute and perfectionistic. The idiographic nature of the second half of the selves questionnaire, which could be used in clinical work, allows criteria of improvement to be defined for each individual. Obviously, a more detailed exploration of the content of a client's actual, ideal and ought selves may provide useful material to work with. It is also likely that the process of identifying such facets of the self will be thought provoking and helpful to clients, whether a quantifiable discrepancy score is obtained or not. Such a technique need not be restricted to alcohol clients alone, and could prove useful with a range of other client groups.
Appendix One: Ethical Approval
19th February 1996

Miss Roberta Fry
Options
24 Grafton Road
Worthing
West Sussex BN11 1QP

Dear Miss Fry,

re: Examining the utility of self concept discrepancy theory in the field of addictive behaviour

Thank you for sending me the re-written consent form in connection with the above study and I can now confirm that I am able to give formal approval for you to proceed with this study.

Yours sincerely,

Andrew T. Nayagam
Chairman - Ethics Committee
Appendix Two: Ethical Approval
6 June 1996

Miss Roberta Fry
Options
24 Grafton Road
Worthing BN11 1QP

Dear Ms Fry

Re: Your Proposal To Extend Your Study To Include Subjects in the Brighton Area

I am writing to confirm that, after consultation with one of my Committee members, I am happy to give approval by Chairman’s Action to your proposal to extend your study - *Examining the Utility of Self Concept Discrepancy Theory in the Field of Addictive Behaviours* - to include subjects recruited in the Brighton area.

As I will not be in the office when this letter is typed I have asked Mrs E Pierce, Administrator of the Ethics Committees in E Sussex, to sign it on my behalf.

Yours sincerely

[Signature]

Dr J Lamberty FRCA
Chairman of Brighton LREC
Appendix Three: Consent Form
WRITTEN CONSENT FORM

This is a research project investigating the relationships between your own views of yourself, how you think people who are important to you see you, and how you feel. It is hoped that your responses to the questionnaire will help us to understand these relationships better, and to establish there relevance to people with a history of using alcohol.

Four questionnaires will be completed during the one off interview, and instruction for completion will be given by the interviewer. In addition you will be asked to complete 'The Background Information Sheet' which asks about your age, current drinking pattern etc. The interview is likely to require between one to two hours of your time, and will take place at the SAAS building here in Worthing.

Participation in this project is entirely voluntary. Your choice to participate will not effect your contact with your key worker at SAAS in any way. The information you give will be strictly confidential.

Name of investigator

Roberta Fry
Trainee Clinical Psychologist
Options
24, Grafton Road,
Worthing.
BN11 1QP

Tel. (01903) 204539

IF YOU WOULD BE WILLING TO HELP, PLEASE WRITE YOUR NAME, ADDRESS AND PHONE NUMBER BELOW IN BLOCK CAPITALS AND GIVE YOUR SIGNATURE WHERE INDICATED.

PLEASE SEND THE COMPLETED FORM IN THE STAMPED ADDRESSED ENVELOPE PROVIDED.

I (Name of participant)................................................................................................................

of (Address of the participant)...........................................................................................................

Phone Number....................................................................................................................................

hereby give my consent to take part in the above investigation, the nature and purpose of which has been explained to me. I understand that participation is voluntary and that it in no way effects the care that I receive.

Signed.................................................................................................. Date............................................
Appendix Four: Background Information
Background Information.

Age:

Sex:

Current drinking pattern:

Rate:

Units per week:

How long in treatment with Options?

How many in-patient de-toxifications?
Appendix Five : Beck Depression Inventory
his questionnaire consists of 21 groups of statements. After reading each group of statements carefully, circle the number (0, 1, 2 or 3) next to the one statement in each group which best describes the way you ave been feeling the past week, including today. If several statements within a group seem to apply equally well, circle each one. Be sure to read all the statements in each group before making your choice.

<table>
<thead>
<tr>
<th>Statement</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
</tr>
</thead>
<tbody>
<tr>
<td>I do not feel sad.</td>
<td>I feel sad.</td>
<td>I am sad all the time and I can't snap out of it.</td>
<td>I am so sad or unhappy that I can't stand it.</td>
<td></td>
</tr>
<tr>
<td>I do not particularly discouraged about the future.</td>
<td>I feel discouraged about the future.</td>
<td>I feel I have nothing to look forward to.</td>
<td>I feel that the future is hopeless and that things cannot improve.</td>
<td></td>
</tr>
<tr>
<td>I do not feel like a failure.</td>
<td>I feel I have failed more than the average person.</td>
<td>As I look back on my life, all I can see is a lot of failures.</td>
<td>I feel I am a complete failure as a person.</td>
<td></td>
</tr>
<tr>
<td>I get as much satisfaction out of things as I used to.</td>
<td>I don't enjoy things the way I used to.</td>
<td>I don't get real satisfaction out of anything anymore.</td>
<td>I am dissatisfied or bored with everything.</td>
<td></td>
</tr>
<tr>
<td>I don't feel particularly guilty.</td>
<td>I feel guilty a good part of the time.</td>
<td>I feel quite guilty most of the time.</td>
<td>I feel guilty all of the time.</td>
<td></td>
</tr>
<tr>
<td>I don't feel I am being punished.</td>
<td>I feel I may be punished.</td>
<td>I expect to be punished.</td>
<td>I feel I am being punished.</td>
<td></td>
</tr>
<tr>
<td>I don't feel disappointed in myself.</td>
<td>I am disappointed in myself.</td>
<td>I am disgusted with myself.</td>
<td>I hate myself.</td>
<td></td>
</tr>
<tr>
<td>I don't feel I am any worse than anybody else.</td>
<td>I am critical of myself for my weaknesses or mistakes.</td>
<td>I blame myself all the time for my faults.</td>
<td>I blame myself for everything bad that happens.</td>
<td></td>
</tr>
<tr>
<td>I don't have any thoughts of killing myself.</td>
<td>I have thoughts of killing myself, but I would not carry them out.</td>
<td>I would like to kill myself.</td>
<td>I would kill myself if I had the chance.</td>
<td></td>
</tr>
<tr>
<td>I don't cry any more than usual.</td>
<td>I cry more now than I used to.</td>
<td>I cry all the time now.</td>
<td>I used to be able to cry, but now I can't cry even though I want to.</td>
<td></td>
</tr>
<tr>
<td>I am no more irritated now than I ever am.</td>
<td>I get annoyed or irritated more easily than I used to.</td>
<td>I feel irritated all the time now.</td>
<td>I don't get irritated at all by the things that used to irritate me.</td>
<td></td>
</tr>
<tr>
<td>I have not lost interest in other people.</td>
<td>I am less interested in other people than I used to.</td>
<td>I have lost most of my interest in other people.</td>
<td>I have lost all of my interest in other people.</td>
<td></td>
</tr>
<tr>
<td>I make decisions about as well as I ever could.</td>
<td>I put off making decisions more than I used to.</td>
<td>I have greater difficulty in making decisions than before.</td>
<td>I can't make decisions at all anymore.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Question</td>
<td></td>
<td>Question</td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>---------------------------------------------------------------------------------------------------</td>
<td>---</td>
<td>---------------------------------------------------------------------------------------------------</td>
<td>---</td>
</tr>
<tr>
<td>14</td>
<td>I don't feel I look any worse than I used to.</td>
<td>19</td>
<td>I haven't lost much weight, if any, lately.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>I am worried that I am looking old or unattractive.</td>
<td></td>
<td>I have lost more than 5 pounds.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>I feel that there are permanent changes in my appearance that make me look unattractive.</td>
<td></td>
<td>I have lost more than 10 pounds.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>I believe that I look ugly.</td>
<td></td>
<td>I have lost more than 15 pounds.</td>
<td></td>
</tr>
<tr>
<td>15</td>
<td>I can work about as well as before.</td>
<td></td>
<td>I am purposely trying to lose weight by eating less. Yes_______No_______</td>
<td></td>
</tr>
<tr>
<td></td>
<td>It takes an extra effort to get started at doing something.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>I have to push myself very hard to do anything.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>I can't do any work at all.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>16</td>
<td>I can sleep as well as usual.</td>
<td>20</td>
<td>I am no more worried about my health than usual.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>I don't sleep as well as I used to.</td>
<td></td>
<td>I am worried about physical problems such as aches and pains; or upset stomach; or constipation.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>I wake up 1-2 hours earlier than usual and find it hard to get back to sleep.</td>
<td></td>
<td>I am very worried about physical problems and it's hard to think of much else.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>I wake up several hours earlier than I used to and cannot get back to sleep.</td>
<td></td>
<td>I am so worried about my physical problems that I cannot think about anything else.</td>
<td></td>
</tr>
<tr>
<td>17</td>
<td>I don't get more tired than usual.</td>
<td>21</td>
<td>I have not noticed any recent change in my interest in sex.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>I get tired more easily than I used to.</td>
<td></td>
<td>I am less interested in sex than I used to be.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>I get tired from doing almost anything.</td>
<td></td>
<td>I am much less interested in sex now.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>I am too tired to do anything.</td>
<td></td>
<td>I have lost interest in sex completely.</td>
<td></td>
</tr>
<tr>
<td>18</td>
<td>My appetite is no worse than usual.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>My appetite is not as good as it used to be.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>My appetite is much worse now.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>I have no appetite at all anymore.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Subtotal Page 2

Subtotal Page 1

Total Score
Appendix Six: SCL-90-R
**DIRECTIONS:**

1. Print your name, identification number, age, gender, and testing date in the area on the left side of this page.

2. Use a lead pencil only and make a dark mark when responding to the items on pages 2 and 3.

3. If you want to change an answer, erase it carefully and then fill in your new choice.

4. Do not make any marks outside the circles.
INSTRUCTIONS:
Below is a list of problems people sometimes have. Please read each one carefully, and blacken the circle that best describes HOW MUCH THAT PROBLEM HAS DISTRESSED OR BOTHERED YOU DURING THE PAST 7 DAYS INCLUDING TODAY. Blacken the circle for only one number for each problem and do not skip any items. If you change your mind, erase your first mark carefully. Read the example before beginning, and if you have any questions please ask them now.

EXAMPLE
HOW MUCH WERE YOU DISTRESSED BY:
Bodyaches

<table>
<thead>
<tr>
<th>NOT AT ALL</th>
<th>A LITTLE BIT</th>
<th>MODERATELY</th>
<th>QUITE A BIT</th>
<th>EXTREMELY</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

1 (?) Headaches
2 Nervousness or shakiness inside
3 Repeated unpleasant thoughts that won’t leave your mind
4 Faintness or dizziness
5 Loss of sexual interest or pleasure
6 Feeling critical of others
7 The idea that someone else can control your thoughts
8 Feeling others are to blame for most of your troubles
9 Trouble remembering things
10 Worried about sloppiness or carelessness
11 Feeling easily annoyed or irritated
12 Pains in heart or chest
13 Feeling afraid in open spaces or on the streets
14 Feeling low in energy or slowed down
15 Thoughts of ending your life
16 Hearing voices that other people do not hear
17 Trembling
18 Feeling that most people cannot be trusted
19 Poor appetite
20 Crying easily
21 Feeling shy or uneasy with the opposite sex
22 Feelings of being trapped or caught
23 Suddenly scared for no reason
24 Temper outbursts that you could not control
25 Feeling afraid to go out of your house alone
26 Blaming yourself for things
27 Pains in lower back
28 Feeling blocked in getting things done
29 Feeling lonely
30 Feeling blue
31 Worrying too much about things
32 Feeling no interest in things
33 Feeling fearful
34 Your feelings being easily hurt
35 Other people being aware of your private thoughts
36 Feeling others do not understand you or are unsympathetic
37 Feeling that people are unfriendly or dislike you
<table>
<thead>
<tr>
<th></th>
<th>NOT AT ALL</th>
<th>A LITTLE BIT</th>
<th>MODERATELY</th>
<th>QUITE A BIT</th>
<th>EXTREMELY</th>
</tr>
</thead>
<tbody>
<tr>
<td>38</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>39</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>40</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>41</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>42</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>43</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>44</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>45</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>46</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>47</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>48</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>49</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>50</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>51</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>52</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>53</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>54</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>55</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>56</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>57</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>58</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>59</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>60</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>61</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>62</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>63</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>64</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>65</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>66</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>67</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>68</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>69</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>70</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>71</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>72</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>73</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>74</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>75</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>76</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>77</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>78</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>79</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>80</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>81</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>82</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>83</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>84</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>85</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>86</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>87</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>88</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>89</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>90</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>

**HOW MUCH WERE YOU DISTRESSED BY:**

- Having to do things very slowly to insure correctness
- Heart pounding or racing
- Nausea or upset stomach
- Feeling inferior to others
- Soreness of your muscles
- Feeling that you are watched or talked about by others
- Trouble falling asleep
- Having to check and double-check what you do
- Difficulty making decisions
- Feeling afraid to travel on buses, subways, or trains
- Trouble getting your breath
- Hot or cold spells
- Having to avoid certain things, places, or activities because they frighten you
- Your mind going blank
- Numbness or tingling in parts of your body
- A lump in your throat
- Feeling hopeless about the future
- Trouble concentrating
- Feeling weak in parts of your body
- Feeling tense or keyed up
- Heavy feelings in your arms or legs
- Thoughts of death or dying
- Overeating
- Feeling uneasy when people are watching or talking about you
- Having thoughts that are not your own
- Having urges to beat, injure, or harm someone
- Awakening in the early morning
- Having to repeat the same actions such as touching, counting, or washing
- Sleep that is restless or disturbed
- Having urges to break or smash things
- Having ideas or beliefs that others do not share
- Feeling very self-conscious with others
- Feeling uneasy in crowds, such as shopping or at a movie
- Feeling everything is an effort
- Spells of terror or panic
- Feeling uncomfortable about eating or drinking in public
- Getting into frequent arguments
- Feeling nervous when you are left alone
- Others not giving you proper credit for your achievements
- Feeling lonely even when you are with people
- Feeling so restless you couldn't sit still
- Feelings of worthlessness
- The feeling that something bad is going to happen to you
- Shouting or throwing things
- Feeling afraid you will faint in public
- Feeling that people will take advantage of you if you let them
- Having thoughts about sex that bother you a lot
- The idea that you should be punished for your sins
- Thoughts and images of a frightening nature
- The idea that something serious is wrong with your body
- Never feeling close to another person
- Feelings of guilt
- The idea that something is wrong with your mind
Appendix Seven: The Selves Questionnaire
Part One : A

Please circle the number which best indicates the extent to which you believe you are actually like the following descriptions:

Smart \ Intelligent

1  2  3  4  5
Not at all true of me Slightly true of me Quite true of me Very true of me Extremely true of me

A Good person

1  2  3  4  5
Not at all true of me Slightly true of me Quite true of me Very true of me Extremely true of me

Caring (about other people's feelings)

1  2  3  4  5
Not at all true of me Slightly true of me Quite true of me Very true of me Extremely true of me

Friendly

1  2  3  4  5
Not at all true of me Slightly true of me Quite true of me Very true of me Extremely true of me

Good looking

1  2  3  4  5
Not at all true of me Slightly true of me Quite true of me Very true of me Extremely true of me

Please continue to the next page.
Now, please take a moment to think about yourself - about what you are like as a person. Think of a word that describes the type of person you think you actually are, write it down above the scale and circle the number which best indicates the extent to which you believe you are like that.

1  Not at all true of me  2  Slightly true of me  3  Quite true of me  4  Very true of me  5  Extremely true of me

Now, think of another word that describes the type of person you think you actually are, write it down and circle the number which best indicates the extent to which you believe you are like that, and so on for the rest of the scales on this page.

1  Not at all true of me  2  Slightly true of me  3  Quite true of me  4  Very true of me  5  Extremely true of me

1  Not at all true of me  2  Slightly true of me  3  Quite true of me  4  Very true of me  5  Extremely true of me

1  Not at all true of me  2  Slightly true of me  3  Quite true of me  4  Very true of me  5  Extremely true of me

1  Not at all true of me  2  Slightly true of me  3  Quite true of me  4  Very true of me  5  Extremely true of me

Many thanks that is A done. Now please continue to Part 1 B.
Part One: B

Please circle the number which best indicates the extent to which you would ideally want to be like the following descriptions:

### Smart / Intelligent

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Not at all true of me</td>
<td>Slightly true of me</td>
<td>Quite true of me</td>
<td>Very true of me</td>
<td>Extremely true of me</td>
</tr>
</tbody>
</table>

### A Good person

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Not at all true of me</td>
<td>Slightly true of me</td>
<td>Quite true of me</td>
<td>Very true of me</td>
<td>Extremely true of me</td>
</tr>
</tbody>
</table>

### Caring (about other people's feelings)

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Not at all true of me</td>
<td>Slightly true of me</td>
<td>Quite true of me</td>
<td>Very true of me</td>
<td>Extremely true of me</td>
</tr>
</tbody>
</table>

### Friendly

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Not at all true of me</td>
<td>Slightly true of me</td>
<td>Quite true of me</td>
<td>Very true of me</td>
<td>Extremely true of me</td>
</tr>
</tbody>
</table>

### Good looking

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Not at all true of me</td>
<td>Slightly true of me</td>
<td>Quite true of me</td>
<td>Very true of me</td>
<td>Extremely true of me</td>
</tr>
</tbody>
</table>

Please continue to the next page.
Now, please take a moment to think about yourself. Think of a word that describes the type of person you would ideally like to be, write it down above the scale and circle the number which best indicates the extent to which you want ideally to be like that.

1  2  3  4  5  
Not at all true of me  Slightly true of me  Quite true of me  Very true of me  Extremely true of me

Now, think of another word that describes the type of person you would ideally like to be, write it down and circle the number which best indicates the extent to which you want ideally to be like that, and so on for the rest of the scales on this page.

1  2  3  4  5  
Not at all true of me  Slightly true of me  Quite true of me  Very true of me  Extremely true of me

1  2  3  4  5  
Not at all true of me  Slightly true of me  Quite true of me  Very true of me  Extremely true of me

1  2  3  4  5  
Not at all true of me  Slightly true of me  Quite true of me  Very true of me  Extremely true of me

1  2  3  4  5  
Not at all true of me  Slightly true of me  Quite true of me  Very true of me  Extremely true of me

Many thanks that is B done. Now please continue to Part 1 C.
Part One: C

Please circle the number which best indicates the extent to which you think you ought to be like the following descriptions

Smart \ Intelligent

1  2  3  4  5
Not at all true of me Slightly true of me Quite true of me Very true of me Extremely true of me

A Good person

1  2  3  4  5
Not at all true of me Slightly true of me Quite true of me Very true of me Extremely true of me

Caring (about other people's feelings)

1  2  3  4  5
Not at all true of me Slightly true of me Quite true of me Very true of me Extremely true of me

Friendly

1  2  3  4  5
Not at all true of me Slightly true of me Quite true of me Very true of me Extremely true of me

Good looking

1  2  3  4  5
Not at all true of me Slightly true of me Quite true of me Very true of me Extremely true of me

Please continue to the next page.
Now, please take a moment to think about yourself. Think of a word that describes the type of person you think you ought to be like, write it down above the scale and circle the number which best indicates the extent to which you believe you ought to be like that.

1  2  3  4  5
Not at all true of me  Slightly true of me  Quite true of me  Very true of me  Extremely true of me

Now, think of another word that describes the type of person you think you ought to be like, write it down and circle the number which best indicates the extent to which you believe you ought to be like that.

1  2  3  4  5
Not at all true of me  Slightly true of me  Quite true of me  Very true of me  Extremely true of me

Many thanks that is C done. Now please continue to Part 2 A.
Part Two: A

Please take a moment to think about how other people see you. Circle the number which best indicates the extent to which your mother, father or friend, (whichever is most meaningful or relevant to you) thinks you are like the following descriptions:

### Smart / Intelligent

<table>
<thead>
<tr>
<th>1</th>
<th>Not at all true of me</th>
<th>2</th>
<th>Slightly true of me</th>
<th>3</th>
<th>Quite true of me</th>
<th>4</th>
<th>Very true of me</th>
<th>5</th>
<th>Extremely true of me</th>
</tr>
</thead>
</table>

### A Good person

<table>
<thead>
<tr>
<th>1</th>
<th>Not at all true of me</th>
<th>2</th>
<th>Slightly true of me</th>
<th>3</th>
<th>Quite true of me</th>
<th>4</th>
<th>Very true of me</th>
<th>5</th>
<th>Extremely true of me</th>
</tr>
</thead>
</table>

### Caring (about other people's feelings)

<table>
<thead>
<tr>
<th>1</th>
<th>Not at all true of me</th>
<th>2</th>
<th>Slightly true of me</th>
<th>3</th>
<th>Quite true of me</th>
<th>4</th>
<th>Very true of me</th>
<th>5</th>
<th>Extremely true of me</th>
</tr>
</thead>
</table>

### Friendly

<table>
<thead>
<tr>
<th>1</th>
<th>Not at all true of me</th>
<th>2</th>
<th>Slightly true of me</th>
<th>3</th>
<th>Quite true of me</th>
<th>4</th>
<th>Very true of me</th>
<th>5</th>
<th>Extremely true of me</th>
</tr>
</thead>
</table>

### Good looking

<table>
<thead>
<tr>
<th>1</th>
<th>Not at all true of me</th>
<th>2</th>
<th>Slightly true of me</th>
<th>3</th>
<th>Quite true of me</th>
<th>4</th>
<th>Very true of me</th>
<th>5</th>
<th>Extremely true of me</th>
</tr>
</thead>
</table>

Please continue to the next page.
Now, using the same person as before (either mother, father or friend) think of a word that describes the type of person they think you are like, write it down above the scale and circle the number which best indicates the extent to which he or she believes you are like that.

1  2  3  4  5
Not at all true of me  Slightly true of me  Quite true of me  Very true of me  Extremely true of me

Now, using the same person as before (either mother, father or friend) think of another word that describes the type of person, that they think you are like, write it down and circle the number which best indicates the extent to which he or she believes you are like that, and so on for the rest of the scales on this page.

1  2  3  4  5
Not at all true of me  Slightly true of me  Quite true of me  Very true of me  Extremely true of me

1  2  3  4  5
Not at all true of me  Slightly true of me  Quite true of me  Very true of me  Extremely true of me

1  2  3  4  5
Not at all true of me  Slightly true of me  Quite true of me  Very true of me  Extremely true of me

1  2  3  4  5
Not at all true of me  Slightly true of me  Quite true of me  Very true of me  Extremely true of me

Many thanks, that is A done. Now please continue to Part 2 B.
Part Two : B

Please take a moment to think about how other people see you. Circle the number which best indicates the extent to which your **mother, father or friend**, (whichever is most meaningful or relevant to you) would *ideally* want you to be like the following descriptions.

<table>
<thead>
<tr>
<th>Smart \ Intelligent</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not at all true of me</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Slightly true of me</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Quite true of me</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Very true of me</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Extremely true of me</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>A Good person</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not at all true of me</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Slightly true of me</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Quite true of me</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Very true of me</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Extremely true of me</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Caring (about other people's feelings)</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not at all true of me</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Slightly true of me</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Quite true of me</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Very true of me</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Extremely true of me</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Friendly</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not at all true of me</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Slightly true of me</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Quite true of me</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Very true of me</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Extremely true of me</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Good looking</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not at all true of me</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Slightly true of me</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Quite true of me</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Very true of me</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Extremely true of me</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Please continue to the next page.
Now, using the same person as before (either mother, father or friend) think of a word that describes the type of person they would ideally want you to be like, write it above the scale and circle the number which best indicates the extent to which he or she would want you to be like that.

1  2 3 4 5
Not at all true of me Slightly true of me Quite true of me Very true of me Extremely true of me

Now, using the same person as before (either mother, father or friend) think of another word that describes the type of person that they would ideally want you to be like, write it down and circle the number which best indicates the extent to which he or she would want you to be like that, and so on for the rest of the scales on this page.

1  2 3 4 5
Not at all true of me Slightly true of me Quite true of me Very true of me Extremely true of me

Many thanks, that is B done. Now please continue to Part 2 C, the final section!
Part Two: C

Please take a moment to think about how other people see you. Circle the number which best indicates the extent to which your mother, father or friend, (whichever is most meaningful or relevant to you) thinks you ought to be like the following descriptions

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Smart \ Intelligent</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Extremely true of me</td>
</tr>
<tr>
<td>Not at all true of me</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Slightly true of me</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Quite true of me</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Very true of me</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Extremely true of me</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>A Good person</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Extremely true of me</td>
</tr>
<tr>
<td>Not at all true of me</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Slightly true of me</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Quite true of me</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Very true of me</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Extremely true of me</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Caring (about other people's feelings)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Extremely true of me</td>
</tr>
<tr>
<td>Not at all true of me</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Slightly true of me</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Quite true of me</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Very true of me</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Extremely true of me</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Friendly</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Extremely true of me</td>
</tr>
<tr>
<td>Not at all true of me</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Slightly true of me</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Quite true of me</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Very true of me</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Extremely true of me</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Good looking</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Extremely true of me</td>
</tr>
<tr>
<td>Not at all true of me</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Slightly true of me</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Quite true of me</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Very true of me</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Extremely true of me</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Please continue to the next page.
Now, using the same person as before (either mother, father or friend) think of a word that describes the type of person they think you ought to be like, write it down above the scale and circle the number which best indicates the extent to which he or she believes you ought to be like that.

1  Not at all true of me  2  Slightly true of me  3  Quite true of me  4  Very true of me  5  Extremely true of me

Now, using the same person as before (either mother, father or friend) think of another word that describes the type of person, that they think you ought to be like, write it down and circle the number which best indicates the extent to which he or she believes you are like that, and so on for the rest of the scales on this page.

1  Not at all true of me  2  Slightly true of me  3  Quite true of me  4  Very true of me  5  Extremely true of me

1  Not at all true of me  2  Slightly true of me  3  Quite true of me  4  Very true of me  5  Extremely true of me

1  Not at all true of me  2  Slightly true of me  3  Quite true of me  4  Very true of me  5  Extremely true of me

1  Not at all true of me  2  Slightly true of me  3  Quite true of me  4  Very true of me  5  Extremely true of me

Many thanks and congratulations for reaching the end of this questionnaire !!!
First of all, we would like you to recall a recent month when you were drinking heavily in a way which, for you, was fairly typical of a heavy drinking period. Please fill in the month and the year.

MONTH _______________ YEAR _______________

We would like to know more about your drinking during this time and during other periods when your drinking was similar. We want to know how often you experienced certain feelings. Please reply to each statement by putting a circle round ALMOST NEVER or SOMETIMES or OFTEN or NEARLY ALWAYS after each question.

First we want to know about the physical symptoms that you have experienced first thing in the morning during these typical periods of heavy drinking.

PLEASE ANSWER EVERY QUESTION

1. During a heavy drinking period, I wake up feeling sweaty.
   ALMOST NEVER  SOMETIMES  OFTEN  NEARLY ALWAYS

2. During a heavy drinking period, my hands shake first thing in the morning.
   ALMOST NEVER  SOMETIMES  OFTEN  NEARLY ALWAYS

3. During a heavy drinking period, my whole body shakes violently first thing in the morning if I do not have a drink.
   ALMOST NEVER  SOMETIMES  OFTEN  NEARLY ALWAYS

4. During a heavy drinking period, I wake up absolutely drenched in sweat.
   ALMOST NEVER  SOMETIMES  OFTEN  NEARLY ALWAYS

The following statements refer to moods and states of mind you may have experienced first thing in the morning during these periods of heavy drinking.

5. When I’m drinking heavily, I dread waking up in the morning.
   ALMOST NEVER  SOMETIMES  OFTEN  NEARLY ALWAYS

6. During a heavy drinking period, I am frightened of meeting people first thing in the morning.
   ALMOST NEVER  SOMETIMES  OFTEN  NEARLY ALWAYS

7. During a heavy drinking period, I feel at the edge of despair when I awake.
   ALMOST NEVER  SOMETIMES  OFTEN  NEARLY ALWAYS

8. During a heavy drinking period, I feel very frightened when I awake.
   ALMOST NEVER  SOMETIMES  OFTEN  NEARLY ALWAYS
PLEASE ANSWER EVERY QUESTION

The following statements also refer to the recent period when your drinking was heavy, and to periods like it.

9. During a heavy drinking period, I like to have a morning drink.
   ALMOST NEVER  SOMETIMES  OFTEN  NEARLY ALWAYS

10. During a heavy drinking period, I always gulp my first few morning drinks down as quickly as possible.
    ALMOST NEVER  SOMETIMES  OFTEN  NEARLY ALWAYS

11. During a heavy drinking period, I drink in the morning to get rid of the shakes.
    ALMOST NEVER  SOMETIMES  OFTEN  NEARLY ALWAYS

12. During a heavy drinking period, I have a very strong craving for a drink when I awake.
    ALMOST NEVER  SOMETIMES  OFTEN  NEARLY ALWAYS

Again, the following statements refer to the recent period of heavy drinking and the periods like it.

13. During a heavy drinking period, I drink more than a quarter of a bottle of spirits per day (4 doubles or 1 bottle of wine or 4 pints of beer).
    ALMOST NEVER  SOMETIMES  OFTEN  NEARLY ALWAYS

14. During a heavy drinking period, I drink more than half a bottle of spirits per day (or 2 bottles of wine or 8 pints of beer).
    ALMOST NEVER  SOMETIMES  OFTEN  NEARLY ALWAYS

15. During a heavy drinking period, I drink more than one bottle of spirits per day (or 4 bottles of wine or 15 pints of beer).
    ALMOST NEVER  SOMETIMES  OFTEN  NEARLY ALWAYS

16. During a heavy drinking period, I drink more than two bottles of spirits per day (or 8 bottles of wine or 30 pints of beer).
    ALMOST NEVER  SOMETIMES  OFTEN  NEARLY ALWAYS

IMAGINE THE FOLLOWING SITUATION:
   (1) You have been COMPLETELY off drink for a FEW WEEKS.
   (2) You then drink VERY HEAVILY for TWO DAYS.

HOW WOULD YOU FEEL THE MORNING AFTER THOSE TWO DAYS OF HEAVY DRINKING?

17. I would start to sweat.
    NOT AT ALL  SLIGHTLY  MODERATELY  QUITE A LOT

18. My hands would shake.
    NOT AT ALL  SLIGHTLY  MODERATELY  QUITE A LOT

19. My body would shake.
    NOT AT ALL  SLIGHTLY  MODERATELY  QUITE A LOT

20. I would be craving for a drink.
    NOT AT ALL  SLIGHTLY  MODERATELY  QUITE A LOT
References


Lisansky, E.S. (1957) Alcoholism in women; social and psychological concomitants. 1 social history data. *Quarterly Journal of Studies on Alcohol, 18,* 588-623


McGuire, M.T., Stein, S. and Mendelson, J. (1966) Comparative psychosocial studies of alcoholic and nonalcoholic subjects undergoing experimentally induced ethanol intoxication. *Psychosomatic Medicine, 28 (1)* 13-26


346


White, W.F. (1965) Personality and cognitive learning among alcoholics with different intervals of sobriety. *Psychological Reports, 16*, 1125-1140


