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Conversion Programme

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Dissertation Title:

Supervision, Stress and Satisfaction in a Learning Disabilities Service

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Caring for the Carers: A Controlled Evaluation of a Workshop Programme for Health Service Staff working in Stressful Clinical Settings (BPS Diploma Research Dissertation, 1993)

Supervision, Stress and Satisfaction in a Learning Disabilities Service (PsychD Research)
DEDICATION AND ACKNOWLEDGEMENTS

This portfolio is jointly dedicated to my mother, who has supported and encouraged me for nearly forty years, and to my baby son, Benedict, who has inspired, captivated, enchanted and wonderfully distracted me over his first eighteen months.

I must acknowledge the support of New Possibilities NHS Trust and BHB Community Healthcare NHS Trust in financing my attendance on the programme and for allowing me time to work on this portfolio, my colleagues and, in particular, the respective Heads of Clinical Psychology Services, Prem Ramasamy and Stuart Bellwood.

I am very grateful to: Ruth Fosker and Aagje Ryan Korving of the Colchester Postgraduate Medical Library; Carol Roberts of the Warner Library, Broomfield Hospital, Chelmsford; Maureen Rouse of the Warley Postgraduate Multidisciplinary Library and Linda Averill and Tracey Tindall of the Information and Resources Section of the British Institute of Learning Disabilities for their assistance in running literature searches and obtaining the many references required.

My sincere thanks go to Dr. Clare Twigger-Ross for her painstaking supervision of the research element of this portfolio and also to Paul Devonshire and Lorraine Nanke for their many helpful comments on earlier drafts of the contents of this portfolio.

Finally, I am most grateful of all to my family: my wife, Katy, and my son, Benedict, for their continued love, tolerance, forbearance, encouragement and support throughout the life of this portfolio.
Section One

PROFESSIONAL AUDIT
1. OVERALL AIMS AND OBJECTIVES

1.1 PRIME AIM
To attain greater professional competence in order to enhance the contribution of clinical psychology to health care.

1.2 PRIME OBJECTIVE
To produce a programme of study, practice and research that will demonstrate increased competence in each of the three areas of academic, clinical and research skills.

1.3 PRIMARY PROCESS
A one year personal study programme tailored by audit to professional
needs and demands leading to examination for the award of a practitioner doctorate in clinical psychology.

2.0 ACADEMIC

2.1 AIMS
To enhance academic competence in three specialist areas of clinical psychology so as to develop the services offered by the department and profession.
To continue strengthening academic skills.
To continue to strengthen existing theory-practice links.
To be updated on current research findings and literature.
To be stimulated through engagement in the academic programme.

2.2 OBJECTIVES
To increase clinical skills through increased expertise and academic competence in the following three areas:
- Clinical hypnosis as an adjunct to assessment and therapy with people with learning disabilities;
- Biological bases of challenging behaviour in people with learning disabilities;
- Current issues in defining, determining and assessing mental incapacity of people with learning disabilities.

2.3 RATIONALE
To broaden expertise in the field of clinical psychology work with people with learning disabilities.
For clinical and professional practice to become better informed as a
result of a deeper and more specialist academic knowledge.
To provide a better service to clients.

2.4 PLAN
January - Initial discussion and selection of precise essay topics
February - Literature searches
March - Reading and study
April - First draft of critical reviews
May - Revision of first draft
June - Production of final draft

3.0 CLINICAL

3.1 AIMS
To increase personal professional competence and to develop services offered and purchased by North Essex Health Authority and Essex Social Services.
To increase specific professional and clinical competence in evaluating out of county residential services for people with learning disabilities who also have challenging behaviour.
To make recommendations for the development of appropriate in county services for people with learning difficulties and particularly challenging behaviour.

3.2 OBJECTIVES
To present a dossier on clinical activity that will describe service developments and the psychological frameworks within which they were undertaken.
To provide clinical psychology input into a joint health and social
services project to re-evaluate the suitability of out of county placements for people with learning disabilities and challenging behaviour.

3.3 RATIONALE

To develop and improve the services purchased and offered by the Health Authority and Social Services for people in North Essex with learning disabilities and challenging behaviours.

To increase service evaluation skills.

To bring about improved access to in county residential services for people with learning disabilities and challenging behaviour.

3.4 PLAN

January - 

February - Initial planning of evaluation project

March - Initial information gathering

April - Detailed planning and development of assessment tool

May - First placement visits and meetings with carers, consultants and social workers

June - Second visits

July -

August - Draft recommendations


4.0 RESEARCH

4.1 AIMS

To increase research competence so as to develop the services offered
by the department and to increase the knowledge available to the profession.

4.2 OBJECTIVES

To develop and execute a piece of research that will enable the Trust to achieve a greater understanding of the relationship between clinical supervision and levels of staff stress.

4.3 RATIONALE

To develop personal research skills and competence.

To enable the Trust to understand the relationship between clinical supervision and staff stress.

To present a contribution to knowledge about the links between clinical supervision and the levels of staff stress within parts of an organisation offering services to people with learning disabilities.

To determine levels of staff stress in different professional areas and to evaluate, within a psychological framework, the relationship between clinical supervision and levels of staff stress.

4.4 PLAN

January  - Discussion with course and Trust staff.

February  - Literature search and review of previous research within Trust.

March    - Research design and Ethics Committee application.

April - September  - Write introduction & methods sections, data collection

September - Data analysis, write results section

October  - Write discussion, references and abstract. Submit draft.
November - Complete necessary revision to manuscript.

December - Bind and submit final draft and remainder of portfolio.

5. PORTFOLIO OUTLINE

a. Professional Audit:
   i. Personal Study Programme
   ii. Details of Previous Clinical Psychology Qualification
   iii. Record of Continuing Professional Development

b. Academic Dossier:
   i. "Clinical hypnosis as an adjunct to assessment and therapy with people with learning disabilities";
   ii. "Biological bases of challenging behaviour in people with learning disabilities";
   iii. "Current issues in defining, determining and assessing mental incapacity in people with learning disabilities".

c. Clinical Dossier:
"The North Essex Assessment Re-Evaluation and Relocation (NEARER) Project - Re-evaluating out of county placements for people with learning disabilities and challenging behaviours".

d. Research Dossier:
"The relationship of clinical supervision to burnout, psychological distress and job satisfaction in health service staff working with people with learning disabilities" (PsychD Research Dissertation).

6.0 SUGGESTIONS FOR TRAINING EVENTS

6.1 LECTURES/SEMINARS
Clinical Hypnosis with people with learning disabilities
Neuropsychological aspects of challenging behaviour
The law relating to people with learning disabilities

6.2 WORKSHOPS
Writing critical reviews
Service development
Refreshers on research design, methodology and statistical analysis

SIGNED.............................................PARTICIPANT

JAMIE G.H. HACKER HUGHES

SIGNED.............................................HEAD OF DEPARTMENT

PREM RAMASAMY

SIGNED.............................................TUTOR IN CPD

PAUL DEVONSHIRE
SUMMARY OF PROFESSIONAL CLINICAL TRAINING AND RECORD OF ALL CONTINUING PROFESSIONAL DEVELOPMENT ACTIVITIES UNDERTAKEN SINCE COMPLETION OF TRAINING

BPS DIPLOMA IN CLINICAL PSYCHOLOGY (October 1990 - April 1994)

SUPERVISED CLINICAL EXPERIENCE (1990-1993)

350 days of supervised clinical experience extending over a continuous three-year period (comprising at least four placements including at least 65 days clinical work plus a further 90 days supervised clinical work).

Placements undertaken in services for:

Adult patients with psychological disorders.

Supervisors: Annette Newton and Farzeen Laskar.)

Children and Adolescents

Supervisors: Steve Hunt and Judy Adams.)
Children and adults with learning disabilities.

Supervisor: Prem Ramasamy.)

Elderly and Neuropsychology.

Supervisor: Dr Eric Warren.)

Post-Traumatic Stress Disorder.

(Traumatic Stress Clinic, Middlesex Hospital.
June 1993 - September 1993
Supervisors: Dr James Thompson and Deborah Lee.)

SECTION I. WRITTEN PAPERS (September 1992)

Paper 1. Birth to Old Age

Content: The impact of genetic, biographical, sexual, cultural, educational and socio-economic factors on clinical problems. Clinical applications of normal development from conception to death (e.g. developmental milestones, socialisation, education, personal and sexual relationships, marriage and the family, pregnancy and childbirth, work and leisure, unemployment and retirement, ageing, death and dying). Clinical problems characteristic of particular social contexts and stages of the life-span, and clinical measurement of age differences and age changes. Implications of the social and
developmental context of clinical problems for assessment, treatment and prevention.

Paper 2. Abnormal Psychology: (Research and Theory)

Content: Abnormalities of behaviour and experience encountered in clinical practice. Knowledge of research on efficacy of treatment procedures. Detailed and up-to-date knowledge of experimental psychology in this field. The effects on specific psychological functions - for example, attention, perception, memory, thinking and feeling - of cerebral dysfunction, other physical illness and physiological abnormalities as well as family and social influences.

(Granted exemption by Cambridge University MPhil in Psychopathology)

Paper 3. Clinical Applications

Methods used to identify and alleviate problems with respect to individuals, couples, families and groups. The formulation of therapeutic aims on the basis of findings. The rationale and use of interview methods, tests and other clinical instruments.

Paper 4. Clinical Services, Research Methods and Professional Issues

Content:
Clinical Services: Issues relating to procedures for clinical investigation or intervention. Clinical services in institutional or community settings.
Applications of Research Methods: Principles of psychological

Professional Issues: Relationships with non-psychologist professionals, including teaching. General issues relating to relevant government policies, social issues and the health service. The development and organisation of clinical services. Professional and ethical considerations.

SECTION II. CASE REPORTS (April 1994)

Content:

Eight case reports (of 3000 words each) demonstrating clinical competence in a wide range of ages, types of problem and clinical procedures, including both assessments and ways of modifying the behaviour of individuals, groups or institutions.

Submitted:

Two representative case reports were submitted from each of the three fields of work in which compulsory placements were required (adult psychological disorders, children, people with a severe learning disability), one report from the elective placement (post traumatic stress disorder) and one other (cognitive analytic therapy).
SECTION III. RESEARCH DISSERTATION (September 1993)

Content:

A dissertation not exceeding 14,000 words consisting of a research report of an empirical investigation of human subjects and of clinical relevance.

Title: Caring for the Carers: A controlled evaluation of a workshop programme for health service staff working in stressful clinical settings.
RECORD OF CONTINUING PROFESSIONAL DEVELOPMENT


9/93 European Congress of Cognitive and Behavioural Psychotherapies
Institute of Education - University of London

2/10/93 Special Care Questioning - Bryan Tully Associates

8/10/93 Mental Health Needs of People with Learning Difficulties - South East Thames Institute of Health Studies

14/12/93 British Psychological Society London Conference (Speaker) -

15/12/93 Caring for the Carers - Evaluating the Effects of a Programme to support Health Professionals working in Stressful Clinical Settings

16/2/94 Dimensions of Change in the NHS - City University

24/3/94 British Psychological Society Annual Conference (Speaker) -

27/3/94 Psychological Effects of the Warrington Bombing

14/4/94 Sex Matters - Pavilion Publishing, King's Fund Institute
25/4/94  Beyond the Basics - BPS Learning Disabilities SIG

27/4/94  The Hill Residential College, Abergavenny

7/6/94  Health of the Nation - New Possibilities NHS Trust

1/7/94  Stress and Disease - Mind Matters Seminars

7/12/94  Sex Matters II - Pavilion Publishing, King's Fund Institute

24/4/95  Beyond the Basics - BPS Learning Disabilities SIG

26/4/95  The Hill Residential College, Abergavenny

5/9/95  BABCP Annual Conference - BABCP

9/9/95  Southampton University

20/10/95  Beyond Prozac - Biomed

1/1/95  PsychD in Clinical Psychology

31/03/96  University of Surrey

22/1/96  Clinical Cognitive Neuropsychology - Institute of Neurology

11/03/96
2. PUBLICATIONS, CONFERENCE PAPERS AND BOOK REVIEWS

PAPERS


CONFERENCE PAPERS


BOOK REVIEWS


Section Two

ACADEMIC DOSSIER
BIOLOGICAL BASES OF CHALLENGING BEHAVIOUR IN PEOPLE WITH LEARNING DISABILITIES

Introduction

In recent years much attention has been focused on the needs of people with learning disabilities who also have challenging behaviour. A great deal of work has been carried out into evaluating various means of service provision (Allen, 1991; All Wales Advisory Panel, 1991; Emerson, 1991; Mansell, 1993) and into devising numerous forms of interventions (LaVigna and Donnellan, 1986; Remington, 1991; Zarkowska and Clements, 1994). Many of these approaches have now been thoroughly documented with several being published in the form of treatment manuals (Holland, 1994; McBrien and Felce, 1992; Presland, 1989).

Unfortunately, a somewhat surprising by-product of this work is that, increasingly commonly, an assumption is often made by many front-line staff that challenging behaviour is always essentially psychological in nature and, therefore, that psychological interventions are necessarily always the best option. In many cases, of course, there are indeed salient psychological factors and, in these situations, suitable psychological interventions based on careful functional analyses have proved to be extremely successful. However, it is equally true that there are a variety of biological conditions which are also important and that these must be adequately addressed if psychological interventions are to be used to maximum effect. Indeed,
in most cases a synthesised biopsychosocial explanation provides a better model for understanding challenging behaviour than categorical "either psychological or physical" explanations.

It is incumbent upon clinical psychologists working with this client group to be aware of all these variables so that their sometimes extremely limited resources may be targeted and used as efficiently as possible. It is, therefore, the aim of this review to cover the relevant literature so that clinical psychologists working in the area might be better informed and consequently will be in a better position to interface with their professional colleagues. In this way psychologists might be able to better employ their unique psychological skills either by minimising the effects of physical conditions through environmental means or by employing knowledge of physical diagnoses to modify interventions appropriately or to explain their effects as a way of providing emotional support to relatives or carers.

Self-Injurious Behaviours

One of the commoner forms of behaviour that receives the label of challenging behaviour is self-injurious behaviour (SIB). Prevalence estimates of SIB among people with learning disabilities range from 8% to 19% with even higher figures of 40% and 49% being reported in severely and profoundly learning disabled people compared to a rate of 12% in people with mild learning disabilities (Oliver, Murphy and Corbett, 1987). For example, Griffin et. al. (1986), in a prevalence survey among 10,000 Texan people with learning disabilities, found a prevalence rate of 13.6% with almost 90% of those showing SIB having
moderate or severe levels of intellectual disability whilst estimates of incidence of SIB among people with learning disabilities varies between 3.5% and 40% (Winchel and Stanley, 1991).

Commonly, psychological and psychiatric theories of SIB postulate volitional control with SIB being motivated either by consequent reinforcement through the giving of attention (Frankel and Simmons, 1976), self-stimulation (Edelson, 1984), or endorphin production (Cataldo and Harris, 1982) or being used as a means of communication (Carr and Durand, 1985; Donnellan, Mirenda, Mesaros and Fassbender, 1984). However, a number of other causal factors also deserve detailed consideration.

**Aggressive and Self-Injurious Behaviours - Genetic Factors**

Palmour (1983) has considered the genetic component of aggressive behaviour and self-injurious behaviours. Whilst acknowledging that, in common with many other psychiatric conditions, aggressive behaviour is multifactorial in nature with both environmental and genetic components playing their part, she holds that a model of a continuum of causation is useful in helping us to approach the question of causation. Thus aggression which is elicited by primarily contextual means would be placed at an environmental pole of the continuum whilst internally elicited aggression would be positioned at a biological pole.

One of the most dramatic and relentless forms of SIB studied by Palmour is Lesch-Nyhan disease, an X-linked recessive condition in which there is a disorder of purine metabolism in which, because of a
deficiency in the enzyme hypoxanthine phosphorybosyltransferase (HPBT) there is excessive purine synthesis (Seegmiller, 1981). The clinical manifestations of Lesch-Nyhan are mild to moderate intellectual disability, choreoathetoid movements, spasticity and self-mutilatory behaviour (most commonly involving the chewing of fingers and lips) which is compulsive in nature.

Goldstein et. al. (1985) suggest that this self-mutilation results from a dopamine supersensitivity with the HPBT deficiency interfering with the synthesis of guanyl nucleotide and thus preventing the regulation of the dopamine receptors by the enzyme guanosine triphosphate (GTP) in the basal ganglia. Similarly, Mizuno and Yugari (1972) propose serotonergic depletion as a pathway to self-mutilation in Lesch-Nyhan and they have achieved positive results through pharmacological interventions derived from this premise.

In addition to self-mutilation, there is also other-directed aggression which may take the form of biting or kicking, pinching or spitting. However, even the clinical features of conditions such as Lesch-Nyhan, which has a clear genetic basis, are not exclusively biological in causation since the self-mutilatory component is also exacerbated by external environmental stressors (Anderson et. al., 1977).

A second, although thankfully rare, genetic syndrome found amongst people with learning disabilities and in which there is a high rate of self-injury is the so-called Cornelia de Lange syndrome (Grossman, 1983). In Cornelia de Lange, which is a congenital condition of as yet unknown aetiology, the clinical manifestations include severe
intellectual disability together with a range of physical characteristics including a narrowed palate and wide upper lip, bushy eyebrows joined in the midline and various skeletal abnormalities.

Other genetic syndromes linked to learning disability and in which there is also a raised incidence of self-injurious behaviour include Rett's syndrome, Gilles de la Tourette syndrome and Fragile X syndrome. Interestingly, Tourette's syndrome is another example of a condition where dopamine hypersensitivity has been proposed as a mechanism (Koslow and Cross, 1982).

Finally, the other classic example of a genetic factor that has been linked to aggression is that of the XYY karyotype reviewed by, amongst others, Vogel and Motulsky (1979). Here, early reports linked the XYY karyotype to criminality and, in particular, to aggression. However, later studies showed that the crimes committed by XYY males were not aggressive and that a degree of learning disability was the factor that had resulted in apprehension and conviction and, therefore, in a statistically unrepresentative concentration in prison populations.

Self-Injurious Behaviour - Non-Genetic Organic Factors

Ferry (1994) reminds us that self-injurious behaviours may also be maintained and, in certain circumstances, increased by damage to nociceptive systems resulting in elevation of pain threshold. This route to SIB is linked to the tentative hypothesis that in certain individuals there is an alteration in the functioning of the opiate systems so that increased release of endogenous opiates (endorphins)
as a consequence of painful stimulation is required for the maintenance of adequate opiateergic tone (Winchel and Stanley, 1991).

Physical Illness and Sensory Deficits

In his study of behavioural problems amongst older people with learning disabilities, James (1986) reported some clients as developing severe behavioural problems arising from problems of physical health. In one case this was as a consequence of deteriorating vision whilst in another the cause was disability following osteoarthritis of the hip. James rightly observes that "It is often difficult or impossible for severely mentally handicapped (sic) people with limited communication to tell others when they have a pain; the start of behavioural problems in a previously well-behaved person should alert the practitioner to undiagnosed physical illness" (James, 1986, p. 344.).

As Coldwell (1990) eloquently describes, it is also common for visually impaired people who have severe learning disabilities to respond to their environment and to their handicap by developing one of a range of challenging behaviours which may include self-mutilation, including self-enucleation, faecal smearing and aggression.

Finally, deafness can also result in behavioural disturbances. Silva et. al. (1982) report on a New Zealand study of developmental and behavioural problems associated with bilateral otitis media with effusion (OME), commonly known as 'glue ear'. OME is the most common cause of hearing loss in children in developed countries (Renvall and
Holmquist, 1976) and is defined as an unresolved middle ear inflammation occurring in the presence of chronic dysfunction of the eustachian tube and resulting in the production of an inflammatory exudate in the middle ear. Silva et. al. (1982) found that children with bilateral OME had a number of developmental problems relating to poor speech articulation, verbal comprehension, motor development and reduced scores on the Stanford-Binet test of intelligence. There were also a number of behavioural problems including reported restlessness, destructiveness and disobedience together with shortened attention spans and reduced popularity. Although carried out on a sample of children of average intellectual ability it is easy to see that some of these findings might be helpful when examining challenging behaviour resulting from deafness in a learning-disabled population.

Hormonal Factors

There is an increasing awareness of the behavioural sequelae of premenstrual syndrome. Jain and Arya (1987) produced the first report of a study investigating the role of premenstrual tension in producing behavioural problems in women with learning disabilities. Using a checklist of their own devising, Jain and Arya reported that 11 of a random sample of 40 learning disabled women showed an accentuation of behavioural disturbance in the pre-menstrual phase together with physical symptomatology and hormonal changes (low levels of plasma progesterone on the 21st day of the menstrual cycle). The authors suggest that if premenstrual tension is treated appropriately using pharmacological means psychological interventions
may then be applied more effectively in order to reduce learned maladaptive behaviour.

Taylor, Rush, Hetrick and Sandman (1993) have also related the phase of the menstrual cycle to levels of SIB in women with learning disabilities. They analysed the catamenial and behavioural records of 9 learning disabled women over a 6 month period and found that the highest frequency of SIB occurred in the first two phases of the cycle (the menses and follicular phases) and that the lowest frequency occurred in the last two phases (the luteal phases and premenstrual phase), thus implying a cyclicity of SIB. They postulate the beta endorphin cycle as an intervening mechanism but also consider the possible roles of dopamine and direct effects of gonadotrophic and steroid hormones.

Neurological Factors - General

The link between neurological impairment and behavioural problems in learning disabled people is somewhat unclear. Earlier studies on non-learning-disabled children, for instance, Rutter, Graham and Yule (1970), had found that children with neurological dysfunctions had a 34% prevalence of psychiatric disorders (this being five times higher than a similar age group in the general population and three times higher than a similarly aged group with non-cerebral chronic physical disorders). Later, in a review of studies of children with acute cerebral injury, Rutter (1981) found that the only psychiatric symptomatology specifically linked to this group was a higher incidence of social disinhibition.
With regard to children with learning disabilities, Richardson, Koller and Katz (1985) conducted a further study on a sample of mildly learning disabled British children. They wished to investigate whether later behavioural disturbance was associated with either stability of upbringing or neurological impairment. In order to assess central nervous system (CNS) impairment a standardised neurological examination was administered when the subjects were 8 to 10 years of age. A comprehensive neurological examination was administered including mental state, orientation, degree of cooperation, speech and language, intactness of cranial nerves, sensory organisation, reflexes, intentional and voluntary movement, strength and tone of muscles and motor coordination. The child was judged to show some neurological abnormality if one or more localising signs of CNS abnormality (including abnormalities in nerve reflexes or cranial nerve function, lateralised dysfunction and pathological reflexes) or two or more non-localising signs (including clearly recognisable dysarthria or dysphonia, hyperkinesis, vestibular problems, abnormal gait, inadequate muscle tone and coordination defects) were present. These appear to be necessarily operational definitions implemented for categorical purposes whereas in reality a continuum of neurological impairment exists rather than such a dichotomous situation.

30% of the children were found to show CNS impairment as defined by Richardson et. al. (1985) but subsequent statistical analysis showed that this group did not differ from the non-CNS-impaired group in later assessments of disturbed and challenging behaviours (including emotional disturbance, hyperactive behaviour, antisocial behaviour and aggressive conduct disorder). The hypothesised link being tested
by this study, the role of CNS impairment as a contributory factor to adult behaviour problems in a learning disabled population, was therefore not supported although a link between behaviour disturbance and instability of upbringing (in relation to parental presence in the home, work and health histories, dealings with courts, police and social services and any changes in caretaking arrangements) was reported.

A later study by Kindlon, Sollee and Yando (1988) compared three groups of 4-16 year olds on measures of behaviour problems as defined by using criteria adopted in the Child Behavior Checklist (CBCL) (Achenbach, 1978; Achenbach and Edelbrock, 1979). The three groups being compared were a group with learning disabilities (LD) but with no hard evidence of neurological dysfunction, a group without learning disabilities but with known neurological dysfunction (defined as either a diagnosis of neurological dysfunction such as cerebral palsy, seizure disorder, or cranial trauma with subsequent coma of at least one week's duration, or findings definitely indicating brain damage on examination with BEAM, CT scan or EEG) (ND), and a third control group drawn from the same psychiatric clinic (PC) population that was used to obtain norms for the CBCL.

Kindlon. et. al. (1988) found that whilst the ND and LD groups had a high rate of disturbance (55%) on many factors, as measured by the CBCL, the group that exhibited the highest levels of aggression and delinquency was the PC group. The significance of this finding is that although there are psychological sequelae to neurological dysfunction their difficulties were less likely to be classified as externally directed aggressive behaviour and that the above measure
was unable to distinguish between the ND and LD groups. A similar result, comparing learning disabled and psychiatric child populations, had also previously been reported by Curry and Thompson (1982).

Neurological Factors - Temporal Lobe Epilepsy

Whilst it is difficult to be certain about the prevalence of behavioural disorders amongst service users with epilepsy (Trimble, 1983), it is generally agreed that they are frequent and that their presence often confounds attempts by colleagues to diagnose and satisfactorily control epileptic seizures (Gumnit, 1985). In addition, there are a number of episodic behavioural disorders which may be mistaken for seizures but which are not caused primarily by a neuronal disturbance of excitation and inhibition. Among these are hysterical or pseudoseizures, episodic psychosis and episodic aggression (Gumnit, op. cit.). Of these, the latter is the only type that falls within the scope of this review.

There are a variety of systems of classifying seizures into different types (myoclonic, tonic-clonic, complex partial etc.) but if one is examining the point at which behavioural problems might occur a temporal classification system, such as that given by Benson (1986) is more useful. Thus an epileptic seizure may be divided into 6 phases: the prodromal phase (a period of behavioural abnormality immediately preceding the seizure); the ictus, the part of the seizure during which the epileptic person is amnesic; the aura, during which the person regains consciousness; the post-ictal state, the recovery phases following the seizure; an inter-ictal period, the
period between seizures and, in very severe cases, the possibility of a chronic psychotic state, such as in epileptic dementing or schizophreniform disorders.

Although in a few rare cases the aggression can be an ictal phenomenon (a study by Delgado-Escueta et. al. (1981) clearly demonstrated the occurrence of a number of challenging behaviours (including boxing, flailing, grabbing, kicking and damaging property) during complex partial seizures in a small number of people with learning disabilities) or a post-ictal phenomenon (Saint-Hilaire, Gilbert and Bouvier, 1980), aggression has usually found to be a multifactorially determined generally interictal phenomenon (Benson, op. cit.). Here many people with epilepsy may become argumentative or aggressive for a few hours this occurring up to several days before having a seizure and, in most cases, the occurrence of the seizure itself will often dramatically relieve this behaviour. In other individuals, however, this irritable, explosive behaviour may persist for long periods without an epileptic seizure occurring either because the epilepsy is very well controlled by anti-convulsant medication or because the seizure frequency is so low that it has been disregarded as a possible causal factor. It is for this reason that questions about epileptic status should form part of any comprehensive assessment of challenging behaviour.

**Neurological Factors - Frontal Lobe Seizures**

An even rarer type of seizure which has been linked to SIB is the frontal lobe seizure (Gedye, 1989). Frontal lobe seizures are characterised by a precise pattern of movements occurring during the
ictal phase. These include involuntary movements of the eyes and face, intense vocalisations and movements of the arms, legs and trunk. However, although there may be amnesia for ictal events there is no loss of consciousness and there is a lack of identifiable features on electroencephalograph (EEG) recordings, computerised tomography (CT) or magnetic resonance imaging (MRI) scans. In addition, however, there may be episodes of SIB ranging from 10 seconds to 30 minutes in length and Gedye argues that these are involuntary in nature requiring recognition as neurological dysfunction rather than being regarded as a volitional form of challenging behaviour.

The implications of this are that the use of detailed neuropsychological testing as a means of localising areas of neural disturbance may sometimes be a more appropriate approach than functional and applied behavioural analyses.

**Neurological Factors – Stereotypic Behaviour**

The final group of behaviours to be considered here where biological causation may be an important factor are the so called stereotypical behaviours. Stereotypy has been defined by, for example, Baumeister and Forehand (1973) as repetitive, seemingly meaningless motor movements engaged in with high frequency by individuals with moderate to profound learning disabilities and which may include arm-flapping, body-rocking and head-banging. A traditional psychological explanation of such behaviour is usually given in terms of self-stimulation through perceptual reinforcement (Lovaas, Newsom and Hickman, 1987). However, authors such as Lewis, Baumeister and
Mailman (1987) propose an alternative neurobiological explanation whereby early developmental insults result in structural alterations in neural morphology which, in turn, effect dopamine transmission and reception mechanisms (and other neurotransmitter pathways), consequently resulting in behavioural changes. In addition, further support is given for this position by chronobiological studies such as that by Brusca (1985) which demonstrate the influence of various endogenous rhythms (ultradian, circadian, monthly and circannual) and the 90 minute basic rest-activity cycle on the cyclicity of stereotypical behaviours.

**Summary and Conclusions**

To misappropriate a metaphor it might be said that in order to be able to see the trees in the wood an understanding of the broad geographical layout of the wood and a knowledge of the different types of species that populate it are both essential. The above review has therefore considered a number of non-psychological approaches which can help us to gain a broader understanding about the causation and maintenance of various sub-types of challenging behaviours that may be exhibited by people with learning disabilities. Specifically, we have considered genetic, physical and hormonal factors before concluding with a lengthy section on various neurological factors, including temporal and frontal lobe seizures and stereotypy.

The rationale for this review has been that there are some areas where psychological approaches to understanding and intervening with challenging behaviours are patently more applicable than others.
There is an increasing tendency amongst health professionals either to "over-psychologise" challenging behaviours or to dichotomise the causes of challenging behaviour into solely physical or psychological categories. In addition to promoting unhealthy inter-professional rivalry this may also place pressure on psychologists to offer something which they cannot deliver - a cure.

It is thus suggested that there are three major ways in which this review might validly inform and improve the work of clinical psychologists. The first is that it highlights the importance of a thorough and comprehensive assessment where genetic, physical, hormonal and other more biological factors are all given adequate consideration before blindly dashing into a potentially restrictive psychological, or even worse, a strictly behavioural, analysis and intervention. Thus proper attention should be given to the potential role of genetic, physical or hormonal factors in giving rise to the behaviour before concentrating on more psychological aspects. Indeed any sufficient psychological model should ideally be rooted in biological theory and a physical diagnosis can be a source of great comfort to families and carers who are otherwise having difficulties coming to terms with the behavioural manifestations of challenging behaviour.

Secondly, a good knowledge of non-psychological factors helps clinical psychologists to interface better with their psychiatric and nursing colleagues, to target their resources effectively and perhaps also sometimes to point other professionals in appropriate directions regarding assessment and intervention.
Thirdly, and as the above review has, I hope clearly shown, there is, in certain instances, a clear role for neuropsychological assessment and testing in localising areas of neural damage and in guiding approaches to further assessment and appropriate pharmacological and psychological management accordingly.
REFERENCES


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Hypnosis - Towards A Definition

 Whole papers (Perry, 1992) and chapters of books (cf. Gibson, 1977; Gibson and Heap, 1991) have been written about the difficulties
inherent in trying to reach a definition of "hypnosis", a term first used by the Scottish doctor, James Braid (Braid, 1843). It is probably therefore helpful, before even considering the various theoretical perspectives, to list the ways in which hypnosis is induced and to consider the main characteristics of hypnosis. Hilgard and LeBaron (1984) list three main components of the process of hypnotic induction: relaxation, imagination and enactment. Once induced, hypnosis has the following basic characteristics: decreased likelihood of initiation of action (Hilgard, 1965); selective attention and/or inattention (Bowers, 1983), reduced reality testing (Sheehan & Perry, 1976); increased suggestibility (Hilgard & Tart, 1966); enhanced capacity for role enactment (Sarbin & Coe, 1972) and, lastly, the possibility of post-hypnotic amnesia (Nace, Orne & Hammer, 1974) and/or post hypnotic suggestion (Orne, Sheehan & Evans, 1968).

The main theoretical controversy is that which exists between those who see hypnosis as a psychological "state", in the same manner as a state of anxiety or anger - (the so-called "state theorists"), and those who do not. Whilst psychoanalytic theory (e.g. Fromm, 1979) sees the hypnotic "state" as a 'regression in the service of the ego' with the "state" of hypnosis being described as 'the royal road to the unconscious', a variety of other modern theoretical positions also exist. For instance, Hilgard's neodissociation theory (Hilgard 1973a, 1973b, 1986) derives from Janet's (1925) original position and posits a dissociation, during hypnosis, between a number of cognitive states and systems. To illustrate this, Hilgard (1986) gives the example of the parallel states of consciousness involved in driving a car where one is involved with manipulating the controls
which operate the vehicle, another is engaged in conversation with a passenger, a third may be ruminating about another topic and so on.

The main alternative stance is that taken by the so-called "non-state theorists", such as Barber (1986) and Sarbin (Sarbin and Coe, 1972), who deny the existence of hypnosis as an alternative state of psychological functioning but rather argue instead that hypnosis is a special type of social situation whereby any effects are merely produced by the compliance of the subject with the expectations of, and suggestions being given by, the hypnotist. A related position is that of the late Nick Spanos (e.g. Spanos, 1982). Like Sarbin, Spanos took the view that hypnosis consists of a strategic enactment and that one can be trained in the requisite skills for hypnosis (from which concept the Carleton Skills Training Programme (Gorassini and Spanos, 1986) was developed).

A third perspective (e.g. Edmonston, 1981) sees hypnosis merely as a form of relaxation and, based on this view, Kroger and Felzer (1976) easily produce a simple and concise definition which defines hypnosis as 'a state of profound relaxation and concentration characterised by increased receptivity and objectivity'.

As can be seen, therefore, the subject of a definition of hypnosis is still a topic of some considerable debate but, as Gibson and Heap (1991) observe, 'all reputable scientists and clinicians are now agreed that it (hypnosis) is simply an interesting psychological phenomenon with some physiological correlates ... which has ... important implications for the work of health professionals' (p. 15).
Suggestibility

Before considering the question of hypnotic susceptibility it is worth briefly reviewing the topic of suggestibility, which has long been the subject of much investigation. Eysenck and Furneaux (1945) distinguished between two uses of the term "suggestibility". "Primary suggestibility" may be defined as the 'uncritical amenability of an individual to outside influences which intimate that a prescribed course of behaviour or action should be followed' (Trippi, 1973, p. 220) and tests of "primary suggestibility" are excellent predictors of hypnotic susceptibility. "Secondary suggestibility", however, refers to such social tendencies as gullibility, credulity and compliance and has no relation to hypnotic susceptibility. That primary suggestibility and hypnotic susceptibility are different constructs is supported by a study by McGlashan, Evans and Orne (1969) which showed that whereas high hypnotic susceptibles were the best candidates for hypnotic analgesia, low hypnotic susceptibles showed the greatest placebo response (thereby implying greater suggestibility). McConnell (1963) has found that an inverse curvilinear relationship exists between suggestibility and chronological age (as chronological age increases so suggestibility decreases until a floor level is reached).

Suggestibility and People with Learning Disabilities

Although Weitzenhoffer (1953) had stated that a person needs to have adequate cognitive ability to enable them to comprehend the nature and intent of instructions given if they are to be effective there is very little research which supports this position. Indeed, Trippi
(1973) has reported indications of increased suggestibility in children with learning disabilities. Woody and Billy (1970) and Shuck and Ludlow (1984) have also investigated how this supposedly greater capacity for suggestibility might be used to facilitate learning by children with intellectual disabilities.

The evidence for increased suggestibility in children with learning disabilities is equivocal. However, Woody and Billy (1970) did not find any evidence that clinical suggestions (of relaxation, reduced test anxiety and increased motivation) were more effective in influencing performance on a measure of intelligence, the Peabody Picture Vocabulary Test, for a moderately learning disabled group than for a non-learning disabled group of children. On the other hand, Shuck and Ludlow (1984) reported that a mildly learning disabled group of adolescents responded more than a normal control group to positive suggestions of improved performance on a paired associate learning task.

**Susceptibility to Hypnosis**

Since the very beginnings of hypnosis, it has long been realised that people differ in their actual susceptibility to hypnosis. The Abbé de Faria (Faria, 1906) estimated that whereas 16% of the population were capable of falling into a "lucid sleep" (now called "deep-trance" subjects) the remainder were "insusceptible" (Faria, 1906). From the late nineteenth century onwards, however, there was a change of view from the previous opinion that the only valid form of hypnosis is "deep-trance" hypnosis to the current view that there is a continuum of hypnotic susceptibility which can be assessed using
standardised scales, such as the Stanford Hypnotic Susceptibility Scale (Weitzenhoffer and Hilgard, 1959).

As in the case of suggestibility, it has long been known that hypnotisability varies with age (Hull, 1933). Morgan and Hilgard (1973) found that hypnotisability (as it is normally understood) begins at around the age of 5 and peaks between the ages of 9 and 12 declining thereafter in proportion to increasing age. Gardner (1977) argues that infants and pre-school children are also hypnotisable, however, and presents a number of lines of evidence, from both research data and clinical observation, in support of the thesis that infants and pre-school children seem able to achieve something similar to, if not identical with, the phenomena experienced in hypnosis with older people.

The extent of hypnotic susceptibility has also been shown to be open to modification, however. Diamond (1974) has reported that observationally presented cues, and in particular verbal modelling cues, are effective in modifying hypnotic susceptibility in a normal population, even in minimally susceptible participants.

Hypnotic Susceptibility in People with Learning Disabilities

A study investigating hypnotic susceptibility in a learning disabled population has been reported by Sternlicht and Wanderer (1963). 20 children and adolescents with mild to severe learning disabilities and aged between 7 and 15 were given a hypnotic induction using the "progressive anaesthesia technique". In this induction technique it is suggested that parts of the body become "stiff and heavy and
without any feeling at all" and that once the entire body feels like this the subject will experience a deep state of sleep.

Once the induction procedure had been administered by an investigator (who was unaware of the IQ of the child) the child was asked to see if they could move a finger that felt "different or funny" as a test of hypnotic susceptibility. A measure of hypnotic depth was then taken with each child being asked to estimate how deep a state of sleep they were in (on a scale ranging from 0 (not at all) to 10 (the deepest state of sleep they had ever been in before)).

Sternlicht and Wanderer found that 60% of the participants were hypnotisable and that the mean self-rated hypnotic depth was approximately 7. Hypnotic depth was not found to be significantly negatively correlated to chronological age (although the findings were in the right direction) but the correlation between IQ and hypnotic depth was found to reach significance at the one percent level. They concluded that the classical position that relatively cognitively impaired persons are not hypnotically susceptible was without foundation and that, within narrow ranges at least, hypnotic depth potentials seemed to be related to intelligence.

The Use of Clinical Hypnosis in Assessment and Therapy in People with Learning Disabilities

The first case studies reporting the use of clinical hypnosis in therapy with people with learning disabilities are those by McCord (1955, 1956a, 1956b, 1956c). However, although some successful examples are reported it is difficult to reach any more general
conclusions as to their efficacy since the number of studies is so limited.

As part of a larger study, (Woody and Herr 1965, 1966), Woody and Herr (1967) conducted a survey amongst American clinical psychologists on their opinions and practices regarding the use of clinical hypnosis with people with learning disabilities. 102 psychologists participated, from whom 84 returned usable data. The mean reply to the question "Do you believe that hypnosis is applicable to counselling the mentally retarded?" was "Uncertain" whilst in reply to the second question "Have you ever used hypnosis with a mentally retarded person?" 78% replied that they had not.

The uncertainty of respondents together with the small number actually using clinical hypnosis does not provide us with either applied clinical or research evidence as to the efficacy or otherwise of clinical hypnosis with people with learning disabilities although another contemporary survey (Woody and Billy, 1966) found that psychologists interested in learning disabilities generally believed that people with learning disabilities can and do benefit from both counselling and psychotherapy.

A very small number of other studies can be located in the literature.

Secter and Gelberd (1964) reported the successful use of hypnosis in dentistry in an uncontrolled study with cerebral palsied children with mild learning disabilities. 8 of 12 children seen for two 2-hour sessions were hypnotisable and it was also reported that the children
who participated "showed improved muscular control over their extremities, as well as an increased range of motion that was not obtainable in the formal physical therapy treatments" (Secter and Gelberd, 1964, p. 265).

Illovsky and Fredman (1976), in another uncontrolled study, used eye-fixation and tape-recorded hypnotic induction followed by suggestions of relaxation, coping with emotional problems and suggestions regarding modification of attitudes towards learning. 48 hyperactive children described as having learning disabilities (but in fact of either borderline or below average cognitive ability) were given fifty five 15-minute sessions of tape-recorded hypnotic suggestion. The number of sessions attended varied from 2 to 49 with the median being 28. 45 of the 48 children were later found to show improvements in at least one of the following areas of teacher-rated behaviour: attention span, desire to learn, following directions, reading ability, restlessness and self-confidence. 20 of the children were found to have relaxed on at least half of the sessions attended and these children were also found to show a significantly greater increase in attention span than the 28 who relaxed on less than half the sessions attended. Although the authors acknowledge the possibility of response bias and expectancy effects, they conclude that hypnosis can successfully be offered to learning disabled primary school children and that teachers will rate such an intervention as being successful.

Lazar (1977), in a single-case study, describes the case of a 12-year-old boy with mild learning disabilities and moderately severe cerebral palsy whose presenting problem was no functional use of the
right hand. The boy was seen for nine sessions over a 2½-month period with some further follow-up sessions after a 7½-week break. Hypnotic imagery of watching an imaginary football game on television was used together with verbal suggestions of relaxation and comfort. By the ninth session the boy was able to flex and extend his right wrist without support, to move his right hand laterally with support, to extend his fingers and to strike, grasp and release a soft spongy ball. Following the ninth session the boy shook hands with his teacher every morning using his right hand. In further follow-up sessions the boy progressed to being able to put his right arm into a coat sleeve and his handwriting improved through being able to steady the paper using his right hand. Lazar concludes that there are strong indications that hypnosis is an effective intervention for use with cerebral palsied clients but admits the need for systematic evaluations of interventions with a large number of participants.

All of the above studies have a number of particular methodological shortcomings as the last author has freely admitted. In the instance of the single case studies (McCord, 1955, 1956a, 1956b, 1956c and Lazar, 1977) there is no evidence of the use of accepted single case design methodology such as the use of either alternating (ABAB) or reversal (ABBA) single baseline or multiple baseline designs and in the group studies (Secter and Gelberd, 1964; Illovsky and Fredman, 1976) there was no use of either alternative treatment or no treatment control groups to control for attention, expectancy, placebo, practice or response bias effects. As such it is difficult to form any definite conclusions about the efficacy or otherwise of interventions which have employed the use of hypnotic techniques as therapeutic adjuncts.
Summary and Conclusions

This necessarily brief review commenced with a consideration of the problem of finding a satisfactory definition of hypnosis, together with the two related key concepts of suggestibility and susceptibility to hypnosis. The few studies that have examined suggestibility and hypnotic susceptibility in people with learning disabilities were then summarised. In the last section the small number of studies which can be found in the literature which reported the use of hypnosis as a therapeutic adjunct with people with learning disabilities were reviewed.

Apart from attempting to clarify the general uncertainty and confusion concerning the definition and nature of hypnosis, this paper has sought to make a distinction between the two related, but often confused, concepts of suggestibility and hypnotic susceptibility. Whilst the limited data on the extent of suggestibility of people with learning disabilities are somewhat equivocal there is considerable evidence that people with learning disabilities are susceptible to hypnotic procedures. This casts some doubt on the classical view that intellectual impairment is incompatible with hypnotisability.

This being the case, however, it is surprising, not to say disappointing, that more cases which have used hypnotic techniques as adjuncts to assessment and/or therapy with people with learning disabilities could not be located, despite an extensive literature search. Indeed, no studies at all were found which employed hypnosis as an aid to assessment. Furthermore, those that reported on the use
of hypnotic procedures as therapeutic adjuncts either lacked methodological rigour or, in the case of group studies, lacked adequate and/or appropriate control groups.

The absence of studies is possibly not solely confined to a learning disabled client population, however, but probably reflects a more general ambivalence in the clinical psychology and related professions to the utilisation of hypnosis or hypnotic procedures as therapeutic techniques. The roots of this ambivalence are various but most probably derive from an underlying ignorance on the subject which in turn gives rise to a number of misconceptions or false assumptions. If this is the case, some way of remedying the current situation might be to incorporate more teaching on the subject into training courses and to establish more research projects into the use, mode of operation, phenomenology and effectiveness of hypnotic techniques.

Until this has been done and until a number of further studies have been conducted into the use of clinical hypnosis as an adjunct to assessment and therapy with people with learning disabilities, however, any interim conclusions that can be drawn regarding the efficacy of hypnosis with this client group must necessarily be extremely limited.
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CURRENT ISSUES IN DEFINING, DETERMINING AND ASSESSING LEGAL INCAPACITY IN PEOPLE WITH LEARNING DISABILITIES

Introduction

In 1991 the Law Commission began a consultation process (The Law Commission, 1991) before recommending changes in legislation to provide a legal framework with which to deal with issues pertaining to mental incapacity and competence. The proposed changes would fill a void in the law which up until now has impeded those who advocate for people with learning disabilities together with those with serious neurological damage and, the biggest class, those with declining abilities as a consequence of dementia. The proposed changes would also incorporate safeguards to protect the mentally incapable from abuse, exploitation and neglect (Dyer, 1993a). The various consultation papers which followed dealt separately with the issues of decision making, competence and consent to medical treatment and with the public law protection of mentally incapacitated and other vulnerable adults.

This review will consider the definitions of incapacity as applied to the above areas and the mechanisms currently used to assess incapacity and competence with special reference to people with learning disabilities. It will conclude by considering the development of instruments which might assist clinical psychologists.
in giving advice on the determination and assessment of incapacity and competence.

Definitions

In a consultation paper specifically on the issue of decision making (The Law Commission, 1993a) it is stated that mental incapacity is a legal concept rather than a psychological or medical one. Incapacity may arise from a variety of conditions and might apply in situations varying from, for instance, voting in an election to making a legally binding contract which, for example, might result in the disposal of a valuable asset.

An important initial distinction must be made between those who are incompetent i.e. mentally incapable of taking decisions, those who are vulnerable i.e. although having the mental capacity to make decisions, not being able to do anything to implement them and those who although they have the capacity to make decisions and the ability to make them are still not necessarily able to make very good decisions (The Law Society's Mental Health Sub-Committee, 1989).

The common law test of incapacity is that a person should be unable to comprehend in broad terms the nature and likely effect of the actions that they are taking. Thus, with regard to financial affairs, in order to demonstrate incapacity a person should not only be incapable of managing their property and affairs but should be so incapable by reason of their disorder.
Therefore, in certain instances the route to incapacity is via the concept of mental disorder, which is again a specifically legal concept rather than a psychological or medical one. In the Mental Health Act 1983 (HMSO, 1983a) mental disorder is defined, in Section 1.2, as meaning: "mental illness, arrested or incomplete development of mind, psychopathic disorder and any other disorder or disability of mind" with Section 1.3 adding that the definition of mental disorder provides that "a person cannot be found to suffer from mental disorder by reason only of promiscuity or other immoral conduct, sexual deviancy or dependence on alcohol or drugs".

However, the use of mental disorder as a route to incapacity is problematic, not only because mental disorder can be used as a gateway for some tests of incapacity but not others but also because interpretations of mental disorder as a concept can, on occasions, vary widely (Ashton, 1994). It was for this reason that The British Psychological Society (1991) produced a report seeking to provide operational criteria for the ascertainment of mental impairment and severe mental impairment.

A related issue is the route whereby incapacity is identified on the basis of the status or category of the person. This is clearly inappropriate for a number of reasons: there are differing degrees of competence within any one group; capacity may fluctuate over time; and no category (with the exception of unconsciousness) corresponds totally with actual incapacity (The Law Society's Mental Health Sub-Committee, 1989).
Decision-making

The current approach to identifying incapacity with regard to decision-making focuses on a person's actual functioning in making a particular decision taking into consideration their choice and underlying values. Thus, in relation to healthcare decisions:

"incapacity should be found to exist only when people lack the capacity to make decisions that promote their own well-being in conformity with their own previously expressed values and preferences".

(President's Committee for the Study of Ethical Problems in Medicine, 1982).

The Law Commission (1993a) therefore recommended that unless the person concerned falls within a listed exception any new jurisdiction on incapacity should be available to persons over the age of sixteen meeting either of the following criteria:

1. (a) suffering from mental disorder within the meaning of the Mental Health Act (1983) and (b) either (i) unable to understand an explanation in broad terms and simple language of the basic information relevant to taking the decision in question including information about the reasonable foreseeable consequences of taking or not taking it or to retain the information for long enough to take an effective decision, or (ii) unable by reason of their disorder to make a true choice in relation to that decision.
2. They are unable to communicate the decision in question to others
who have made reasonable efforts to understand it."
(The Law Commission, 1993a, p. 36).

In their response to the above, the Law Society's Mental Health Sub-Committee (Law Society, 1993) suggested that the definition of legal incapacity was not wide enough and should be extended beyond Section 1(2) of the Mental Health Act (1983) to include brain conditions and other conditions such as profound amnesic syndrome.

**Competence and consent to medical intervention**

As Bicknell (1989) observes, the gaining of consent for a medical procedure from an adult with learning disabilities living in the community is a complex issue. The present state of the law is that no one, except the adults themselves, is able to give valid consent, whatever the degree of disability or legal competence (Dyer, 1987) and a similar position applies to others mentally incapacitated through unconsciousness, dementia, and mental illness (Dyer, 1993b).

In the United States, however, the duty of caring for similar people who cannot make decisions concerning their own affairs by reason of mental incompetence belongs to the courts who delegate it to court appointed guardians (Downes, 1992).

The Law Commission have now held further consultations similar to those previously held on the issue of decision-making with regard to competence and consent to medical intervention (The Law Commission, 1993b). The current legal position is that of the appeal judge, Lord Brandon, in his judgment on the case of Re: F, (Brandon, 1990),
namely that the test of the capacity to consent is whether or not the person is able to understand the nature or purpose of an operation or other intervention.

The legal test of capacity used in the Mental Health Act, 1983 (HMSO, 1983a) goes somewhat further in that the test of competence to consent to medical treatment is whether or not the person is capable of understanding the nature, purpose and likely effects of the intervention.

As in the previous consultation paper on decision-making, where the Law Commission concluded by proposing that a threshold of mental disorder should be included in the test for incapacity unless there was an inability to communicate, the Law Commission proposed, with regard to consent to medical intervention, that "a person should not be regarded as being incapacitated unless it is established that he or she is suffering from a mental disorder as defined in Section 1 of the Mental Health Act, 1983." (The Law Commission, 1993b, p. 14).

Taking into account the Mental Health Act Code of Practice, 1983 (HMSO, 1983b) where, in order to be considered to have capacity, "an individual must be able to understand what medical treatment is and that somebody has said that they need it and why treatment is being proposed; understand in broad terms the nature of the proposed treatment; understand the principal benefits and risks and understand what the consequences would be of not receiving the proposed treatment" (The Law Commission, 1993b, p. 15), the Law Commission further proposed that: "a mentally disordered person should be considered unable to take the medical treatment decision in question.
if he or she is unable to understand an explanation in broad terms and simple language of the basic information relevant to taking it including information about reasonably foreseeable consequences of failing to take it or being unable to retain the information for long enough to take an effective decision." (The Law Commission, 1993b, p. 16).

The Commission invited comments on whether or not it is necessary to specify that the fact that the decision may differ from that which might be taken by an ordinary prudent person is not, in itself, a sufficient basis for a finding of incapacity (Lancet, 1993). Alves, one of the two authors of The British Psychological Society's (1991) report referred to above, has commented on the unacceptability of using the outcome of decisions as a criterion for determining whether incapacity is present (personal communication), although this might at first sight appear to be the very basis on which to judge capacity.

The Law Commission also proposed that: "a mentally disordered person should be considered unable to take the medical treatment decision in question if he or she can understand the information relevant to taking the decision but is unable because of their mental disorder to make a true choice in relation to it." (The Law Commission, 1993b, p.21).

Lastly, they proposed that: "a person, whether or not suffering from a mental disorder should be considered unable to take the medical treatment decision in question if he or she is unable to communicate
their decision to others who have made reasonable attempts to understand it". (The Law Commission, 1993b, p. 22).

It is also proposed that where there is doubt about a person's capacity a new judicial forum should be set up to take decisions on difficult cases.

In addition to all of the above the Law Commission further proposed a series of special categories whereby "there should be a special category of steps requiring the approval of a judicial forum before decisions are taken in relation to an incapacitated person except where such a step is essential to prevent the immediate risk of serious harm, the proposed special categories being: sterilisation operations for purposes of contraception or menstrual management; operations to allow for the donation of non-regenerative tissue or bone marrow; withdrawal of nutrition or hydration necessary for the continuation of life". (The Law Commission, 1993b, p. 36).

Similar provisions to these have now recently been instituted in Australia where sterilisation operations on minors with learning disabilities can now not be performed without the prior sanction of the family court (Mair, 1992).

Finally, it has been proposed that non-therapeutic research or experimentation should not be lawful on an incapacitated participant unless "The research is into mental disorder or other incapacitating conditions suffered by the participant; the research entails only an insubstantial foreseeable risk to the participant's physical or mental health; the research has been approved by the appropriate
local research ethics committee; the agreement of the medical treatment proxy, attorney or nearest relative has been sought; before seeking such agreement the purpose of the research procedures to be used and the foreseeable risks to the participant have been explained and the participant does not object to participation and has made no contradictory decision relating to such participation".

Public law protection for mentally incapacitated and other vulnerable adults

With regards to a definition of vulnerability, the Law Commission proposed that "a person is vulnerable if by reason of old age, infirmity or disability (including mental disorder within the meaning of the Mental Health Act 1983) he is unable to take care of himself or protect himself from others".

They further proposed that public law protection should be available to incapacitated, mentally disordered or vulnerable persons aged 16 or over (The Law Commission, 1993c) and made specific proposals for social services departments to be given clearer and more appropriate powers. However, in many parts of the Law Commission's proposals it has been observed that the language and terminology is reminiscent of that used in the Children Act thus raising concerns that incapacitated and vulnerable adults might themselves be treated like children. A presumption of capacity is therefore being strongly advocated by a number of concerned parties (Marchant, 1993).
Assessment of Incapacity.

In making assessments of incapacity, a presumption of capacity is generally made in the absence of contradictory evidence with incapacity being assessed by the degree of disability and the effect of this on the decision in question. Generally, lawyers seek advice on this question from medical practitioners but their evidence may not always be relevant and that of a psychologist, teacher, nurse or carer might be of equal or greater significance. Ashton (1994) suggests that lawyers should form their view based on all available evidence with the final decision on incapacity being made by a judge, having taken into account all available advice.

The task of determining capacity to give valid consent to medical intervention, however, is currently the personal responsibility of the medical practitioner who is proposing to administer the intervention. The determination of capacity should take into account the principles outlined in the Mental Health Act Code of Practice (HMSO, 1983b) but should also allow for the fact that, in some cases, capacity may vary over time. Additionally, every assessment of capacity should be made in relation to a particular proposal for medical intervention.

Letts (1992) describes how medical practitioners generally make assessments of capacity in conversation with the client but that, taking into account confidentiality issues, it would seem prudent that medical practitioners should also consult relatives, carers, friends and health professionals, including psychologists. Letts points out that only information necessary to the client's own
interests should be divulged, that all assessments of capacity should be fully recorded in clinical notes and that intervention can only proceed once the practitioner has determined that the client is capable of giving valid consent.

It is very clear from the above that not only are the definitions of legal incapacity themselves extremely vague but also that the procedures currently being used to assess capacity seem not only inadequate but also lacking in methodological rigour. Indeed, although it is the task of the medical practitioner to evaluate mental incapacity there appears to be no discernible training in this activity nor are there any published studies on the reliability and validity of such evaluations. For all of the preceding reasons, therefore, clinical psychologists, amongst others, have a clear role in assisting, or advising on, the determination of capacity and competence as has been advised by The British Psychological Society (1991).

Surprisingly, however, the literature on this subject is extremely sparse and there are very few recent papers that have a direct bearing on the question. Murphy and Clare (1995) have very recently reviewed the sources of 'supplemental data with which to assist courts in addressing causal, predictive and remediation questions about ... functional abilities' (Grisso, 1986) but only cite one specific measure directly concerning the evaluation of functional capacity in people with learning disabilities, namely that developed by Morris, Niederbuhl and Mahr (1993), which is described in more detail below. Similarly, when Tustin and Bond (1991) reviewed the relevant literature, they found only one paper reporting a
professional assessment of capacity in respect of decision making in a person with learning disabilities (Shapiro and Sheridan, 1985).

In Australia, as in the United Kingdom, there is a legal principle that, with regard to medical intervention, adults have the right to decide what happens to their own bodies unless this has been taken away by an appropriate legal authority. Any decisions about proposed medical intervention have to be made on the basis of informed consent and competence, a key issue, is difficult to define. Legislation introduced in certain Australian states therefore assigns the responsibility for assessing ability to consent to a Guardianship Board.

Since one particular state, South Australia, had adopted a definition of valid consent (similar to that proposed by the Law Commission) that emphasises the concepts of actions and consequences, Tustin and Bond (1991) considered that, since these concepts are also used by psychologists when examining decision-making, it would be possible to analyse the legal concept of capacity to give informed consent in a manner which has relevance to the work of other professionals working with people with learning disabilities.

They therefore compared the opinions given by the Guardianship Board on a random sample of 194 people with mild learning disabilities with six other measures: a consent questionnaire administered to the clients, biographical information, the assessments of residential managers, scores on a measure of adaptive behaviour, the Adaptive Functioning Index (Marlett, 1971), living situation and the assessment of medical and dental officers.
The consent questionnaire administered to clients was based on the legal definition of the ability to give informed consent based upon the concepts of alternative actions and their foreseeable consequences. The questionnaire concerned medical and dental interventions and contained seven questions about the reason for intervention, nature of intervention, cooperative responses required from the client, consequences and side effects of intervention, the existence of alternatives and the ability to choose by giving or withholding permission. Test-retest and inter-rater reliability data were both found to be satisfactory. Using a variety of measures, the consent questionnaire was found to be the single best predictor of assessments made by the Guardianship Board.

The other study in this area is that of Morris, Niederbuhl and Mahr (1993). They developed an instrument that assessed three legal criteria described by Grisso (1986) that must be considered when giving informed consent: knowledge (understanding the facts relevant to the decision to be made); cognitive ability (the ability to evaluate the risks and benefits of proposed and alternative interventions) and voluntariness (the ability to make a decision voluntarily without coercion or other undue influence).

Using vignettes based on those used by Weithorn and Campbell (1982), Morris et. al. (1993) developed protocols, structured interviews and standardised scoring procedures designed to assess: comprehension of the nature of the presenting problem and the nature of the proposed intervention; evaluation of risks and benefits of proposed and alternative interventions; comprehension of involvement in, and rights and options pertaining to, the decision making process and the
ability to express a clear rationalised decision. Inter-rater reliability coefficients were satisfactory.

Morris et. al's study produced two key findings: it clearly demonstrated a direct relationship between a determination of capacity to give informed consent and degree of intellectual disability but also showed that the area in which the majority of people with learning disabilities experience most difficulties is that concerning their legal rights and options, explaining this second finding in terms of learned helplessness theory (Abramson, Seligman and Teasdale, 1978) in that many people with learning disabilities are often not given much choice over what happens to them and complying with the proposals of their caregivers becomes a way of life.

Although these are the only papers in the area to date, taken together, the above three studies demonstrate the utility of assessment protocols in determining the capacity to give informed consent by people with learning disabilities.

**Summary and Conclusions**

The current literature on competence and mental capacity abounds with definitions and approaches to assessment that are legalistic, rather than psychological or medical in nature. At present, decisions about capacity are generally made, often only on the basis of an informal model of adequate decision-making, either by medical practitioners or by judges although the Law Commission has recently recommended the creation of a new judiciary, similar to those in existence in other
parts of the world, to advise on questions of determination of capacity.

Increasingly, however, the value of professional advice and opinions from psychologists and others is now being recognised although there remains a paucity of standardised assessment instruments to assist in the determination of mental capacity. The development of assessment protocols such as those described above for use with people with learning disabilities has a number of advantages. In addition to having standardised instruments to guide our assessments of capability, professionals can use the results to document the justification for their recommendations and to communicate the bases of their recommendations to others.

Of course, the criteria used in such instruments must carefully balance the risks of infringing the rights of people with learning disabilities to make informed decisions with the risks of incorrectly assessing a level of self-determination that may expose our clients, to whom we have a duty of care, to unnecessary harm. Further research into a number of different aspects of the use of such assessment instruments is therefore required including further work on reliability and validity such as correlation with other widely used measures of cognitive function, reasoning ability and adaptive behaviour and comparisons with the opinions of other professionals.

Nevertheless, the move towards the development of formalised procedures and instruments to assist psychologists in advising our legal and medical colleagues on the determination of competence and
capacity is a welcome one. It is hoped that there will be an expanding literature on this subject area in the forthcoming future.
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Section Three

CLINICAL DOSSIER
THE NORTH ESSEX ASSESSMENT

RE-EVALUATION AND RELOCATION

(NEARER)

PROJECT

1995

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NORTH ESSEX HEALTH AUTHORITY /
ESSEX SOCIAL SERVICES
RE-ASSESSMENT TEAM

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Services for People with Learning Disabilities and Challenging Behaviours living in Mid-Essex and North-East Essex. A Proposed Infrastructure.
THE NORTH ESSEX HEALTH AUTHORITY /
ESSEX SOCIAL SERVICES ASSESSMENT,
RE-EVALUATION AND RELOCATION
<NEARER> PROJECT

THE PROJECT LIFE-CYCLE

The Initial Conference

In November 1994, North Essex Health Authority (NEHA) and Essex Social Services (ESS), together with local Providers, convened a one day conference entitled "Developing Local Services for People with Learning Disabilities and Challenging Behaviour".

The purpose of the conference was threefold:

- To examine the capacity of local services for people with learning disabilities in North (North-East, Mid- and West) Essex to provide services for those with challenging behaviour;

- To challenge beliefs and values as to the accepted ways of treating those clients;

- To explore (bearing in mind the recommendations of the Mansell Report (Mansell, 1992)) new models of local services with which to move into the 21st Century.
The conference was chaired by Ms Chris Lovell (Clinical Psychologist, Service Development Manager, Learning Disability Services, Gwent Community NHS Trust) and was addressed by Judith Lavender (General Manager, Community Care, North Essex Health Authority), Professor Jim Mansell (Tizard Centre, University of Kent at Canterbury), Craig McNulty (MIETS Unit, Bethlem and Maudsley NHS Trust) and Raghu Raghavan (Crisis Prevention Assessment and Treatment Team, Oxfordshire Learning Disability NHS Trust).

In addition, the conference divided into work groups to address two main issues:

- To explore local priorities and concerns in meeting the needs of those with challenging behaviour.
- To try to identify the key elements of an effective local action plan for services for challenging behaviour in North Essex.

Conference Decisions

The conference agreed on a number of initiatives:

- Identification of agency roles and responsibilities
- An audit of present services
- An improvement in inter-agency collaboration
- Joint strategic planning and working to develop a seamless service
- Joint commissioning of future services including community teams and the development of a multi-skilled Outreach Team
- A joint education, training and support strategy building on
existing skills
- An initiative to conduct a needs-led assessment of current out-of-county placements
- A decision to move, subject to re-assessment, current extra-contractual referrals back in county and to cease initiating further out-of-county placements as soon as possible
- The development of a range and choice of appropriate and individualised, accessible, flexible and adequately resourced living, respite and day units.

In summary, the above amounted to a clear action agenda for joint planning and commissioning of services (Gormley, 1995).

The Strategy Paper

Prior to the conference, and at the request of my managers, the strategy paper "Services for people with learning disabilities and challenging behaviours - towards a needs-led strategy" (Hacker Hughes, 1994) was written. This document was subsequently revised (Hacker Hughes, 1995 - attached) as part of a later submission to North Essex Health Authority. The original document, however, contributed in part to the formulation of New Possibilities NHS Trust's (NPT) preliminary strategy paper "Principles surrounding the provision of outreach intensive support services by the specialist services health care team" (Gerrie, 1995) which in turn has led to a successful bid to NEHA for the funding of a Challenging Behaviours Outreach Team and some assessment/intervention beds. At the time of writing, a manager has now been appointed to lead the outreach team and following recruitment of the remaining members it is envisaged that the new team
will commence pilot operation across the Mid- and North-East Essex area with effect from October 1995.

The NEARER Project

A second initiative was to convene a team of professionals to re-assess, with a view to relocation, all North Essex clients with learning disabilities and challenging behaviours who had been either funded solely by NEHA or jointly by NEHA and ESS and placed in out-of-county placements specifically on account of their posing challenging behaviours which could not be met by existing local resources.

It was later decided that this initiative should be called the North Essex Assessment Re Evaluation and Relocation Project with the appropriately titled acronym, NEARER.

Composition of the NEARER Project Team and Steering Group

An initial meeting of the team and steering group was called on February 27 1995.

The Project Team consisted of four health and social work professionals: an Occupational Therapist (Sanju Baveja, Essex and Herts NHS Trust (E&H)), a Chartered Clinical Psychologist (Jamie Hacker Hughes, NPT), a Social Worker (Carol Martin, ESS) and a Community Learning Disabilities Nurse (Ken Smith, NPT).

The Project Steering Group comprised of the Health Authority Deputy Health Commissioner for Learning Disabilities (Jim Gormley, NEHA),
the two relevant service managers (Faye Gerrie, Director of Specialist Support, NPT and Cate Hartigan, Locality General Manager, Uttlesford, E&H) from the two relevant NHS Trusts involved and a social services learning disabilities team leader (Peter Carrington, ESS).

The Mandate

The purpose of the initial meeting was to clarify the objectives of the project and the roles and structures of the project team and project steering group, to identify the resources allocated to the project and to agree the working methods of the project group (to include collation of existing information on existing clients and communication with existing networks around the selected clients).

The Time Scale

It was agreed with the project sponsors (the senior management teams of all involved agencies in Health and Social Services) that the assessment of 11 selected clients was to be completed by the end of June 1995, that the summary of needs of the total group would be completed by mid July 1995 and that a presentation of individual needs, common needs, lessons learned and the options for a service development to meet the identified needs would be made to the sponsors in early September 1995.

Initial Planning

The project team met again on 13 March to share initial resumés of the 11 clients identified for re-assessment. The individual members of the
The project team had prepared these from readily available NEHA, NPT, E & H and ESS files following the initial meeting on 27 February. The methodology for initial assessment was then discussed. After much discussion it was decided to adopt the Essex Community Care Services Procedures as the basis of assessment.

The Assessment Format

It was agreed that all the elements of the Essex Community Care Assessment Form (COM3), the Specialist Addition for Assessment of People with Learning Disabilities (COM3C), the Occupational Therapy Report Form (COM3E), the Functional Assessment Form (COM3H), Consumer Needs Dictionary (COM3J), and Community Care Review Form (COM8) (all Essex County Council Social Services Department, 1994) should be amalgamated to form a thoroughly comprehensive assessment tool.

This instrument could then be used:

- to gather and record basic demographic data
- to formulate a multidimensional history
- to assess current levels of physical and mental health
- to assess psychological, occupational and social levels of function
- to document current management approaches (social, pharmacological and behavioural)
- to assess the quality of the environment, facilities, structure, and level of skill provided in the current out-of-county placement
- to obtain the views of all key stakeholders (including the client and their relatives, all relevant professionals and the management and staff of the current placement)
- to evaluate individual care packages and to assess progress made since placement, recording all strengths and weaknesses of the current placement
- to record and document all unmet needs in, and all risks posed by, the current placement
- to form the basis for a recommended package of future care (short term and long term) based on individual need.

In this way the important issues highlighted in the King's Fund's report on the evaluation of challenging behaviour services (Emerson, Cambridge and Harris, 1991) would also be adequately addressed. Also, this format of assessment instrument enabled the assessment to be 'opportunity-based' rather than 'readiness-' or 'suitability-based' (Seed and Kaye, 1994) and thus allow truly needs-based assessment which would lead to more accurate specifications as to the type and range of future service infrastructure required.

The resulting existing list obtained by amalgamating the items from the four instruments (and eliminating the many duplications) was then put into numerical order to ensure uniformity across the project team when collating information with the aim of seeking to facilitate future discussions and presentations.
The completed instrument (PRISM) was as follows:

The Person-Centred and Placement-Based Review and Re-Assessment of Individual Needs, Service Delivery and Management Structures (PRISM)

1. Description of placement (staffing levels, physical environment).
2. Social history (family background, significant relationships).
3. Medical history (diagnosis and medication).
4. Psychological history (level of social and behavioural functioning).
5. Care plans (basic care (dental, chiropody, hair care, optician etc), day care, social skills, support networks, benefits, community integration).
6. Information regarding services from other professionals and agencies.
7. Degree of contentment with current placement (including progress since admission, individual's view, social worker's view, consultant's view, GP's view, other professionals' view, residential staff view, parents' view).
8. Long term plan (goals, future aims/objectives, review process).
10. Unmet needs (from consumer needs dictionary).
Initial Assessments

From the assimilated list the team agreed which sections of PRISM could be addressed and formulated prior to a visit, on the basis of a more extensive search of the four existing sets of files (NEHA, ESS, E&H and NPT). All additional information required would be collected by two members of the team carrying out at least one, and more commonly two, visits to the placement in order to ascertain the remaining required information.

In essence each team member would be responsible for coordinating a number, generally three, of assessments and would be joined in each of these individual assessments by a different member of the team. In this way the assessment process would be maximally multidisciplinary and multiprofessional and it was hoped that the likelihood of an objective overall perspective being achieved would thus be increased.

It was agreed that allocations for visits would be finalised at the next meeting and this duly took place on 30 March. Between 30 March and 12 June the assessment process continued with initial visits being made to each of the 11 placements.

Results of Initial Assessments

When the project team next met on 12 June to discuss initial findings it was agreed that team members had found it particularly helpful that two members had completed each reassessment because of the wider perspective that this approach offered. The team also discussed a
number of similarities that had been initially observed across several placements, these being as follows:

- Lack of quality reviews
- Little or no staff awareness of quality assurance procedures
- No evidence of local authority inspection reports in some placements
- Lack of the use of care plans
- Limited staff training, particularly external courses
- General lack of formally trained staff
- Poor quality day care
- Little evidence of the use of advocacy services
- Limited recording of information
- Absence of adequate operational policies
- Little positive identification of long term goals.

In addition concerns were expressed that:

- some clients remained in a placement simply because there was no facility for move-on
- in a number of placements, gardens and farms were worked "therapeutically" by clients with little gain to the individual client but with at least some gain to the establishment involved.

**Subsequent Assessment**

The project team agreed the schedule of remaining visits and also arranged a schedule of meetings to occur throughout July at which the results of reassessment of each client would be presented to the remainder of the team by the assessment coordinator and then discussed
in detail by the whole project team. This would then allow a comprehensive multi-professional formulation which in turn could facilitate joint decision making as to the specific recommendations on the care packages required in preparation for final preparation.

When the project team and steering group next met on 29 June they discussed the initial reports of the first and subsequent visits, finalised arrangements for review meetings throughout July and August, discussed relevant quality issues and reports of other services visited and highlighted all common elements identified from the assessments.

**Framing the Report**

The format of the formal report of the project to the sponsors was then discussed, as was the business case to be made for new service developments. It was suggested that the history of the clients prior to placement offered valuable lessons as to what had gone wrong with local service provision in the past and shed light as to how local services could be improved in the future. In addition the quality of individual placements needed to be addressed and, in particular, the question of whether or not they met the needs of the individual clients.

A number of general issues needed to be addressed here, including staff training, quality assurance and monitoring as well as the question of specialist input. Finally, it was agreed that the mechanisms for ongoing local (North Essex) review and liaison should
be addressed before finalising short and long-term care packages for each client with, if possible, associated provisional costings.

It was agreed that the team should meet six times in July to present and discuss reports of individual client assessments and to agree recommended short and long-term care packages and that the team and steering group should then meet in early August in order to discuss draft recommendations and again in mid-August to formulate clear recommendations before final presentation of the work of the project to the sponsors in early September.

**Purpose and Structure of Reports**

The format of each individual's final report and a schedule of enclosures was also agreed.

It was agreed that there should be, for each individual, both a full report and a summary.

The complete file of the full report would be held initially by NEHA but would be passed, following completion of PRISM, to the relevant key professional in Health or Social Services in order to initiate an action plan.

The full report would be prefaced by a summary containing, in readily available and easily digestible form, the essential client details together with the key issues arising from and highlighted by PRISM as follows.

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CLIENT REPORT SUMMARY

1. Name
2. Placement Address
   Telephone Number
   Contact(s)
3. Date of Birth
4. Home Address
5. Brief History
6. Level of Functioning
7. Reason for Current Placement
8. Past Service Deficiencies Leading to Current Placement
9. Placement
   a) Brief Description
   b) Stated Philosophy
   c) Operational Policies / Procedures / Quality Assurance
   d) Staffing Levels/Ratio/Training
   e) Care Planning
   f) Communication
   g) Day Services / Advocacy
10. Information re: Services from Other Agencies
11. Cost
12. Review Process
13. Appropriateness
14. Unmet Needs
15. Risks
16. Recommended Care Plans
   a) Short Term
   b) Long Term.
It was also agreed that the format for full reports should be as follows:

**FULL CLIENT REPORT**

1. Name
2. Date of Birth
3. Placement Address
4. Contact(s)
5. Telephone Number
6. Social Worker
7. Psychiatrist and GP
8. Home Address
9. Next of Kin
10. Guardianship
11. MHA Status
13. Description of Placement: (Staffing Levels and Physical Environment)
14. Social History: (Family Background and Significant Relationships)
15. Medical History: (Medical Diagnosis and details of Current Medication)
16. Psychological History:
   (Social and Behavioural Functioning and Current Management Plans)
17. Care Plans (Basic Care, Dental, Chiropody, Hair Care, Optician Day Care, Social Skills, Support Networks, Community Integration)
18. Information regarding Services from other agencies:
   (GP, Psychiatrist, Clinical Psychologist, Other Professionals)
19. Degree of Contentment with Current Placement:
The latter fell into three parts

- Deficits in original service provision leading to initial out of county placements

A number of common themes ran through the majority of case histories. Families felt unsupported and children, and later adults, were often moved frequently as placements found themselves unable to meet their needs.

- Shortcomings in the county's placement review procedures

Concerns that were raised by the Project Team had not been highlighted in previous reviews. Three clients were found to need urgent re-assessment as to the ability of the placement to meet their needs. There was a strong indication that an "out of sight - out of mind" philosophy had been operating. Local staff attending reviews appeared to feel disempowered as there were no local alternatives.

- Deficiencies in current out of area services.

The quality of placements was found to vary enormously with only three clients being appropriately placed. The Project Team expressed concern that there was no incentive to Providers to move clients on.
- Deficits in original service provision:

The following specific deficits were identified:

- Lack of communication and joint working between Education, Health and Social Services both at an early stage and during transition

- Lack of structures and mechanisms for coordination of work undertaken by statutory agencies

- Failure to recognise individuals' needs at an early stage

- Lack of support to families from multiprofessional outreach services

- Lack of adequate multiprofessional assessments

- Lack of local facilities, e.g. no in county medium secure units or appropriate staff expertise

- Inadequate discharge procedures from Mental Health Act sections

- Insufficient local coordination

- Lack of specialist educational services

- Lack of community support.

- Shortcomings in the county's placement review procedures
With regard to current review procedures the following shortcomings were identified:

- Section 117 procedures or DoH Guidelines not always being adhered to

- Reviews were placement led, with placements being allowed to set their own agendas

- Lack of structured agendas

- Lack of clear objectives

- Failure to monitor progress against objectives

- Lack of ability to use contracting mechanisms more clearly to ensure quality of care

- Lack of use of agreed placement review process

- Lack of structure to medical review

- Absence of single health coordinator

- No unannounced visits

- Deficiencies in current out of area services.
Finally, in respect of the quality of current out-of-county placements the following shortcomings were identified:

- Inadequate training and staff development (internal and external)

- Inadequate quality assurance procedures

- Lack of specific objectives and goals for individual clients

- Lack of detailed care programmes and individual programme plans

- Inappropriate placements

- Lack of individualised programmes

- Inadequate mechanisms and structures for local liaison

- Inadequate procedures and operational policies

- Inadequate discharge planning.

**Agreeing the Recommendations**

The meeting then considered the number of people judged to be appropriately placed and for whom there was no strong case for relocation and agreed that 2 clients were appropriately placed with a further client agreed to be appropriately placed for an additional period of a year.
However, when the meeting considered the number of clients who were deemed to be inappropriately placed and who should be reprovided for in North Essex it was considered that 7 clients were inappropriately placed and should be provided for locally. Of these at least one required a medium secure facility, one or two required a further period of assessment and intervention and the remainder required small well resourced residential units. It was considered that the appropriate move for the remaining client would be to a satellite unit of his present unit as he had established a social circle there and had no remaining strong links, family or otherwise, with North Essex.

**Future Service Infrastructure**

Finally the meeting considered the infrastructure of local services required and agreed to adopt the framework outlined in Hacker Hughes (1994, 1995) with minor modifications. It was agreed that some further preparatory work should be commenced on the report before the next meeting on the 14th August at which the final version of the report would be agreed for presentation to the sponsors on 4th September.

**Agreeing the Final Report**

At the 14th August meeting the final content of the NEARER Project report, including final recommendations was agreed, a Chief Executive's Summary was written and the format of the formal presentation of to the project report to the NEARER Project sponsors was discussed and agreed.
Presenting the Final Report

The agreed format for the final presentation of the NEARER Project Report and its findings was as follows.

1. Chief Executives' Summary  Peter Carrington - ESS  (5 mins)
2. The Project Lifecycle  Jamie Hacker Hughes - NPT  (10-15 mins)
3. The Human Dimension  Sanju Baveja - E&H  
   - Three vignettes  Jamie Hacker Hughes - NPT  (15 mins)
   Ken Smith - NPT  
4. Interim Questions  Sponsors (Jim Gormley-NEHA) (10 mins)
5. Lessons Learned  Cate Hartigan - E&H  (5 mins)
6. Proposed Infrastructure  Jamie Hacker Hughes - NPT  (15 mins)
   Faye Gerrie - NPT  
7. Recommended Actions  Jim Gormley - NEHA  (5 mins)
8. Final Questions  Discussion and Close  Jim Gormley - NEHA (Chair) (20 mins)

(TOTAL PRESENTATION TIME - 90 MINUTES)

Finally the Team and Steering Group arranged to individually prepare presentation materials and to convene for final preparations on the morning of 4th September.

The full NEARER Project Report was presented to the sponsors on 4th September following which a working group was established to take the recommendations and proposals forward.
THE NORTH ESSEX ASSESSMENT RE-EVALUATION AND RELOCATION (NEARER) PROJECT

SUMMARY

North Essex has little or no specialist "in-county" service provision for those people with intellectual disabilities whose behaviours or needs challenge service providers.

Approximately 30 clients with challenging behaviours are currently placed in services outside Essex.

The effects of this are threefold:

- Negative impact on the quality of life of these individuals and their families

- Often arbitrary levels and quality of services

- An "out of sight - out of mind" tendency leading to consequent shortcomings in the monitoring and review processes

The 1994 Leez Priory Conference agreed inter alia on an initiative to conduct a needs-led assessment of current out of area placements and this (the NEARER Project) was planned and executed between March and August 1995.
All North Essex clients with learning disabilities and challenging needs who had been funded either solely by Health or jointly by Health and Social Services and who had been placed out of area specifically on account of their challenging behaviour were re-assessed. 11 clients met these criteria.

As a result of the project work, 8 of these 11 clients were found to be placed inappropriately and suitable for relocation to a range of new services which, it is recommended, should now be encouraged and developed within North Essex.

The benefits of such a locally provided range of services would be:

- Accessible services within or near a client's own home community

- Increased control over monies currently being spent out of Essex

- An enhanced skill-base within purchasers and providers in North Essex

- Closer, more efficient and cost-effective monitoring of service provision

The project team and steering group therefore made the following recommendations:
RECOMMENDATIONS

Local investment is required in order to develop a range of services which will enable clients to receive appropriate services within or near their home community.

A review is indicated that should investigate all possible mechanisms for funding.

There needs to be a structure in place which will include detailed mechanisms that will enable and facilitate communication and liaison between statutory bodies.

Contracts must stipulate specific services, plans, objectives and goals that will allow effective monitoring to take place and be carried out.

Any new services provided must be thoroughly vetted before any clients are placed there.

Guidelines should be developed that will create a structured framework on which a comprehensive review process can be based.

A Social Worker and a (non-Medical) Health Care Worker should undertake joint reviews in conjunction with the responsible Consultant Psychiatrist.

The use of unannounced review visits is strongly recommended.
Joint working, cooperation and liaison between agencies should commence in childhood.

The role of the local GP and the Consultant Psychiatrist in prescribing and supervising medication should be reviewed and guidelines issued accordingly.

The recommended infrastructure for future service delivery should be based on a "through-put" model (see below).
It is envisaged that the individual components of the model would be created by a mixture of Health, Social Services and Private and Voluntary Sector initiatives. It is incumbent upon the Chief Executives of all relevant agencies, in consultation with their Senior Management Teams, to create a fertile culture and environment in which these components will rapidly grow into place.

It is imperative that ample resources (financial and otherwise) be dedicated to this initiative. These must ensure a sufficient degree of both structure and flexibility to establish and maintain a comprehensive, efficient and free-flowing service system that will not "silt up".
REFERENCES


1.0 Introduction

1.1 Over the past six or seven years or so, the provision of services for people with learning disabilities and severely challenging behaviours has received increasing amounts of attention. That this is the case derives mainly from the fact that within most health districts the provision of institutional service provision for people with learning disabilities "is rapidly becoming an anachronism" (Emerson, Beasley, Offord and Mansell, 1992). As a result, as the process of resettlement into the community of individuals from formerly large institutions continues, the residue of those institutional populations awaiting resettlement necessarily includes a proportionally ever increasing fraction of people who, in addition to their learning difficulties, exhibit one or more types of challenging behaviour (Kiernan and Moss, 1990). Not only have the claimed advantages and disadvantages of differing models of service provision been thoroughly examined (e.g. Blunden and Allen, 1987) but the operation of supposedly exemplary services has also recently come under the spotlight (e.g. Hoefkens and Allen, 1990).
1.2 This paper will attempt to present, in a succinct and easily digestible fashion a digest culled from the literature of the key facts about challenging behaviours: definitions, contributory causes, and epidemiological factors before discussing the possible models of service provision available and finally, arguing for a strategic initiative that will provide the right models, types and mix of services to meet local needs for the foreseeable future.

2.0 Challenging Behaviour - Definitions

2.1 A number of alternative definitions of challenging behaviour are listed here:

a) Challenging behaviour may be defined as one or more of the following:

"1. behaviour or behavioural severity which is inappropriate given a person's age and level of development;

2. behaviour which is dangerous to the person themself or to others;

3. behaviour which constitutes a significant additional personal handicap either by interfering with the learning of new skills or by excluding the person from important learning opportunities;

4. behaviour which causes significant stress in the lives of those who live and work with the person and which impairs the quality of their lives to an unreasonable degree;
5. behaviour which is contrary to social norms."

(After Zarkowska and Clements, 1988).

b) "A small number of people ...at times exhibit behaviour which is so challenging that services have extreme difficulty in meeting their needs.

The behaviours shown often involve: aggression to others, self injury, destruction of the environment or other distressing or life threatening features which necessitates special provision."

(Blunden and Allen, 1987).

c) "Severe challenging behaviour refers to behaviour of such an intensity, frequency or duration that the physical safety of the person or others is likely to be placed in serious jeopardy, or to behaviour which is likely to seriously limit or delay access to, or the use of, ordinary community facilities".

(Emerson et. al., 1987).

2.2 Thus, in summary, the terms "challenging behaviour" or "severe behaviour disorder" designate a diverse set of behaviours that present severe management problems in ordinary residential settings and which may include irrationally violent or destructive acts (against property, the self or others) and socially offensive behaviours such as, for example: masturbating in public, smearing faeces, or eating potentially dangerous objects. The term is therefore not a psychiatric diagnosis as such but instead is more commonly used as a "catchall"
term which may be used to describe, amongst others, people with learning difficulties who commit offences, but which also includes people with learning disabilities whose disturbed behaviour results from superimposed mental illness.

3.0 What causes Challenging Behaviour?

3.1 A number of varying and very different factors can be said to be involved in this wide and non-homogenous group of problem or disturbed behaviours that are now generally all referred to as challenging behaviours, although the new term "challenging needs" is now also beginning to find its way into common usage.

3.2 Amongst these, however, some of the following main categories can be broadly distinguished:

a) Learned Behaviour: Depending on their previous reinforcement history an intellectually disabled person may have learned that violent antisocial acts may be a very effective means of attracting and retaining the attention of others.

b) Neurological Impairment: A small number of syndromes (including, for example, phenylketonuria (PKU) and Lesch-Nyhan Syndrome) similarly also result in, or rather are associated with, behavioural problems and disorders.

c) Mental Health Problems: In some people with learning disabilities, behaviour disorder may perhaps be an atypical symptom of psychiatric problems that have previously remained undiagnosed
d) Autism: Autism (Kanner syndrome) is the most severe of a number of psychiatric disorders (others including hyperkinetic, conduct and emotional disorders) occurring at an early stage of development in people with learning disabilities and abnormalities of behaviour and emotion.

e) Discomfort or Pain: Violent or antisocial reactions may simply be a means of communicating discomfort, pain or distress.

4.0 What is the prevalence and range of Challenging Behaviour?

4.1 Published studies estimating the prevalence of severe behaviour disorders vary extremely widely with estimates ranging from 7 to 17% in community based accommodation (Kiernan, 1991) to as many as 40-50% in hospital populations especially in those with severe and profound learning disabilities (Wing, 1989). One crude estimate is available from the Wessex survey which suggests that out of 100,000 total population there will be approximately 10 children and 20 adults with severe behaviour problems.

4.2 With regards to autistic syndromes, Wing et. al. (1976) estimates the prevalence of infantile autism in the child population at large to be 0.3 per 1000, whilst a related form, Asperger's syndrome, although commoner and probably exceeding 2 per 1000, is generally less strongly associated with learning disability.

4.3 Detailed epidemiological information specific to a local area, such as North Essex, can only be really obtainable by the establishment of a regularly updated, multiagency special needs case
register. One recent study however, the MIETS evaluation study (Dockrell et. al., 1992), found that on average there were 14.5 adults with mild learning disabilities and challenging behaviours in each district.

4.4 The range of potential recipients of a comprehensive challenging behaviours service might include the following:

a) People with mental health problems and challenging behaviours.

b) People with developmental delay, sensory deficits and/or severe learning disabilities who also display challenging behaviours.

c) People with neurological and behavioural syndromes such as Lesch-Nyhan, PKU or Prader-Willi's syndrome.

d) People of borderline intellectual capacity (generally defined as those with WAIS IQ scores of between 70 and 80) who nonetheless exhibit challenging behaviours.

e) Petty offenders, clients detained for assessment and intervention under sections of the Mental Health Act, 1983 and/or clients requiring forensic support who are currently receiving therapeutic or residential placements "out of area".

5.0 Alternative Models of Service Provision (Mansell, 1992)

5.1 In the past, challenging behaviours services were provided in line with two basic models. Whilst some units have attempted to intervene
with individuals with learning disabilities and challenging behaviours alongside non-disturbed individuals, in others the policy has been to group individuals with behaviour problems into one "special treatment unit".

5.2 Advantages of the "special treatment unit" approach:

a) Provision of a controlled environment

b) Capacity to contain episodes of very challenging behaviour without causing disturbance to others.

c) Particular expertise in assessment of and intervention with challenging behaviours.

d) Adaptation of the environment in order to reduce certain problems otherwise experienced in other settings.

e) A dual role as both intervention and resource centres to which other non-unit staff can turn for help and advice.

5.2 Most, if not all, of these features can, of course, be provided in generic community-based facilities.

5.3 Disadvantages of the "special treatment unit" model:

a) Placing individuals in alternative "special treatment unit" environments makes little sense if clients are subsequently returned to previous settings where little or no attempts have been made to
isolate and modify original causative or maintaining factors. A comprehensive challenging behaviours service should therefore be based around a "throughput" model.

b) Since the aim for all people with learning disabilities should be to be able to live as normal and independent a life as possible one should be aware of the potential difficulties in acceptance or reacceptance into community based facilities once individuals have been associated with "special units".

c) The assembly of individuals displaying very challenging behaviours into one setting contains the inherent danger of presenting inappropriate models of behaviour to other individuals using the same service.

d) Services should beware of the dangers of referring all difficult clients to specialist challenging behaviours services as "an easy option". Also, families and carers will not be helped at all in the long run if specialist units are used for "crisis admissions". A related danger is that if special units become depositories for individuals with extremes of behaviour rather than settings for short-stay intensive interventions, specialist challenging behaviour units run the danger of "silting up".

e) Unless adequately trained, supported and resourced, small segregated units may become professionally isolated, inward-looking and demoralised. This may eventually lead to frequent staff burnout, low morale, and drops in staffing to dangerously low levels.
5.4 In cases where special units appear to work well, therefore, they tend to:

- provide services on a time-limited basis;
- have high staffing levels;
- feature a clear staff commitment to a service plan;
- have clear and well defined routes of ongoing rehabilitation;
- provide an extension of intervention approaches into clients' normal environments.

5.5 Alternative and/or complementary approaches to the above models.

Possible alternative models include the following, not necessarily exhaustive, list (Mansell, 1992):

a) Specialist teams with the primary responsibility of developing new services for people with challenging behaviours.

b) Specialist outreach teams whose primary function is to support people with challenging behaviours in their use of existing local services.

c) The attachment of either or both of the above types of specialist services to Community Learning Disability Teams (CLDTs).

d) Establishing "flying squads" of local staff capable of responding sensitively but effectively to crisis situations in local services.
5.6 The way forward - Ideal service requirements

Ideally, services for people with challenging behaviours in addition to their learning disabilities should be based on the value statements set out in "An Ordinary Life" (Blunden and Allen, 1987), namely:

a) "People with learning disabilities and challenging behaviours have the same human value as anyone else.

b) People with learning disabilities and challenging behaviours have a need and right to live like others in the community.

c) Services should recognise the individuality of people with learning disabilities and challenging behaviours".

d) Furthermore, services should ideally be based on principles aligned with O'Brien's (1987) five service accomplishments of:

i) Community Presence - the right to live and spend time in the community.

ii) Participation - opportunities to mix with other non-disabled people in the course of daily life and to have the opportunity to form valued relationships at home, at work or in education and in community and leisure activities.

iii) Autonomy and Choice - an enhancement of available choices and protection of human rights.
iv) Competence - help to experience a growing ability to perform useful and meaningful activities with whatever assistance is required.

v) Status and Respect - the right to be seen to have and treated with the same status and respect as other valued members of the community".

5.7 General objectives of a comprehensive challenging behaviours service

Services for those with challenging behaviours and learning disabilities should also seek to meet the following specific objectives (Mansell, 1992):

a) To employ the skills of members of different professions, working in co-operation with other agencies, to provide a high quality of assessment, intervention and care for people with learning disabilities and challenging behaviours.

b) To maximise the individual abilities of people with learning disabilities and challenging behaviours and to promote a standard of care that maintains dignity and a full and varied life.

c) To ensure that high levels of services are provided to all recipients, irrespective of race, gender, culture, residence or other characteristics.

d) To provide support for the families and other informal carers of people with learning disabilities and challenging behaviours.
e) To provide interventions in the least restrictive environment possible that is nonetheless compatible with the need to provide appropriate treatment and care for people with a learning disability who suffer from physical or mental ill health.

f) To provide health care services from locations which are accessible to people with learning disabilities and challenging behaviours, and to their families and informal carers.

g) To ensure that people with learning disabilities and challenging behaviours are entitled to the same degree of respect to which all people are entitled.

h) To ensure that information collected about recipients of services for people with learning disabilities and challenging behaviours is not divulged to staff or members not concerned with the provision of intervention with, or care of, the recipient.

5.9 Specific objectives of a comprehensive challenging behaviour service

Services for those with challenging behaviours and learning disabilities should also seek to meet the following specific objectives (Mansell, 1992):

a) Intervention in the home setting, wherever possible, with support being provided for families and primary carers.
b) A rapid response to crises by a well trained, multiprofessional outreach team constituted of an appropriate skill mix and skilled in both assessment and intervention techniques for use with people with both learning disabilities and challenging behaviours, who have access to resources for ongoing research, training and support.

c) Where admission to a resident facility is indicated, this should ideally be made to locally accessible residential units with links to peripatetic community services.

d) In addition to facilities for assessment of, and intervention with, people displaying acute episodes there should also be a suitable and comprehensive range of additional and complementary services such that residential and daycare facilities continue to be made available to those with longer term problems.

e) There should be close liaison and dialogue between members of the above specialist challenging behaviour team and other local learning disability and mental illness teams in order to provide advice and input in the cases of people with dual diagnoses, i.e. those people, often with mild learning disabilities, who also have superimposed mental illness, receiving services from local mental illness services.
6.0 Specific proposals for a comprehensive challenging behaviours service to serve the people of North Essex

6.1 Bearing the above objectives closely in mind let us finally consider how such a service might best be provided in North Essex. It would be my considered recommendation that a comprehensive local service should be based on the following infrastructure:

a) The Overall Model

The essence of the recommended infrastructure is that it should be based on a throughput model. Thus an individual client might be directed, after a period of assessment and intervention, either to the medium secure accommodation or, more commonly to the high-support accommodation. Equally, clients might conceivably be placed directly into either of the above. Following a suitable period the hope would be that clients would move onto less highly staffed (low-support) accommodation (either directly in the case of those in the high-support accommodation or indirectly in the case of those in the medium secure accommodation).
The recommended infrastructure is, therefore, as shown in Fig 1 below:

```
GENERIC SERVICES

ASSESSMENT/INTERVENTION

MEDIUM- AND HIGH-SUPPORT

SERVICES

MEDIUM SECURE FACILITY

LOW-

SUPPORT

ACCOMMODATION

ACCOMMODATION

LONG-TERM MEDIUM SECURE UNIT
```

FIG 1. RECOMMENDED INFRASTRUCTURE
It is envisaged that this model would link into existing services in the following way:

![Diagram](image)

**FIG 2. INTEGRATED MODEL**
b) Assessment and Intervention Services

Short term access should be made available to one or more locally based residential units (with no more than six beds each at most) for short term, highly focused more intensive assessment and intervention (Mansell, 1992).

In most cases admission should be to specialist assessment/intervention units specialising in the assessment of, and intervention with, acutely challenging behaviours in people with learning disabilities.

This could possibly either be located together with general psychiatric services or together with other facilities for people with learning disabilities but could also be situated as a stand-alone unit.

Co-location of this unit/ these units with the outreach team base(s) would seem to be the most sensible option.

Admission times should be strictly time limited and comprehensive and precise discharge plans should be an absolute pre-requisite for admission to avoid this facility/ these facilities "silting up".

It is recommended that there should be at least two, and possibly three, of these units, one for Mid- and North-East Essex and one for West Essex (or, possibly one for each of these former districts).
One viable option that would merit further exploration might be to explore the possibility of developing these units in partnership with another agency, eg St Andrews Northampton, Partnerships in Care or The MIETS Unit.

c) High-Support and Low-Support Accommodation

A range of additional specialised locally situated highly supported housing (in units no larger than four-bedded units), with high ratio 24 hour staffing by care staff trained in the management of severe challenging behaviours would be necessary for the group of clients identified by the joint re-assessment project who could not live either at home or in ordinary supported housing.

This service could also provide respite and very short term assessment facilities in separate or adjacent units.

Any such service should, however, also plan for throughput, with foreseeable timescales, limited admissions, mandatory four month reviews and possible ongoing rehabilitation and resettlement arrangements and options pre-agreed before admission.

This part of the service should have further access to a comprehensive range of less highly staffed or supported (low-support) community based accommodation so that service users might continue to be placed most appropriately.

It is recommended that such a service should be widely distributed through the centres of population of North Essex and either be
provided in conversions of ordinary housing or on a small site providing services for people with learning disabilities but should be in any case based in small community based staffed houses or apartments rather than in large residential homes or centres (Mansell, 1992).

d) Generic Psychiatric Services

In the minority of cases, where the level of intellectual disability is minimal, in situations where local general psychiatric services have been specially trained in the management of people with learning disabilities, and where these personnel are in turn supported by the specialist multiprofessional team, the above role could possibly be alternatively carried out by general acute local psychiatric services.

In North Essex this would call for considerably more liaison and dialogue between the four provider NHS Trusts of specialist learning disabilities, Social Services and the two providers of generic mental health services than exists at the moment.

If this could not be achieved then it is recommended that the providers of specialist learning disability services would have to take the lead, although this would run counter to the current themes of normalisation and social role valorisation that presently influence current models of service provision.
f) Medium Secure and Long Term Medium Secure Facility

Finally, there would be a requirement for a 6-bedded medium secure facility and a 4-bedded long term medium secure facility both of which should have at least peripheral security. These should be staffed with a high ratio of skilled staff, trained in the management of clients with dangerous and offending behaviour. The staff groups should be supported by a multi-professional team and have access to specialist forensic resources for both assessment and intervention purposes.
REFERENCES


CARING FOR THE CARERS:

A CONTROLLED EVALUATION OF A WORKSHOP PROGRAMME FOR HEALTH SERVICE STAFF WORKING IN STRESSFUL CLINICAL SETTINGS

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ABSTRACT

A programme of eight workshops, combining an educational component with a psychodynamically oriented group, was conceived and designed with the aim of reducing the effects of psychological stress on health service staff working in stressful clinical environments. The effectiveness of the programme in reducing levels of burnout and sickness-related absence, and in bringing about changes in coping styles, was evaluated in a controlled study.

Participants in the programme showed a significant improvement in measured levels of one of the three elements of burnout, lack of personal accomplishment, as well as some significant reductions in seeking emotional and instrumental social support and the use of disengagement coping styles. When the participants in this group were compared to those in two control groups (a waiting list control group and an alternative treatment control group) on the above measures, the latter changes in coping styles were found to have occurred in the experimental group only and not in the two other groups.

However, two additional measures, sickness-related absenteeism and the assessed competence of participants in the completion of two scenarios examining the hypothetical application of coping skills, revealed no apparent differences between groups.

The implications of these findings and the utility of this type of programme in bringing about reductions in levels of staff stress, together with the most appropriate types of measures for assessing
such changes, are discussed in the light of findings from this and related research. Suggestions are also made for possible directions for further research in this area.
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DEDICATION AND ACKNOWLEDGEMENTS

This dissertation is dedicated to the memory of my late father.

Thanks are due to: my research supervisor, Ms Suzanne Collins, and Dr Jon Sklar, both of whom originally conceived the great need for, and subsequently conducted the majority of the clinical parts of, the programme; Dr Barbara Sahakian for her initial advice on research design and methodology and Mr Malcolm Adams for his helpful comments on statistical issues. Thanks must also go to all the above for their comments on earlier drafts of this manuscript and to Dr Colin James for his rating of the hypothetical coping scenarios. Last, and most certainly not least, my appreciation must go to the programme participants themselves, not only for their participation in the study but also for their cooperation and continued patience in completing and returning the many questionnaires.
"Every day the nurse confronts stark suffering, grief and death as few other people do. Many nursing tasks are mundane and unrewarding. Many are, by normal standards, distasteful, even disgusting, others are often degrading; some are simply frightening" (Hingley, 1984).

**Stress in the health service**

Many jobs in the health service are, by their very nature, subject to high levels of stress (Spencer, 1986; Harvey, 1992). In a recent survey of 1800 nurses (Cole, 1992), 93 per cent of nurses questioned said that they felt stressed at work, with 26 per cent saying that they felt 'very' stressed. In a similar study of occupational therapists, speech therapists and physiotherapists, Kersner and Stone (1990) found that 82 percent of members of the latter three health professions surveyed also reported feeling stressed. Also Lawes (1992), in a survey of 500 staff from a variety of disciplines working in a learning disabilities unit, found over 50 per cent to be suffering high levels of stress.

Many recent surveys of occupational stress in the health professions (e.g. Cole, 1992; Cull, 1991; Cushway, 1992; Firth, 1986; Firth-Cozens, 1987; Hipwell, Tyler and Wilson, 1989; Lansdown, Pike and Wilson, 1990 and Payne and Firth-Cozens, 1987) cite a variety of potential stressors including: poor and ineffective communication, lack of managerial support, little control of work rate and uncertainty about the future. However, Jacoben (1986) found that emotional stressors rated highest of ten sources of stress perceived
by nurses working in one of many clinically stressful areas, a special care baby unit. Many organisational factors are, of course, also involved (Dawkins, Depp and Selzer, 1985; Jones, Janman, Payne and Rick, 1987) but many health professionals themselves believe that the major stresses are created as a result of lack of support rather than as a result of external factors (Hingley and Harris, 1986). Adley (1987) suggests that although many nurses do turn informally to colleagues, support is felt to be lacking from their managers and teams and the majority of nurses feel inadequate in accessing appropriate levels of support for themselves. Adley reports that, in one survey, 70 per cent of nurses felt that hospitals did not help them with stress related problems. As one of the replies to Cole's (1992) survey stated, "I feel the main problem is a total lack of support for all nurses" (Cole, 1992 p. 26). It is claimed (Orlans, 1986) that the sense of isolation caused by the above lack of support leads to nurses heading the list of members of professions who go to seek psychiatric help.

**Stress and Burnout**

One of the effects of prolonged occupational stress that has received much attention in recent years is that of 'burnout' (Freudenger, 1974). The term burnout is generally now used to describe those suffering from uncontrollable pressure (Hiscox, 1991) who go on to display negative changes in work related attitudes and in behavioural responses to occupational stress (Cherniss, 1980). Burnout may be defined as feelings of physical, emotional and mental exhaustion associated with an intense involvement with recipients of care over a prolonged period of time (Pines and Aronson, 1981). It has also been
described as a maladaptive psychophysiological and behavioural response to the effects of occupational stressors, (Cronin-Stubbs and Rooks, 1985). Bailey (1988) neatly encapsulates the relationship between stress and burnout as "stress as the snapshot, burnout as the movie", with stress being the product at any one particular moment whilst burnout refers to the process that seems to be gradually taking place in chronically stressed individuals with the passage of time (Bailey 1988 p. 346). Cherniss (1980) described a three stage model of burnout with a perceived imbalance between demand and resources leading to not only the more short term effects of anxiety, tension, fatigue, and exhaustion but also the longer term effects of changes in attitude and behaviour manifested as an increased degree of cynicism and detachment.

The experience of burnout may be characterised by physical exhaustion, a lowering of empathic ability, low self esteem and a lowering of attitudes towards work, life and other people generally (Cherniss, 1980 and Pines et al, 1981) and Proctor (1990) is among many who give a moving account of the personal experience of burnout. She describes symptoms including physical and emotional exhaustion, sleep difficulties, diminished concentration, apprehension and irritability, loss of interest, detachment, anger, frustration, isolation and loneliness. Other symptoms in the cluster surrounding the condition are fatalism, callousness, patient victimisation, verbal aggression, cynicism, dehumanisation and emotional impoverishment in relationships (Davidson and Jackson, 1985).

Perhaps more work into the development of the construct of burnout and its subsequent research and investigation has been done by
Maslach (summarised in, for example, Maslach, 1982) than anyone else. Maslach herself describes burnout as a syndrome of emotional exhaustion, depersonalisation and reduced personal accomplishment which is a continuous, rather than a dichotomous, variable.

Maslach and Jackson (1986) have developed an instrument, the Maslach Burnout Inventory, which has since been used in several subsequent studies to investigate the effects of occupational stress on the members of several differing professions. The Maslach Burnout Inventory provides scores on three subscales which represent the three complementary aspects of the burnout syndrome: emotional exhaustion, depersonalisation and lack of personal accomplishment. The emotional exhaustion subscale measures feelings of being emotionally exhausted and stretched by one's work; the depersonalisation subscale assesses an impersonal and unfeeling response towards one's clients or patients and the personal accomplishment subscale taps feelings of competence and satisfaction in and with one's work. Whereas the original (Maslach, 1981) version of the instrument measured ratings of both frequency and intensity the current version only measures the frequency with which people experience such feelings, because of the extremely high correlations between the two variables.

**Burnout in health professionals**

Burnout has been studied in a number of health professionals, with the majority of studies having been conducted in the United States and the United Kingdom (e.g. Ceslowitz, 1989; Firth, McIntee, McKeowen and Britton, 1985; Firth, McIntee, McKeowen and Britton,
Firth et al. (1986), in a study of 200 qualified United Kingdom nurses, found mean burnout scores to fall in the low and moderate ranges, but with depersonalisation scores being lower than in Maslach's original studies. Ceslowitz (1989) in a study of 150 United States staff nurses found mean levels of burnout to fall within the moderate range. McGrath et al. (1989) found that, in a study of 171 Northern Ireland nurses, whereas the nurses experienced less burnout on the emotional and depersonalisation subscales than Maslach and Jackson's (1981) standardisation sample, almost all of the respondents (94-97 per cent) fell into the high burnout category on the personal accomplishment subscale. Finally, Tracy et al. (1992) found, in a sample of 36 American social workers, that despite moderate levels of personal accomplishment, and little or no depersonalisation, there was a moderate to high level of emotional exhaustion.

In addition to studies such as the above that have sought to assess the degree of burnout experienced by members of different professions, a number of studies have also examined the relationships between assessed burnout and a number of other potential intervening and moderating variables. These variables may broadly be classified as being situational, intrapersonal or interpersonal. Situational variables include demographic characteristics such as age, education and marital status, occupational role and work setting. Intrapersonal variables include, amongst others, personal coping strategies. Finally, interpersonal variables include the influences of peer and
only intrapersonal and interpersonal variables will be further considered here.

**Burnout and Coping**

Most of the coping research in the literature derives from the stress and coping theory of Lazarus and colleagues (Lazarus and Folkman, 1984). This views stress as a relationship between the person and the environment that is appraised by a person as exceeding their resources and thus endangering well being. Within this context burnout may be seen as a diminished ability to continue adapting to stress (McConnell, 1992). The process known as 'coping' describes the combined cognitive and behavioural efforts which go into managing those stressful encounters which are perceived as taxing available personal resources. This occurs as the result of a two stage appraisal process which, it is argued, must first occur (Billings and Moos, 1981). In the first stage, primary cognitive appraisal, situations are appraised in relation to physical and psychological well being and appraised as either positive, irrelevant, benign or harmful. If the event or situation has been appraised as harmful the second stage, secondary cognitive appraisal, evaluates the availability and adequacy of personal resources to prevent or minimise harm and it is here that available coping options are reviewed and evaluated. Finally, if required, coping strategies are selected and mobilised.

Lazarus and Folkman's (1984) theoretical framework originally distinguished between two major types of foci of coping: emotion-focused coping (which aims to minimise emotional and psychological
distress) and problem-focused coping (which aims to deal directly with the event, problem or situation responsible for provoking the distress). More recent research, however, has suggested that this dichotomy is somewhat simplistic and authors have variously suggested: adding a third category of coping strategies, relationship-focused coping (Coyne and Downey, 1991); using a tripartite model of individual, group and organisational coping strategies (Shinn and March, 1983); or, alternatively, suggesting a recategorisation, using methods of coping, into control- and escape-oriented coping (Latack, 1986). Latack's (1986) model describes control-oriented coping as 'actions and cognitive reappraisals that are proactive (whilst escape-oriented coping consists of) actions and cognitive reappraisals that suggest an ... avoidance mode' (p. 378).

**Burnout and coping in the health professions**

The findings from research relating coping to burnout may be said to be somewhat confused and contradictory at the very least.

Kimmel (1981) studied 135 health care workers and found growth coping (creative engagement and productivity) to be negatively related to burnout whereas self-blame coping was positively related. Keller (1982) found no differences between use of coping methods and burnout in 103 student nurses. Maslach and Jackson (1982) found higher levels of burnout amongst professionals using withdrawal strategies and lower levels amongst those who used social coping strategies (such as getting advice and talking about work stressors).
Shinn and Mørch (1983) described two studies of 141 group workers and 82 child care workers. They found that the proportions of variance in four indices of strain which were accounted for by individual coping strategies were extremely small. Also, whereas problem-focused strategies were effective at individual and group levels, the more emotion-focused strategies were not. On the other hand emotion-focused coping at the organisational level accounted for substantial proportions of the variance in attitudes towards employers.

Stone, Jebsen, Walk and Belsham (1984) found environmental factors to be more significant in the burnout of critical care nurse than either the amount of social support or the use of particular coping strategies.

Chiriboga and Bailey (1986) found, in a study of 554 nurses, that the use of anticipatory coping was negatively related to burnout. Hare, Pratt and Andrews (1988) studied 312 nurses and found that, of all the situational, interpersonal and intrapersonal factors studied, tension releasing (emotion-focused) and instrumental (problem-focused) coping were, respectively, among the most powerful positive and negative predictors of burnout.

Ceslowitz (1989), in her study, found nurses who used the coping strategies of planful problem solving, positive reappraisal, and seeking social support to experience decreased levels of burnout whereas those who used the strategies of escape or avoidance, self-controlling and confronting to show increased levels. Boyle, Grap, Younger and Thornby (1991) studied 103 critical care nurses and found that the use of emotion-focused coping was positively
correlated to burnout, whereas problem-focused coping was not and, indeed, accounted for very little of the variance.

Leiter (1991) in a study based on Latack's (1986) model found, in a study of 177 Canadian psychiatric hospital workers from various disciplines (including nurses, occupational therapists, psychologists, psychiatrists, social workers and others), that control coping strategies were associated with decreased burnout whilst escapist strategies were associated with increased burnout. In a second study (Leiter, 1992) of 124 health and social service workers, he found control coping strategies to correlate negatively with depersonalisation and positively with increased personal accomplishment.

In summary, therefore, the above eleven studies show that the relationship between coping and burnout is unclear and requires further research. However, there are clear indications that problem-focused coping strategies may, in general, be more efficacious than those strategies of emotion-focused coping in reducing aspects of burnout.

The role of support

Many different studies have pointed to the role of support in buffering against the effects of burnout. For example, Constable and Russell (1986) found, amongst 310 military hospital nurses, that lack of supervisor support was one of the major determinants of burnout. Pines (1983) lists six basic functions of a social support system: emotional challenge, emotional support, listening, technical support,
technical challenge and the sharing and testing of social reality and produces evidence that listening and emotional support are amongst the most important and that lack of availability of shared social reality testing and emotional support correlates significantly with burnout.

Scully (1983) argues that the process of support can influence both the organisation and the work group whereas its content can assist not only the group but also the individuals that comprise it. Shinn and Mørch (1983), therefore, translate the results of their research on coping into recommendations for all three levels of their tripartite model: that organisations should not just provide appropriate supervision and training but also give their workers emotional support and recognition; that the fostering of instrumental support amongst co-workers is important and that the individual should ventilate feelings and discuss problems and potential solutions with their peers.

Many writers from the health professions (e.g. Epting, 1981; Holland, 1981; Howden and Levison, 1987; Stoter, 1992 and Tschudin, 1981, 1990) have called for the establishment of support groups in order to boost the development of both individual and group coping skills. However, not all research points to the unquestionable efficacy of support groups. Weiner, Caldwell and Tyson (1983) compare one successful with two unsuccessful nurse support groups and conclude that such groups work best if initiated in response to a felt need, if the group's problems are primarily interpersonal, if the early ventilation of intense negative emotions is discouraged and if the group is highly structured.
Booth and Faulkner (1986) investigated some of the factors which made the establishment and maintenance of successful staff support groups problematic (including the fear of being seen to need help, the incorporation of different grades of staff and a fear of loss of confidentiality) and Faulkner and Maguire (1988) suggest various basic ground rules in order to ease these difficulties. Harvey (1992), however, questions the unhesitating formation of a support group as an universal panacea but recommends wider changes in practice at both individual and organisational levels.

Hare and Pratt (1987), therefore, suggest that interventions aimed at reducing burnout be aimed both at organizational issues (such as supervisory support and peer relationships) and also at assisting individuals to use more instrumental coping strategies (perhaps through both formal training and work-related counselling).

**Changing peoples' coping style**

Research on the results of interventions designed to promote the above changes has, however, also been equivocal. Whereas West, Horan and Games (1984) discovered that instruction in coping skills (through cognitive restructuring) to 60 intensive care nurses resulted in stress reduction, Walpole (1984) reported that no significant differences in burnout were found when coping skills were introduced and modelled to a group of 39 registered nurses. Milne, Walker and Bamford (1987) evaluated an eight session support group for 12 health visitors which was designed to facilitate their professional coping. Evaluation of the group, using various measures, showed no significant differences in professional coping over the
course of the group. Finally, however, McCue and Sachs (1991) found that, in a controlled evaluation of a half day stress management workshop for 43 American medical registrars, which included instruction in various coping strategies, the intervention was successful in that the workshop group improved on the Maslach Burnout Inventory emotional exhaustion subscale and deteriorated less on the depersonalisation subscale than the 21 controls. Relatively few papers could be found which investigated the effect of interventions using a psychodynamic approach. Papers which discuss this area, however, include Balint (1964, 1969), Menzies (1970) and Menzies Lyth (1988).

**Burnout, support, coping and absenteeism**

The link between burnout, coping and absenteeism is also somewhat unclear. Cole's (1992) survey found that although 93 per cent of the nurses surveyed reported at least some degree of stress, the average nurse took only 4.7 days off work because of sickness in the twelve months preceding the survey. However, of these, two days (42 per cent) were considered to be stress related. In a specific study of burnout, support and absenteeism, Firth and Britton (1989) found that perceived lack of support and emotional exhaustion predicted the absences of more than four days and more than seven days respectively of 106 nursing staff working in a variety of long stay settings. Furthermore, feelings of depersonalisation (another component of burnout) were correlated with departure from the post in the subsequent two years. In testing to see whether their intervention, designed to promote coping, had any effects on absenteeism, however, Milne, Walker and Bamford (1987) found that the sickness records of
The seven health visitors who had attended the series of eight workshops did not differ significantly from those five who had not.

The current study

The current study allowed the relationship between all of the above issues to be further investigated. As an indirect consequence of preparations made within a district health authority during the Gulf War for coping with any trauma-related psychological problems arising in patients, staff and relatives, two individuals from the then district's mental health services, a clinical psychologist and a consultant psychotherapist, decided to organise and run a series of eight workshops combining an educational component with a psychodynamically oriented and facilitated supervision group run along the lines of a Balint group (Balint, 1969).

The aim of the programme was to assist health service staff working in stressful clinical areas to develop skills in understanding and dealing with the psychological effects of exposure to traumata occurring within the contexts of their everyday working lives. It was proposed to accomplish this by incorporating two elements into the programme: an educational component, whereby staff could learn practical skills useful in dealing with stressed colleagues; and an experiential component, where staff could have the opportunity of experiencing, in a group setting, staff-patient relationships by working with the psychodynamics of the interaction.

As can be imagined, the consequences of burnout are potentially harmful not only to the staff but also to the clients with whom, and
the institutions in which they work (Maslach and Jackson, 1982) with burnout potentially leading to an overall deterioration in the quality of care provided by health professionals. The implications for the health service regarding client care and the potential additional effects on the absenteeism, turnover and morale of staff are enormous.

It was hoped, therefore, that through the provision of key staff with the necessary skills and resources to effectively manage the psychological effects of stressful clinical work, improvements in both personal and clinical effectiveness would result. It was also hoped that the programme might have more indirect effects, through leading to a more general reduction in staff turnover and sickness-related absenteeism, in areas where the workload was clinically stressful.

The organisation of this programme provided the ideal opportunity to evaluate a new type of approach (the combination of psychodynamic experiential and psychoeducational elements) with regard to its effects on burnout, coping styles and absenteeism. It was proposed by the author that the effectiveness of this intervention be evaluated in a controlled study. A protocol was therefore designed and developed by the author to enable the effectiveness of this clinical programme to be evaluated by comparing the group of personnel participating in the programme of workshops with three control groups (a waiting list control group, an alternative treatment control group (receiving written information on stress management techniques only) and a 'same-status' control group (of peers working on the same units as the participants)) on a number of measures. The measures decided
on included : individual burnout and coping style scores, ratings of competence at dealing with two scenarios involving issues pertaining to work-related trauma, and the number of days of sickness-related absenteeism over the course of the study.

It was hypothesised that, if the combined programme was effective in achieving its aims (as outlined above): participants in the programme would show reductions in all three elements of individual burnout scores as well as changes in coping skills (manifested by both changes of profile on an inventory of coping styles and increases on ratings of competence on the work-related trauma scenarios). It was further hypothesised that: these changes would be apparent, not only within the group of participants over the course of the intervention, but also when the group of participants was compared to two of the control groups: a waiting list control group and a smaller, alternative treatment, control group. Finally, it was hypothesised that if the programme was effective, and if participants effectively communicated the skills that they had acquired to their colleagues (as the programme was designed to encourage them to) these changes would not be confined merely to the programme participants but that administration of the same measures to a group of same-status colleagues (the same-status control group) would show that the beneficial effects of programme attendance had also been passed to other colleagues of similar status to, and working on the same units as, the participants themselves.

The null hypotheses being tested were that: participation in the programme would not bring about any statistically significant changes in either burnout scores or coping styles over the course of the
intervention and also that no significant differences would be found in any of the above measures, or on measures of absenteeism or coping competence, when the group of participants was compared with the three other control groups: a waiting list control group, an alternative treatment control group and the same-status control group.

ETHICAL COMMITTEE APPROVAL

Ethical committee authorisation for the research project was sought from the district ethical committee and granted by them (Ref: DEC91/142) in their letter dated 18 November 1991. (Appendix A). Their approval stipulated that the anonymity of participants be preserved. This was accommodated by participant data being coded before analysis by the researcher (JHH).
METHOD

DESIGN

A mixed design was used with: four levels of between-groups independent variable (namely the type of group: i.e. experimental group, waiting list control, alternative treatment control and same-status control); two levels of within-groups independent variable (pre- and post- measures); and four types of dependent variables (three measures of burnout, fifteen measures of coping style, a measure of coping competence and one measure of sickness-related absenteeism).

PARTICIPANTS

27 members of staff (25 females and two males), most of whom occupied senior clinical posts within the health service and who worked directly with patients in stressful clinical settings, participated in the study and completed pre- and post- measures. Subjects were recruited onto the programme by means of a poster (Appendix B) distributed through the then health authority. Subjects were not randomly allocated to the various groups but, instead, were assigned to treatment, waiting list control and alternative treatment control groups in order of application to the programme. This was done because of the restriction in size of the number of participants in each group of the programme, but also because it was important to recruit the first (experimental) group and get it up and running as soon as possible. The third control group (the same-status control group) was formed by the individuals in the treatment group each
nominating a partner of equal age and same status to, and working in the same unit as, themselves.

Of the 27 subjects eventually evaluated: 16 were nurses, two were midwives, four were occupational therapists, three were dieticians, one was a social worker and one was a health visitor. Their ages ranged from 23 to 54 and their mean age was 37.26 (SD 9.54). A one way analysis of variance showed that the difference in composition of the groups in terms of age was not found to be statistically significant ($F(3,27) = .11, p = .95$). Because only two of the 27 subjects were males (one in the same status control group and one in the minimal treatment group) the question of gender composition of groups was not taken into account.

Kruskal-Wallis one way analysis of variance tests were also used to compare groups' levels of the three elements of burnout and coping styles at the beginning of the study. There were found to be no statistically significant differences in any of the three elements between members of the experimental, waiting list and alternative treatment groups with one exception, Mental Disengagement, where the alternative treatment control group's scores were lower than those of the other two groups ($H = 11.21$, d.f. = 2, $p < .01$).

Among the clinical areas in which the subjects worked were the following: oncology, neurotrauma, genito-urinary medicine and HIV, acute psychiatry, palliative care, radiotherapy, psychogeriatrics, coronary care, neurorecovery, transplant service, intensive care, the special care baby unit and a challenging behaviours service.
Full details of the composition of the various groups are shown in Table 1 below.

<table>
<thead>
<tr>
<th>GROUP</th>
<th>Experimental Group</th>
<th>Waiting List Control Group</th>
<th>Minimal Treatment Control Group</th>
<th>Same Status Control Group</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
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<td>5</td>
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<td>3</td>
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<td>1</td>
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AGE

<table>
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<td>WAITING LIST</td>
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<td>11.5</td>
<td>25-53</td>
</tr>
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<td>MINIMAL TREATMENT</td>
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<td>10.1</td>
<td>27-54</td>
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<tr>
<td>SAME STATUS</td>
<td>37.5</td>
<td>9.9</td>
<td>25-54</td>
</tr>
</tbody>
</table>
MEASURES

The effectiveness of the programme was measured through the use of four measures:


This has three separate subscales measuring three different dimensions of burnout, which is conceptualised as a continuous variable but for which three separate elements are measured. The Emotional Exhaustion subscale assesses feelings of being emotionally overstretched and exhausted by one's work; the Depersonalisation subscale measures an unfeeling and impersonal response towards clients and patients and the Personal Accomplishment subscale assesses feelings of competence and successful achievement in one's work with people. The frequency with which the subject experiences feelings related to each subscale is assessed using a seven point, fully anchored, response format.

A high degree of burnout is reflected in high scores (upper third of the normative distribution) on the Emotional Exhaustion and Depersonalisation subscales and in low scores on the Personal Accomplishment subscale.

An average degree of burnout is reflected in average scores (middle third of the normative distribution) on all three subscales.
Internal reliability (Cronbach's Alpha, n = 978) varies between .45 (mental disengagement) and .93 (use of alcohol or drugs) although the majority of subscales fall between .60 and .80. Eight week test-retest reliability coefficients vary between .42 (behavioural disengagement) and .86 (turning to religion), although the majority fall between .51 and .69 (Carver et al 1989).

Correlations between subscales are low, but these tend to cluster into strategies that are generally adaptive (active coping, planning, suppression of competing activities, restraint coping, positive reinterpretation and growth, and the seeking of emotional and instrumental social support) and tendencies of generally more questionable value (denial, mental and behavioural disengagement and the use of humour, alcohol and drugs).

Evidence for the convergent and discriminant validity of the COPE is based on the facts that coping strategies postulated as functional are linked to 'beneficial' personality qualities whereas 'less functional' ones are inversely related to these and also that these correlations, together with correlations with items from a social desirability scale, are not overly strong.

3) Scores of assessed competence, made by a blind rater on 11 point Likert scales, on two separate hypothetical scenarios (Appendix E) involving work related trauma. These are then combined to give a single score on a 21 point scale.

This is a new approach to measuring coping competence and was conceived of and designed by the author in consultation with the
consultant psychotherapist. As this type of measure was being used for the first time, however, qualitative information is not yet available but it was hoped that if the measure showed signs of promise further qualitative evaluations would be conducted.

4) Number of days of sickness-related absenteeism over the period of the study (commonly regarded as a correlate of burnout e.g. Gray-Toft and Anderson, 1981).

This short term measure was used as this particular evaluative study was designed as a pilot study. It is intended to obtain further follow up data on absence for the year following attendance on the programme. This data was not considered to be feasible for inclusion here, however, given the external time constraints governing the reporting of the study and the uncertainty of receiving the requisite data from the participants after a longer time period.

PROCEDURE

GENERAL

Two eight week programmes, run jointly by a consultant psychotherapist and a clinical psychologist, were run over two terms of the 1991-2 academic year. Each programme consisted of an educational component of eight one hour workshops (the programme for one term of which is attached as Appendix F) which covered instruction in, and discussion of, issues related to practical coping techniques including: active listening, counselling, and applying these techniques in traumatic environments. Each of these was
followed, after a short break, by a 50 minute facilitated psychodynamic supervision group, run along lines described by Balint (1952, 1969) and by Sklar (1991).

The Balint group framework, developed from group psychotherapeutic work with medical practitioners, encourages staff, who during the course of their work are dealing with patients' psychological problems, to become aware of and sensitive to more unconscious processes. This is done without the use of formal analysis but instead by the establishment of an 'analytical stance' within the staff member. An analytic setting is thus created by the therapist in which staff members can discern something of the ways of analytic working and in which thoughts and ideas may develop, be listened to, criticised and evaluated by the rest of the group (Sklar, 1991).

Balint himself described the aim of such groups as:

to develop ... a sensitivity to the patient's emotional problems, to enable them to understand those problems more safely and in greater depth and then to help them acquire skills and to use this understanding for the goal of therapeutic effect. A precondition for the acquisition of this increased empathy and therapeutic skill is a general loosening up of ... personality, especially with regard to ... professional work. (The staff member) ... must be able to notice and tolerate emotional factors ... rejected or ignored before and ... must learn to accept them as worthy of ... attention (Balint, 1952).
EXPERIMENTAL GROUP

The seven participants participating in and completing the programme during the Michaelmas term comprised the experimental group. They were asked to complete the various measures before the beginning of the first session, and after the end of the last session, of the programme (i.e. before and after an interval of eight weeks).

WAITING LIST CONTROL GROUP

The eight participants participating in the Easter term acted as a waiting list control group over the experimental period. The first set of measures were sent out by post to arrive at the beginning of the experimental group's programme and the second set similarly posted to arrive at the finish of the programme. All material was accompanied by a stamped addressed envelope for return of the completed questionnaires.

ALTERNATIVE TREATMENT CONTROL GROUP

The five participants already on the waiting list to participate in the programme in the following academic year acted as the alternative treatment (minimal intervention) control group during the experimental period. Again, the first set of measures were sent out by post to arrive at the beginning of the experimental groups' programme and the second set were similarly posted to arrive at the end of the programme. However, the first set of questionnaires was also accompanied by copies of two articles on practical approaches to stress management (Parry, 1990 and Burnard, 1991) which the members
of the group were asked to read over the following eight weeks. All material was, as before, accompanied by a stamped addressed envelope for return of the completed questionnaires.

SAME-STATUS CONTROL GROUP

The seven participants participating in the programme during the Michaelmas term, i.e. the members of the experimental group, each nominated a partner of similar age and status to, and working in the same unit as, themselves. These individuals constituted the same-status control group. Because of the delay in the recruitment of these individuals it was unfortunately not possible to collect pre-group measures from this group and so pre-/post-group comparisons could not, unfortunately, be made for this group. However, post-group measures were again sent out by post to arrive at the end of the programme, and were accompanied by a stamped addressed envelope for the return of the questionnaires, with the request that the questionnaires be completed and returned as soon as possible.

DETAIL

Members of each group were asked to complete the Maslach Burnout Inventory and COPE questionnaire at the beginning and at the end of the experimental period. In addition, at the end of the experimental period, members of each group were asked to provide written answers as to how they would cope with each of the two scenarios of work related trauma and also to provide details of any sickness-related absences that had occurred over the whole experimental period.
Ratings of competence on the two work-related trauma scenarios were made on a single-blind basis by an impartial expert rater, another consultant psychotherapist. All other questionnaires were scored by the author.

Following scoring, all data was entered and analysed by the author using the CSS-Statistica package, version 3.1, on an Elonex PC 208-M personal computer with a Vision monochrome monitor.

Because the experimental design is a mixed design the ideal method of analysis would be a mixed model analysis of variance. However, because of the nature of the majority of the dependent variables, many of which involved ordinal data with a non-normal distribution, an equivalent method which combined different non-parametric tests was used. Kruskal-Wallis one way analysis of variance tests were therefore used to test for between group differences on the various pre- and post- measures, using the first three groups and all four groups respectively. Kruskal-Wallis one way analysis of variance tests were also employed to test for between group differences using difference scores obtained on all the repeated measures dependent variables within the experimental, alternative treatment and waiting list control groups. Finally, Wilcoxon matched pairs signed ranks tests were used, comparing pre- and post- measures, to further examine within group changes.
RESULTS

The main results are individually presented below with the data being shown in Tables 2 to 9. All other data are included in the additional tables which are appended as Appendices G.1 to G.11.

Burnout Scores

Within Groups Analysis

Scores obtained before and after the intervention by each group were compared and tested for significance using Wilcoxon matched pairs signed ranks tests.

The following significant within group differences were found:

Experimental Group:

The experimental group showed a statistically significant rise in scores on the Personal Accomplishment subscale of the Maslach Burnout Inventory. (Wilcoxon, \( p < .05 \), one-tailed).

Alternative Treatment Control Group

The alternative treatment control group showed a statistically significant increase in scores on the Emotional Exhaustion subscale of the Maslach Burnout Inventory. (Wilcoxon, \( p < .05 \), one-tailed).

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Between Groups Analysis

Firstly, Kruskal-Wallis one way analysis of variance tests were used to examine differences in post-group measures over all four groups. Difference scores between pre- and post- measures of burnout were then computed for all groups except the same-status control group for whom pre-group measures were unavailable. One way Kruskal-Wallis analysis of variance tests were then again conducted to establish whether or not the differences between difference scores obtained reached statistical significance.

Post-Group Measures

Emotional Exhaustion

The difference between post-group measures of Emotional Exhaustion was the only difference in post-group measures which approached significance on a one way between groups Kruskal-Wallis analysis of variance test ($H = 6.89$, d.f. = 3, $p = .07$).

Personal Accomplishment and Depersonalisation

None of the between group comparisons on the Personal Accomplishment or Depersonalisation subscales reached or approached statistical significance.
The data on burnout scores for all groups are shown in Tables 2 to 4 below.
### TABLE 2. EMOTIONAL EXHAUSTION

<table>
<thead>
<tr>
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<th>Post- Test</th>
<th>Within Group Significance (Wilcoxon)</th>
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<td>$SD$</td>
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<td></td>
</tr>
<tr>
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<td></td>
</tr>
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<td></td>
<td></td>
</tr>
<tr>
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<td>28.8</td>
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<tr>
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<td>$n = 7$</td>
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<td>17.9</td>
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Results of Kruskal-Wallis ANOVAs:

- Comparison of difference scores (pre-post) across first three groups ($N=20$)
  
  $H = 4.9$, d.f. = 2, n.s.

- Comparison of pre-test scores across first three groups ($N=20$)
  
  $H = 2.9$, d.f. = 2, n.s.

- Comparison of post-test scores across all four groups ($N = 27$)
  
  $H = 6.9$, d.f. = 3, $p = .07$
TABLE 3.  DEPERSONALISATION

<table>
<thead>
<tr>
<th>Group</th>
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<th>Post- Test</th>
<th>Within Group Significance (Wilcoxon)</th>
</tr>
</thead>
<tbody>
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<td>3.8</td>
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</tr>
<tr>
<td>Same Status Control Group</td>
<td>-</td>
<td>-</td>
<td>5.9</td>
</tr>
</tbody>
</table>

Results of Kruskal-Wallis ANOVAs:

- Comparison of difference scores (pre-post) across first three groups (N=20)
  \[ H = .03, \text{d.f.} = 2, \text{n.s.} \]

- Comparison of pre-test scores across first three groups (N=20)
  \[ H = 4.3, \text{d.f.} = 2, \text{n.s.} \]

- Comparison of post-test scores across all four groups (N=27)
  \[ H = 2.8, \text{d.f.} = 3, \text{n.s.} \]
<table>
<thead>
<tr>
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<th>Pre- Test</th>
<th>Post- Test</th>
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</thead>
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Results of Kruskal-Wallis ANOVAs:

Comparison of difference scores (pre-post) across first three groups ($N=20$)
$H = 2.9$, d.f. = 2, n.s.

Comparison of pre-test scores across first three groups ($N=20$)
$H = 5.3$, d.f. = 2, n.s.

Comparison of post-test scores across all four groups ($N = 27$)
$H = 2.5$, d.f. = 3, n.s.
COPE Inventory Scores

Within Groups Analysis

As with the burnout scores, scores obtained by each group before and after the intervention were compared and tested for significance using Wilcoxon matched pairs signed ranks tests.

The following comparisons reached significance.

Disengagement Behaviours

The experimental group showed a statistically significant decrease in the Focussing On and Venting Emotions, (Wilcoxon, \( p < .05 \), two-tailed) and Mental Disengagement, (Wilcoxon, \( p < .05 \), two-tailed) subscales of the COPE.

Between Groups Analysis

Again, difference scores between pre- and post- measures on all subscales were computed for experimental, alternative treatment and waiting list control groups. A comparison of group difference scores was then made and a one way Kruskal-Wallis analysis of variance test conducted to see if any of the between group differences in difference scores reached or approached statistical significance.

Changes which were found to reach statistical significance were as follows.
Problem-Focused Coping: Seeking Social Support for Instrumental Reasons

The decrease in mean subscale score shown by the experimental group exceeded the equivalent changes in the waiting list and alternative treatment control groups. The overall between groups difference scores comparison was significant (Kruskal-Wallis, $H = 6.28$, d.f. = 2, $p < .05$).

Emotion-Focused Coping: Seeking Social Support for Emotional Reasons

The decrease in mean subscale score shown by the experimental group exceeded the equivalent changes in the alternative treatment and waiting list control groups. The overall between groups difference scores comparison was found to be significant. (Kruskal-Wallis, $H = 7.95$, d.f. = 2, $p < .05$).

Disengagement Behaviours: Mental Disengagement

The decrease in mean subscale score shown by the experimental group exceeded the equivalent changes shown by the waiting list and alternative treatment control groups. Again, the overall difference scores comparison reached significance (Kruskal-Wallis, $H = 6.31$, d.f. = 2, $p < .05$). All other between group comparisons of difference scores on the COPE inventory subscales failed to reach statistical significance on Kruskal-Wallis tests.

The data on COPE inventory scores for all groups are shown in Tables 5 to 8 below.
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<thead>
<tr>
<th></th>
<th>Pre- Test</th>
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<th>Post- Test</th>
<th></th>
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<td>n.s.</td>
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Results of Kruskal-Wallis ANOVAs:

Comparison of difference scores (pre-post) across first three groups ($N=20$)

$H = 6.3$, d.f. = 2, $p < .05$

Comparison of pre-test scores across first three groups ($N=20$)

$H = 1.3$, d.f. = 2, n.s.

Comparison of post-test scores across all four groups ($N = 27$)

$H = 1.2$, d.f. = 3, n.s.
<table>
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<tr>
<th></th>
<th>Pre- Test</th>
<th>Post- Test</th>
<th>Within Group Significance</th>
</tr>
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Results of Kruskal-Wallis ANOVAs:

Comparison of difference scores (pre-post) across first three groups ($N=20$)

$H = 7.9$, d.f. = 2, $p < .025$

Comparison of pre-test scores across first three groups ($N=20$)

$H = 0.2$, d.f. = 2, n.s.

Comparison of post-test scores across all four groups ($N = 27$)

$H = 4.4$, d.f. = 3, n.s.
### TABLE 7. FOCUSING ON AND VENTING EMOTIONS.

<table>
<thead>
<tr>
<th>Group</th>
<th>Pre- Test</th>
<th>Post- Test</th>
<th>Within Group Significance (Wilcoxon)</th>
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<tr>
<td><strong>Experimental Group</strong></td>
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<td></td>
</tr>
<tr>
<td><strong>Alternative Treatment</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Control Group</td>
<td>11.0</td>
<td>2.6</td>
<td>11.4</td>
</tr>
<tr>
<td>$n = 5$</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Same Status Control Group</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>$n = 7$</td>
<td></td>
<td></td>
<td>8.9</td>
</tr>
</tbody>
</table>

Results of Kruskal-Wallis ANOVAs:

Comparison of difference scores (pre-post) across first three groups ($N=20$)

$H = 3.8$, d.f. = 2, n.s.

Comparison of pre-test scores across first three groups ($N=20$)

$H = 1.5$, d.f. = 2, n.s.

Comparison of post-test scores across all four groups ($N = 27$)

$H = 2.3$, d.f. = 3, n.s.
TABLE 8. MENTAL DISENGAGEMENT

<table>
<thead>
<tr>
<th></th>
<th>Pre- Test</th>
<th>Post- Test</th>
<th>Within Group Significance (Wilcoxon)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$M$</td>
<td>$SD$</td>
<td>$M$</td>
</tr>
<tr>
<td><strong>Experimental Group</strong> n = 7</td>
<td>7.7</td>
<td>1.3</td>
<td>6.0</td>
</tr>
<tr>
<td><strong>Waiting List Control Group</strong> n = 8</td>
<td>8.6</td>
<td>1.2</td>
<td>8.1</td>
</tr>
<tr>
<td><strong>Alternative Treatment Control Group</strong> n = 5</td>
<td>6.0</td>
<td>.7</td>
<td>6.8</td>
</tr>
<tr>
<td><strong>Same Status Control Group</strong> n = 7</td>
<td>-</td>
<td>-</td>
<td>7.9</td>
</tr>
</tbody>
</table>

Results of Kruskal-Wallis ANOVAs:

Comparison of difference scores (pre-post) across first three groups ($N=20$)

$H = 6.3$, d.f. = 2, $p < .05$.

Comparison of pre-test scores across first three groups ($N=20$)

$H = 11.2$, d.f. = 2, $p < .01$

Comparison of post-test scores across all four groups ($N = 27$)

$H = 5.3$, d.f. = 3, n.s.
Assessed Competence on Coping Scenarios and Number of Days Absence

Kruskal-Wallis analyses of variance and conventional analyses of variance (ANOVA) were respectively used to compare between group differences of scores on the above last two measures. Both comparisons failed to reach statistical significance.

The data on assessed competence on coping scenarios and absence are shown in Table 9 below.
TABLE 9. COPING COMPETENCE & ABSENCE.

<table>
<thead>
<tr>
<th>Group</th>
<th>COPING COMPETENCE</th>
<th>ABSENCE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>M</td>
<td>SD</td>
</tr>
<tr>
<td>Experimental Group</td>
<td>9.7</td>
<td>2.5</td>
</tr>
<tr>
<td>n = 7</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Waiting List Control Group</td>
<td>11.5</td>
<td>2.2</td>
</tr>
<tr>
<td>n = 8</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alternative Treatment Control Group</td>
<td>9.0</td>
<td>3.1</td>
</tr>
<tr>
<td>n = 5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Same Status Control Group</td>
<td>8.9</td>
<td>1.6</td>
</tr>
<tr>
<td>n = 7</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Results of Kruskal-Wallis ANOVA:

Comparison of Coping Competence scores across all four groups \((N = 27)\);

\(H = 5.2,\) d.f. = 3, n.s.

Results of one way ANOVA:

Comparison of Absence across all four groups \((N = 27)\);

\(F(3,23) = 1.1,\) n.s.
Summary of Results

The experimental group were found to show a significant increase in their feelings of personal accomplishment, indicating a reduction in one of the three elements of burnout, over the course of the study. When changes in use of coping strategies were examined, the group also showed a significant reduction in the use of two of the 'disengagement' types of coping behaviour, focussing on and venting emotions and mental disengagement, which are argued to be less useful in coping with stress.

A significant increase in another element of burnout, emotional exhaustion, was shown by the alternative treatment control group.

The waiting list group showed no significant changes, in either direction, in burnout or changed use of coping strategies.

When the changes made over the course of the study within groups were compared between groups, however, the pattern of results found here was rather more complicated.

The rise in emotional exhaustion shown by the alternative treatment group was found to be larger than both the equivalent slight rise shown by the experimental group and the fall in emotional exhaustion shown by the waiting list control group. The overall between groups comparison approached, but did not attain, statistical significance.
All other between group comparisons on the other two elements of burnout, depersonalisation and lack of personal accomplishment failed to reach statistical significance.

When within group changes in use of coping strategy were compared between groups the decline in the use of mental disengagement strategies by the experimental group was found to be significantly larger than the slight increase in the use of these strategies shown by the alternative treatment group.

Between group comparisons also revealed some further significant changes when the experimental group were compared to the alternative treatment and waiting list control groups even though the within group changes inside the experimental group had failed to reach significance. The experimental group were found to show a decreased use in strategies involving the seeking of support for emotional and instrumental reasons when compared with the alternative treatment and waiting list control groups.

Lastly, comparisons between groups of responses to the two paper coping scenarios and measures of sickness-related absenteeism all failed to show any significant differences.
DISCUSSION

The above summary of results shows that some aspects of the experimental hypotheses being tested were found to have been supported by the results of the study. Specifically, participation in a combined programme of psychoeducational workshops on effective listening, counselling and their application in stressful clinical environments, when combined with attendance in related Balint groups, which sought to engender an awareness of more unconscious issues, seems to have brought about a reduction in one of the three elements of burnout, as conceived of and measured by the Maslach Burnout Inventory (Maslach and Jackson, 1986), namely a reduction in the lack of, or more properly an increase in the feelings of, personal accomplishment.

This change was shown to have occurred within the experimental group but not in any of the control groups. However, one of the control groups, the 'alternative treatment control' who had received some literature on practical approaches to stress management whilst waiting to attend a similar programme in the following academic year, showed a significant increase in another element of burnout, emotional exhaustion, over the experimental period, perhaps indicating that a top down bibliographic approach may hinder, rather than help, in the prevention of burnout. Such an increase was not confined to the alternative treatment group, however, and even occurred in the experimental group. That this was the case is, perhaps, not too surprising when it is considered that the study took place over the three months leading up to Christmas, a time of the
year widely regarded to be more stressful than other periods of the year (Holmes and Rahe, 1967).

Those changes that did reach significance just did so with a five percent level of significance being used as the criterion, in some instances on one-tailed non-parametric tests. Thus, the changes that did occur were, although small, in the expected direction and, at the very least, suggest evidence of a trend.

The fact that a higher level of significance was not generally found and that the number of effects which were found to approach or reach significance was comparatively limited derives from the fact that a relatively small number of subjects was used, with larger groups being ideally required in order to detect additional effects. If larger groups could have been studied, and different measures employed, then multivariate statistics could also have been used and the increased chance of Type I errors, through the use of repeated analyses, would then be correspondingly reduced. It is not considered, however, that the use of non-parametric tests resulted in any significant loss of statistical power.

Nonetheless, that other significant changes in the other elements of burnout did not occur is, of course, disappointing and may perhaps also be explained by the timing of the study occurring, as it did, over the approach to a highly stressful time of the year.

The intervention sought to heed Hare and Pratt's (1987) suggestion that interventions aimed at reducing burnout be aimed both at interpersonal and intrapersonal issues. The psychoeducational element
was aimed at the more interpersonal issues of developing skills in effective listening and counselling and by seeking to capitalize on these by encouraging organisation, or reorganisation in the workplace so that these issues might be more properly addressed. However, the intervention also sought to address more intrapersonal issues through the medium of the Balint group.

It is difficult to tell which of the two elements in the programme may have been responsible for bringing about the changes in burnout and the use of coping styles and further research comparing and contrasting the effectiveness of the two elements in further controlled studies would be necessary in order to shed further light on the possible answer. However, feedback received at the end of the first term's programme was to the effect that participants "were very interested in the experiential group. Several of them spoke about their greater sense of confidence in relation to their work. There is now a sense that instead of being just a passive cog in the machine they can enjoy a capacity to think about what they are doing and also to speak up both in relation to their junior staff as well as people they work for who are more senior" (Sklar, personal communication).

Furthermore, feedback on the psychoeducational element implied that "participants found the atmosphere in the seminars more comfortable and commented on the value of trust and positive feedback and on the increased ability, over the duration of the programme, to support and enable each other" (Collins, personal communication).

The relationship between the above feedback and the associated findings of increased personal accomplishment is difficult to ignore.
and it appears, therefore, that it was, perhaps, the combined participation in both elements of the programme that was responsible for having brought about this change.

On the other hand it may be that the workshop programme was more responsible for bringing about some of the changes that were found to have occurred in the use of differing coping strategies. This seems to be borne out by the fact that participants voluntarily went on to form themselves into an ongoing mutual support group. The mutual support element may thus explain the otherwise surprising corresponding decrease in the experimental groups scores on the subscale measuring the seeking of social support for both instrumental and emotional reasons within their own workplaces. Only further research will further clarify these issues.

As discussed in the introduction the present evidence from research which has evaluated attempts to bring about changes in coping styles is, at the best, equivocal. Even more so are the results of research on the links between these changes in coping styles and the achievement of any corresponding changes in levels of burnout. Nonetheless, some significant changes in the use of coping strategy were found to have occurred in the group of programme participants under study.

Specifically, members of the experimental group showed a reduction (which just reached significance) over the course of the study in the tendency to use the strategy of mental disengagement (which also compared significantly to the corresponding increase shown by the alternative treatment control group). This strategy may be classified
as either a disengagement (Carver et al, 1989) or escape-oriented (Latack, 1986) coping strategy, and both of these strategies have been linked by Leiter (1991) to increased burnout. The reduced use of these disengagement or escape-oriented strategies should reduce the risk of increased burnout, therefore, and this seems to have been at least partly borne out by the results.

It is instructive to examine the nature of the other revealed changes shown by the experimental group in the use of differing coping strategies when compared to the waiting list and alternative treatment control groups. The decrease in the use of seeking social support for instrumental reasons, already mentioned above, seems to demonstrate an increased capacity to cope individually which, it is hypothesised, corresponds to the rise in feelings of greater personal accomplishment. Similarly, the decreased tendency to seek support for emotional reasons implies that the metaphorical "cat" is hopefully "being kicked" less often in the workplace, again indicating the adoption of a more mature coping style (Boyle, 1991). As mentioned above, participants were now also more able to give and obtain mutual support through the framework of the latterly formed follow-up support groups. The differences that were found to occur between the use of these strategies shown by the alternative treatment and waiting list control groups, however, also perhaps show at least some of the benefits of reading the stress management literature.

It was surprising that the study did not find any differences between groups on the two 'paper' coping scenarios. This finding may reflect the fact that completion of these scenarios involved a more hypothetical and intellectual exercise, which perhaps fell outside
the range of experience of all of the subjects, rather than the reporting of more generally used episodic or situational coping styles as measured by the COPE.

Also, and again somewhat surprisingly, no differences were found when rates of absenteeism were compared between groups. As discussed in the introduction, the data linking absenteeism to burnout, coping and support is, again, not completely clear and it was expected that this study might have shown greater differences between groups. In retrospect, far too short a period of time was sampled after the experimental period and a comparison of groups over, say, the six months after the experimental period may have shown the differences that were originally hypothesised. This point should be addressed in any further future studies, and will be addressed in the follow-up study planned by the author.

The other possible explanation for the lack of these latter measures to reveal any differences may, however, simply be that these may be more objective measures than the Maslach Burnout Inventory or COPE questionnaire, which are measures that may be tapping more subjective elements of occupational stress.

Finally, perhaps the other obvious flaw in this study was that the size of the alternative treatment group should ideally have been equivalent to the size of the other groups. On this occasion, however, neither this, nor the random allocation of subjects to the different experimental conditions, was possible given the method of subject recruitment that was used and the method of subjects' subsequent allocation to the various groups made, as described above,
on the basis of the order of participants' application to the programme. These points should be addressed in any future studies.

Taken together, however, the results show that the personal accomplishment element is an important constituent of the construct of burnout and that this feeling of personal accomplishment can be increased, and thus overall burnout decreased, by participation in such a programme. Since McGrath et al (1989) found that almost all their respondents fell into the high burnout category on the personal accomplishment subscale, the finding that this is an element which can be affected through the means of a targeted intervention is very encouraging and has important implications for the way in which psychologists and occupational health professionals seek to tackle the problems of stress in health service personnel.

The results of the effects of the programme on coping styles also have important implications for theory. Firstly, they seem to lend support to Shinn and Mørch's (1983) concept of a tripartite model of coping by showing the importance of coping strategies that can be employed at individual, group and organisational levels. Secondly, the results also seem to support Gselowitz's (1989), Leiter's (1991,1992) and Maslach and Jackson's (1992) findings that high levels of burnout are related to the use of escape or withdrawal coping strategies (such as mental disengagement), whereas lower levels are related to the use of more proactive control and social coping strategies (such as the seeking of support for emotional and instrumental reasons). The experimental group showed a lowering in the use of mental disengagement strategies and, because they were getting instrumental and emotional social support from their
participation in the programme, they also sought less emotional and instrumental social support in the workplace itself. Thirdly, the results also seem to support Hare et al's findings (1988) on the respective positive and negative relationships of tension-releasing coping strategies (such as the focussing on and venting of emotions) and instrumental coping strategies (such as the seeking of instrumental social support) with burnout, since it was in several of these areas that the experimental group were found to have made changes.
SUMMARY AND CONCLUSIONS

As a pilot study, this study of the effectiveness of a new type of clinical programme, which combined psychoeducational and experiential approaches to the problem of stress in the workplace and which used real clinical staff working in real and genuinely stressful clinical situations, seems to have produced some interesting and encouraging preliminary results.

Specifically, participants in the eight week programme were found to show a decrease in one of the three elements of burnout and to also show some significant changes in measures of episodic coping styles. These results help to shed more light on the complicated relationship between ways of coping and the precipitation and maintenance of, and protection from, the psychological effects of work-related clinical stress.

Although the changes which were found to have occurred were limited they were not confined to changes occurring solely within the experimental group. On the contrary, one of the changes in burnout and three of the changes in coping styles were also found to have occurred when a between groups comparison was made. The use of a larger number of subjects may, perhaps, have resulted in an even greater number of effects being detected.

Changes in a new measure of coping, the hypothetical scenarios of coping competence, did not reveal differences between groups however and it may be that this new measure, in its present form, does not
adequately assess the changes in coping that may have occurred over the study.

The failure to detect a hypothesised change in stress-related absenteeism and sickness was instead more probably directly related to the short period of time over which such a change was being examined. It is hoped that the planned subsequent follow-up measures may detect this hypothesised change.

In conclusion, however, this study may be said to provide some encouraging preliminary results about the efficacy of this type of intervention in helping to alleviate the ever increasing problems of work-related stress that are occurring within the workplace in many clinical areas of today's health services.
18/11/91

Mr J G H Hacker Hughes
Westcott House
Jesus Lane
Cambridge
CB5 8BP

Dear Mr Hughes

CARING FOR THE CARERS (DEC91/142)

I refer to your recent application to the District Ethical Committee regarding the above project and I am pleased to inform you that this project was approved by the Committee at its meeting on 15 November 1991.

Furthermore, whilst I am sure that every effort is already made to preserve the confidentiality of any patient information used in this study, could you please ensure that the team of investigators are aware that everyone who has access to patient information appreciates the importance of maintaining the confidentiality, particularly in respect of the use of computers and the statutory regulations laid down in the Data Protection Act 1984.

Investigators are reminded that all electromedical equipment, including items purchased or on loan for research purposes, must be safety tested by the Instrument Laboratories, Medical Physics, before they are used. If this project involves the use of any equipment which has not already been checked please contact Mr Peter Ward, District Biomedical Equipment Manager.

Yours sincerely

Dr G E Berrios MA (Oxon), M.D., F.R.C.Psych, FBPsS
Chairman
District Ethical Committee
WHO CARES FOR THE CARERS?

A WORKSHOP FOR NURSING, MEDICAL AND ALLIED PROFESSIONAL COLLEAGUES WORKING DIRECTLY WITH PATIENTS IN STRESSFUL CLINICAL SETTINGS IN THE DISTRICT. WE WILL MEET 8 TIMES IN THE AUTUMN TERM.

AIM

To develop skills in better understanding staff relationships in the stress of everyday traumas that effect our working life.

TASKS

i. To learn practical skills useful in dealing with stressed colleagues.

ii. To experience, in a group setting, staff-patient relationships, by working with the psychodynamics of the interaction.

TIME

Tuesday 11.45 a.m. to 1.45 p.m. - commencing 8th October 1991.

VENUE

CHPAS, Training Suite, Foxton House, Addenbrooke's Hospital.

Limited to 12 places.

Dr Jon Sklar
Psychoanalyst, Consultant Psychotherapist

Suzanne Collins
Clinical Psychologist

APPLICATION FORM

I would be pleased to join a workshop for the 8 meetings.

Name: Position:

Work Address: Work Phone Number:

Please return application to:

Dr J Sklar
The Department of Psychotherapy
2 Bene't Place
Lensfield Road
Cambridge CB2 1EL - Tel: (0223) 66461 extension 222
**APPENDIX C**
**MASLACH BURNOUT INVENTORY**

Please indicate how often you currently experience the following thoughts &/or feelings:

<table>
<thead>
<tr>
<th>How often:</th>
<th>Never</th>
<th>A few times a month</th>
<th>A few times a year or less</th>
<th>Once a week</th>
<th>A few times a week</th>
<th>Every time a day</th>
</tr>
</thead>
<tbody>
<tr>
<td>I feel emotionally drained from my work</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>I feel used up at the end of the workday</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>I feel tired when I get up in the morning and have to face another day at work</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>I can easily understand how my patients feel about things</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>I feel I treat some patients as if they were impersonal objects</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Working with people all day is really a strain for me</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>I deal very effectively with the problems of my patients</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>I feel burned out from my work</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>I feel I’m positively influencing other people’s lives through my work</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>I’ve become more callous towards people since I started my present job</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>How often:</td>
<td>Never</td>
<td>A few times a month</td>
<td>Once a month</td>
<td>A few times a week</td>
<td>Once a week</td>
<td>Every day</td>
</tr>
<tr>
<td>-----------</td>
<td>-------</td>
<td>---------------------</td>
<td>-------------</td>
<td>-------------------</td>
<td>-------------</td>
<td>-----------</td>
</tr>
<tr>
<td>I worry that this job is hardening me emotionally</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>I feel very energetic</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>I feel frustrated by my job</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>I feel I'm working too hard at my job</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>I don't really care what happens to some patients</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Working with people directly puts too much stress on me</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>I can easily create a relaxed atmosphere with my patients</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>I feel exhilarated after working closely with my patients</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>I've accomplished many worthwhile things in this job</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>I feel as if I'm at the end of my tether</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>In my work I deal with emotional problems very calmly</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>I feel that patients blame me for some of their problems</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

Thankyou.
COPE
APPENDIX D

We are interested to know how people respond when they confront difficult or stressful events in their lives. There are lots of ways to try to deal with stress. This questionnaire asks you to indicate what you generally do and feel, when you experience stress events. Obviously, different events bring out somewhat different responses, but think about what you usually do when you are under a lot of stress.

Then respond to each of the following items by circling one number using the choices listed just below. Please try to respond to each item separately in your mind from each other item. Choose your answers thoughtfully, and make your answers as true FOR YOU as you can. Please answer every item. There are no “right” or “wrong” answers, so choose the most accurate answer for YOU—not what you think “most people” would say or do. Indicate what YOU usually do when YOU experience a stressful event.

1=I usually don’t do this at all
2=I usually do this a little bit
3=I usually do this a medium amount
4=I usually do this a lot

<table>
<thead>
<tr>
<th>Item</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. I try to grow as a person as a result of the experience.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. I turn to work or other substitute activities to take my mind off things.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. I get upset and let my emotions out.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. I try to get advice from someone about what to do.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. I concentrate my efforts on doing something about it.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. I say to myself “this isn’t real”.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. I put my trust in God.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. I laugh about the situation.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. I admit to myself that I can’t deal with it, and quit trying.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. I restrain myself from doing anything too quickly.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11. I discuss my feelings with someone.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12. I use alcohol or drugs to make myself feel better.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13. I get used to the idea that it happened.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14. I talk to someone to find out more about the situation.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
15. I keep myself from getting distracted by other thoughts or actions. 123
16. I daydream about things other than this. 123
17. I get upset, and am really aware of it. 123
18. I seek God's help. 123
19. I make a plan of action. 123
20. I make jokes about it. 123
21. I accept that this has happened and that it can't be changed. 123
22. I hold off doing anything about it until the situation permits. 123
23. I try to get emotional support from friends and relatives. 123
24. I just give up trying to reach my goal. 123
25. I take additional action to try to get rid of the problem. 123
26. I try to lose myself for a while by drinking alcohol or taking drugs. 123
27. I refuse to believe that it has happened. 123
28. I let my feelings out. 123
29. I try to see it in a different light, to make it seem more positive. 123
30. I talk to someone who could do something about the problem. 123
31. I sleep more than usual. 123
32. I try to come up with a strategy about what to do. 123
33. I focus on dealing with this problem, and if necessary let other things slide a little. 123
34. I get sympathy and understanding from someone. 123
35. I drink alcohol or take drugs in order to think about it less. 123
36. I kid around about it. 123
37. I give up the attempt to get what I want. 123
38. I look for something good in what is happening. 123
39. I think about how I might best handle the problem. 123
40. I pretend that it hasn't really happened. 123
41. I make sure not to make matters worse by acting too soon. 123
<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
</tr>
</thead>
<tbody>
<tr>
<td>try hard to prevent other things from interfering with my efforts at dealing with this.</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>go to movies or watch TV, to think about it less.</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>accept the reality of the fact that it happened.</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>ask people who have had similar experiences what they did.</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>feel a lot emotional distress and I find myself expressing those feelings a lot.</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>take direct action to get around this problem.</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>try to find comfort in my religion.</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>force myself to wait for the right time to do something.</td>
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<td>2</td>
</tr>
<tr>
<td>make fun of the situation.</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>reduce the amount of effort I'm putting into solving the problem.</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>talk to someone about how I feel.</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>use alcohol or drugs to help me get through it.</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>learn to live with it.</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>put aside other activities in order to concentrate on this.</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>think hard about what steps to take.</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>act as though it hasn't even happened.</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>do what has to be done, one step at a time.</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>learn something from the experience.</td>
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<td>2</td>
</tr>
<tr>
<td>pray more than usual.</td>
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<td>2</td>
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</tbody>
</table>

- Male..... Female.....

- .........
Please could you write a couple of paragraphs (maximum 100 words each) on the reverse of this form indicating how you might understand each of the following two scenarios:

1. The Senior Registrar who works in your unit has been attending later and later for the ward round. Two patients comment to you on how grey he has been looking recently. Hospital gossip is that his marriage is awry. You overhear junior nurses talking contemptuously about him, saying that he seems to always make decisions against nursing advice "when he attends". How would you understand and handle such a situation?

2. A young child is brought to hospital with severe head injuries following a car accident. After three weeks intensive nursing he sadly dies. During this time only mother visited as father seemed too upset to visit the hospital. Despite talking several times to one nurse in particular, mother seemed very distant from the impact of the death of her son and was described as being spaced out. One of your nursing staff who had been particularly working with the mother becomes exceedingly upset at the little boy's death and telephones in the next day to say that she is ill and unable to work. How might you understand such matters?

Your answers will be treated in the strictest confidence and are not being used as part of any personal evaluation but as part of the research project evaluating the effectiveness of the 'Caring for the Carers' programme.

Please enter your name and the date below and, writing your answers overleaf, return as soon as possible to Suzanne Collins at the Ida Darwin.

Thankyou very much.

Name ........................................ Date ........................................
## APPENDIX F

### WHO CARES FOR THE CARERS?

**Course outline for staff training - Autumn 1991**

_Suzanne Collins and Dr. Jon Sklar_

Tuesdays 11.45 a.m. - 1.45 p.m. - CHPAS Training Suite, Porter House, Addenbrooke's Hospital, Hills Road, Cambridge

<table>
<thead>
<tr>
<th>Date</th>
<th>Time</th>
<th>Topic</th>
<th>Presenter</th>
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<td></td>
<td>Listening</td>
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<td>Responding without interrupting</td>
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<td>Dr. Sklar</td>
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<td>Elena Moses</td>
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<td>December 3rd</td>
<td>11.45</td>
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### APPENDIX G.1. ACTIVE COPING

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<td>Waiting List Control Group</td>
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<td>1.9</td>
<td>10.9</td>
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<td>n = 8</td>
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<tr>
<td>Alternative Treatment Control Group</td>
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<tr>
<td>n = 7</td>
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</table>

Results of Kruskal-Wallis ANOVAs:

- **Comparison of difference scores (pre-post) across first three groups ($N=20$)**
  
  $\text{H} = .9, \text{d.f.} = 2, \text{n.s.}$

- **Comparison of pre-test scores across first three groups ($N = 20$)**

  $\text{H} = 1.2, \text{d.f.} = 2, \text{n.s.}$

- **Comparison of post-test scores across all four groups ($N = 27$)**

  $\text{H} = 2.0, \text{d.f.} = 3, \text{n.s.}$
**APPENDIX G.2. PLANNING**

<table>
<thead>
<tr>
<th></th>
<th>Pre- Test</th>
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<th>Post- Test</th>
<th></th>
<th>Within Group Significance (Wilcoxon)</th>
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<tbody>
<tr>
<td></td>
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<td>$SD$</td>
<td>$M$</td>
<td>$SD$</td>
<td>n.s.</td>
</tr>
<tr>
<td>Experimental Group</td>
<td>13.1</td>
<td>2.6</td>
<td>14.6</td>
<td>1.6</td>
<td>n.s.</td>
</tr>
<tr>
<td>Waiting List Control Group</td>
<td>12.0</td>
<td>1.5</td>
<td>11.9</td>
<td>1.6</td>
<td>n.s.</td>
</tr>
<tr>
<td>Alternative Treatment Control Group</td>
<td>13.2</td>
<td>2.4</td>
<td>12.4</td>
<td>3.2</td>
<td>n.s.</td>
</tr>
<tr>
<td>Same Status Control Group</td>
<td>-</td>
<td>-</td>
<td>12.4</td>
<td>3.2</td>
<td>-</td>
</tr>
</tbody>
</table>

Results of Kruskal-Wallis ANOVAs:

Comparison of difference scores (pre-post) across first three groups ($N=20$)

$H = 1.4$, d.f. = 2, n.s.

Comparison of pre-test scores across first three groups ($N = 20$)

$H = 4.4$, d.f. = 2, n.s.

Comparison of post-test scores across all four groups ($N = 27$)

$H = 6.0$, d.f. = 3, n.s.
### APPENDIX G.3. SUPPRESSION OF COMPETING ACTIVITIES

<table>
<thead>
<tr>
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<th>Pre- Test</th>
<th>Post- Test</th>
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<td></td>
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<td>SD: 1.9</td>
</tr>
<tr>
<td><strong>Waiting List Control Group</strong></td>
<td>M: 10.5</td>
<td>SD: 1.1</td>
<td>M: 9.6</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>SD: 0.9</td>
</tr>
<tr>
<td><strong>Alternative Treatment Control Group</strong></td>
<td>M: 10.6</td>
<td>SD: 2.1</td>
<td>M: 10.0</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>SD: 2.7</td>
</tr>
<tr>
<td><strong>Same Status Control Group</strong></td>
<td>M: -</td>
<td>SD: -</td>
<td>M: 10.4</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>SD: 2.2</td>
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</tbody>
</table>

Results of Kruskal-Wallis ANOVAs:

- **Comparison of difference scores (pre-post) across first three groups** (N=20)
  \[ H = 0.2, \text{d.f.} = 2, \text{n.s.} \]

- **Comparison of pre-test scores across first three groups** (N = 20)
  \[ H = 0.5, \text{d.f.} = 2, \text{n.s.} \]

- **Comparison of post-test scores across all four groups** (N = 27)
  \[ H = 0.7, \text{d.f.} = 3, \text{n.s.} \]
### APPENDIX G.4. RESTRAINT COPING

<table>
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<th>Post- Test</th>
<th>Within Group Significance (Wilcoxon)</th>
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<td>Experimental Group</td>
<td>11.6</td>
<td>2.3</td>
<td>11.5</td>
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<td>$n = 7$</td>
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Results of Kruskal-Wallis ANOVAs:

Comparison of difference scores (pre-post) across first three groups ($N=20$)

$H = 4.3$, d.f. = 2, n.s.

Comparison of pre-test scores across first three groups ($N = 20$)

$H = 4.2$, d.f. = 2, n.s.

Comparison of post-test scores across all four groups ($N = 27$)

$H = 5.2$, d.f. = 3, n.s.
APPENDIX G.5. POSITIVE REINTERPRETATION AND GROWTH

<table>
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<td>M</td>
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Results of Kruskal-Wallis ANOVAs:

Comparison of difference scores (pre-post) across first three groups (N=20)

\(H = 0.9, \text{ d.f.} = 2, \text{ n.s.}\)

Comparison of pre-test scores across first three groups (N = 20)

\(H = 0.3, \text{ d.f.} = 2, \text{ n.s.}\)

Comparison of post-test scores across all four groups (N = 27)

\(H = 2.2, \text{ d.f.} = 3, \text{ n.s.}\)
APPENDIX G.6. ACCEPTANCE

<table>
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<th>Post- Test</th>
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<tr>
<td>Experimental Group</td>
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Results of Kruskal-Wallis ANOVAs:

Comparison of difference scores (pre-post) across first three groups ($N=20$)

$H = 0.9$, d.f. = 2, n.s.

Comparison of pre-test scores across first three groups ($N = 20$)

$H = 3.5$, d.f. = 2, n.s.

Comparison of post-test scores across all four groups ($N = 27$)

$H = 2.0$, d.f. = 3, n.s.
APPENDIX G.7. DENIAL

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</tr>
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Results of Kruskal-Wallis ANOVAs:

Comparison of difference scores (pre-post) across first three groups (N=20)

\[ H = 4.4, \text{ d.f.} = 2, \text{ n.s.} \]

Comparison of pre-test scores across first three groups (N=20)

\[ H = 2.8, \text{ d.f.} = 2, \text{ n.s.} \]

Comparison of post-test scores across all four groups (N = 27)

\[ H = 2.3, \text{ d.f.} = 3, \text{ n.s.} \]
### APPENDIX G.8. TURNING TO RELIGION

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Results of Kruskal-Wallis ANOVAs:

- Comparison of difference scores (pre-post) across first three groups ($N=20$)
  
  $H = 2.0$, d.f. = 2, n.s.

- Comparison of pre-test scores across first three groups ($N = 20$)
  
  $H = 2.2$, d.f. = 2, n.s.

- Comparison of post-test scores across all four groups ($N = 27$)
  
  $H = 2.2$, d.f. = 3, n.s.
## APPENDIX G.9. BEHAVIOURAL DISENGAGEMENT

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Results of Kruskal-Wallis ANOVAs:

Comparison of difference scores (pre-post) across first three groups ($N=20$)

$H = 1.2$, d.f. = 2, n.s.

Comparison of pre-test scores across first three groups ($N = 20$)

$H = 0.1$, d.f. = 2, n.s.

Comparison of post-test scores across all four groups ($N = 27$)

$H = 3.5$, d.f. = 3, n.s.
APPENDIX G.10.  USE OF ALCOHOL AND / OR DRUGS

<table>
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Results of Kruskal-Wallis ANOVAs:

Comparison of difference scores (pre-post) across first three groups (N=20)

\( H = 4.3, \text{ d.f.} = 2, \text{ n.s.} \)

Comparison of pre-test scores across first three groups (N = 20)

\( H = 0.5, \text{ d.f.} = 2, \text{ n.s.} \)

Comparison of post-test scores across all four groups (N = 27)

\( H = 1.1, \text{ d.f.} = 3, \text{ n.s.} \)
## APPENDIX G.11. USE OF HUMOUR

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Results of Kruskal-Wallis ANOVAs:

- Comparison of difference scores (pre-post) across first three groups ($N=20$)
  \[ H = 0.3, \text{d.f.} = 2, \text{n.s.} \]

- Comparison of pre-test scores across first three groups ($N = 20$)
  \[ H = 1.8, \text{d.f.} = 2, \text{n.s.} \]

- Comparison of post-test scores across all four groups ($N = 27$)
  \[ H = 3.8, \text{d.f.} = 3, \text{n.s.} \]
REFERENCES


SUPERVISION, STRESS & SATISFACTION
IN A
LEARNING DISABILITIES SERVICE

JAMIE G. H. HACKER HUGHES

PSYCHD CONVERSION

UNIVERSITY OF SURREY

1996
ABSTRACT

Two studies were carried out in a health service trust providing services to people with learning disabilities in order to investigate the use of clinical supervision and its relationships with a number of variables.

In the first, a preliminary survey was conducted on a stratified sample of 250 employees, representing all professional groups and all levels of staff employed by the trust, in order to determine the extent to which clinical supervision was practised and to examine the range and variety of ways in which clinical supervision is carried out. 53 questionnaires were returned which clearly showed a very wide variation in frequency, quality, form and scope of supervision.

In the second study, the relationships between clinical supervision, burnout, psychological distress and job satisfaction were more closely examined, particularly with a view to testing the hypotheses that clinical supervision is associated with decreased burnout and psychological distress and increased job satisfaction.

The participants in the second study were 42 of the 70 members of a specialist support directorate, where different frequencies of clinical supervision were employed by the various professional groups.

Although no significant relationships were demonstrated between frequency of clinical supervision and psychological distress or job satisfaction, the use of multidimensional scaling techniques showed
these relationships to be in the predicted directions. The frequency of clinical supervision was, however, found to be significantly related to one of the three dimensions of burnout, personal accomplishment.

The nature of the relationships between all of the above variables is discussed in the light of previous research and a model is proposed which seeks to explain the observed effects of clinical supervision. Suggestions for future study are also made.
1.0 Introduction

Clinical supervision is a relatively new procedure, having been proposed for the nursing profession only as recently as 1993.

One of the supposed functions of clinical supervision is a "restorative function", with clinical supervision aiming to prevent or deal with negative attitudes related to physical or psychological stress within the emotional impact of professional work.

It has been asserted that clinical supervision, if properly conducted, can increase work satisfaction and reduce stress.

However, to date there have been no reported studies that have sought specifically to test this assertion. The studies to be described here were therefore conceived with the aims of determining the range and scope of clinical supervision in practice and then continuing by testing the assertion that clinical supervision can increase work satisfaction and reduce stress.

Specifically, the initial study is a preliminary survey of the use of clinical supervision, and the second study seeks to examine the relationships between clinical supervision, job satisfaction and
stress, both studies being carried out in an NHS Trust providing services to people with learning disabilities.

This introductory chapter will define the key concepts of stress, burnout, job satisfaction and clinical supervision and will then review the literature reporting the results of research that has been carried out on the above in populations of health workers and, specifically, on those health workers working in services for people with learning disabilities. Finally, the two current studies will be introduced.

1.1 Stress in Health Service Employees

The concept of stress is an elusive one because it is poorly defined. However, a number of definitions draw on an 'engineering analogy' (Cox, 1978) whereby stress is seen as a constraining force on a person who attempts to cope with this force and, in consequence of the resulting strain, becomes distressed and fatigued. In a similar vein, Parry (1990) describes stress as "a normal part of everyday life ... (which) ... occurs whenever our bodies and minds are faced with demands which tax or exceed our capacity to respond" (p. 87). Thus, the determining factor as to whether or not a situation is regarded by an individual as being stressful is the way in which that particular individual interprets that situation (Cox, 1978). That is to say, the same situation might be regarded by a number of different individuals as being stressful to varying degrees.

A number of different authors have formulated many varied response-based, stimulus-based and interactional models and definitions of
stress. The current view, however, may still be summarised by the following transactional definition which was originally given by Cox (1978):

Stress, it is argued, can only be sensibly defined as a perceptual phenomenon arising from a comparison between the demands placed on people and their ability to cope. An imbalance in this mechanism, when coping is important, gives rise to the experience of stress and to stress responses. The latter represent attempts at coping with the source of stress. Coping is both psychological (involving cognitive and behavioural strategies) and physiological. If normal coping is ineffective, stress is prolonged and abnormal responses may occur. The occurrence of these, and prolonged exposure to stress per se, may give rise to functional and structural damage. The progress of these events is subject to great individual variation. (p. 25).

It has been estimated that stress and stress-related illnesses are responsible for the loss of 40 million working days per year (Orlans, 1986) and it is further believed that the employees of the largest employer in Britain, the National Health Service, have a special susceptibility to stress-related illness because of the particular nature of their employment which often involves being with individuals at times of great suffering or need (Payne and Firth-Cozens, 1987). It is perhaps not surprising to learn, therefore, that whole books have been written on the subject of stress management specifically for health professionals (eg Sutherland and Cooper, 1990; Burnard, 1991).
Although most studies that have been carried out on stress in health professionals have focused on either doctors (eg Richards, 1989) and or general nurses (eg Bailey and Clarke, 1989), there have also been studies on several other professional groups including community psychiatric nurses (Carson, Bartlett and Croucher, 1991), occupational therapists (Sweeney, Nichol and Kline, 1991) and psychologists (Cushway, 1992). Representatives of all these groups are involved in both of the studies which are to be described here.

Some commonly identified sources of stress that have been identified as being particularly pertinent to health professionals (Bailey, 1985; Firth and Morrison, 1986) include: workload, patient care, interpersonal relationships, knowledge and bureaucratic and political constraints.

1.2 Burnout

Burnout is a particular form of stress that is especially relevant in human service environments. Burnout may be defined as the feelings of physical, emotional and mental exhaustion that are associated with an intense involvement with the recipients of care over a prolonged period of time (Pines and Aronson, 1981). Burnout is a particularly disabling form of stress which is usually recognised when previously committed carers lose their motivation, enthusiasm and commitment to caring (Bailey, 1988, p. 328). Burnout can thus also be seen (Marshall, Kasman and Cape, 1982) as a loss of motivation for creative involvement.
This loss of motivation, or disengagement, occurs as a response to the stress or strain experienced in the job and generally occurs in three stages: an initial perceived imbalance between demand and resources; a variety of short-term effects (which may include anxiety, exhaustion, fatigue and tension) and, finally, changes in attitude and behaviour, with the individual becoming increasingly detached and cynical (Cherniss, 1980).

Perhaps more work into the development of the construct of burnout and its subsequent investigation and measurement has been carried out by Maslach (1982) than anyone else. Maslach (ibid) has conceptualised burnout as a continuous variable that ranges from low to high degrees of experienced distress in three related dimensions of an unified syndrome. She has developed an instrument, the Maslach Burnout Inventory (MBI) (Maslach 1981a, 1986), which consists of 22 statements regarding attitudes and personal feelings which assess the three aspects of the burnout syndrome: emotional exhaustion (feelings of being emotionally exhausted by one's work - 9 items), depersonalisation (an impersonal and unfeeling response towards one's clients - 15 items) and lack of personal accomplishment (feelings of incompetence and lack of personal achievement in one's work - 8 items). The MBI is by far the most used measure of burnout in comparison to other measures, although a number of other measures exist such as, for example, the Staff Burnout Scale for Health Professionals (Jones, 1980).

Research on the MBI has indicated that the inventory provides a valid way of measuring the burnout component of occupational stress eg Belcastro, Gold and Hays, 1983.
The internal reliability of the MBI has been found to be acceptable with split-half reliability coefficients for frequency and intensity having been determined to be .74 and .81 respectively (Maslach, 1981a).

Green and Walkey (1988) have confirmed the three factor structure and demonstrated the construct validity of the MBI by conducting a principal components analysis of previously published data followed by three- and four- factor varimax rotations.

The MBI can thus be seen to be a reliable, valid and very useful tool with which to assess and quantify levels of burnout.

A number of studies have been carried out which have found high levels of burnout in a variety of health professionals. The majority of these studies have been conducted in the United States and the United Kingdom (eg Ceslowitz, 1989; Firth, McIntee and Britton, 1985; Firth, McIntee, McKeowen and Britton, 1986; Lahoz and Mason, 1989; McGrath, Reid and Boore, 1989; Morrice, 1984; Rafferty, Lemkau, Purdy and Rudisill, 1986 and Tracy, Bean, Gwatkin and Hill, 1992).

Two studies on medical practitioners (Morrice, 1984 and Rafferty, Lemkau and Rudisill, 1986) both found moderate to high levels of burnout. Morrice (1984) found generally high levels of burnout amongst general practitioners and, similarly, Rafferty, Lemkau, Purdy and Rudisill (1986) found that 67 American family practice physicians scored in the moderate to high range on all three of the burnout subscales.
The majority of studies have, however, been carried out into burnout in nurses. Firth, McIntee, McKeowen and Britton (1985) used the MBI to assess levels of burnout in 200 qualified British nurses. Whilst they found mean burnout scores to be in the low to moderate ranges, the scores they obtained for personal accomplishment were broadly in line with those obtained from other studies whereas depersonalisation scores were found to be lower than in Maslach's original standardisation sample. This latter finding could either be interpreted as reflecting a genuinely reduced incidence or alternatively could possibly indicate a lowered awareness in staff of this aspect of stress.

In support of the above findings of moderate levels of burnout in British nurses, Ceslowitz (1989) found mean burnout scores in 150 American staff nurses to fall within the moderate range.

McGrath, Reid and Boore (1989), in a study on 171 Northern Ireland nurses, found, similarly to Firth et al (1985) that whereas the nurses experienced less burnout on the depersonalisation and emotional exhaustion subscales than in Maslach and Jackson's (1981) standardisation sample, 94-97% fell into the high burnout category on the lack of personal accomplishment subscale. In addition, however, they also found that 27% of responders described symptoms which could be classified as showing mild psychiatric morbidity when tested with the 28 item version of the General Health Questionnaire (GHQ 28, Goldberg, 1978), this demonstrating a relationship between these two constructs.
The above three studies, therefore, show that the level of burnout in British nurses seems to be lower than that of doctors but also seem to indicate a characteristic pattern of a low degree of burnout on the depersonalisation scale, a moderate degree of burnout on the emotional exhaustion scale and a high degree of burnout on the personal accomplishment scale.

In studies on other health professionals, a survey of 1250 USA pharmacists was conducted by Lahoz and Mason (1989) using the MBI. The three factor structure of the MBI was again confirmed but the subscale scores obtained from pharmacists were found to be significantly lower than those that have been obtained from studies on other health professionals.

Finally, Tracy, Bean, Gwatkin and Hill (1992) found little or no depersonalisation, moderate levels of personal accomplishment and moderate to high levels of emotional exhaustion in a sample of 36 American social workers.

These last two studies together serve to illustrate that doctors and nurses appear to have higher levels of burnout than other related professional groups.

Whilst the above studies demonstrate some variations in levels and patterns of burnout across different professional groups, in general they show that health professionals often have moderate to high levels of burnout and that the level of burnout shown in the personal accomplishment subscale usually exceeds that shown in the other two subscales. Any intervention that would reduce levels of burnout and,
in particular, that aspect of burnout which is related to a lack of feelings of personal accomplishment would seem to be a worthwhile endeavour.

1.3 Job Satisfaction

Job satisfaction may be literally defined as the degree of satisfaction that one obtains from one's employment. Since physical and mental illness combine to render employees unfit for work they also reduce job performance and/or lessen the satisfaction obtained by employees from their work. Job satisfaction is thus one of many ways in which stress outcomes or symptoms become reflected in the workplace (Sutherland and Cooper, 1990) (other indicators including reduced efficiency and absenteeism).

Several different self-report scales are available with which to assess job satisfaction and these include, amongst others, the Job Description Inventory (JDI) (Hackman and Oldham, 1975), Job Satisfaction Index (Brayfield and Rothe, 1951), Job-Related Pressure and Dissatisfaction Inventory (Weyer, Hodapp and Neuhaeuser, 1980), and Minnesota Satisfaction Questionnaire (MSQ) (Weiss, Dawis, England and Lofquist, 1967).

The literature linking feelings of job satisfaction to stress in general goes back over 20 years. Indeed, Menzies (1970), in a seminal psychodynamic paper, wrote of the way in which the nursing service as it was then constituted provided unusually little in the way of job satisfaction for staff and students and of how its absence added to stress.
Much more recently, a British study conducted by Guppy and Gutteridge (1991) investigated the association between reported stress (assessed with items derived from Gray-Toft and Anderson's (1981) Nursing Stress Scale) and job satisfaction (measured using Brayfield and Rothe's (1951) basic job satisfaction index) in 234 general hospital nursing staff. A significant negative correlation was found between job satisfaction and stress with high levels of stress being associated with low levels of job satisfaction.

Kirkcaldy and Siefen (1991) sampled 111 medical and allied staff in a large German child and adolescent psychiatric hospital and found (using the Job-Related Pressure and Dissatisfaction Inventory (Weyer, Hodapp and Neuhaeuser, 1980)) high degrees of interrelationship between job dissatisfaction, job pressure and relationships with co-workers. Relationships with co-workers may thus be seen to be an important variable.

Similarly, Richardsen and Burke (1991) in a survey of 2584 Canadian physicians found that high levels of occupational stress were associated with less job satisfaction (both measured by five-point Likert scales) and high job satisfaction was related to having fewer specific work stressors. It can thus be seen that the number of particular stressors is as important as the general level of perceived stress.

Wolfgang (1991) compared 280 nurses and 279 pharmacists on measures of perceived job stress (as measured by the Health Professions Stress Inventory (HPSI) (Wolfgang, 1988)) and job dissatisfaction (Caplan, Cobb, French, Harrison and Pinneau, 1975). It was found that whilst
the nurses reported significantly higher job stress than the pharmacists (lending further support to the two studies cited in the preceding section), the pharmacists had higher levels of job dissatisfaction. For both groups, levels of job dissatisfaction increased as perceived stress increased.

Page (1992), examined the relationship between stress and job satisfaction in 196 Canadian nurses in the more general context of a study examining theories of perfectionism and self-efficacy. As in the studies reported above, significant negative correlations were obtained between the number of reported nursing stressors (as assessed by the Nursing Stress Scale (Gray-Toft and Anderson, 1981)) and job satisfaction (measured using Brayfield and Rothe's (1951) 18-item Job Satisfaction Scale).

Another British study was that of Rees and Cooper (1992) who carried out a major study examining levels of occupational stress in 1176 employees of all occupational groups within a large health authority in the UK using the Occupational Stress Indicator (OSI) (Cooper, Sloan and Williams, 1988). When Rees and Cooper compared results obtained from their sample with a normative group of workers from non-health care sectors (Cooper, Sloan and Williams, 1989) they found that the health care workers reported greater pressures at work but fewer symptoms of ill health and similar levels of job satisfaction in comparison with previous studies (Rees and Cooper, 1990). They did find, however, that both job satisfaction and ill-health were related to sickness absence which again illustrates the ways in which the effects of stress become manifested in the workplace.
Dunn, Rout, Carson and Ritter (1994) investigated occupational stress in 112 care staff working in nursing homes. A specific 44-item stressor checklist was developed and job satisfaction was measured using Warr, Cook and Wall's (1979) scale. Job satisfaction was found to be significantly negatively correlated with three factors from the stressor checklist, one of which was the amount of support received. Support therefore seems to have an important role as a moderating variable affecting the level of job satisfaction.

The only study that could be identified from the literature that examined the relationship between stress, job satisfaction and psychological distress is that of Baglioni, Cooper & Hingley (1990) although, in a study on general practitioners, Cooper, Rout and Faragher (1989) linked low levels of psychological well-being to low levels of job satisfaction.

Baglioni et al (1990) surveyed 521 nurse managers from one NHS health authority in the southwest of England. Stress was assessed by a specifically developed 71-item job stress questionnaire, psychological distress by the Crown-Crisp Experiential Index (CCEI) (Crown and Crisp, 1979) and job satisfaction by a slightly adapted version of Brayfield and Rothe's (1951) Job Satisfaction Index.

In regression analyses, 30% of the variance in job satisfaction was accounted for by three job stressor variables: career stress, superiors and organisational stress and home vs work conflicts, while 20% of the variance in the CCEI and its subscales was accounted for, mainly by cognitive and behavioural coping factors. The only stressor which was consistently found to be a predictor of psychological
distress and mental health outcome measures was the stress associated with a high workload.

In general, therefore, the above studies clearly demonstrate a negative relationship between stress (in terms of both the general levels of stress and the number of specific perceived stressors) and job satisfaction although given that several different measures of both stress and job satisfaction were used, the individual studies are, of course, not directly comparable with one another. However, it follows that if the level of experienced stress can be reduced this will be associated with an increased level of reported job satisfaction.

1.4 Burnout and Job Satisfaction

A number of studies have used the MBI specifically to examine the relationship between job satisfaction and burnout.

For instance, Rafferty et al (1986) found significant negative correlations between the MBI burnout subscales and simple five-point Likert ratings of job satisfaction.

Hiscott and Connop (1990) examined dimensions of general health, occupational burnout and job satisfaction in a stratified sample of 123 mental health workers from a large Canadian psychiatric hospital (psychiatric nurses and nursing assistants, social workers, occupational therapists and psychologists). Job satisfaction was measured by a number of five-point Likert scales while the MBI was used to assess burnout. Other health problems were measured by
assessing frequencies of reported symptoms indicating job-related stress.

Hiscoct and Connop found that, of all the occupational groups, psychiatric nursing assistants showed less job satisfaction, higher levels of burnout and a greater incidence of negative physical and psychological symptoms of stress than the other professional groups and related this to their having less authority and professional autonomy than the other professional groups.

Siefert, Jayaratne and Chess (1991) report two consecutive (1979 and 1989) surveys of job satisfaction and burnout conducted in national samples (853 and 882 respectively) of American social workers. Burnout was measured using modified versions of Maslach and Jackson's (1981) subscales while job satisfaction was measured by a single four-point item derived from Quinn and Shepard (1971). Significant predictors of depersonalisation and burnout were found to be role conflict and ambiguity, lack of comfort and dissatisfaction with financial rewards. Depersonalisation may thus, perhaps, be seen to be specifically linked to only one of the elements of job satisfaction, financial satisfaction, although lack of support has again been revealed as being associated with reduced job satisfaction.

Tracy, Bean, Gwatkin and Hill (1992) conducted a pilot survey to examine staff burnout and sources of job stress and job satisfaction in a sample of 36 American social workers. They found a moderate level of personal accomplishment and little or no depersonalisation but moderate to high levels of emotional exhaustion. These findings were compared to Maslach and Jackson's (1986) normative sample and
were found to be broadly comparable. It is of note, however, that the scale which indicated the most burnout in social workers was the emotional exhaustion scale whereas that found to indicate more burnout in nurses was the personal accomplishment scale.

The only significant relationship between emotional exhaustion and sources of job satisfaction concerned those workers who viewed an opportunity to increase knowledge and skills about human behaviour and social problems as a source of job satisfaction with this group having significantly lower emotional exhaustion scores than those who did not rate this as a source of satisfaction. The opportunity to increase knowledge and skills is, of course, itself related to feelings of personal accomplishment.

In a longitudinal study, Kirk, Koeske and Koeske (1993) followed a cohort of 82 American social workers during their first 18 months service. At three points over this time a battery of measures were administered including the MBI and other measures designed to assess health, job stress and job and life satisfaction. Over the period of the study the participants experienced increasing amounts of job stress, emotional exhaustion and depersonalisation and reported significantly more stress-related physical and depressive symptoms.

However, over the same period their levels of personal accomplishment and job satisfaction remained stable. Again, this seems to indicate the different burnout patterns between nurse and social workers. More importantly, however, this study also indicated that personal accomplishment is perhaps more closely related to job satisfaction than either emotional exhaustion or depersonalisation whilst the
latter are more related to measures of psychological distress including symptoms of depression and somatic problems.

Cameron, Horsburgh and Armstrong-Stassen (1994) used a multivariate approach to examine similarities and differences in job satisfaction and burnout in a Canadian sample of 623 registered nurses and 231 nursing assistants. They used a burnout scale adapted from Maslach and Jackson (1981) and two independent measures of overall job satisfaction: the Quality of Work-life Feelings (QWL-F) Scale (Sashkin and Lengerman, 1987) and the Minnesota Satisfaction Questionnaire (MSQ) (Weiss, Dawis, England and Lofquist, 1967). Both groups were found to be only moderately satisfied with their jobs and there were no significant inter-group differences on either burnout or job satisfaction. However, an interaction was found showing that senior qualified nurses reported the highest job satisfaction and the lowest levels of burnout again implying a link to levels of personal accomplishment.

Finally, Lloyd, Streiner and Shannon (1994) studied the levels of burnout, depression, job and life satisfaction in 268 Canadian emergency physicians. Burnout was measured using the MBI whilst depression, satisfaction with life and job satisfaction were measured using the Centre for Epidemiologic Research Self-Report Depression Scale (CES-D) (Radloff, 1977), the Satisfaction with Life Scale (SWLS) (Diener, Emenns, Larson et al, 1987) and the Emergency Physician Job Satisfaction Measurement Instrument (EPJS) (Lloyd, Streiner, Shannon and Hahn, 1994). 46% of the physicians showed medium to high levels of emotional exhaustion, 93% medium to high levels of depersonalisation and 79% low to medium levels of personal
accomplishment. 61% were satisfied with their lives and 75% were satisfied with their jobs. For physicians, therefore, the two scales registering higher levels of burnout are the depersonalisation and personal accomplishment scales although the other studies on physicians cited previously showed high levels of burnout on all three scales.

The above studies demonstrate the relationship found in a number of studies involving health professionals between levels of job satisfaction and burnout. Furthermore and more specifically, however, the findings indicate that of the three elements of the burnout syndrome, personal accomplishment seems to be more closely related than the others to high levels of job satisfaction whereas emotional exhaustion and depersonalisation both seem to be more closely related to levels of depression and somatic problems.

1.5 Support

Before considering the topic of clinical supervision specifically, the role of support and its relationships to burnout and job satisfaction will be examined briefly since, in a number of the studies reviewed above, support has been cited as one of the moderating variables.

As Milne, Walker and Bamford (1987) state: "There is a growing acceptance amongst health professionals that health services require more than just their clinical skills and experience in order to be successful. In addition, there is a realisation that services need to provide them with a support system which enables them to work
effectively" (p. 49). Similarly, Maguire and Faulkner (1988) write: "That health professionals need support in order to cope with their clinical reality cannot be disputed but if effective support is to be available for all professionals it requires a commitment at all levels" (p. 1011). Indeed, Adey (1987) suggested that although nurses turn informally to colleagues for support more formal support is generally lacking from teams and managers with most nurses feeling inadequate about accessing appropriate support when they needed it.

A number of studies (including Cronin-Stubbs and Rooks, 1985; Hingley and Harris, 1986; Hare, Pratt and Andrews, 1988; Firth and Britton, 1989; Ceslowitz, 1989; Boyle, Grap, Younger and Thornby, 1991; Cole, 1992 and Hacker Hughes, 1993) have examined the relationships between support and burnout in health professionals.

Cronin-Stubbs and Rooks (1985), in an American study, examined the relationships between burnout and social support in 296 nurses working in medical units, operating theatres, critical care units or psychiatric units and found an association between lower amounts of emotional support received and a higher degree of experienced burnout.

Hingley and Harris (1986) state that major stressors seem to be created not by external factors but by lack of support which is experienced and/or expressed in practice and Firth and Britton (1989) also related one of the three elements of burnout, depersonalisation, in a group of nurses to a lack of perceived support.
Hare, Pratt and Andrews (1988) examined various predictors of burnout in professional and para-professional staff working in hospitals and nursing homes. They found that one of the most powerful negative predictors of burnout was instrumental, problem-focused coping and suggested various interventions for minimising burnout, focussing *inter alia* on organisational issues such as supervisory support and peer relationships.

In a second predictive study, Firth and Britton (1989), found that perceived lack of support from a superior and emotional exhaustion predicted the frequency of sickness absences of more than four and seven days respectively over a two year period in a sample of 106 qualified British nursing staff.

Ceslowitz (1989) examined the relationship between burnout and the use of various coping strategies among 150 randomly selected staff nurses from four hospitals. She found that planful problem solving and seeking social support were strategies used by those nurses who experienced decreased levels of burnout.

Boyle, Grap, Younger and Thornby (1991) also found, in a study of 103 critical care nurses, a significant negative relationship between work-related and non-work-related social support and burnout.

In a 1992 Nursing Times survey of 1800 nurses on the subject of stress at work (Cole, 1992) one nurse commented: "I feel the main problem is a total lack of support for all nurses". 77% of respondents said that they dealt with undue pressure informally through the time-honoured means of confiding in a colleague.
Hacker Hughes (1993) reported on the effects of a programme of eight workshops, combining a psycho-educational component with a psychodynamically oriented support group, in reducing levels of burnout on a group of 27 health service staff working in stressful clinical settings. Participants in the workshop programme showed a significant improvement in measured levels of one of the three elements of burnout, lack of personal accomplishment.

A further study, Pawzy, Wellisch, Pasnau and Liebowitz (1983), studied levels of job satisfaction and support among five groups of nurses working at an American hospital. It was found that the nurses who expressed the most job satisfaction worked on those units which were traditionally regarded as being most stressful with the highest turnover rates. Pawzy et. al. (1983) suggested that a possible explanation might be related to the psychosocial support provided for those units by liaison psychiatrists. In other words, those wards where staff expressed most job satisfaction were those where staff also received more support.

In summary, therefore, all the studies reported above indicate that reduced levels of burnout and increased job levels of satisfaction are both related to increased levels of support. Although support can come from a variety of sources including both peers and supervisors and can be provided in a variety of ways including both informal and formal means, the amount of perceived and experienced support can nonetheless be seen to have an important role in moderating the effects of burnout and in enhancing levels of job satisfaction.
1.6 Clinical Supervision

One particular form of organisational support, clinical supervision, has recently become an important issue for health professionals. Having been initially proposed for the nursing profession by a government strategy paper (Department of Health, 1993), three recent publications on the subject (Butterworth and Faugier, 1994; Kohner, 1994; UKCC, 1995) have now been widely distributed and supported by the various British government health departments.

Whereas the Oxford English Dictionary (1990) defines "to supervise" as: to oversee the execution of a task" and "to oversee the actions or work of a person", Hooton (1994) states that the concept and definitions of clinical supervision focus on a "positive process which is a negotiated, sharing interaction, designed to improve professional and personal clinical practice. Rather than being intended, therefore, as managerial oversight it is intended to be a facilitative exchange between practising professionals centred on interpersonal support and with the intention of enabling the development of professional skills." (p. 8).

In practice, clinical supervision involves one professional meeting regularly with others, either individually or in groups, specifically to discuss the clinical aspects of their work.

Clinical supervision has been defined by UKCC (1995) as "a process based on a clinically focused professional relationship between the practitioner engaged in clinical practice and a clinical supervisor. It complements, but does not take the place of, formal programmes of
education. This relationship involves the clinical supervisor applying clinical knowledge and experience to assist colleagues to develop their practice, knowledge and values. This relationship will, therefore, enable practitioners to establish, maintain and improve clinical standards and to promote innovation in clinical practice. Clinical supervision is not: the exercise of managerial responsibility and managerial supervision; a system of formal individual performance review procedures or intended to be hierarchical in nature" (p. 2).

Some additional definitions that have been formulated (Walshe and Bridge, 1995) are also helpful here. "Clinical supervision is a complex collaborative process between clinicians. A supervisor is a clinician with appropriate skills, knowledge and experience. A supervisee is a clinician who seeks to objectively reflect upon and discuss their clinical work" (p. 1).

The aims of clinical supervision have been stated by Castledine (1994) (p. 1135). "Clinical supervision should encourage expert peer support, guidance and direction for all health professionals, whatever their level of expertise. It is supposed to be a process of review, based firmly in the professional practice of the individual".

Procter (1992) outlines three main functions of clinical supervision:

A formative function involves an educative process through reflection which should encourage both personal and professional development. Clinical supervision should therefore facilitate the transfer of an
individual health professional's knowledge base into the clinical area.

A normative function aims to offer a degree of quality control ensuring high standards of professional practice through adherence to professional policies and procedures. The supervisor is seen as ensuring that often scarce human materials and resources are used to best advantage to clients.

Finally, a restorative function recognises the emotional stress that health professionals may experience, emphasising the understanding of this in order to deal with reactions. As a protective device, therefore, it is thought that clinical supervision aims to prevent or deal with negative attitudes related to physical and psychological stress within the emotional impact of professional work (Hooton, 1994). Maslach (1982) uses the coal mining analogy of "pit head time" where miners have the opportunity to "wash off the grime from the job during work time".

It is therefore believed that clinical supervision, if conducted properly, can improve performance, maintain the quality of client care, increase work satisfaction and reduce stress (Kohner, 1994).

Huebner (1992) studied 139 American school psychologists using the MBI, a stress inventory and a demographic and job satisfaction questionnaire that had been designed specifically for the study. The latter included demographic items and items related to job satisfaction and supervision satisfaction. Huebner found that approximately a third of the psychologists showed high levels of
emotional exhaustion and low levels of personal accomplishment whereas approximately a tenth showed high levels of depersonalisation. Overall job satisfaction and supervision satisfaction were both significantly related negatively to emotional exhaustion.

Palsson, Hallberg, Norberg and Isovaara (1994) examined the effects of group clinical supervision as a means of social support on 32 Swedish cancer nurses in a study using semi-structured interviews. The nurses felt that there was a great need to unburden themselves of job-related thoughts and feelings and to receive support after being in emotionally demanding care situations. The nurses also felt that clinical supervision had provided them with a source of relief (an emotional component) but also with feelings of confirmation and a means of professional development (aspects that are more related to feelings of personal accomplishment and job satisfaction).

The effects of group clinical supervision on burnout over a one year period were evaluated in a controlled study conducted on nurses working with severely demented patients by Berg, Hansson and Hallberg (1994). The 19 nurses who had been given systematic group clinical supervision showed a significant decrease in burnout whilst the 20 nurses on the control ward showed no similar changes. Berg et al (1994) conclude that it seems reasonable to assume that systematic clinical supervision decreases the negative outcome of stress caused by the psychological burdens imposed by nursing care.

Finally, Hallberg (1994) evaluated the effects of systematic group clinical supervision on burnout and job satisfaction in all nurses
Only four studies could be identified which have examined the links between supervision, burnout and job satisfaction with only the latter three of these being specifically concerned with clinical supervision. All of the latter three studies have relatively small sample sizes and all also concern themselves with group clinical supervision. However, in both of the latter two studies either a decrease in burnout or an increase in job satisfaction was found.

1.7 Learning Disability Services

Stress and Burnout

In comparison to the above literature, comparatively little research has been done into stress and burnout in staff working in learning disability services. The next section, therefore, will review the little research that has been carried out to date in this area.

Allen, Pahl and Quine (1990) concluded that working in the learning disability field was moderately stressful but that there were no significant differences between the levels of stress experienced by those working in hospital or community settings.

In a larger, American, study, Corrigan (1993) surveyed 322 clinicians and administrators from a large state hospital and developmental
centre. Two underlying constructs were revealed by factor analysis: lack of administrative control and practice-related stress. No differences were found, however, between stress levels of members of staff who worked with individuals with learning disabilities and those who worked with individuals with psychiatric problems. However, nurses and psychiatrists reported greater job-related stress than other professional staff groups.

O'Hare (1995) surveyed 272 staff working in a learning disability unit, using a specifically designed questionnaire. A third of staff surveyed experienced stress indicators with the most commonly reported being aches and pains, headaches, exhaustion, changes in appetite and sleeplessness. Several staff felt frustrated, irritated, angry, overtired, helpless, anxious and unable to concentrate and tobacco, alcohol and medication were used by many to combat frustrations.

With regards to sources of stress, three quarters felt that there were insufficient staff to cover shifts generally, two thirds thought that there were insufficient staff to cover their own shift and almost one third felt unable to cope with their present workload. Over two thirds did not trust, and one third never felt valued by, management whilst nine tenths trusted, and over nine tenths felt valued by, colleagues. Over one half felt threatened by organisational changes taking place in the organisation.

Working with people with learning disabilities can therefore be seen to be moderately stressful although there do not seem to be marked
differences between stress levels in learning disabilities and general psychiatry.

Job Satisfaction

Power and Sharp (1988) compared sources of stress and job satisfaction among 181 learning disability and 24 hospice nurses. The learning disability nurses identified the main stressors (as measured by the Nursing Stress Scale (Gray-Toft and Anderson 1981)) as being stress related to workload, conflict with other nurses and nursing environment. Job Satisfaction in learning disability nurses (measured by the Job Description Index (JDI) (Smith, Kendall and Hulin, 1969) was lower for satisfaction with supervision, co-workers and pay but higher for promotion prospects than in hospice nurses. Satisfaction with supervision can thus be seen to be an important aspect for those working with people with learning disabilities.

With regards to the relationships between stress, job satisfaction and psychological distress, nursing stress in the learning disability group correlated negatively with job satisfaction but positively with state-trait anxiety and non-psychotic psychiatric disturbance (measured by the State-Trait Anxiety Inventory (STAI, Spielberger, Gorsuch and Luschene, 1990) and the General Health Questionnaire - 60 item (GHQ-60, Goldberg, 1972) respectively).

In a review, Sharrard (1992) cited the main causes of high job stress and low job satisfaction in staff working with people with learning disabilities as being: working with clients; lack of control and role; isolation; poor organisation and lack of reward and personal
issues. Possible solutions that were identified included: individual efforts to cope with stress; resources and social support. Thus, again, social support has been cited as one of several possible solutions to the high levels of stress and low levels of job satisfaction found in this group of staff.

Lawes (1992), in a study of 213 staff working in a learning disability unit found that staff experienced significantly more pressures than a normative sample of workers in industry. Staff experienced less job satisfaction and higher levels of physical and mental ill health than a normative group of industrial workers, thus placing them at a greater risk of developing a range of serious stress related problems. Over 50% of staff reported one or more symptoms of ill health as occurring frequently or very frequently. Thus although levels of stress and job satisfaction are not necessarily different for staff working with people with learning disabilities when compared to general psychiatry, working in learning disabilities can clearly be seen to be stressful when compared with a normative group of other workers.

More specifically, in comparison with other workers, staff reported greater pressures arising from relationships with other people and the organisational structure and climate of the unit. Significant factors identified included isolation, lack of support, working long hours and adopting a negative role. Major pressures, however, were associated with poor resources and too much work, poor management supervision, support, communication and attainment. Again, it can be seen that lack of support has been identified as an important factor.
Qualified nurses felt under more pressure from their work and felt more out of control and were most dissatisfied with their jobs and with organisational processes. However, administrative staff reported the highest levels of mental ill health. No differences were found between hospital or community staff but women staff reported higher levels of job satisfaction and part-time workers experienced significantly less job pressures.

Recommendations were made for action at three levels: an organizational level, a training and staff development level and a counselling service level. Specific recommendations included the adoption of an EAP service, staff stress workshops, regular monitoring of stress levels in the organisation and quality action groups to enhance the sense of control felt by care staff.

The only study that could be located in the learning disabilities literature examining the relationship between burnout and job satisfaction is that by Razza (1993). Razza studied 236 direct care staff working in group homes for individuals with learning disabilities. When a path analysis of the data was conducted four variables were found to contribute to job satisfaction (measured by a scale devised by Price and Mueller, 1986). These were burnout (measured using the MBI), satisfaction with supervision, agreement of the job with personal goals and values and employment history (all measured either using specifically designed scales or using the Price and Mueller (1986) scales). Both burnout and satisfaction with supervision can again be seen to be related to levels of job satisfaction in this group.
The above studies show low levels of job satisfaction in staff working with people with learning disabilities and *inter alia* relate this both to levels of burnout and to lack of support and (in the latter study only) also to low degrees of satisfaction with supervision.

### 1.8 Summary and Conclusions

A number of studies, reviewed above, clearly demonstrate the high levels of burnout and low levels of job satisfaction found in health workers. Burnout and job satisfaction have been shown to be negatively related to one another. Of the three elements of burnout, one, personal accomplishment, seems to be more related to job satisfaction than the others. The other two elements of burnout, depersonalisation and emotional support, do however appear to be more related to certain aspects of psychological distress, including symptoms of depression and somatic problems.

Support has been revealed as an important factor which affects both burnout and job satisfaction and which perhaps operates through its influence on coping mechanisms. A relatively new form of structured organisational support that has been widely introduced into the health service is clinical supervision but there have been very few studies to date examining its effects and there are limitations to the few studies that have been carried out.

Staff working with people with learning disabilities have been found to show both low levels of job satisfaction and high levels of burnout and psychological distress. Although lack of support has been
cited as an important factor relatively few studies have evaluated this. Indeed, no studies at all could be identified which have examined the effects of clinical supervision in a population of staff working with people with learning disabilities.

1.9 Aims of the Current Studies.

It was decided to carry out two related studies.

In the first, a preliminary survey would be carried out in a health service trust providing services to people with learning disabilities in order to determine the extent to which clinical supervision was practised and to examine the range and variety of ways in which clinical supervision is carried out.

In the second study, the relationships between clinical supervision, burnout, psychological distress and job satisfaction would be more closely examined particularly with a view to testing the assertion that clinical supervision is associated with decreased burnout and psychological distress and increased job satisfaction. Detailed hypotheses will be outlined at the beginning of each of the next two chapters.
CHAPTER TWO

CLINICAL SUPERVISION

IN A LEARNING DISABILITIES TRUST:

A PRELIMINARY SURVEY

2.1 Introduction

As explained in Chapter 1 above, it was decided to conduct a preliminary study surveying the use of clinical supervision in an NHS trust providing services to people with learning disabilities (Hacker Hughes and Herron, 1995). This survey would not seek to test any specific hypotheses as such but instead would be an exploratory survey of the nature, amount and quality of supervision taking place in this NHS trust. This preliminary study will therefore be reported initially in this chapter as a means of setting the following study into its proper context.

2.2 Method

Design

A questionnaire study was adopted as the means of investigation.

Participants

The questionnaire was circulated to 250 employees, this representing approximately one quarter of the trust's workforce. Participants were selected in a stratified sample taken from all settings, both
institutional and community, with care being taken to ensure that all professional groups and all levels of staff employed by the trust were adequately represented.

Measures

A specifically designed 12-item questionnaire (Appendix 1) was constructed to examine the nature, amount and quality of supervision currently being given and received within the trust.

A very broad definition of supervision was taken and given to respondents as part of the questionnaire (see Appendix 1) with the following different approaches all being included under the title of supervision: formal supervision, advice, discussion, demonstration, explanation and modelling.

The 12 questionnaire items asked: who supervision was received from, how regularly it was received, whether it was offered automatically or not, what form supervision took, whether supervision was conducted on an individual or group basis, whether it was conducted formally or informally, whether it was related to particular clients care needs or to a more general topic, how readily available supervision was, how useful recipients found it and what recipients felt might make it more useful. Finally, the questionnaire asked whether professionals were aware of statutory regulations concerning supervision and whether there was any opportunity to discuss professional issues in supervision.
Procedure

The questionnaires were distributed together with a covering letter. The completed questionnaires were analysed using the SPSS-PC statistics package.

2.3 Results

53 questionnaires were returned (a response rate of 21.2%). Since the questionnaires were distributed through internal mail this response rate can be favourably compared with those commonly obtained in postal surveys.

Characteristics of Sample

6 (11.3%) of the questionnaires were returned by males and 47 (88.7%) by females.

14 (26.4%) were returned by staff members aged under 30, 33 (62.3%) by staff members aged between 31 and 50 and 6 (11.3%) by staff members aged between 51 and 65.

37 (69.8%) questionnaires were returned by people working in institutional settings, and 16 (30.2%) by those working in community settings.

33 (62.3%) of the questionnaires were received from direct care staff, 15 (28.3%) from professionals and 5 (9.4%) from managers.
18 (34%) questionnaires were received from junior grades, 11 (20.8%) from middle grades and 23 (43.4%) from senior grades.

Only 1 questionnaire (1.8%) was returned by a senior manager or head of service and no questionnaires were returned by directors.

This profile is in line with profiles of the total population (the whole Trust) obtained in other studies (e.g. Lawes, 1992; O'Hare, 1995) thus indicating that the results could be generalised to the total population.

Who was supervision received from?

15 (28.3%) received supervision from ward or service managers, 14 (26.4%) from directors or others, 14 (26.4%) from team leaders or equivalent, 3 (5.7%) from clinical nurse specialists, and 2 (3.8%) from named nurses or keyworkers. 5 (9.4% of the sample) received supervision from nobody.

When asked who they would ideally like to receive supervision from, 19 (35.8%) said ward or service managers, 11 (20.8%) said team leaders, 9 (17%) said 'others', 7 (13.2%) said directors, 5 (9.4%) said clinical nurse specialists, 1 (1.9%) said the chief executive and 1 (1.9%) said named nurses or keyworkers.

How regularly was supervision received?

22 (41.5%) received supervision at least monthly, 13 (24.5%) at least daily, 7 (13.2%) less than monthly, 3 (5.7%) fortnightly and
(5.7%) weekly. 5 (9.4%) received no supervision at all. The greatest range in frequency of clinical supervision was found in the professional group.

22 (41.5%) ideally wished to receive supervision monthly, 10 (18.9%) fortnightly, 10 (18.9%) daily, 6 (11.3%) quarterly, 4 (7.5%) weekly and 1 (1.9%) at some other time interval.

Was supervision offered automatically?

40 (75.6%) said that supervision was offered automatically, 13 (24.5%) that it was not offered automatically or had to be requested. 50 (94.3%) said that they wished regular supervision to be offered automatically.

Was regular supervision stipulated in employees' contracts?

40 (75.5%) thought that it was, and all felt that it should be, stipulated.

What forms did supervision take?

42 (79.3%) said that supervision took over three forms, 5 (9.4%) said two or more, 5 (9.4%) said discussion only and 1 (1.9%) said advice only.

20 (37.7%) said that they wished that supervision should take four or more forms, 14 (26.4%) three or more, 6 (11.4%) two or more. Of the remaining 13 (24.5%) who felt that supervision should take a specific
form, 8 (15.1%) requested discussion only, 4 (7.5%) advice only and 1 (1.9%) modelling only.

On what bases was supervision received?

40 (75.6%) received individual supervision only, 1 (1.8%) received group supervision only and 12 (22.6%) received both types.

44 (83%) said that they would prefer to receive individual supervision, 2 (3.7%) group supervision and 7 (13.3%) would prefer to receive both types.

How formal was supervision?

30 (56.6%) received informal supervision, 12 (22.6%) received formal supervision and 11 (20.8%) received both types.

34 (64.2%) wished to receive supervision informally, 12 (22.6%) would prefer formal supervision and 7 (13.2%) wished to receive both types.

What was the scope of supervision?

36% of supervision concerned general topics, 31% concerned specific client issues and 33% concerned both of the above areas.

24 (45.3%) wished that supervision was of both types, 19 (35.8%) requested supervision on general issues and 10 (18.9%) requested supervision on particular clients' care needs.
How urgently could supervision be made available?

22 (41.5%) felt that if supervision was required urgently it would be made available the same day, 18 (33.9%) within a week, 4 (7.6%) within a fortnight, 3 (5.7%) within a month and 5 (9.5%) within some other interval. 1 (1.8%) felt that it would never be made available.

38 (71.6%) felt that urgent supervision should be available the same day and 15 (28.4%) felt that it should be available the same week.

How useful was supervision?

18 (33.9%) felt that supervision was very useful, 16 (30.2%) that it was extremely useful, and 13 (24.5%) that it was quite useful. 6 (11.4%) felt that the supervision received was not at all useful.

What would make supervision more useful?

17 (32.1%) asked for increased frequency, 15 (28.3%) for increased availability, 12 (22.7%) for increased quality, 5 (9.4%) for easier access and 4 (7.5%) for a different form of supervision.

Awareness of statutory regulations concerning supervision

Although 32 (60.4%) were aware of professional statutory regulations, 21 (39.6%) were not.
Opportunity to discuss professional issues

41 (77.4%) had the opportunity to discuss professional regulations, guidelines and procedures. 12 (22.6%) had no such opportunity.

Other comments

13 of the respondents made additional comments in response to the request for other comments. The full list of comments is recorded below.

"Because of the range of issues covered sometimes discussion proves too superficial"

"(My manager) fulfils their supervisory capacity well but more of the working day should be allocated to this"

"My clinical work is not supervised"

"I'm happy with the supervision sessions. I can request them more frequently as and when"

"Any time spent on discussion is usually done on time owing"

"The supervision is adequate"

"Supervision sessions have only re-started recently"
"I feel (supervision) is a one-way process"

"I am able to get informal advice from my supervisor"

"In terms of clinical supervision this facility has never been available"

"Venue is at times difficult. Supervision usually takes place within the residents' home"

"As a professional, I feel there is a lack of peer supervision"

These comments amply serve to illustrate the variety of scope, frequency and quality of supervision revealed by the survey.

2.4 Discussion

Any discussion on the above must be prefaced by the remark that the above analysis was based on 53 questionnaires. Nevertheless care was taken to ensure that the sample surveyed constituted a representative sample of employees and analysis of the questionnaires returned confirmed the representativeness of the sample.

A very broad definition of supervision was taken including: formal supervision, advice, discussion, demonstration, explanation and modelling. The responses to questions on the frequency, form and scope of supervision indicated that a wide variety of patterns and types of supervision were being practised within the trust.
The survey showed that frequency of supervision varied widely across the trust. Whilst a quarter claimed to receive daily supervision, the majority received monthly supervision (also the most commonly requested) with a tenth receiving no supervision at all. Urgent supervision was usually available the same week whilst nearly three quarters of staff felt that it should be available the same day.

The quality of supervision also seemed to vary markedly. Almost a third found supervision to be extremely useful but a tenth felt that the supervision that they receive was not at all useful. Increased frequency, increased availability and better quality of supervision were all requested.

Supervision was not always offered automatically and whilst virtually all respondents feel that it should have been, with supervision arrangements being stipulated in contracts of employment, one quarter of respondents were not offered regular supervision automatically. One third of respondents were also unaware of any statutory professional requirements concerning supervision.

Current supervision took a number of different forms and the majority of supervision was carried out informally and on an individual basis. This also appeared to be what the majority of staff wanted, with almost half the respondents requesting supervision on general issues as well as on particular client needs. A fifth of respondents did not have the opportunity to discuss professional guidelines, procedures or regulations.
The pattern of supervision practices found within the trust, therefore, showed a wide variation from the more clearly defined forms of clinical supervision that had been outlined by Hooton (1994) and UKCC (1995) i.e. "a facilitative exchange" which is not "the exercise of managerial ... supervision; a system of formal ... review procedures or intended to be hierarchical in nature".

Indeed, some of the additional comments received only served to illustrate this very effectively. This being the case, it is difficult to ascertain whether either the formative, normative and restorative functions cited by Procter (1992) or the encouragement of peer support, guidance and direction advocated by Castledine (1994) could realistically be achieved.

That is to say, given the diversity of frequency, types and styles of supervision revealed by this study it was not possible to ascertain clearly the functions and effects of this supervision. A further study would be required to establish what positive effects were associated with supervision, if any, and what functions it served.

2.5 Summary

The preliminary study clearly showed a very wide variation in frequency, quality, form and scope of supervision. This variation may have arisen from a true confusion about the precise meaning of the term "supervision" since this often has different meanings in clinical, social work and human resources contexts. Alternatively this variation may merely have been an inevitable consequence of the broad definition of supervision that had initially been taken.
Nevertheless, the wide variation that was found in the frequency of supervision, particularly in the professional groups, also ideally lent itself to a second comparative study being carried out to investigate the relationship between the frequency of clinical supervision (with clinical supervision itself now needing to be much more closely defined) and a variety of other variables. Given the diversity revealed by the first study frequency was chosen as the only variable which could easily be measured with little or no ambiguity.

Specifically, the main study would, through using a number of different professional groups each of which was having clinical supervision at a different frequency, seek to test Kohner's (1994) assertion that higher frequency clinical supervision is related to increased job satisfaction and reduced levels of burnout and psychological distress, an assertion that had been as yet untested by the existing literature.
CHAPTER 3

SUPERVISION, STRESS & SATISFACTION IN AN NHS TRUST FOR PEOPLE WITH LEARNING DISABILITIES

3.1 Introduction

Of approximately 50 studies reviewed above, the majority reviewed examined various relationships between stress, burnout, psychological distress and job satisfaction. The findings of all these studies demonstrated a clear relationship between perceived stress and burnout, together with showing a negative relationship between burnout and job satisfaction.

When the role of support was examined it was shown that as the amount of support increased so levels of burnout reduced and ratings of job satisfaction increased.

To date, however, there have been only two studies (Berg, Hansson and Hallberg, 1994 and Hallberg, 1994) that have specifically examined the role of clinical supervision as a mediating factor in this process. Both of these are Scandinavian studies and their results are somewhat contradictory in that whilst Berg et. al. (1994) found an association between clinical supervision and reduced burnout, Hallberg (1994) found no such association although she did report an increase in levels of job satisfaction.
Whilst the learning disabilities literature has a few studies examining the relationships between stress, burnout, psychological distress and job satisfaction there has been very little research on the effects of support on the above. Furthermore, there have been no studies to date which have examined the effects of clinical supervision as a mediating factor on burnout, health and job satisfaction.

Since the above preliminary survey had shown a wide variation in the practice of clinical supervision it was thought appropriate to conduct a case study on one of the directorates of the trust, the Specialist Support Directorate, where numerous different arrangements for clinical supervision existed, in order to determine the relationship of frequency of clinical supervision (which could be measured with little or no ambiguity and which had been found to vary extremely widely) to levels of burnout, psychological distress and job satisfaction.

3.2 Hypotheses

The study would seek to examine relationships between the constructs of burnout, psychological distress and job satisfaction and, in particular, their relationship to clinical supervision.

The specific hypotheses derived from the literature to be tested in the study were as follows:
Hypothesis 1

The three components of the burnout syndrome (emotional exhaustion, depersonalisation and personal accomplishment) are differentially associated with measures of psychological distress.

a) Levels of emotional exhaustion and depersonalisation are positively related to levels of psychological distress i.e. high levels of emotional exhaustion are associated with high levels of psychological distress.

In particular, emotional exhaustion and depersonalisation are associated with symptoms of anxiety and insomnia and severe depression.

b) Levels of personal accomplishment are negatively related to psychological distress i.e. high levels of personal accomplishment are associated with low levels of psychological distress.

Hypothesis 2

There is a differential relationship between the three components of the burnout syndrome and job satisfaction.

a) There is a negative relationship between feelings of emotional exhaustion and depersonalisation and job satisfaction i.e. low levels of emotional exhaustion and depersonalisation are associated with high levels of job satisfaction.
b) There is a positive relationship between feelings of personal accomplishment and job satisfaction i.e. high levels of personal accomplishment are associated with high levels of job satisfaction.

**Hypothesis 3**

Frequency of clinical supervision is positively related to levels of:

a) job satisfaction and

b) personal accomplishment.

i.e. higher frequency clinical supervision is associated with high levels of a) job satisfaction and b) personal accomplishment.

**Hypothesis 4**

Frequency of clinical supervision is negatively related to levels of:

a) emotional exhaustion and depersonalisation and

b) psychological distress.

i.e. low frequency clinical supervision is associated with high levels of: a) emotional exhaustion and depersonalisation and b) psychological distress.
The remainder of this chapter will report details of the design of the study, the participants and the measures and procedures used.

3.3 Multidimensional Scaling

A variety of multidimensional scaling techniques would be used to explore further the nature of the relationship between variables when all groups were considered and also in order to reveal more clearly the basis of any differences that might be found between groups when a number of variables were considered together.

3.4 Ethical Committee Approval

Ethical Committee Authorisation for the study was sought from the relevant ethical committees and granted by them in their letters of 24th April and 18th July respectively. Their approval stipulated that the anonymity of participants be preserved.

3.5 Design

There were eight levels of between-groups independent variable (namely the type of occupational groups: psychiatrists, psychologists, community nurses and clinical nurse specialists, occupational therapists, speech and language therapists, physiotherapists, music and drama therapists and dietitians) and four types of dependent variable (five measures of psychological distress, three measures of burnout, five measures of job satisfaction and one measure of clinical supervision).
As explained previously, the eight different occupational groups listed above were chosen because of the wide variation in frequency of clinical supervision that had been found to exist across these professional groups.

3.6 Participants

The participants in the study were the 70 members of the Specialist Support Directorate of an NHS trust providing services to people with learning disabilities, all of whom were members of the occupational groups listed above.

All the psychiatrists, psychologists, occupational therapists, speech and language therapists, physiotherapists, dietitians, music, drama and art therapists, community nurses and clinical nurse specialists working in an NHS trust providing services for people with learning disabilities were invited to participate in the study.

3.7 Measures

Three questionnaires were used: the Maslach Burnout Inventory (Maslach and Jackson, 1986) (Appendix 2); the General Health Questionnaire (28 item version, Goldberg and Hillier, 1979) (Appendix 3) and the Job Satisfaction Scales from the Job Diagnostic Survey (Hackman and Oldham, 1975) (Appendix 4). In addition, participants were asked about the frequency with which they receive clinical supervision as defined in UKCC (1995) (Appendix 5). Participants were provided with copies of this definition.
The four measures are described in detail below:

The General Health Questionnaire - 28 item version (GHQ-28).
(Goldberg and Hillier, 1979).

The General Health Questionnaire is a self-administered screening questionnaire which is designed for use in consulting settings aimed at recognising and detecting those with a discernible psychological or psychiatric disorder. It concerns itself with two major classes of phenomena. The first of these is an inability to carry out the normal functions that are traditionally associated with a state of good health whilst the second concerns the appearance of novel phenomena which are of a distressing nature. The General Health Questionnaire may therefore be thought of as comprising a set of questions which, when taken together, form a lowest common multiple of symptoms which might be encountered in various known psychological and psychiatric disorders. The symptoms to which it refers are those which best differentiate those suffering from recognised and recognisable psychological and psychiatric disturbance from those others who consider themselves as being "well" (Goldberg and Hillier, 1979).

The scaled 28-item version of the General Health Questionnaire (Goldberg and Hillier, 1979) consists of four subscales developed on the basis of a principal components analysis, these being: somatic symptoms, anxiety and insomnia, social dysfunction and severe depression. It has been emphasised that the four separate subscales represent dimensions of symptomatology and do not necessarily represent psychiatric diagnoses.
The frequency with which a participant experiences symptoms related to each subscale is assessed using a four point, fully anchored, response format. Each item consists of a question asking whether the participant has recently experienced a symptom or particular item of behaviour on a scale ranging from 'less than usual' to 'much more than usual'. The four-point response scale may be scored either as a bimodal response scale or as a multiple response Likert scale. (Goldberg and Williams, 1988). The latter method of scoring was chosen for the current study in order to conserve as much information as possible.

When the GHQ-28 was being developed, it was possible to extract clinical ratings from the original validity study carried out on the GHQ in order to validate the A, B and D scales of the GHQ-28. The rating for somatic symptoms correlated more highly with the A scale than the others, psychiatrists' ratings of morbid anxiety correlated highly with the B scale and psychiatrists' depression ratings correlated highly with the D scale, (Goldberg and Hillier, 1979).

Reliability coefficients (Cronbach's Alpha) for the GHQ have been found to vary from 0.82 to 0.93 with split half reliability varying from 0.83 to 0.95 and test-retest reliability varying from 0.73 to 0.76, (Goldberg and Williams, 1988).
Maslach Burnout Inventory (Second Edition) (Maslach and Jackson, 1986)

This has three separate subscales measuring three different dimensions of burnout, which is conceptualised as a continuous variable but for which three separate elements are measured. The Emotional Exhaustion subscale assesses feelings of being emotionally overstretched and exhausted by one's work; the Depersonalisation subscale measures an unfeeling and impersonal response towards one's clients and the Personal Accomplishment subscale assesses feelings of competence and successful achievement in one's work with people. The frequency with which the participant experiences feelings related to each subscale is assessed using a seven point, fully anchored, response format.

A high degree of burnout is reflected in high scores (upper third of the normative distribution) on the Emotional Exhaustion and Depersonalisation subscales and in low scores on the Personal Accomplishment subscale.

An average degree of burnout is reflected in average scores (middle third of the normative distribution) on all three subscales.

A low degree of burnout is reflected in low scores (lower third of the normative distribution) on the Emotional Exhaustion and Depersonalisation subscales and in high scores on the Personal Accomplishment subscale.
The Maslach Burnout Inventory comprises 22 items: nine from the Emotional Exhaustion subscale; five from the Depersonalisation subscale and eight from the Personal Accomplishment subscale.

The three factor structure of the Maslach Burnout Inventory has been confirmed in several studies including, for example, Green and Walkey, 1988.

Reliability coefficients for the three separate subscales (Cronbach's Alpha, n = 1316) have been found to be: Emotional Exhaustion .90 (s.e.m. 3.80); Depersonalisation .79 (s.e.m. 3.16); Personal Accomplishment .71 (s.e.m. 3.73) (Maslach and Jackson, 1986).

Test-retest reliability coefficients over a four week period have been found to be: Emotional Exhaustion .82; Depersonalisation .60; Personal Accomplishment .80 (all p < .001) (Maslach and Jackson, 1986).

The Maslach Burnout Inventory is also argued to have good convergent validity (interviews conducted in preliminary interviews with burned-out workers and correlations with independent co-worker behavioural ratings) (Maslach and Jackson, 1986).
The Job Satisfaction Scales from the Job Diagnostic Survey (Hackman and Oldham, 1975).

The Job Satisfaction Scales from the Job Diagnostic Survey consist of a 14 item questionnaire (Hackman and Oldham, 1975) which itself is comprised of five short scales of specific satisfactions: growth satisfaction (four items); satisfaction with job security (two items); satisfaction with compensation (two items); satisfaction with co-workers (three items) and satisfaction with supervision (three items).

Participants report directly how satisfied (or dissatisfied) they are with different aspects of their jobs.

The degree to which the participant experiences satisfaction with each item on the questionnaire is measured using a seven-point fully anchored response format which are scored using the Likert method.

Subscale scores are calculated by taking the mean of the scores on the various subscale items.

Hackman and Oldham (1975) report satisfactory reliability and validity data from their standardisation study on 658 employees occupying 62 different jobs in 7 organisations. Over its development the JDS was taken by 1,500 employees working on over 100 different jobs in 15 different organisations.

Internal consistency reliability coefficients for the subscales were found to vary from .56 (satisfaction with co-workers) to .84 (growth satisfaction).
satisfaction) while discriminant validity (as measured by taking the median value of correlations between the sub-scale items and all of the other items in the other scales - the median "off-diagonal" correlation coefficient) was found to vary between .23 (satisfaction with co-workers) to .28 (growth satisfaction).

Frequency of Clinical Supervision

Each participant was asked to indicate how often they received clinical supervision (as defined in the United Kingdom Central Council on Nursing and Midwifery Position Statement (UKCC, 1995) which was printed in full on an attached sheet) (Appendix 5) by underlining the appropriate frequency. This definition was much more precise than that that had been used in the preliminary survey and thus the type of supervision received was controlled for. The number of clinical supervision sessions received per year was then calculated.

3.8 Procedure

The three questionnaires (Appendices 2-4), together with an information letter, were distributed to members of the eight occupational groups described above following consultation with management and after ethical committee approval had been sought and granted. Apart from details of occupational group, gender and age, all questionnaires were completed anonymously.
4.0 Introduction

This chapter will report the results of analyses. The results will be presented in order of the hypotheses being tested.

4.1 Characteristics of Sample

In all, 42 members of staff, 32 (68.8%) females and 10 (21.2%) males participated in the study. This represented 60% of the staff of the specialist services directorate which is an extremely good return rate considering that questionnaires were circulated by internal mail.

Of these 42, three (7.1%) were dietitians (75% of the possible total), one (2.4%) was a music therapist (25% of the possible total), four (9.5%) were physiotherapists (50% of the possible total), four (9.5%) were speech and language therapists (50% of the possible total), three (7.1%) were psychiatrists (43% of the possible total) nine (21.4%) were community nurses and clinical nurse specialists (65% of the possible total), seven (16.7%) were occupational therapists (70% of the possible total) and eleven (26.3%) were psychologists (92% of the possible total). Thus whilst virtually all
the psychologists were represented only one of the four music therapists participated.

The dietitians, music therapist, physiotherapists and speech and language therapists were all females. All three of the psychiatrists were males. Five of the community nurses were males and four were females. One of the occupational therapists was male and six were females. One of the psychologists was male and ten were females. The gender composition of the groups was thus very different.

The ages of participants ranged from 23 to 61 and the mean age of all participants was 40.6 (SD 9.1). The mean age of the dietitians was 44.4 (SD 9.3). The mean age of the music therapists was 24.7 (SD 0.0). The mean age of the physiotherapists was 52.5 (SD 6.4). The mean age of the speech and language therapists was 33.7 (SD 7.0). The mean age of the psychiatrists was 52.7 (5.2). The mean age of the nurses was 38.8 (SD 3.6). The mean age of the occupational therapists was 41.8 (SD 6.6). The mean age of the psychologists was 36.7 (SD 9.3). The ages of the group members were found to be significantly different on a one way analysis of variance (F (7,41) = 4.75, p = 0.00).

The above details of group composition are shown, for clarity, in Table 1 overleaf.
TABLE 1. Composition of Groups Participating in the Study.

<table>
<thead>
<tr>
<th>Group</th>
<th>Males</th>
<th>Females</th>
<th>Total</th>
<th>%</th>
<th>Age Range</th>
<th>Mean</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dietitians</td>
<td>0</td>
<td>3</td>
<td>3</td>
<td>7.1</td>
<td>40-55</td>
<td>44.4</td>
<td>9.3</td>
</tr>
<tr>
<td>Music</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>2.4</td>
<td>24-24</td>
<td>24.7</td>
<td>0.0</td>
</tr>
<tr>
<td>Therapists</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physio-</td>
<td>0</td>
<td>4</td>
<td>4</td>
<td>9.5</td>
<td>46-61</td>
<td>52.5</td>
<td>6.4</td>
</tr>
<tr>
<td>Therapists</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Speech</td>
<td>0</td>
<td>4</td>
<td>4</td>
<td>9.5</td>
<td>23-38</td>
<td>33.7</td>
<td>7.0</td>
</tr>
<tr>
<td>Therapists</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Psychiatrists</td>
<td>3</td>
<td>0</td>
<td>3</td>
<td>7.1</td>
<td>46-56</td>
<td>52.7</td>
<td>5.2</td>
</tr>
<tr>
<td>Community</td>
<td>5</td>
<td>5</td>
<td>9</td>
<td>21.4</td>
<td>35-46</td>
<td>38.8</td>
<td>3.6</td>
</tr>
<tr>
<td>Nurses</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Occupational</td>
<td>1</td>
<td>6</td>
<td>7</td>
<td>16.7</td>
<td>32-51</td>
<td>41.6</td>
<td>6.6</td>
</tr>
<tr>
<td>Therapists</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Psychologists</td>
<td>1</td>
<td>10</td>
<td>11</td>
<td>26.3</td>
<td>25-51</td>
<td>36.7</td>
<td>9.3</td>
</tr>
<tr>
<td>TOTAL</td>
<td>10</td>
<td>32</td>
<td>42</td>
<td>100.0</td>
<td>23-61</td>
<td>40.6</td>
<td>9.1</td>
</tr>
</tbody>
</table>
4.2 Measures

Scales were computed for each of the measures and the summary results are as shown in Table 2 below.

<table>
<thead>
<tr>
<th>MEASURE</th>
<th>RANGE</th>
<th>MEAN</th>
<th>SD</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>MBI</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emotional Exhaustion</td>
<td>3-40</td>
<td>19.0</td>
<td>9.7</td>
<td>42</td>
</tr>
<tr>
<td>Depersonalisation</td>
<td>0-12</td>
<td>2.4</td>
<td>2.7</td>
<td>42</td>
</tr>
<tr>
<td>Personal Accomplishment</td>
<td>5-50</td>
<td>33.1</td>
<td>9.6</td>
<td>42</td>
</tr>
<tr>
<td>GHQ-28</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A Scale Somatic Symptoms</td>
<td>0-8</td>
<td>4.6</td>
<td>2.2</td>
<td>42</td>
</tr>
<tr>
<td>B Scale Anxiety Symptoms and Insomnia</td>
<td>0-8</td>
<td>3.8</td>
<td>2.2</td>
<td>42</td>
</tr>
<tr>
<td>C Scale Social Dysfunction</td>
<td>0-9</td>
<td>5.8</td>
<td>2.1</td>
<td>42</td>
</tr>
<tr>
<td>D Scale Severe Depression</td>
<td>0-7</td>
<td>0.5</td>
<td>1.3</td>
<td>42</td>
</tr>
<tr>
<td>Total GHQ-28 Total</td>
<td>7-32</td>
<td>15.1</td>
<td>5.2</td>
<td>42</td>
</tr>
<tr>
<td>JOB SATISFACTION</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Growth</td>
<td>3-7</td>
<td>5.7</td>
<td>0.8</td>
<td>42</td>
</tr>
<tr>
<td>Job Security</td>
<td>2-7</td>
<td>4.8</td>
<td>1.3</td>
<td>42</td>
</tr>
<tr>
<td>Pay</td>
<td>1-6</td>
<td>4.4</td>
<td>1.6</td>
<td>42</td>
</tr>
<tr>
<td>Co-Workers</td>
<td>1-7</td>
<td>5.9</td>
<td>0.5</td>
<td>42</td>
</tr>
<tr>
<td>Supervision</td>
<td>3-7</td>
<td>5.6</td>
<td>1.1</td>
<td>42</td>
</tr>
<tr>
<td>CLINICAL SUPERVISION</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Frequency</td>
<td>0-48</td>
<td>12.4</td>
<td>13.3</td>
<td>42</td>
</tr>
</tbody>
</table>
The means obtained generally equate reasonably well to those norms obtained in other studies. For instance, Maslach and Jackson (1986) report means for emotional exhaustion, depersonalisation and personal accomplishment in mental health workers of 16.89 (SD 8.90), 5.72 (SD 4.62) and 30.87 (6.37) respectively.

Whilst no norms are available for the Likert method of scoring the GHQ-28 a mean of 5.03 is obtained if the scores are converted to the GHQ method scoring. A score of 5 is generally accepted to be the cut-off point indicating some psychological distress.

Finally, Hackman and Oldham (1975) report means of 5.42 (SD 0.92), 5.28 (SD 1.27) and 4.82 (SD 1.32) for the JDS short scales of satisfaction with co-workers, supervision and growth satisfaction respectively.

4.3 Hypothesis 1

Hypothesis 1 stated that the three components of the burnout syndrome (emotional exhaustion, depersonalisation and personal accomplishment) would be differentially associated with measures of psychological distress.

Hypothesis 1a) stated that levels of emotional exhaustion and depersonalisation would be positively related to psychological distress, in particular to anxiety and insomnia and severe depression.
Hypothesis 1b) stated that levels of personal accomplishment would be negatively related to psychological distress.

**Correlations between Burnout (MBI) and Psychological Distress (GHQ-28)**

Pearson product-moment correlation coefficients were calculated and the data are shown in Table 3 below. Emotional exhaustion was found to be significantly correlated to the GHQ-28 Total \( (p = 0.001) \) and depersonalisation was found to be significantly correlated to anxiety symptoms and insomnia and the GHQ-28 Total \( (p = 0.01) \) and highly significantly correlated to severe depression \( (p = 0.001) \). All other correlations were not significant.

**TABLE 3. Correlations between Psychological Distress and Emotional Exhaustion, Depersonalisation and Personal Accomplishment \( (N = 42) \)**

<table>
<thead>
<tr>
<th>Scale</th>
<th>EE</th>
<th>DP</th>
<th>PA</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>0.34</td>
<td>0.08</td>
<td>0.03</td>
</tr>
<tr>
<td>B</td>
<td>0.26</td>
<td>0.37*</td>
<td>0.08</td>
</tr>
<tr>
<td>C</td>
<td>0.01</td>
<td>0.22</td>
<td>0.01</td>
</tr>
<tr>
<td>D</td>
<td>0.29</td>
<td>0.59**</td>
<td>0.24</td>
</tr>
<tr>
<td>T</td>
<td>0.45*</td>
<td>0.39*</td>
<td>0.08</td>
</tr>
</tbody>
</table>

1-tailed significance: \* = .01 \*\* = .001

Key: EE - Emotional Exhaustion; DP - Depersonalisation; PA - Personal Accomplishment; A - Somatic Symptoms; B - Anxiety and Insomnia; C - Social Dysfunction; D - Severe Depression; T - GHQ-28 Total
While emotional exhaustion and depersonalisation were found to be associated with high levels of psychological distress, particularly anxiety and insomnia and severe depression, with four significant correlations and all of the correlations being in the predicted direction, levels of personal accomplishment was not found to be associated with low levels of psychological distress and none of the correlations were in the direction predicted.

4.4 Hypothesis 2

Hypothesis 2 stated that there would be a differential relationship between the three components of the burnout syndrome and job satisfaction.

Hypothesis 2a) stated that there would be a negative relationship between feelings of emotional exhaustion and depersonalisation and job satisfaction i.e. low levels of emotional exhaustion and depersonalisation would be associated with high levels of job satisfaction.

Hypothesis 2b) stated that there would be a positive relationship between feelings of personal accomplishment and job satisfaction i.e. high levels of personal accomplishment would be associated with high levels of job satisfaction.
Correlations between Burnout (MBI) and Job Satisfaction

Pearson product-moment correlation coefficients were calculated and the data are shown in Table 4 below. Depersonalisation was found to show a significant negative correlation ($p = 0.01$) with growth satisfaction.

All other correlations were not significant although all correlations (except those between emotional exhaustion and satisfaction with co-workers and between personal accomplishment and satisfaction with co-workers and satisfaction with supervision) were in the predicted directions with several of these correlations approaching but not reaching statistical significance.

TABLE 4. Correlations between Burnout and Job Satisfaction ($N = 42$)

<table>
<thead>
<tr>
<th>Scale</th>
<th>EE</th>
<th>DP</th>
<th>PA</th>
</tr>
</thead>
<tbody>
<tr>
<td>GS</td>
<td>-0.29</td>
<td>-0.42*</td>
<td>0.26</td>
</tr>
<tr>
<td>JS</td>
<td>-0.22</td>
<td>-0.27</td>
<td>0.20</td>
</tr>
<tr>
<td>PS</td>
<td>-0.12</td>
<td>-0.31</td>
<td>0.24</td>
</tr>
<tr>
<td>CS</td>
<td>0.48</td>
<td>-0.11</td>
<td>-0.24</td>
</tr>
<tr>
<td>SS</td>
<td>-0.32</td>
<td>-0.25</td>
<td>-0.12</td>
</tr>
</tbody>
</table>

1-tailed significance: $* = .01$ $** = .001$

Key: EE - Emotional Exhaustion; DP - Depersonalisation; PA - Personal Accomplishment; GS - Growth Satisfaction; JS - Satisfaction with Job Security; PS - Satisfaction with Pay; CS - Satisfaction with Co-workers; SS - Satisfaction with Supervision
Thus, whilst there was found to be a trend towards a negative association between emotional exhaustion and depersonalisation and job satisfaction, with one significant correlation and all but one of the correlations being in the predicted directions, no significant correlations were found between personal accomplishment and job satisfaction, although three of the five correlations were in the direction predicted.

4.5 Hypothesis 3

Hypothesis 3 stated that frequency of clinical supervision would be positively related to: a) levels of job satisfaction and b) personal accomplishment.

Frequency of Clinical Supervision

The summary data are shown in Table 5 overleaf. A between group comparison on frequency of clinical supervision was found to be highly significant on a Kruskal-Wallis one way analysis of variance test ($X^2 = 19.66, p = 0.007$).

Frequency of clinical supervision ranged from 0 to 48 sessions per year (Mean 12.4, SD 13.3) with the highest number of sessions of clinical supervision being received by the psychologists and the lowest by the physiotherapists and the speech therapists.
**TABLE 5. Frequency of Clinical Supervision**

<table>
<thead>
<tr>
<th>Group</th>
<th>Mean</th>
<th>SD</th>
<th>Cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dietitians</td>
<td>10.0</td>
<td>3.5</td>
<td>3</td>
</tr>
<tr>
<td>Music Therapists</td>
<td>12.0</td>
<td>0.0</td>
<td>1</td>
</tr>
<tr>
<td>Physio-Therapists</td>
<td>1.5</td>
<td>0.3</td>
<td>4</td>
</tr>
<tr>
<td>Speech Therapists</td>
<td>1.5</td>
<td>2.0</td>
<td>4</td>
</tr>
<tr>
<td>Psychiatrists</td>
<td>4.0</td>
<td>3.5</td>
<td>3</td>
</tr>
<tr>
<td>Community Nurses</td>
<td>9.0</td>
<td>5.2</td>
<td>9</td>
</tr>
<tr>
<td>Occupational Therapists</td>
<td>12.3</td>
<td>16.7</td>
<td>7</td>
</tr>
<tr>
<td>Psychologists</td>
<td>26.2</td>
<td>14.0</td>
<td>11</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td>12.4</td>
<td>13.3</td>
<td>42</td>
</tr>
</tbody>
</table>

Results of Kruskal-Wallis one way analysis of variance

Comparison of scores across all eight groups

\[ X^2 = 19.66, \ p = 0.007 \]
Correlations between Supervision Frequency and Job Satisfaction

Pearson product-moment correlation coefficients were calculated and the data are shown in Table 6 below. Frequency of supervision was not found to be correlated to any of the measures of job satisfaction although two of the correlations (satisfaction with pay and satisfaction with supervision) approached significance.

TABLE 6. Correlations between Supervision Frequency and Job Satisfaction (N=42)

<table>
<thead>
<tr>
<th>Scale</th>
<th>GS</th>
<th>JS</th>
<th>PS</th>
<th>CS</th>
<th>SS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Supervision</td>
<td>0.16</td>
<td>0.00</td>
<td>-0.30</td>
<td>0.00</td>
<td>0.29</td>
</tr>
<tr>
<td>Frequency</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

1-tailed significance:  
* = .01  ** = .001

Key: GS - Growth Satisfaction; JS - Satisfaction with Job Security;  
PS - Pay Satisfaction; CS - Satisfaction with Co-Workers; SS - Satisfaction with Supervision

No positive relationship was therefore established between job satisfaction and frequency of supervision.
Correlations between Supervision Frequency and Personal Accomplishment

Pearson product-moment correlation coefficients were calculated and the data are shown in Table 7 below. Frequency of supervision was found to be significantly correlated ($p = 0.01$) to levels of personal accomplishment.

TABLE 7. Correlations between Supervision Frequency and Personal Accomplishment ($N = 42$)

<table>
<thead>
<tr>
<th>Scale</th>
<th>Personal Accomplishment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Supervision</td>
<td>0.43*</td>
</tr>
<tr>
<td>Frequency</td>
<td></td>
</tr>
</tbody>
</table>

1-tailed significance: $* = 0.01$ $** = 0.001$

A positive relationship was therefore established between frequency of supervision and personal accomplishment.
4.6 Hypothesis 4

Hypothesis 4 stated that frequency of clinical supervision would be negatively related to: a) levels of emotional exhaustion and depersonalisation and b) psychological distress i.e low frequency clinical supervision would be associated with high levels of: a) emotional exhaustion and depersonalisation and b) psychological distress.

Correlations between Clinical Supervision Frequency, Emotional Exhaustion and Depersonalisation.

Pearson product-moment correlation coefficients were calculated and the data are shown in Table 8 below. Frequency of clinical supervision was not found to be significantly correlated with either emotional exhaustion or depersonalisation. The relationship with emotional exhaustion was, however, in the predicted direction.

TABLE 8. Correlations between Supervision Frequency and Emotional Exhaustion and Depersonalisation (N = 42)

<table>
<thead>
<tr>
<th>Scale</th>
<th>Emotional Exhaustion</th>
<th>Depersonalisation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Supervision</td>
<td>-0.13</td>
<td>0.06</td>
</tr>
</tbody>
</table>

1-tailed significance: * = .01 ** = .001
Correlations between Supervision Frequency and Psychological Distress

Pearson product-moment correlation coefficients were calculated and the data are shown in Table 9 below. No significant correlations were found although all the correlations apart from that with somatic symptoms were in the predicted direction and the correlation with social dysfunction approached, but did not reach, significance.

TABLE 9. Correlations of Supervision Frequency to Psychological Distress (N=42)

<table>
<thead>
<tr>
<th>Scale</th>
<th>A</th>
<th>B</th>
<th>C</th>
<th>D</th>
<th>T</th>
</tr>
</thead>
<tbody>
<tr>
<td>Supervision Frequency</td>
<td>0.16</td>
<td>-0.13</td>
<td>-0.33</td>
<td>-0.09</td>
<td>-0.16</td>
</tr>
</tbody>
</table>

1-tailed significance: * = .01 ** = .001

Key: A - Somatic Symptoms; B - Anxiety and Insomnia; C - Social Dysfunction; D - Severe Depression; T - GHQ-28 Total
No negative relationship was therefore established between frequency of clinical supervision and emotional exhaustion, depersonalisation or psychological distress although several of the correlations were in the predicted direction.

4.7 Multi-Dimensional Scaling

Smallest Space Analysis

In order to further examine the relationships between the variables when all groups were considered together, an unconditional Smallest Space Analysis (SSA) (Lingoes, 1973; Shye, 1978) was carried out for the GHQ-28, burnout, job satisfaction and supervision frequency variables.

The SSA is a means of multi-dimensional scaling which generates a plot based on a correlation matrix in which variables that are more similar to one another than others are plotted closer together.

Thus, although previous analyses examined the nature of all bivariate correlations, the SSA allows relationships between variables to be examined when all variables are considered simultaneously. A visual representation provides clarification which in turn facilitates interpretation and thus a more complete understanding can be gained of the sometimes complex interrelationships between variables.

Both the Guttmann-Lingoes Coefficient of Alienation and Kruskal's Stress Coefficient were found to be acceptably low. (Guttmann-Lingoes
Coefficient of Alienation = 0.09 in 60 iterations. Kruskal's Stress Coefficient = 0.07).

As can be seen in Figure 1 overleaf, the SSA plots clustered the job satisfaction variables together in one group, together with frequency of clinical supervision, the burnout variables in a second and the GHQ-28 variables (with the exception of social dysfunction) into a third.

The burnout variable of depersonalisation (DP) was also seen to be closely related to depression (DEP), somatic (SOM) and total psychological distress (TOT), the variable of emotional exhaustion (EE) to anxiety (ANX) and depression (DEP) and the variable of personal accomplishment (PA) to all of the measures of job satisfaction and also to social dysfunction (SOC).

Therefore, although the bi-variate correlations do not support all of the hypotheses the SSA shows that the structure of the data is very much as predicted.
FIGURE 1. SMALLEST SPACE ANALYSIS
FIGURE 2. MULTIPLE SCALOGRAM ANALYSIS SHOWING BURNOUT AND FREQUENCY OF SUPERVISION.
2a) Overall Plot 2b) Emotional Exhaustion 2c) Depersonalisation 2d) Personal Accomplishment 2e) Supervision Frequency
Multiple Scalogram Analyses

Multiple Scalogram Analyses were used as a means of further examining the differences between groups (with several variables being considered together) to see if groups differed in any other respects apart from frequency of clinical supervision.

The Multiple Scalogram Analysis (MSA) (Lingoes, 1973; Zvulun, 1978) is a method of multi-dimensional scaling which asks the question whether, if \( N \) points are enclosed in a space defined by the largest possible number of vectors, is it possible for the coordinates to be transformed in such a way so that for any fixed variable all groups falling within a given classification will be placed in a contiguous region of the space.

In other words, the MSA seeks to partition space in such a way that there is the best possible fit between a classification of a variable and its representation in geometric space. This being the case, those groups frequently achieving the same classifications will be plotted closest together in geometric space whilst those that are least similar will be plotted further apart.

In addition to plotting an overall plot of the groups, showing the similarities and differences between them, however, the MSA programme also produces a series of sub-plots for each variable so that for each variable the plots may be divided into regions separating the points assigned to each magnitude of the variable. Thus it is possible, for each group, to examine the way in which each variable contributes to the overall picture.
In this way MSA differs from other multi-dimensional scaling techniques, such as cluster analysis, because in addition to examining similarities and differences between groups, the factors contributing to those differences can be further examined.

A two dimensional MSA was therefore carried out on all eight groups in order to further examine the relationships between frequency of clinical supervision and burnout and job satisfaction respectively.

In order to carry out MSA analyses on the above data it was necessary to convert mean group scores into categorical data with each category being allocated a number and groups being coded according to the category assigned. Each group can therefore be represented by a profile of scores showing the categories of each variable into which each group falls. The data matrices generated are as shown in Appendices 6 and 7.
The overall MSA plot is shown in Figure 2a above. Initial interpretation of this plot shows that groups are generally similar with the exception of the psychologists and the psychiatrists. The main factors contributing to these differences are those of personal accomplishment and supervision frequency with the psychologists having high levels of personal accomplishment and high frequency clinical supervision whilst the psychiatrists have low levels of personal accomplishment and low frequency clinical supervision.

Figure 2b shows regional distribution of groups on the category of emotional exhaustion. This clearly shows the music therapists to be the only group with low levels of emotional exhaustion with four groups (the dietitians, physiotherapists, psychologists and psychiatrists) having medium levels and the remaining three groups (the speech and language therapists, occupational therapists and community nurses) having high levels of emotional exhaustion.

Figure 2c shows the item plot for depersonalisation. Here all groups can clearly be seen to share low levels of depersonalisation.

Figure 2d shows the regional distribution of groups as divided by the category of personal accomplishment. The psychologists, dietitians and music therapists are the only groups to have high levels of personal accomplishment whilst the psychiatrists are the only group to show low levels. All the remaining groups (the physiotherapists, speech and language therapists, occupational therapists and community nurses) show medium levels.
Finally, Figure 2e shows the regional distribution of groups on the category of frequency of clinical supervision. The speech and language therapists, physiotherapists and psychiatrists all receive clinical supervision at a low frequency, the music therapists, community nurses and dietitians have clinical supervision at a medium frequency, and psychologists and occupational therapists both receive high frequency clinical supervision.

To summarise, therefore, whilst depersonalisation does not discriminate between groups, those groups that are having low frequency clinical supervision are those with medium to high levels of emotional exhaustion and low to medium levels of personal accomplishment.

Those groups who are having medium frequency supervision are those with low to high levels of emotional exhaustion and medium to high levels of personal accomplishment.

Finally, those groups who are having high frequency supervision are those with medium to high levels of emotional exhaustion and medium to high levels of personal accomplishment.

The above results show that emotional exhaustion, depersonalisation and personal accomplishment are all different constructs. It also appears from Figures 2b) 2d) and 2e) that differences in frequency of supervision are related to differences in personal accomplishment in the group having medium emotional exhaustion.
Job Satisfaction and Frequency of Supervision

The MSA plots for these data are shown as figures 3a to 3g overleaf.

Figure 3a shows the overall plot which shows that all groups are broadly similar with the exception of the music therapists. The music therapists stand apart because they indicated high levels of job satisfaction on all measures of specific satisfaction whilst other groups varied in the degree of satisfaction that they expressed.

Growth satisfaction is shown in Figure 3b and all groups can be seen to have high levels of growth satisfaction.

Figure 3c shows satisfaction with job security. The physiotherapists, psychiatrists, nurses and occupational therapists have medium levels of satisfaction with job security whilst the dietitians, music therapists, psychologists and speech and language therapists are highly satisfied with job security.

Satisfaction with pay is shown in Figure 3d. The dietitians and music therapists are highly satisfied with their pay whilst all other groups show a medium level of satisfaction.

Figure 3e shows level of satisfaction with co-workers. All groups can be seen to show high levels of satisfaction with their co-workers.

Satisfaction with supervision is shown in Figure 3f. With the exception of the speech and language therapists all groups are highly satisfied with the supervision that they receive.
Finally, frequency of clinical supervision is shown in Figure 3g. The speech and language therapists, physiotherapists and psychiatrists all receive clinical supervision at a low frequency, the music therapists, community nurses and dietitians have clinical supervision at a medium frequency, and psychologists and occupational therapists both receive high frequency clinical supervision.

Since all groups show medium to high scores on the Job Satisfaction subscales regardless of the amount of clinical supervision received, analysis of the overall MSA plots confirmed the lack of significant correlations found between the job satisfaction subscales and frequency of clinical supervision, even though specific satisfactions showed varying distributions across groups and the distribution of satisfaction with pay and job security were found to be similar as shown by the similarity in partitioning of space between Figures 3c and 3d.
FIGURE 3. MULTIPLE SCALOGRAM ANALYSIS SHOWING JOB SATISFACTION AND FREQUENCY OF CLINICAL SUPERVISION
3a) Overall Plot 3b) Growth Satisfaction 3c) Job Security 3d) Pay Satisfaction 3e) Co-worker Satisfaction 3f) Supervision Satisfaction 3g) Supervision Frequency.
4.8 Summary of Results

Relationships between Measures

Hypothesis 1

Hypothesis 1 stated that the three components of the burnout syndrome (emotional exhaustion, depersonalisation and personal accomplishment) would be differentially associated with measures of psychological distress.

Hypothesis la) stated that levels of emotional exhaustion and depersonalisation would be positively related to psychological distress, in particular to anxiety and insomnia and severe depression.

Hypothesis lb) stated that levels of personal accomplishment would be negatively related to psychological distress.

Total psychological distress was found to be significantly correlated to emotional exhaustion (p = 0.01), anxiety symptoms and insomnia and total psychological distress were found to be significantly correlated to depersonalisation (p = 0.01) and depression was also found to be highly significantly correlated to depersonalisation (p = 0.001). All other correlations were not significant although many were in the predicted directions.
Hypothesis 2

Hypothesis 2 stated that there would be a differential relationship between the three components of the burnout syndrome and job satisfaction.

Hypothesis 2a) stated that there would be a negative relationship between feelings of emotional exhaustion and depersonalisation and job satisfaction i.e. low levels of emotional exhaustion and depersonalisation would be associated with high levels of job satisfaction.

Hypothesis 2b) stated that there would be a positive relationship between feelings of personal accomplishment and job satisfaction i.e. high levels of personal accomplishment would be associated with high levels of job satisfaction.

Depersonalisation was found to be negatively (p = 0.01) correlated to growth satisfaction. All other correlations were non-significant although the majority were in the predicted direction.

Hypothesis 3

Hypothesis 3 stated that frequency of clinical supervision would be positively related to: a) levels of job satisfaction and b) personal accomplishment.

Frequency of supervision was not found to be correlated to any of the measures of job satisfaction.
However, frequency of clinical supervision was found to be significantly correlated to personal accomplishment (p = 0.01).

Hypothesis 4

Hypothesis 4 stated that frequency of clinical supervision would be negatively related to: a) levels of emotional exhaustion and depersonalisation and b) psychological distress i.e low frequency clinical supervision would be associated with high levels of: a) emotional exhaustion and depersonalisation and b) psychological distress.

Frequency of clinical supervision was not found to be significantly correlated with either emotional exhaustion or depersonalisation nor were any significant correlations found between frequency of clinical supervision and any of the measures of psychological distress.

Smallest Space Analysis

A SSA showed the three elements of burnout to be closely related to one another and the various measures of job satisfaction were also shown to be closely interrelated. Depersonalisation was shown to be closely related to depression, total distress and somatic symptoms. Emotional exhaustion was shown to be related to anxiety and personal accomplishment was shown to be related to social dysfunction as well as to measures of job satisfaction.

Frequency of clinical supervision was found to be closely related to all of the measures of job satisfaction and more related to personal
accomplishment than to either emotional exhaustion and depersonalisation. Frequency of supervision was also shown to be more related to social dysfunction than to all the other measures of psychological distress.

In summary, therefore, the SSA showed the majority of the relationships between variables to be in the directions hypothesised although not all of these had attained statistical significance in earlier analyses.

Differences between Groups

Groups were found to differ significantly on frequency of supervision on Kruskal-Wallis analyses of variance.

In the first MSA the groups were well differentiated. The psychologists and psychiatrists, moreover, showed respectively high and low levels of personal accomplishment and supervision frequency. It seems that differences in frequency of supervision may mediate differences in personal accomplishment in the group of professions showing medium levels of emotional exhaustion.

The second MSA showed that all groups were broadly similar to one another with respect to job satisfaction, with the exception of the music therapist (who expressed high levels of job satisfaction on all subscales).
CHAPTER 5

DISCUSSION

5.1 Introduction

The previous chapters describe the execution and analysis of a preliminary survey into the scope of supervision followed by a more detailed study on the relationship of clinical supervision to a number of variables. The latter study was carried out in one of the divisions of an NHS trust providing services for people with learning disabilities. The division in question was comprised of representatives of all the professional groups employed by the trust. Each of these groups was practising a different model of clinical supervision whereby frequency of clinical supervision differed markedly across the different professional groups.

This chapter will discuss the results of the main study in the light of the hypotheses being tested and of previous findings. Methodological constraints of the present study and avenues for possible future research will also be considered.

5.2 Relationships between Measures - Testing the Research Hypotheses

Burnout and Psychological Distress

It was hypothesised that levels of emotional exhaustion and depersonalisation would be positively related to psychological
distress whilst levels of personal accomplishment would be negatively related to psychological distress.

This finding would support the results of Power and Sharp (1988) and McGrath, Reid and Boore (1989) who both found an association between levels of burnout and non-psychotic psychiatric disturbance.

Whilst no significant correlations were found between psychological distress and personal accomplishment, significant relationships were found between the emotional exhaustion subscale of the MBI and GHQ-28 Total and between the depersonalisation subscale of the MBI and the anxiety symptoms and insomnia, severe depression and GHQ-28 Total subscales of the GHQ-28. Furthermore, a smallest space analysis found all measures of psychological distress except social dysfunction to be more closely related to depersonalisation and emotional exhaustion than to personal accomplishment.

The correlations found between emotional exhaustion and depersonalisation and the total GHQ-28 score support Power and Sharp's (1988) and McGrath et al's (1989) findings of an association between burnout and psychological distress, whilst the specific and strong (p = 0.001) correlations of depersonalisation with anxiety symptoms and insomnia and severe depression, support Meier's (1984) findings of moderately strong correlations between burnout scores and clinical depression.

When the inter-correlations of the GHQ-28 (Goldberg and Hillier, 1979) subscales were examined (see Appendix 8), it was found that all
subscale scores significantly correlated with the total score, as one might reasonably expect.

The other significant inter-correlation found was that between the anxiety symptoms and insomnia and severe depression subscales (see Appendix 8). This, again, is perhaps not extremely surprising given the related nature of these two constructs. Goldberg and Williams (1988) reported a correlation of 0.71 between psychiatrists' ratings of anxiety and depression and emphasised that the four separate subscales of the GHQ-28 represented dimensions of symptomatology and did not necessarily represent categorically differing psychiatric diagnoses.

In summary, therefore, results obtained using SSA were consistent with the hypotheses that whereas emotional exhaustion and depersonalisation are related to psychological distress, personal accomplishment is independent of distress. However, predicted relationships between pairs of variables were not all statistically significant.

Burnout and Job Satisfaction

It was hypothesised that there would be a positive relationship between personal accomplishment and job satisfaction and a negative relationship between job satisfaction and depersonalisation and emotional exhaustion.

Such a finding would confirm the many results from the literature showing a negative relationship between stress and job satisfaction.

However, the only significant relationship that was found in this study was a negative relationship (p = 0.01) between the depersonalisation subscale of the MBI and the growth satisfaction subscale of the JDS (Hackman and Oldham, 1975).

Interestingly, this was the only subscale of the JDS that Maslach and Jackson (1986) had themselves reported to be negatively correlated with depersonalisation although their findings of a negative association between growth satisfaction and emotional exhaustion could not be replicated here.

That no further significant relationships could be found between depersonalisation and job satisfaction may be explained by the relatively low levels of depersonalisation that were reported. It is thought that this is a social desirability effect whereby health staff are reluctant to admit feelings of cynicism and detachment towards their clients.

The smallest space analysis, however, clearly showed job satisfaction to be more closely related to personal accomplishment than to either
depersonalisation or emotional exhaustion and the fact that the relationships were in the hypothesised directions prevents us from rejecting these particular hypotheses.

Clinical Supervision, Personal Accomplishment and Job Satisfaction

In this, one of the most important elements of this study, it was hypothesised that frequency of clinical supervision would be positively related to levels of job satisfaction and personal accomplishment.

Such findings would support the results of Berg, Hansson and Hallberg (1994) and Hallberg (1994) who found associations between clinical supervision and reduced burnout and increased job satisfaction, respectively.

In addition, the findings would also support the established literature of the effects of social support on burnout (Cronin-Stubbs and Rooks, 1985; Ceslowitz, 1989; Boyle, Grap, Younger and Thornby, 1991 and Hacker Hughes, 1993) and on burnout and job satisfaction (Stewart and Arklie, 1994).

Clinical Supervision and Job Satisfaction

No significant relationship could be established between frequency of clinical supervision and job satisfaction on the basis of correlation coefficients and this, perhaps, casts some doubt on the relationship between clinical supervision and other forms of social support.
The UKCC (1995) definition of clinical supervision specifically points out that clinical supervision should not be "the exercise of managerial responsibility and supervision, a system of formal individual performance review procedures or intended to be hierarchical in nature" (p. 2). If it was to be construed in this light, however, it would be seen not to be as effective as a means of social support. Indeed, the previous study showed that supervision was often conducted in formal, hierarchical settings. Furthermore clinical supervisors are often designated senior professionals working in the same department as the supervisee which deleteriously affects such important aspects of social support as perceived confidentiality and separation from performance review procedures.

However, the smallest space analysis clearly located frequency of clinical supervision within the area of space occupied by the various measures of job satisfaction which implies that the relationship is in the hypothesised direction even if the correlations did not reach statistical significance. Perhaps also there is a measurement issue involved here whereby measurement of the frequency of supervision alone is not a sufficiently rich measure of the effectiveness of clinical supervision. Indeed, the preliminary survey also showed variations in duration, scope and quality of supervision in addition to variations in frequency. This point requires detailed investigation in future studies.

Clinical Supervision and Personal Accomplishment

A significant association was found between frequency of clinical supervision and one of the three elements of burnout, personal
accomplishment and this relationship was shown clearly in the smallest space analysis.

This finding is in line with the various intentions that: "(clinical supervision) is intended to be a facilitative exchange between practising professionals centred on interpersonal support and with the intention of enabling the development of professional skills" (Hooton, 1994, p. 8); "this (clinical supervision) relationship involves the clinical supervisor applying clinical knowledge and experience to assist colleagues to develop their practice, knowledge and values" (UKCC, 1995, p. 2); and "(clinical supervision has) a formative function (which) involves an educative process through reflection which should encourage both personal and professional development" (Procter, 1992).

This result also supports the recent findings of Berg et al (1994) on the positive effects of clinical supervision on burnout although in this context it was nonetheless disappointing that similar relationships could not also be found between frequency of clinical supervision and emotional exhaustion or depersonalisation.

It is additionally worth noting here that personal accomplishment was, however, the only dimension of burnout to be affected by the programme reported by Hacker Hughes (1993) which used a combination of a psycho-educational component with psychodynamically based social support.

Also, since McGrath, Reid and Boore (1989) found that the subscale in which the majority of their respondents reported high levels of
burnout was the personal accomplishment subscale it is encouraging to note the positive effects of clinical supervision upon this subscale of burnout.

Lastly, this finding also adds strength to the argument that personal accomplishment (or, more properly, the lack of it) is a very different construct from the other two dimensions of burnout. That this is the case is recognised by Maslach and Jackson (1986) who state that "the personal accomplishment subscale is independent of the other subscales and its component items do not load negatively on them. In other words, personal accomplishment cannot be assumed to be the opposite of emotional exhaustion or depersonalisation. Indeed, the correlations between the personal accomplishment subscale and the other subscales are low" (p.7).

**Clinical Supervision, Emotional Exhaustion, Depersonalisation and Psychological Distress**

It was hypothesised that frequency of clinical supervision would be negatively related to levels of emotional exhaustion, depersonalisation and psychological distress.

No significant relationships were found between supervision and either of the above elements of burnout or psychological distress although the smallest space analysis showed frequency of supervision to be located at a greater distance from all of these elements (except, interestingly, the measure of social dysfunction) than the distance to personal accomplishment and job satisfaction. This again
supports the differences discussed above between personal accomplishment and the other two elements of burnout.

No significant relationships were found between frequency of supervision and psychological distress. As discussed above, however, the smallest space analysis implied a relationship between frequency of clinical supervision and social dysfunction which should be more closely examined in future studies.

Lastly, when the relationships between the subscales of the Maslach Burnout Inventory (Maslach and Jackson, 1986) were examined (see Appendix 9) it was found that only the emotional exhaustion and depersonalisation subscales were significantly inter-correlated (r = 0.47, p = 0.001). This correlation was found to be of the same order as that reported by Maslach and Jackson (1986) (r = 0.52) which was in accord with the above authors' theoretical expectations that emotional exhaustion and depersonalisation are related, albeit separate, aspects of burnout (Maslach and Jackson, 1986).

5.3 Differences between Groups

Frequency of Clinical Supervision

When differences between groups were examined it was found that there was indeed a marked difference in frequency of clinical supervision between professional groups ($X^2 = 19.66, p = 0.007$) thus justifying the initial rationale for choosing the specialist services directorate in which to conduct the study. The frequency with which clinical supervision was received was found to vary between no
sessions and 48 sessions annually, with the mean number of annual sessions of clinical supervision, across all professional groups, being 12.4 (SD 13.3).

The mean number of clinical supervision sessions received annually by the members of the different professional groups were, in descending order: psychologists (26.2), occupational therapists (12.3), music therapists (12), dietitians (10), community nurses (9), psychiatrists (4) and physiotherapists and speech and language therapists (both 1.5). It may well be that different professional groups differ with respect to the ethos and practice of clinical supervision and these findings would support such a hypothesis which should be investigated further in future studies.

Emotional Exhaustion

The only other significant difference between professional groups was that found for the emotional exhaustion subscale of the Maslach Burnout Inventory (Maslach and Jackson, 1986) ($X^2 = 16.04$, $p = 0.025$).

Whilst the music therapists showed a low level of emotional exhaustion (Mean = 3.0) and the psychologists (Mean = 13.3), dietitians (Mean = 14.3), psychiatrists (Mean = 15.3) and physiotherapists (Mean = 18.0) all showed medium levels of emotional exhaustion (in terms of Maslach and Jackson, 1986), the community nurses (Mean = 21.4), occupational therapists (Mean = 26.7) and speech therapists (Mean 27.5) both showed high levels of emotional exhaustion.
The above finding might possibly be explained by the fact that the community nurses, occupational therapists and speech therapists do not work in such cohesive departmental settings as the other professionals and perhaps, therefore, receive less in the way of peer social support.

Alternatively, the higher levels of emotional exhaustion in the latter three groups may be related to the greater degree of direct client clinical contact engaged in by members of these occupational groups.

Lastly, the result for the music therapists may well not be representative of the profession as a whole since only one music therapist actually participated in the study and it may not be reasonable to generalise these results to the other members of the same department.

5.4 Measures

The results obtained for depersonalisation were somewhat lower than those obtained in other studies (Maslach and Jackson, 1986). As discussed above, it may be that this was an effect of social desirability with participants being reluctant to endorse items that showed them to have a detached, cynical or uncaring attitude towards their clients.

5.5 Methodological Considerations

There are a number of methodological points that deserve comment.
Although a cross-sectional design was used there was considerable variation in the size of professional groups and the age of group members that could not be controlled for. In addition, there was also an absence of a control group all of whose members should have been receiving no clinical supervision at all. It is also possible that there may have been quite a wide variation in styles of clinical supervision which was also not controlled for.

It is suggested that these various shortcomings be addressed by future controlled studies where longitudinal designs are used to examine the effects of clinical supervision on the different dimensions of burnout over time. The model, method, frequency and characteristics of clinical supervision should also all be stipulated as clearly as possible.

5.6 Theoretical Implications and Directions for Future Research

The above study has demonstrated clearly that burnout is a complicated concept and has also supported Maslach and Jackson's (1986) assertion that personal accomplishment is independent to, but not the opposite of, the other dimensions of emotional exhaustion and depersonalisation. Whilst depersonalisation seems to be closely related to depression and somatic symptoms, and emotional exhaustion is more closely related to symptoms of anxiety, personal accomplishment appears to be more related to the social dysfunction component of psychological distress and to such other factors as job satisfaction. In other words, there appears to be a distinction (which was clearly shown in the SSA) between the affective variables and the more job-oriented variables.
Previous studies (e.g. McGrath, Reid and Boore (1989)) have shown that personal accomplishment, or, more properly the lack of it, is a frequently reported aspect of burnout and Hacker Hughes (1993) has previously reported that personal accomplishment seems to be the only dimension of the burnout syndrome to be affected by a programme of social support. It appears from this that clinical supervision may be important in playing the role of social support in moderating the effects of emotional exhaustion on personal accomplishment. Perhaps, and in order to be as effective as possible, it may be that clinical supervision also needs to be informal, collaborative and non-hierarchical. However, this needs to be more clearly demonstrated in future studies.

Although the studies described here have investigated the relationships between variables, the mechanisms through which these relationships might be mediated were not examined. However, coping theory offers a possible avenue for future research into this area.

Coyne, Aldwin and Lazarus (1981) define coping as efforts, both cognitive and behavioural, that can be used to manage environmental and internal demands and conflicts that affect an individual or tax or exceed that person's resources.

Latack (1986) differentiates between control-oriented (actions and thoughts directed towards taking charge of problematic situations) and escape-oriented (cognitive and behavioural avoidance) coping styles. Leiter (1992) relates the former negatively to emotional exhaustion and positively to personal accomplishment whilst the
latter is related negatively to emotional exhaustion only. In addition, control coping has been found by Leiter (1991) to be positively related to the use of organisational support (supervisor and co-worker support).

A different approach to coping is taken by Carver, Scheier and Weintraub (1989) who distinguish between problem-focused and emotion-focused coping. Here, seeking support may be classified as being either a problem-focused or emotion-focused strategy depending on whether the support is being sought for instrumental or emotional purposes.

Leiter (1991) has related control-oriented coping styles (Latack, 1986) (i.e. actions and thoughts directed towards taking charge of problematic situations) positively to the use of organisational and co-worker support and has also (1992) found that the use of control-oriented coping styles is related positively to personal accomplishment.

Since theories on coping and stress (Monat and Lazarus, 1985) have argued that both emotional and cognitive coping mechanisms can be stimulated through intervention (such as, perhaps, clinical supervision) it is possible that such changes in problem-focused coping may in turn lead to an increase in feelings of personal accomplishment. Further research will, of course, be required in order to clarify the precise nature and mechanisms of such relationships.
5.7 Summary and Conclusions

Following a preliminary survey into general supervision practices, a study on the use of clinical supervision was carried out in a specialist support directorate of an NHS trust providing services to people with learning disabilities. Different frequencies of clinical supervision were found to have been employed by the various professional groups within the directorate. The study investigated the relationships between clinical supervision, psychological distress, burnout and job satisfaction.

Whilst the study revealed significant relationships between the various measures of burnout and psychological distress that were used, the relationships of these measures to measures of job satisfaction were somewhat less clear.

Although no significant relationships were demonstrated between frequency of clinical supervision and either psychological distress or job satisfaction it was found that there was a significant relationship between clinical supervision and one of the three dimensions of burnout, personal accomplishment. Furthermore, the majority of the other relationships tested were also shown to be in the predicted directions.

It is hypothesised that clinical supervision could be instrumental in changing mechanisms of problem-focused and control-oriented coping and that it may therefore moderate the effects of emotional exhaustion on personal accomplishment and job satisfaction.
Although these preliminary results are encouraging, it is suggested that these areas of research might be further addressed in future studies.
APPENDICES
APPENDIX 1

SUPERVISION SURVEY

PROFESSION: ...................... GRADE: .................

--------------------------------------------------------

Actually     Ideally

1. Who do you receive supervision from?
   
   Nobody □ □
   Nursing Assistant/Support Worker □ □
   Named Nurse/Key Worker □ □
   Team Leader □ □
   Ward Manager/Services Manager □ □
   Clinical Nurse Specialist □ □
   Other □ □

2. How regularly do you receive supervision?
   
   Not at all □ □
   At least daily □ □
   Weekly □ □
   Fortnightly □ □
   Monthly □ □
   Quarterly □ □
   Half yearly □ □
   Annual □ □
   - Other □ □

3. Is this offered automatically or do you request it? Is this part of your contract?
   
   Not offered automatically □ □
   Offered □ □
   Requested □ □
   In contract □ □

4. What form does supervision take? Tick as many options as are applicable.
   
   Advice □ □
   Demonstration □ □
   Discussion □ □
   Explanation □ □
   Modelling/Working alongside □ □
   Other □ □

5. Do you receive supervision on an individual □ □
   or group basis? □ □

330
<table>
<thead>
<tr>
<th>Question</th>
<th>Actually</th>
<th>Ideally</th>
</tr>
</thead>
<tbody>
<tr>
<td>6. Is it formal or informal?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Is it related to particular clients care needs or to a more general topic</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. If you need supervision urgently, how readily available is this?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Same day</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Same week</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Same fortnight</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Same month</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. How useful do you find supervision?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not at all useful</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Quite useful</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Very useful</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Extremely useful</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. What would make it more useful?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Increased frequency</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Increased availability</td>
<td></td>
<td></td>
</tr>
<tr>
<td>A different form</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Easier Access</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Better quality supervision</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
</tr>
<tr>
<td>11. If you belong to a profession or group of workers, are you aware of the statutory regulations concerning supervision to your professional group?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>12. Is there an opportunity to discuss professional regulations, guidelines, new procedures in supervision?</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

Any other comments:

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

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

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

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

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

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

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

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

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

.................................................................
Please indicate how often you currently experience the following thoughts &/or feelings:

<table>
<thead>
<tr>
<th>How often:</th>
<th>Never</th>
<th>A few times a month</th>
<th>Once a month</th>
<th>A few times a year or less</th>
<th>Once a week</th>
<th>A few times a week</th>
<th>Every day</th>
</tr>
</thead>
<tbody>
<tr>
<td>I feel emotionally drained from my work</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>I feel used up at the end of the workday</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>I feel tired when I get up in the morning and have to face another day at work</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>I can easily understand how my patients feel about things</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>I feel I treat some patients as if they were impersonal objects</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>Working with people all day is really a strain for me</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>I deal very effectively with the problems of my patients</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>I feel burned out from my work</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>I feel I’m positively influencing other people’s lives through my work</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>I’ve become more callous towards people since I started my present job</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>How often:</td>
<td>Never</td>
<td>A few times a year or less</td>
<td>Once a month</td>
<td>A few times a month</td>
<td>Once a week</td>
<td>A few times a week</td>
<td>Every day</td>
</tr>
<tr>
<td>-------------------------------------------------------------------------</td>
<td>-------</td>
<td>---------------------------</td>
<td>--------------</td>
<td>---------------------</td>
<td>-------------</td>
<td>-------------------</td>
<td>-----------</td>
</tr>
<tr>
<td>I worry that this job is hardening me emotionally</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>I feel very energetic</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>I feel frustrated by my job</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>I feel I'm working too hard at my job</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>I don't really care what happens to some patients</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>Working with people directly puts too much stress on me</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>I can easily create a relaxed atmosphere with my patients</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>I feel exhilarated after working closely with my patients</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>I've accomplished many worthwhile things in this job</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>I feel as if I'm at the end of my tether</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>In my work I deal with emotional problems very calmly</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>I feel that patients blame me for some of their problems</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
</tbody>
</table>

Thankyou.
# General Health Questionnaire

Please read this carefully:

We would like to know if you have had any medical complaints, and how your health has been in general, **over the past few weeks**. Please answer **ALL** the questions on the following pages by **underlining** the answer which you think most nearly applies to you. Remember that we want to know about recent complaints, not those that you had in the past.

It is important that you try to answer **ALL** the questions.

## Have you recently:

<table>
<thead>
<tr>
<th>Question</th>
<th>Better than usual</th>
<th>Same as usual</th>
<th>Worse than usual</th>
<th>Much worse than usual</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Been feeling perfectly well.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Been feeling in need of a good tonic?</td>
<td>Not at all</td>
<td>No more than usual</td>
<td>Rather more than usual</td>
<td>Much more than usual</td>
</tr>
<tr>
<td>3. Been feeling run down and out of sorts?</td>
<td>Not at all</td>
<td>No more than usual</td>
<td>Rather more than usual</td>
<td>Much more than usual</td>
</tr>
<tr>
<td>4. Felt that you are ill?</td>
<td>Not at all</td>
<td>No more than usual</td>
<td>Rather more than usual</td>
<td>Much more than usual</td>
</tr>
<tr>
<td>5. Been getting any pains in your head?</td>
<td>Not at all</td>
<td>No more than usual</td>
<td>Rather more than usual</td>
<td>Much more than usual</td>
</tr>
<tr>
<td>6. Been getting a feeling of tightness or pressure in your head?</td>
<td>Not at all</td>
<td>No more than usual</td>
<td>Rather more than usual</td>
<td>Much more than usual</td>
</tr>
<tr>
<td>7. Been having hot or cold spells?</td>
<td>Not at all</td>
<td>No more than usual</td>
<td>Rather more than usual</td>
<td>Much more than usual</td>
</tr>
<tr>
<td>8. Lost much sleep over worry?</td>
<td>Not at all</td>
<td>No more than usual</td>
<td>Rather more than usual</td>
<td>Much more than usual</td>
</tr>
<tr>
<td>9. Had difficulty in staying asleep once you are asleep?</td>
<td>Not at all</td>
<td>No more than usual</td>
<td>Rather more than usual</td>
<td>Much more than usual</td>
</tr>
<tr>
<td>10. Felt constantly under strain?</td>
<td>Not at all</td>
<td>No more than usual</td>
<td>Rather more than usual</td>
<td>Much more than usual</td>
</tr>
<tr>
<td>11. Been getting edgy and bad tempered?</td>
<td>Not at all</td>
<td>No more than usual</td>
<td>Rather more than usual</td>
<td>Much more than usual</td>
</tr>
<tr>
<td>12. Been getting scared or panicky for no good reason?</td>
<td>Not at all</td>
<td>No more than usual</td>
<td>Rather more than usual</td>
<td>Much more than usual</td>
</tr>
</tbody>
</table>
13. FOUND EVERYTHING GETTING ON TOP OF YOU.

14. BEEN FEELING NERVOUS AND STRUNG-UP ALL THE TIME?

15. BEEN MANAGING TO KEEP YOURSELF BUSY AND OCCUPIED?

16. BEEN TAKING LONGER OVER THE THINGS YOU DO?

17. FELT ON THE WHOLE YOU WERE DOING THINGS WELL?

18. BEEN SATISFIED WITH THE WAY YOU'VE CARRIED OUT YOUR TASK.

19. FELT THAT YOU ARE PLAYING A USEFUL PART IN THINGS?

20. FELT CAPABLE OF MAKING DECISIONS ABOUT THINGS?

21. BEEN ABLE TO ENJOY YOUR NORMAL DAY-TO-DAY ACTIVITIES?

22. BEEN THINKING OF YOURSELF AS A WORTHLESS PERSON?

23. FELT THAT LIFE IS ENTIRELY HOPELESS?

24. FELT THAT LIFE ISN'T WORTH LIVING?

25. "THOUGHT OF THE POSSIBILITY THAT YOU MIGHT HATE AWAY WITH YOURSELF?"

26. FOUND AT TIMES YOU COULDN'T DO ANYTHING BECAUSE YOUR NERVES WERE TOO BAD?

27. FOUND YOURSELF WISHING YOU WERE DEAD AND AWAY FROM IT ALL?

28. FOUND THAT THE IDEA OF TAKING YOUR OWN LIFE KEPT COMING INTO YOUR MIND?
JOB SATISFACTION QUESTIONNAIRE

Please indicate how satisfied you are with each aspect of your job listed below. Write the appropriate number in the blank beside each statement.

**How satisfied are you with this aspect of your job?**

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Extremely Dissatisfied</td>
<td>Slightly Dissatisfied</td>
<td>Neutral</td>
<td>Slightly Satisfied</td>
<td>Satisfied</td>
<td>Extremely Satisfied</td>
<td></td>
</tr>
</tbody>
</table>

1. The amount of job security I have.
2. The amount of pay and fringe benefit I receive.
3. The amount of personal growth and development I get doing my job.
4. The people I talk to and work with in my job.
5. The degree of respect and fair treatment I receive from my manager.
6. The feeling of worthwhile accomplishment I get doing my job.
7. The chance to get to know other people whilst at work.
8. The amount of support and guidance I get from my supervisor.
9. The degree to which I am fairly paid for what I contribute.
10. The amount of independent thought and action I exercise in my job.
11. How secure things look for me in the future in this organisation.
12. The chance to help other people while at work.
13. The amount of challenge in my work.
14. The overall quality of supervision I receive in my work.

Finally, please indicate (by underlining the appropriate frequency), how often you generally receive clinical supervision for your clinical work. For the purposes of this question the term clinical supervision that we are adopting is as defined on the attached sheet.

I receive clinical supervision on the clinical aspects of my work at least:

Weekly Fortnightly Monthly Bimonthly Quarterly Half-Yearly Annually None

Thankyou.

Now please return all questionnaires to Jamie Hacker Hughes at Bridge.
Clinical supervision is a process based on a clinically-focused professional relationship between the practitioner engaged in clinical practice and a clinical supervisor. It complements but does not take the place of formal programmes of education. This relationship includes the clinical supervisor applying clinical knowledge and experience to assist colleagues to develop their practice, knowledge and values. This relationship will, therefore, enable practitioners to establish, maintain and improve clinical standards and promote innovation in clinical practice.

Clinical supervision is not:

- The exercise of management responsibility and managerial supervision.

- A system of formal individual performance review procedures, or

- intended to be hierarchical in nature.
## APPENDIX 6

### Burnout and Frequency of Supervision

<table>
<thead>
<tr>
<th>Group</th>
<th>EE</th>
<th>DP</th>
<th>PA</th>
<th>SF</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dietitians</td>
<td>Medium</td>
<td>Low</td>
<td>High</td>
<td>Medium</td>
</tr>
<tr>
<td>Music Therapists</td>
<td>Low</td>
<td>Low</td>
<td>High</td>
<td>Medium</td>
</tr>
<tr>
<td>Physio-Therapists</td>
<td>Medium</td>
<td>Low</td>
<td>Medium</td>
<td>Low</td>
</tr>
<tr>
<td>Speech Therapists</td>
<td>High</td>
<td>Low</td>
<td>Medium</td>
<td>Low</td>
</tr>
<tr>
<td>Psychiatrists</td>
<td>Medium</td>
<td>Low</td>
<td>Low</td>
<td>Low</td>
</tr>
<tr>
<td>Community Nurses</td>
<td>High</td>
<td>Low</td>
<td>Medium</td>
<td>Medium</td>
</tr>
<tr>
<td>Occupational Therapists</td>
<td>High</td>
<td>Low</td>
<td>Medium</td>
<td>High</td>
</tr>
<tr>
<td>Psychologists</td>
<td>Medium</td>
<td>Low</td>
<td>High</td>
<td>High</td>
</tr>
</tbody>
</table>

Key: EE - Emotional Exhaustion; DP - Depersonalisation; PA - Personal Accomplishment
## APPENDIX 7

### Job Satisfaction and Frequency of Supervision

<table>
<thead>
<tr>
<th>Group</th>
<th>GS</th>
<th>JS</th>
<th>PS</th>
<th>CS</th>
<th>SS</th>
<th>SF</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dietitians</td>
<td>High</td>
<td>High</td>
<td>High</td>
<td>High</td>
<td>High</td>
<td>Med.</td>
</tr>
<tr>
<td>Music Therapists</td>
<td>High</td>
<td>High</td>
<td>High</td>
<td>High</td>
<td>High</td>
<td>Med.</td>
</tr>
<tr>
<td>Physio-Therapists</td>
<td>High</td>
<td>Medium</td>
<td>Medium</td>
<td>High</td>
<td>High</td>
<td>Low</td>
</tr>
<tr>
<td>Speech Therapists</td>
<td>High</td>
<td>High</td>
<td>Medium</td>
<td>High</td>
<td>Medium</td>
<td>Low</td>
</tr>
<tr>
<td>Psychiatrists</td>
<td>High</td>
<td>Medium</td>
<td>Medium</td>
<td>High</td>
<td>High</td>
<td>Low</td>
</tr>
<tr>
<td>Community Nurses</td>
<td>High</td>
<td>Medium</td>
<td>Medium</td>
<td>High</td>
<td>High</td>
<td>Med.</td>
</tr>
<tr>
<td>Occupational Therapists</td>
<td>High</td>
<td>Medium</td>
<td>Medium</td>
<td>High</td>
<td>High</td>
<td>High</td>
</tr>
<tr>
<td>Psychologists</td>
<td>High</td>
<td>High</td>
<td>Medium</td>
<td>High</td>
<td>High</td>
<td>High</td>
</tr>
</tbody>
</table>

Key: GS - Growth Satisfaction; JS - Satisfaction with Job Security; PS - Satisfaction with Pay; CS - Satisfaction with Co-workers; SF - Supervision Frequency
APPENDIX 8

Inter-Correlations of Psychological Distress (N = 42)

<table>
<thead>
<tr>
<th>Scale</th>
<th>A</th>
<th>B</th>
<th>C</th>
<th>D</th>
<th>T</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>1.00</td>
<td>0.35</td>
<td>0.02</td>
<td>0.10</td>
<td>0.69**</td>
</tr>
<tr>
<td>B</td>
<td>0.35</td>
<td>1.00</td>
<td>0.00</td>
<td>0.43*</td>
<td>0.61**</td>
</tr>
<tr>
<td>C</td>
<td>0.02</td>
<td>0.00</td>
<td>1.00</td>
<td>0.35</td>
<td>0.40**</td>
</tr>
<tr>
<td>D</td>
<td>0.10</td>
<td>0.43*</td>
<td>0.35</td>
<td>1.00</td>
<td>0.59**</td>
</tr>
<tr>
<td>T</td>
<td>0.69**</td>
<td>0.61**</td>
<td>0.40*</td>
<td>0.59*</td>
<td>1.00</td>
</tr>
</tbody>
</table>

1-tailed significance: * = .01      ** = .001

Key: A - Somatic Symptoms; B - Anxiety and Insomnia; C - Social Dysfunction; D - Severe Depression; T - GHQ-28 Total
**APPENDIX 9**

*Inter-Correlations of Burnout (N = 42)*

<table>
<thead>
<tr>
<th>Scale</th>
<th>EE</th>
<th>DP</th>
<th>PA</th>
</tr>
</thead>
<tbody>
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<td>EE</td>
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<td>0.47**</td>
<td>0.10</td>
</tr>
<tr>
<td>DP</td>
<td>0.47**</td>
<td>1.00</td>
<td>0.08</td>
</tr>
<tr>
<td>PA</td>
<td>0.10</td>
<td>0.08</td>
<td>1.00</td>
</tr>
</tbody>
</table>

1-tailed significance: * = .01 ** = .001

Key: EE - Emotional Exhaustion; DP - Depersonalisation; PA - Personal Accomplishment; SF - Supervision Frequency
### APPENDIX 10

**Inter-Correlations of Job Satisfaction (N = 42)**

<table>
<thead>
<tr>
<th>Scale</th>
<th>GS</th>
<th>JS</th>
<th>PS</th>
<th>CS</th>
<th>SS</th>
</tr>
</thead>
<tbody>
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<td>GS</td>
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<td>0.57**</td>
<td>0.01</td>
<td>0.46#</td>
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<tr>
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<td>0.45*</td>
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<td>0.22</td>
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<tr>
<td>PS</td>
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<td>0.45*</td>
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<td>0.18</td>
<td>0.11</td>
</tr>
<tr>
<td>CS</td>
<td>0.01</td>
<td>-0.28</td>
<td>0.18</td>
<td>1.00</td>
<td>-0.26</td>
</tr>
<tr>
<td>SS</td>
<td>0.46*</td>
<td>0.22</td>
<td>0.11</td>
<td>-0.26</td>
<td>1.00</td>
</tr>
</tbody>
</table>

1-tailed significance:  
* = .01  
** = .001

Key: GS - Growth Satisfaction; JS - Satisfaction with Job Security; PS - Satisfaction with Pay; CS - Satisfaction with Co-workers; SF - Supervision Frequency
REFERENCES


between a ward for severely demented patients and a similar control ward. *Journal of Advanced Nursing*, 20, 742-749.


