The Role of Schema Avoidance in Substance Misuse

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Adult Mental Health Essay

'Beating the Blues' is a cognitive based computerised package for depression. It is currently used in Primary Care to address the 'Step One' need of the NICE guidelines for depression. It is delivered primarily, but not exclusively, by Graduate Mental Health workers. Critically discuss the use of computerised packages in Primary Care with specific reference to ethical and professional dilemmas.

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INTRODUCTION

The National Institute for Clinical Excellence (NICE) guideline for depression (2004) recommends computerised self-help packages as part of a stepped-care approach to treatment. This means that one of the first interventions for mild depression in primary care should be computerised therapy, only using more intensive interventions if necessary.

In this essay, I will critically discuss the use of computerised packages in this way. I am going to focus on cognitive behavioural therapy (CBT) programmes because they are the most common. CBT is based on the idea that a person develops beliefs about themselves, others and the world through their early experiences. These are then manifested through their thoughts, feelings, behaviours and physiological reactions to certain situations. CBT aims to help people to change their maladaptive thoughts and behaviours. The systematic, practical nature of this therapy lends itself well to programming.

I will make particular reference to the programme 'Beating the Blues' because it is frequently used and I have previous experience of using it. This influenced me to choose this essay title. I will not discuss internet, phone or virtual reality computer packages, because they have not been as widely used. I will mainly draw on literature from Proudfoot (who was involved in developing 'Beating the Blues'), Marks, Pointon and Cavanagh and Shapiro, because they seem to have done most work in this area.

I would like to say something about my own attitude towards the topic. I have only limited experience of using computer packages. However, it made me think that there could be potential for this intervention. It also made me concerned that it could be inappropriately used and that a client’s risk factors might go
unnoticed. I was unsure whether I was in favour of using them or not. I therefore wanted to update my knowledge on developments since that time.

To help structure the essay, I will discuss ethical then professional dilemmas around using computer packages. However, in some cases this divide is rather arbitrary. The dilemmas I have chosen to focus on were determined by personal interest, as outlined above, as well as themes that emerged from the literature. In terms of ethical dilemmas, I have concentrated on these areas: To what extent will clients be allowed to choose whether to have computerised therapy? And how can we address issues of risk and confidentiality when using computer programmes? For professional dilemmas, I have focussed on these areas: How cost-effective are computer packages? How should they be used? What are the potential limitations of using them?

ETHICAL DILEMMAS

To What Extent Would Clients Be Able to Choose Whether to Have Computerised Therapy?

I will begin with the ethical dilemmas. One ethical dilemma is that in the National Health Service (NHS), where we are being encouraged to use computerised interventions for milder problems, to what extent would clients have choice over the mode of therapy? I am going to address this by discussing the rationale for using computer-based packages, the advantages of allowing clients choice, and the difficulties of giving choice.

Part of the rationale for using computerised therapy is that it is part of the stepped care approach that aims to provide the lowest level intervention first in order to make the NHS more cost-effective. Another part of the rationale is that while approximately 20% of people consulting their General Practitioners (GPs)
have anxiety or depression (Fox et al., 2004), there is a lack of therapists to meet this need. My experience of working with Clinical Psychologists who work in primary care is that they have relatively long waiting lists due to the high demand. Computerised CBT could help to reduce these. The speed of access to computer therapy may also prevent the person's difficulties from becoming worse and therefore reduce long-term cost to the health service as well.

However, some people may prefer not to have computerised therapy. Many government documents stress the importance of patient choice when deciding on interventions. Choice is important because it helps the client to engage initially and to remain motivated.

A difficulty in giving choice is that it may be hard to provide equal access. I will give some examples. In the past, I have found that clients in employment can have problems fitting sessions around their work, particularly if their employer is unaware of their difficulties. Fox et al. (2004) point out that the times when the computer can be used may be relatively inflexible. This could mean that employed people might find it difficult to access. The NICE guidelines for the use of computerised CBT also say that cultural factors may affect the helpfulness of intervention. For example, Pointon (2004) points out that in ‘Beating the Blues’ the case study characters are all white. Some people might find this alienating, when the idea is to normalise depression and anxiety. In addition, Cavanagh and Shapiro (2004) say that computer packages are designed for people with no previous experience of computers. However, I think that familiarity with computers could affect outcome. This would imply that age might be a barrier as older people have been less exposed to computers in their lifetime. This may also be related to socio-economic status (SES). It could be that people of low SES have had less exposure to computers and therefore would respond less well to computerised therapy. However, the widespread use of computers in schools is likely to moderate this.
On the other hand, there is some evidence that computerised therapy can benefit a range of people. Newman et al. (1997) anecdotally report that participants of varying ages, education, and computer literacy have responded well to computerised packages. Part of the assessment for computerised therapy would be to determine whether someone could benefit from them. It is also important to try to reduce barriers, so that those who wish to use them can do.

After discussing the rationale for using computer-based packages, the advantages of giving clients choice, and factors that might limit choice, I think that each of these factors is important. In my opinion, they should be given equal consideration when thinking about suitable interventions.

**How Can Risk Be Managed When Using Computer Packages?**

Another potential ethical difficulty with computerized packages is how to manage risk. Risk management would involve assessing the client’s risks and devising a plan to manage them. I will discuss to what extent this might be achieved through the computer system itself, assessment of risk before use, and facilitation of computer sessions.

One of the problems with computerised interventions is that it may not be apparent if a client is finding the material difficult. Proudfoot, Goldberg et al. (2003) say that after each session of ‘Beating the Blues’ a report, including risk factors, is completed and printed for the GP. However, it is not clear when the GP might look at this and it seems improbable that this would happen at the end of each session. In addition, Pointon (2004) says that people may not wish to tell a computer if they are feeling suicidal. She proposes that the therapeutic relationship is important to enable disclosure of such information. On the other hand, Marks (1999) says that people often find it easier to disclose sensitive
risk-related information to a computer, for example, drug-taking, sexual behaviour and suicidal ideas. So far, the evidence seems unclear as to whether risk factors would be reported to a computer or not.

Another way to manage risk is through assessment of suitability for computerised therapy. The NICE guidelines for the use of computerised CBT say that disorder severity and co-morbidity need to be considered. Van Den Berg et al. (2004) list some exclusion criteria as suicidal plans, psychosis and substance dependence. It would also be helpful to assess whether the client has social support and is aware of other help available. It would probably be unwise to allow people who are at high risk to use computer packages.

Another issue in risk management is what level of facilitation may be required, if any. This is in itself an ethical dilemma because, as previously discussed, the point of computerised therapy is to free up time for therapists to see more severe cases. I will say more later about how level of facilitation also relates to cost-effectiveness.

The NICE guideline for the use of computerised CBT states that there is a lack of evidence about the amount of support required from a facilitator. There are some programmes that can supposedly be used without facilitation. However, even if risk information is given to a computer someone would need to review it. There may also be a need for post-therapy assessment, clinical supervision and management support.

This leads to another issue: what kind of professional would be needed to facilitate the sessions? When I facilitated a client using 'Beating the Blues', I was an Assistant Psychologist and I thought it was appropriate. I think that someone with knowledge of CBT and risk assessment skills would be needed. Fox et al. (2004) believe that either an Assistant Psychologist or a Nurse Specialist in CBT
could carry out the role. However, Van Den Berg et al. (2004) cited an example where administration staff were carrying out the facilitation role for 'Beating the Blues' after 2 hours of training. They felt that this fitted the skills of an administrator because it entailed administrative and customer support skills, and promoted self-help. On balance, my view remains that it would probably be helpful to have a facilitator who was qualified to assess risk and explain various aspects of CBT, if needed.

To summarise, risk needs to be considered when thinking about suitable interventions. Although there are facilities for computers to take risk information, there are difficulties with this. An assessment of suitability, combined with the use of a facilitator, who should be a clinician, would probably allow risk to be managed at an acceptable level.

Would Computer Packages Provide Sufficient Client Confidentiality?

Another ethical dilemma in the use of computers is whether confidentiality can be maintained. Confidentiality is important because it enables the client to disclose information, which allows appropriate interventions to be chosen.

Proudfoot, Swain et al. (2003) say that on 'Beating the Blues' confidential information is encrypted so that it cannot be read by hackers, and that the client should be informed of this. Since this facility is available, it is likely that confidential information would be relatively safe.
PROFESSIONAL DILEMMAS

How Cost-Effective Are Computer Packages?

Now I will move onto professional dilemmas in the use of computer packages. The first area I am going to cover is how cost-effective they are. This forms part of the NICE guideline’s rationale for using them, as outlined above. However, if they are not cost-effective in practice, this would create a dilemma. In order to evaluate cost-effectiveness, I am going to discuss cost of packages, human resources required, evidence of their effectiveness, drop-out rates and service user views.

To begin with, I will examine whether computer packages are cheaper than therapists. I initially assumed that they would be cheaper, but there appears to be mixed evidence on this. For example, Kenardy et al. (2003) report that computerized packages are a sixth to a third more cost-effective than usual therapy, while Cavanagh and Shapiro (2004) report that ‘Beating the Blues’ costs roughly the same as a course of traditional therapy. Pointon (2004) also provides an example of a service where ‘Beating the Blues was more expensive than a therapist. The service bought a licence for 40 people per year to use ‘Beating the Blues’ at a cost of £4000, but only 25 people used it. This means that it cost £160 per person for 8 sessions (£20 per session) and some of them may not have completed all 8 sessions. It is therefore unclear as to whether computerised interventions save money. It would also depend on the choice of programme, as cost varies. This would have to be carefully calculated when considering using them.

Next, I will look at the human resources needed for computerised therapy. Marks et al. (2004), along with many others, say that computerised interventions save considerable therapist time. When I facilitated a client’s use of ‘Beating the
Blues' it appeared to save the clinician time by orientating the client to CBT. In addition, I was able to carry out other work while the client used the computer. Some programmes may save more therapist time than others. Marks (1999) reports that this ranges from 5% to 95%. The evidence seems to show that clinician time saved by computerised interventions, although variable, can be quite considerable. This is an important factor in the context of a shortage of therapists as outlined above.

However, even if computers require less money and resources, effectiveness also needs to be considered. Studies of computer interventions have produced mixed results. Proudfoot, Goldberg et al. (2003) found that 'Beating the Blues' had a beneficial effect on depression and anxiety, which was maintained at 6-month follow-up. However, White et al. (2000) found that there was little change on measures of anxiety and depression over the course of computerised therapy.

Other studies compare computer-based interventions to other interventions. The NICE guidelines for the use of computerized CBT reports that 4 of the 7 studies they examined showed computerised CBT to be more effective than GP care. This also means that 3 out the 7 showed that it was not. McCrone et al. (2004) compared 'Beating the Blues' to GP care for depression and anxiety. They found that 'Beating the Blues' produced greater improvements on standardised measures as well as more symptom-free days. Another piece of research (Marks 1999) compared computerised methods to bibliotherapy (use of self-help books). It found that computerised exposure therapy had equivalent outcomes to bibliotherapy, although bibliotherapy would presumably be cheaper and more convenient. A further set of studies compared computerised therapy to face-to-face therapy. Cavanagh and Shapiro (2004) conducted a meta-analysis, which is usually considered a good type of evidence. They found that computerised therapy was not as good as usual therapy, although it was better than wait-list
controls. However, another piece of research by Cavanagh et al. (2003) found that computerised CBT has equivalent efficacy to traditional therapy.

So far, evidence on the effectiveness of computer packages is inconclusive. Computer packages have been found to implement some aspects of cognitive-behavioural therapy more effectively than others (Newman et al. 1997), which may partly explain the variable outcomes.

It is worth noting that there is only evidence for computerized packages for certain disorders. This is because the range of programmes is limited and the research has focussed on a few areas. The NICE guidelines recommend computerised packages for mild depression because they think they are effective for that disorder. They also report that there are benefits for stress. Marks (1999) says that computer packages have also been found to be effective for phobias, anxiety, panic, obsessive compulsive disorder, depression and stopping smoking. Proudfoot, Goldberg et al. (2003) additionally say that computerised packages are effective for managing chronic pain and sexual dysfunction. Therefore, computer packages could potentially be used for these disorders, but for others, evidence of effectiveness will need to be found.

Another outcome measure that can be used is level of drop-out from treatment. Again, there are mixed results. Proudfoot et al. (2004) found that drop-out rates were equivalent for 4 sessions of computerized therapy and 12 sessions of usual therapy. However, this is not an equivalent comparison. Meanwhile, Van Den Berg et al. (2004) report a 45% drop-out rate for 'Beating the Blues', which is slightly more than other forms of treatment. Where feedback was attained, a range of reasons for drop-out were given, both positive (e.g. felt better) and negative (e.g. did not like the programme). Proudfoot, Swain et al. (2003) report that lack of time and inappropriateness of the package were other reasons for drop-out. Some of the reasons for drop-out seem to be similar to those for face-
to-face therapy, so it remains unclear why the drop-out rate is higher. One possibility is suggested by Anderson et al. (2004). They say that when computers are used as an adjunct to therapy rather than instead of face-to-face therapy it does not seem to affect drop-out rate. This may indicate the importance of the therapeutic relationship in maintaining engagement in treatment. In conclusion, more detailed information is needed from people who have dropped out, although it may be difficult to achieve a representative sample.

A further evaluation of computer packages is the service users' views. I hypothesised that service users might think that computerised therapy was insufficient, so I reviewed the literature to explore the issue. Feedback about computerised therapy is generally quite positive (e.g. Van Den Berg et al. 2004). Pointon (2004) provides quotes from service users, for example, 'The effects have lasted and I'm still using what I learned'. Proudfoot, Swain et al. (2003) report that 82% of clients who had had previous one-to-one therapy rated 'Beating the Blues' as being as good. However, Jacobs et al. (2001) found that satisfaction was higher with traditional therapy. When comparing individual to group work, White et al. (2000) found that 44% of participants would prefer a computer to a group, 44% either, and 12% would prefer a group. Perhaps this is because computer therapy is seen as being less intimidating. User feedback therefore seems to be generally positive. However, not all these studies gained anonymous feedback so there is a risk that clients were being compliant.

To conclude, the evidence for the cost-effectiveness of computer therapy is currently limited and inconclusive. Kaltenthaler et al. (2002) conducted a systematic review of the evidence and rated it as being of poor to moderate quality. One problem is that a lot of the research has been carried out by the same people, some of whom were involved in the development of specific packages. This increases the possibility that they were vulnerable to bias. Some
of the trials were conducted in university settings, with researchers as facilitators, and sessions spaced at a frequency that would be unlikely in practice. This reduces the generalisability of the findings to clinical populations. Participants were often self-selected, which may mean that they were unrepresentative. Another problem is small sample sizes (White et al. 2000), which reduce the power of the studies to detect any patterns in the data. Also, the evidence-base for computerised therapy is continually expanding so that articles from a few years ago are already out-dated. Cavanagh and Shapiro (2004) say that more evidence is needed, particularly on the effectiveness of certain programmes and facilitator involvement. Proudfoot, Swain et al. (2003) also say that reasons for drop-out need to be looked at further.

To assess cost-effectiveness of computer programmes, I have discussed cost of packages, human resources needed, effectiveness of computerised therapy, drop-out rates and user views. It is unclear whether computer packages are cheaper than therapists, or how effective they are. There seems to be a higher drop-out rate than for traditional therapy. However, computers appear to save clinicians' time and service users are generally positive. More research is needed to investigate these issues. Another dilemma about this is that we might be reluctant to gather evidence, because if computers are found to be as effective as a therapist, it might devalue our work.

How Should Computer Packages Be Used?

With several possible ways to use computer packages, there may be an issue about which to choose. I will now evaluate these.

Jacobs et al. (2001) say that there is a continuum of level of involvement of computers. This ranges from stand-alone programmes, to facilitated packages, to computers as an adjunct to therapy, to therapy without computers. They
argue that the level of computer involvement should depend on the individual's needs. However, there is limited research about the best ways to use computers. It relates mostly to the use of stand-alone programmes and computers as an adjunct to therapy. The evidence for using stand-alone programmes has been reviewed above, so I will now look at the research related to using computers as an adjunct to therapy. Pointon (2004) reports that computer packages have been found to be a helpful introduction to CBT before therapy. The NICE guidelines for computerised CBT packages also say that there is preliminary evidence that when computers are added to traditional therapy it increases the effectiveness. This has been found for panic disorder, generalized anxiety disorder and obsessive-compulsive disorder (Kenardy et al. 2003). So far, therefore, the only evidence that we have relates to using stand-alone programmes and using computers as an adjunct to therapy. The evidence is very limited so not much can be concluded at this time.

What Are the Limitations of Computer Packages?

It is important to think about some of the limitations of computerised therapy, and how these might create dilemmas about using it. One dilemma is whether computer packages can provide consistency of care. Proudfoot, Goldberg et al. (2003) say that the advantage of computers is that they 'Don't get tired and have off-days'. This is true to some extent. However, I would argue that a computer could be less consistent than a therapist, in that they break down, often quite suddenly and without obvious reason. This is something that needs to be taken into consideration when considering whether to use computer packages.

An expectation cited by the NICE guideline is that computerised therapy would provide individualised care. Proudfoot, Goldberg et al. (2003) say that 'Beating the Blues' is customised to the specific difficulties the client is having. However, there could be a debate about how personalised a computer programme could
be. An inherent aspect of computers is that they can only respond to any particular scenario in the way they were programmed to, whereas clinicians can be more creative. Computers cannot take into account different contexts or respond to specific issues. This would need to be considered.

Linked to this, another limitation is that the packages are generally based on certain diagnoses. This is not a concept that is generally used in psychology, which instead emphasises understanding each client as an individual. Also, in my own experience of deciding to have therapy, there were not specific issues that I wanted to address. Computer therapy cannot be used like this currently, because it requires a diagnosis. The other difficulty related to this is that in order to cater for people with different disorders, it would be necessary to buy a number of packages, which could be expensive.

A further potential limitation is that computerised therapies do not seem to include an important part of therapeutic process, namely, the relationship between therapist and client. First, I am going to discuss the importance of the therapeutic relationship, then the degree to which computers can mimic that.

Rogers (2003), among others, has emphasised the importance of the therapeutic relationship in facilitating change. Also, a lot of research has shown that the relationship is the key factor in therapy (e.g. Orlinsky et al, 1994). I will now give some examples of when a therapeutic relationship may be particularly important. According to Illman (2004), people who have problems in relationships may prefer computerised therapy because it is less intimate than usual therapy. However, these may be the people who would most benefit from a therapeutic relationship. This causes a further dilemma in that the client's choice of intervention may not be the most potentially beneficial one. Sivyer (2004) also says that people with depression may be isolated and find it difficult to express their feelings. He thinks that they would benefit from expressing their
feelings to someone warm and empathic, to discourage them from isolating themselves. To summarise, there is much benefit to be gained from a therapeutic relationship. The question is whether computer packages can provide this.

In response to this, those that have worked on the development of therapeutic computer programmes have argued that computers can form a relationship with clients. Cavanagh and Shapiro (2004) say that computer packages are designed to mimic non-specific factors in therapy, for example, therapeutic alliance and trust. There are many dimensions to just those two concepts and I cannot imagine how the programme developers might go about elucidating what the vital aspects are and then incorporating them into the package. Some of the aspects that Anderson et al. (2004) say have been included on computer programmes are: questioning, focussing, rephrasing, clarifying, and interpreting. However, this does not cover everything that a therapist does. Proudfoot, Goldberg et al. (2003) say that they attempted to make the voice-over on ‘Beating the Blues’ empathic. However, Fox et al. (2004) report that some clients found ‘Beating the Blues’ patronising and thought that some of the responses were offensive or insincere. On the other hand, there is a study by White et al. (2000) which found that all participants who took part felt that the computer understood them. In summary, although there have been attempts to make computer packages realistic, I cannot imagine that they could ever replicate the creative and genuine responses of a human therapist.

CONCLUSION

One of the ethical dilemmas of using computer packages as part of the stepped-care approach is to what degree clients would have choice in this. Although there are pragmatic reasons for advancing the stepped-care approach, there is also a good argument for allowing patient choice. However, choice may be
moderated by which interventions are likely to be helpful. I believe that 3 factors should be equally considered in thinking about intervention options: limited resources in the NHS; client choice; and likelihood of benefit. Further research should be done into how such negotiations are carried out with clients.

Another dilemma is how to manage risk. It seems that some aspects are built into computer packages to help with this. However, a risk assessment would be required before considering whether computerised therapy is a suitable option. Policy documents also state that risk assessment should be ongoing. It is difficult to understand how this is being done in places where the facilitator is a member of administrative staff. Facilitation by someone who could assess risk would be necessary to monitor it on an ongoing basis. If an Assistant Psychologist was to be the facilitator, further training in risk assessment might be necessary.

I was initially concerned that there might be problems with confidentiality in using computers, but on looking at the literature it seems that the confidentiality issue has been addressed. Storing information on computers might actually be safer than storing in filing cabinets.

The issue as to whether computer packages are more cost-effective than therapists has not been completely resolved. Contrary to my expectation, it is not clear that they are cheaper, although they do seem to save clinicians time. There is also mixed evidence about effectiveness. This may be partly due to the newness of the technology, which means that limited research has been carried out, with more in some areas than others. There is also a lack of high quality research produced by people not linked to manufacturers. There is some evidence of a high drop-out from computer-based interventions, which needs to be further investigated. What this means for therapists is that a cost-benefits analysis would have to be carried out before purchasing packages. Also since
packages are paid for per client, it may be helpful to start with one package and a few clients and carry out outcome measurement. A subscription to a particular programme could be terminated if there are not sufficient gains.

Another professional dilemma is how programmes should be used. A review of the literature revealed that research was only available for using facilitated packages and using computers as an adjunct to therapy. The outcome of this discussion was not conclusive; therefore these still need to be evaluated.

Another set of dilemmas related to the limitations of computer packages. One issue was whether computers could be consistent, and on balance, I think that they could be consistent enough. In terms of whether they can be tailored to the individual, I see them as being less individualised than therapists, partly because they operate on the basis of diagnoses. This implies that computer packages would probably be most helpful for people with discrete difficulties. If a client presents with multiple or complex issues, computerised therapy may not be appropriate, and the person should be offered individual therapy. There is also the issue of whether a computer can provide a therapeutic relationship. My prejudice was to think that computers would not be able to provide a therapeutic relationship and I did not find anything in the literature that caused me to change my mind.

To conclude, there are several ethical and professional issues surrounding the use of computers in therapy. Computer packages appear to have some evidence in their favour. However there are also a number of precautions that need to be considered before implementing computerised therapy, for example, the lack of high quality evidence and knowledge about who it is useful for and how it should be used. After writing this essay, I have learned more about the issues related to the use of computer programmes in primary care. However, I am still uncertain as to whether I am in favour of using them and in what
circumstances. It seems likely that these will be used more in the future because of the emphasis placed on them in the stepped care approach. Perhaps through my future experience and evaluation of them I will be able to reflect more on how helpful they may be.
REFERENCES


Professional Issues Essay

Assertive Outreach: Creative Use of Resources or Therapeutic Stalking?

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Year 2

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INTRODUCTION

What is Assertive Outreach (AO)?

AO is advocated by key government documents, such as The National Service Framework for Mental Health (1999), The National Institute for Clinical Evidence guideline for schizophrenia (2002) and Keys to Engagement (Sainsbury Centre for Mental Health, 1998). These state that people with mental health problems need specialist services, such as AO, that can prevent crises or intervene early. They particularly support the use of AO with people who make high use of in-patient services.

From the general literature, there seems to be several key principles underlying AO. Minghella et al. (2002) define it as a model of care involving multi-disciplinary working, high staff-client ratio, 24 hour coverage, high frequency service and a full range of treatments provided. They say that the model is designed for people with severe mental health problems who may lose contact with mental health services. Hemming et al. (1999) reviewed the literature and found that most authors cited similar characteristics to the above, with the addition of it being an ongoing service rather than time limited, providing assistance with practical tasks, and being community based. The service user group Rethink (Took, 1999) also uses a definition of AO that is broadly in line with the above.

Although it is possible to pick out the broadly accepted principles of AO from the literature, there is nonetheless some conflicting views about the definition and distinction from other, similar, models. The literature is confusing at times because a range of different names are used to describe similar concepts, for example, assertive outreach, assertive community treatment and assertive casework. These sometimes seem to be used to mean the same thing.
However, in other papers, these names are used to identify slightly different kinds of services. Indeed, even some papers that call what they are studying AO, do not seem to be talking about AO as it is usually defined. In this essay, I have included papers that seem to relate to the most common definition of AO, as stated above.

**How I Will Approach the Question**

The essay title appears to ask for an evaluation of AO on the grounds of both outcomes and ethics. The title of the essay implies that AO is either a 'good use of resources' or 'therapeutic stalking'. It is possible to consider the question in this way, and I will explore that. I will therefore divide the essay into these two parts to help to structure it, drawing links between the two sections throughout.

However, it is clear from my reading of the literature that some people accept that AO is coercive but think that the benefits of 'stalking' make it a good use of resources. Inherent in this is the idea that potential benefits to the clients and others can be used to justify a possible infringement of the client's human rights. This is an ethical question that is common in mental health settings and so I will attempt to address this too.

**My Position in Relation to the Question**

Prior to starting to write this essay I did not really know what AO was. Part of the reason that I chose this essay title was that I hoped to gain new knowledge through the literature search and my reflections when writing it. I also wanted to develop my skills in evaluating models and so this also drew me to this particular essay.

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1 I have chosen to write in the first person to enable me to reflect on the literature, my personal opinions.
Once I had found some information on AO, I formed quite a negative view of it, because I saw it as having negative implications for people's rights to self-determination. Therefore, although I have tried to find evidence for and against, my natural bias at the start of this essay was against AO, and this is probably reflected in the papers I have chosen to discuss and the way in which I discuss them.

**IS ASSERTIVE OUTREACH A GOOD USE OF RESOURCES?**

To begin to answer the question of whether AO is a good use of resources, it is necessary to define what 'good use of resources' means. It could be interpreted in different ways, for example, that it is clinically effective, cost-effective, users are satisfied, and so on. I will try to cover each of these aspects in the following discussion.

I will define what I mean by each of these terms. According to Wikipedia (website), 'Clinical effectiveness is a measure of the extent to which a particular intervention works', 'Cost-effectiveness refers to the comparison of relative expenditure...and outcomes', and, user satisfaction 'is a ...term used to capture the idea of measuring how satisfied [clients] are', with the service. Clearly there is some overlap between these terms, however, in order to bring some structure, the evidence available for AO will be split into categories under these headings. I am particularly interested in what service users think of AO, because of my concern that they may find it intrusive.

**Cost-effectiveness**

One of the drives for promoting AO seems to have been that it was expected to be a cost-effective method of providing services to people who are high users of
services. Many studies have been carried out which seem to suggest that it is cost-effective. These studies have focused mainly on the cost-reduction brought about by fewer hospital admissions, probably because this is an explicitly stated aim of AO. However, they also mention other possible areas of cost reduction. Olfson (1990) conducted a review of the research on AO and found that the evidence seemed to show that AO reduced hospital admissions. One example of such a study is by Sanderson et al. (1996). They found that people using AO services experienced less involuntary admissions and used crisis services less. The study seemed to indicate that frequent contact with clients enabled early interventions at the first sign of relapse. Another example is a study by Hambridge and Rosen (1994). They conducted evaluations of two AO services and found that there was a 35% decrease in hospital admissions and a 62% reduction in the number of bed days.

I found one study that found that AO was not cost-effective. Ford et al. (2001) studied three services over a five-year period, measuring, among other things, resource use and cost. All three services began as AO services, but after 18 months one of the teams changed it's approach and the other disbanded. Therefore, Ford et al. (2001) compared the three teams. They found no differences except that the team that had remained an AO service cost more. However, it seems that they only measured cost of providing the service and did not take into account factors that may have offset some of these costs, for example, reduced use of other services. Therefore, this does not seem to be a fair evaluation of cost-effectiveness.

User Satisfaction

I am aware that service users are a diverse group of people, however when considering whether service users as a whole are satisfied with AO, some generalisation is necessary. There is overall some support for AO being a good
use of resources from the service user's perspective. The organisation Rethink, which represents the views of users of mental health services, say in their policy document on AO that they support the development of AO teams (Took, 1999). However, they think that the name 'assertive outreach' should be changed, as it may imply a threat to clients' autonomy. They conducted a study of one AO service and found that 80% of clients thought that the service had been very beneficial to them (Took, 1999).

I found another study that explored how service users felt that AO had impacted on their mental health. This was a study by Graley-Wetherell and Morgan (2001), funded by the Sainsbury Centre for Mental Health. They interviewed service users, as well as carers and staff, about their experiences of AO. Unfortunately, they do not make clear how the participants were recruited, so it is possible that this was not random. Nonetheless, the service users reported feeling less paranoid and having better relationships with their neighbours since being with the service.

There have also been surveys that have revealed what exactly service users found helpful about AO. Williamson (2001) says that one area that service users seem to be especially satisfied with is with the practical support in everyday living, such as housing and benefits. There is evidence for this from the statements of participants in the study by Graley-Wetherell and Morgan (2001). One respondent said, 'I was being evicted that day...they got me a place to go to straight away'. Other participants reported a large increase in benefit payments.

Another particularly helpful aspect of AO identified by service users in this study was general day-to-day support. One participant said, 'They supported me through the death of my husband and I now have some contact with my family'.
A respondent who was a carer said, ‘They...explained to us what happens when our son hears voices’.

Despite these positive client views, other authors have found poor levels of client satisfaction. Phillips *et al.* (2001) say that many clients are not satisfied with AO. McGrew *et al.* (1996) found that there were particularly low levels of service user satisfaction with medical treatments received from an AO team. Another area of dissatisfaction identified by a respondent in the Sainsbury Centre for Mental Health study was, surprisingly, that they felt that they were not getting enough contact from the team; ‘I would like to see them in the evenings or at weekends, as that is when I get most lonely’. This implies that the service did not strictly adhere to AO principle, where services should be 24-hour, seven days a week.

**Clinical Effectiveness**

Despite the anecdotal evidence from service user statements that AO has improved their mental health, I could not find many studies that measured outcomes and unequivocally found that service users felt better after being seen by an AO service. I did find one study by Lang *et al.* (1999), in which quality of life was measured before and during treatment in an AO service. They found that quality of life improved between the two time-points. However, unfortunately, they did not use a control group and therefore it is difficult to know how AO would compare to a different treatment or no treatment. In addition, the way in which quality of life was measured differed between the two time-points and this may have had an influence on the results. Furthermore, both the clients and the clinicians may have been motivated to show that an improvement occurred. Overall, I do not think that this is particularly good evidence for the clinical effectiveness of AO. Other more robust studies showing effectiveness may exist but could not be located.
Gralely-Wetherell and Morgan (2001) say that overall the evidence about the effectiveness of AO has been conflicting. Olfson (1990) reviewed all the evidence up until 1990 and found that, although early researchers found that AO was effective in managing symptoms and improving functioning, this was not replicated by later studies. However, it must be borne in mind that the model is likely to have developed further since 1990, and therefore it is not clear whether this conclusion still applies.

Even some evidence from individual studies has been conflicting. An example of this is a study by Minghella et al. (2002) which collected information on two AO teams to measure their effectiveness. They found that, although clients generally engaged and felt positively about the services, they did not perceive positive change in their quality of life. It is difficult to know what to conclude from this. Furthermore, the study was limited in that neither of the services adhered fully to the AO model, for example, neither provided an out of hours service. This was even shown by their own measure of treatment fidelity. This highlights one of the difficulties in investigating the effectiveness of AO, which is that treatment fidelity seems to be quite poor in general; this reduces the generalisability of the findings from particular studies. Another problem with the lack of treatment fidelity is that the model cannot be expected to be effective if it is not used in the correct way. Indeed, an article by Marshall and Lockwood (1998) concludes that AO teams are only effective when they have been targeted at high users of hospitals. This is not surprising since this is the group that AO has been designed for.

I think that there is still insufficient evidence to conclude that AO is clinically effective. It cannot necessarily be inferred that if AO can demonstrate cost-effectiveness and user satisfaction it improves mental health. For example, it is possible that clients' use of other services does not decrease due to better mental health but because they have access to 24-hour intensive service that
they use instead of other services. On the other hand, it may be that it is not particularly important whether mental health is improved if service users benefit in other ways. However, the government does emphasise the importance of using effective, evidence-based treatments. Despite this, it seems that they are advocating the use of a model of treatment for which there is not sufficient evidence for its effectiveness. Perhaps it is necessary to seek this evidence and elucidate in what circumstances and with which clients the model is generally effective. In doing this, it is important to take into account the diversity of the potential service users and that this model will not be suitable for everyone who meets the broad criteria.

I will now summarise my response to the question of whether AO is a good use of resources. So far, it seems that most studies show that AO is cost-effective. User satisfaction data are equivocal, with some people reporting positive views and others reporting negative views. In terms of whether it is clinically effective, there seems to be a lack of high-quality evidence in this area, and so it is not possible to make any firm conclusions.

**IS ASSERTIVE OUTREACH THERAPEUTIC STALKING?**

**Assertive Outreach is Therapeutic Stalking**

I will discuss the question of whether AO is 'therapeutic stalking' in terms of ethical issues as well as service user views. I think it would be helpful to further explain my own view about the ethics of AO. As I have previously stated, my view at the start of writing this essay was that, although I would not go as far as to say that AO is stalking, it could be intrusive to clients. This reaction was partly based on a previous experience I had. I used to work in a substance misuse service, where we used motivational interviewing and were quite pro-active about contacting people who failed to attend the service. Wikipedia (web-site)
defines motivational interviewing as a style of counselling that uses 'direction, in which therapists attempt to influence clients to consider making changes, rather than non-directively explore themselves'. I was always slightly uncomfortable with this as I felt that at times it might not have been respectful of people's rights to choose not to attend the service or not to change their substance use. I thought that if people did not want to attend, they should be able to withdraw from the service, especially if they were not obviously in distress. When considering this essay, I made a link between my previous experience and what I read about AO, and this made me feel negatively about the model.

Similarly, in the literature, the main argument that AO is 'therapeutic stalking' seems to stem from the lack of choice clients may perceive in whether they use the service. In his review paper, Williamson (2002) states that the ethical judgement on AO depends on the 'extent and nature of client choice'. He says that one of the implications of the principles of AO is that clinicians will be persistently trying to deliver a service to people who are refusing it and not legally bound to accept it. He questions whether this is justified. He states that many other authors have challenged AO on the grounds that it is coercive and disregards people's 'rights to autonomy and privacy' and says that AO can be perceived to be an oppressive method of social control.

Williamson (2002) also points out that the degree of choice may be perceived differently by clients than it is by clinicians. He says that practitioners may not see themselves as being coercive, but their clients might. Additionally, clients may value their autonomy and liberty more than the clinicians, who have to consider a range of other issues, such as risk.

Indeed, there is some evidence that clients do not feel that they have much choice about whether they use an AO service. In the study by Graley-Wetherell and Morgan (2001), one of the participants said, 'I don't need the nurse and
injections, but I feel I have to really, if I don’t they might put me on a worse drug or even in hospital.

Another issue that may be relevant here is that it seems to me that applying pressure to clients may adversely affect outcome. As I mentioned, I used to work in a substance misuse service, where some people were compelled by the courts or by social services to attend. It was notable that these people often seemed to be less motivated, harder to engage and appeared less able to reduce their substance misuse.

A final point that occurs to me is that there is a risk that particular groups of clients may be more likely to be subjected to coercive services. An example of this is that Monaghan et al. (2005) found that people under that age of 45 were more likely to have perceived themselves to have been subject to what they call 'leverage'. The difficulty with this study is that it is hard to know whether there is a difference between older and younger people in what they may perceive as 'leverage'. In addition to this, Takei et al. (1998) found that, African-Caribbean immigrants were more likely to receive compulsory treatment than their white peers.

**Assertive Outreach is Not Therapeutic Stalking**

The argument that AO is not ‘therapeutic stalking’ seems to be mainly based on the premise that if this particular group of clients were not coerced into using an AO service, they would end up in hospital, which would be an even worse infringement of their personal autonomy. According to Test and Stein (2001), this is a major part of the rationale for AO. Bond et al. (2001) emphasise that helping people to avoid hospitalisation ultimately means that they will have more choice. There is evidence, as cited above, that AO does seem to prevent people
from needing hospital admissions. Personally, I find this argument quite enticing and it has made me view AO more positively.

On the other hand, I have heard some clients say that they would actually rather be in hospital than in the community, even if this was long-term. This seems to be because they would feel safer and believe that the risk to themselves and/or others would be reduced. Therefore, I am aware that the assumption that people would rather be cared for in the community than in hospital may be inaccurate, so I looked for some service user views on this issue. A Rethink study (Took, 1999) found that 90% of AO service users would rather live in the community than hospital. In addition, a participant in the study by Graley-Wetherell and Morgan (2001) seemed to view being out of hospital as a positive effect of using the AO service; 'They keep me out of hospital'. However, McGrew et al. (1996) conducted a service user survey and found that only 1.8% of clients cited 'less hospitalisation' as a positive aspect of AO. It is not clear whether this is because they did not view this positively or they simply did not experience it. I think that it is likely that views on hospitalisation will differ between service users. Therefore, it should not be assumed that all service users would view less hospitalisation as a positive outcome, which would be worth being 'stalked' for.

Another argument put forward is that AO services do actually try to provide people with as much choice as possible, and therefore are not stalking people at all. Test and Stein (2001) say that nowadays AO services try to help clients to be as autonomous as possible. They say that, although in the past services had developed intervention plans without clients, practices have now changed, and these are done collaboratively. I think that this depends on how the client sees this process; for example, it may not be perceived as collaborative if the client feels they have no choice but to do it. However, there is evidence that some service users do not find AO intrusive. Firn and Burns (2004) say that despite concerns most clients actually prefer it to standard care. There is also some
evidence from Graley-Wetherell and Morgan (2001) that clients of AO services did not feel that they were being pushed to do things. One respondent said, 'I wasn't keen at first but they went at my pace'.

As I have said, I was particularly interested in the service users' views of AO. I was surprised to find that the service user body Rethink was actually broadly supportive of such services. The Rethink policy document on AO states that AO is helpful because some people may lose contact with services because they are homeless, have problems travelling or do not want to mix with people with mental illness (Took, 1999). Indeed, there is evidence that certain groups are less likely to use mental health services; for example, people from Black and Minority Ethnic groups (Cheung & Snowden, 1990), adolescents (Srebnik et al., 1996), and men (Deane & Todd, 1996). In this way, the Rethink document points out how AO may help a greater range of people to use mental health services than those that otherwise would do.

Is AO Both a Good Use of Resources and Therapeutic Stalking?

To me, the major link between the two parts of the essay question is that if it was not thought that AO was a 'good use of resources', there would be no justification for 'therapeutic stalking' at all. As I said at the beginning, an alternative to AO being either 'a good use of resources' or 'therapeutic stalking' is that it may be both. Some proponents of the model state that AO is indeed 'therapeutic stalking', but that this is necessary and presumably acceptable because of the risk to the clients and members of the public of not doing it. This would seem to imply that personal freedom and choice comes second to personal and public safety. Williamson (2002) reports that some authors that defend AO would say that it is sometimes necessary to override an individual's personal autonomy for their own or others' benefit. I can see that there is a need to protect people from harm, and prevent levels of risk from getting to the point
where hospitalisation is required. However, this implies that all people who use AO services pose a considerable risk to themselves or others. I have not read anything that explicitly said that this was a criterion for AO.

Another justification for 'therapeutic stalking' that is sometimes proposed is that it is necessary to ensure that people get the appropriate treatment. An example of this argument is in a book by Burns and Firn (2002). They believe that there is a need for compulsion in order to ensure appropriate treatment. They say that when services used to wait for clients to come to them, they were often very ill by the time they came. However, in the context of AO, they also emphasise the importance of responding to a person's expressed need, partly in order to engage with them. Holloway and Carson (2001) take a milder view but point out that there is a tension between empowering a person to choose not to receive a service and neglecting them by not acting in their best interest.

Whether or not 'therapeutic stalking' is necessary and/or acceptable is linked to the issue of capacity and informed consent to assessment and intervention. Holloway and Carson (2001) say that this issue is particularly salient when a person does not think that they have any mental health issues and there may be concern about whether the person has capacity to make decisions about treatment. I can see that if a person was distressed but did not have capacity to decide whether to use a service, a more assertive approach could be deemed ethical. This is because it might prevent their difficulties from getting worse to the point where they would require hospitalisation, which would be an even greater infringement of their liberty, as discussed earlier. However, as Williamson (2001) points out, if the person is not reporting distress and there is no particular risk then there would be a questionable 'ethical mandate' for intervention.
Conclusions

I will now summarise my main points. Overall I viewed the essay as an evaluation of AO in terms of outcomes and ethical issues. Firstly, I tried to evaluate whether AO was a 'good use of resources'. I did this by considering cost-effectiveness, client satisfaction and clinical effectiveness.

There is good evidence that AO is cost-effective, mainly in terms of reducing cost by decreasing in-patient treatment. This would suggest that, if everything else was equal, AO would be a useful model of treatment for this client-group. This is particularly relevant in the context of a National Health Service that is cash-strapped and therefore needs to be mindful of overall service costs.

Client views on AO were mixed, which might be expected. However, the main area of satisfaction that emerged was with practical help with issues such as housing or benefits. This may indicate that there is a need for more professionals with specialty in these areas, for example, social workers, in assertive outreach teams.

In terms of clinical effectiveness, the evidence for this was complicated by the lack of adherence to the model by several of the AO services that were studied. This makes it difficult to make generalisations from those pieces of research. The general consensus seemed to be that when the model was adhered to and targeted the intended population, it was effective. The difficulty is that if the model is not generally used in as rigorous a way as this, the evidence cannot be taken to mean that all AO services are effective. Perhaps there is a need for adherence to the model to be audited to elucidate the reasons for non-adherence. It is possible that there are good reasons for using it slightly differently but this needs to be explained and it still needs to demonstrate
effectiveness. It would be helpful to elucidate under what conditions the model is effective.

Secondly, I addressed the question of whether AO is 'therapeutic stalking'. One of the primary arguments that AO is 'therapeutic stalking' is that clients may not have much choice about whether they use the service or not. There was some evidence from service user views that this is sometimes perceived as the case. Perhaps there needs to be more inquiry into how service users perceive AO services and particularly power issues.

The main argument that AO is not therapeutic stalking is that if the targeted population were not the recipients of AO, they may be compelled to stay in hospital instead. However, as I mentioned above, the services do not always seem to target the people they are meant to. This would have implications for the ethical status of these particular AO services. Another argument made by some writers is that AO services do provide people with as much choice as possible, and therefore are not coercive. This was supported by some service users views. A further argument made by the Rethink policy document is that AO helps people to access services, when they might find it difficult, for example if they are homeless. This is a very different way of looking at AO and one that I find quite compelling.

The final area I discussed was the argument put forward by some writers that AO is 'therapeutic stalking', but that this is necessary and therefore acceptable because of issues of risk and acting in the best interest of the person, particularly when they are unable to make decisions for themselves. Overall, I think that the ethical issues involved in AO are complex and there needs to be an ongoing dialogue about these.
One observation that I have made of AO during the literature search for this essay is that there seems to be at times quite a divergence between the principles of AO as they are generally defined and the way the model is actually practised. This has made it difficult to define what AO is, to make any generalisations from research and to make any general comments on AO. As I have mentioned, this would seem to be an important area to pay more attention to in the future.

Throughout the course of this essay, my opinions on AO kept changing. I think by the end I felt more positively towards it, but only in circumstances where the person may not have the capacity to make a decision about their treatment and/or they are at risk of being sectioned. I still think that I will always find the issue of respecting someone’s autonomy versus overriding it to act in the person’s best interest difficult and I am sure that it will continue to emerge whatever setting I work in. I hope that I will be able to use the rest of my training as well as future supervisors to discuss these issues. However, perhaps it is helpful to maintain a questioning position in relation to ethical issues.
REFERENCES


Problem-Based Learning Reflective Account

March 2006

Year 1

Word Count - 1993
THE PROBLEM

The Task

At first, the nature of the task was unclear to me. The outcome was for our case discussion group (CDG) to do a presentation on the topic ‘Relationship to Change’ in 6 weeks’ time. From what I read about problem-based learning, I understood that the process was as important as the outcome (Wood 2003). It seemed that we were supposed develop through the task, not just acquire information.

How We Carried it Out

For the first 2 weeks, we discussed the title ‘Relationship to Change’ and how to approach the task. We decided to reflect on the development of our case discussion group (CDG) and the year group, and compare this to theories of change. We researched the theories and chose to use Tuckman’s (1965) model of group development, Prochaska et al.’s (1992) model of change and Williams’ (1999) model of transitions. We decided to present Tuckman’s (1965) model through a spoof video. We also wanted to ask the rest of the year for their reflections on the group development, which we did by questionnaire. We each wrote particular parts of the presentation then put the 3 main sections together – the theories, our reflections and the year group reflections. Finally, we practiced our presentation.

Strengths and Weaknesses of the Approach Taken By the Group

The main weakness of our approach was that we failed to reduce the number of items in our presentation. This meant that we needed several extra meetings to complete the task, and the presentation slightly lacked focus. The strengths of
the approach we took was that everyone in the group contributed and the theories we used gave structure to our work.

THE GROUP PROCESS

The Group Process

At the start of the task, everyone had different ideas about the presentation, which led to conflict. I think that one meeting in particular was quite stressful for most people. After this, it seemed that everyone made an effort to address this, by being particularly considerate and listening to each other. However, this did fluctuate over the course of the task. For example, in week 4 we had a great time making the video for our presentation, which seemed to help us to bond more. However, in week 5, time pressure to complete the task appeared to increase anxiety levels, which meant that we listened to each other less.

Weaknesses of the Group

One of the problems I think the group had in the first couple of weeks was poor communication and lack of compromise. Some people stated strong views while others said little. I think that these factors led to repetition of the same discussions, with no clear resolution, and contributed to the sense of frustration.

Another difficulty was that the group consisted of more ‘ideas’ people than ‘implementers’. This meant that a lot of time was spent discussing and producing ideas, although it was not clear how these could all be included in the presentation.
A further weakness of the group was that we assumed that everyone should have at least one of their ideas included. This added to the difficulty of how to fit everything into the presentation.

Lastly, it seemed difficult for the group to reflect after the task was over. Everyone made positive comments and there was not much critical analysis. I think that we were all keen to move on from the task as soon as it had finished, because of the intensity of it.

Strengths of the Group

One of the strengths of the group was that we addressed the difficulties we had in an open way. This led to the idea of reflecting on the development of the case discussion group for our presentation. Another strength of the group was that we shared a similar sense of humour, which helped us to bond.

THE PRESENTATION

The Presentation

I was nervous before the presentation, but the presence of the rest of the group made me feel quite confident when I was presenting my section. The presentation was interactive and funny. Afterwards, we all thought that it went really well.

Strengths and Weaknesses of the Presentation

One of the weaknesses of our presentation was that it had many items in it, which could have been confusing for the audience. I think that that the strengths
of the presentation were that we were able to bring the different sections together and also that we made it lively and engaging.

**RELEVANCE OF THE TASK TO CLINICAL PRACTICE**

**Theory Practice Links**

Studying the theories allowed me to see how well they applied in practice. We used Tuckman's (1965) model of group development as our primary model. Some parts of it really fitted our experiences, for example, the storming stage, when everyone wants to exert control. However, it was particularly helpful to learn to critique models. For example, Tuckman's (1965) model of group processes involves a linear development of the group, whereas in our group, we felt that at some points we moved back into earlier stages.

**Relevance of the Task to Clinical Practice**

The task emphasised for me some of the advantages and disadvantages of working in a team. We had difficulties in making decisions because everyone had very different ideas, however it was also an advantage to be exposed to a range of ideas that we might not have thought of as individuals. It is possible that in a multi-disciplinary team (MDT) there might be an even more disparate group of people, so these effects might be exacerbated. It would therefore be important to value individual views and be flexible.

The task also highlighted a useful way to deal with difficulties in relationships. In our group, we were able to discuss the difficulties we initially had early on and in an open way. I think that this fostered better relationships within the group and increased cohesion. This could be generalised to relationships with colleagues and clients.
A final way in which the task was relevant to practice is that as part of our work we will sometimes have to give presentations. For the task, we spent time thinking about how to make our presentation interesting. We decided that it should be varied, involve the audience, use various speakers and a range of media. It would be helpful to consider how to make presentations at work engaging in a similar way.

Reflection on the Task in the Light of Clinical Practice

I wrongly assumed that our case discussion group was made up of similar people and it would be easy for us to work together. I have now realised that in can be difficult to work as a team in any context, whether that is at university or work. This has helped me to see the links between university and work and how skills can be transferred across settings. One thing that I have been able to do is to be more flexible when working with others, and I hope to continue developing my skills.

Relevance of the Task to Service User Issues

In the context of the clinical psychology course, the trainees are the service users. One of the aspects of the task that I liked was that we were allowed to guide our own learning. It gave me the impression that we were being treated with respect and having our past experiences valued. This helped me to feel comfortable on the course overall. I think that this would be a helpful experience to bear in mind when working with service users as clients and colleagues.

Relevance of the Task to Ethical Issues in Clinical Settings

I noticed that when we had a tutor facilitating the group, we behaved differently. I think that this is because we wanted to be viewed positively by someone we saw
as an authority figure. It occurred to me that in a supervision context this would not be helpful, and that I should be aware of this so that I can try to avoid it.

Relevance of the Task to Difference and Diversity

As I mentioned above, differences between people can make a task more difficult or slow, but it can also lead to a rich discussion based on different points of view. I do not think that I would find the group useful if we shared the same opinions all the time.

LEARNING FROM THE TASK

Personal Learning

This exercise has overall made me think about how I tend to function in groups. I have realised that it is important for me to feel that I am part of a group. This is recognised by Tuckman’s (1965) model of group development, which suggests that when a group is ‘forming’, people will try to fit in.

The task also helped me to see that I am a very focussed and pragmatic person. This meant that at times I was frustrated and annoyed at the lack of progress on the task. I had the urge to tell people what to do, in order to move the task on. At first I was reluctant to do this because I wanted to be accepted by the group, but as time went on, I felt more confident in stating my opinions. Again, this is a stage in Tuckman’s (1965) model of group development, the ‘norming’ stage, when members become comfortable giving and receiving feedback.
Relationship Between Personal and Professional Learning from the Task

My reflections above have highlighted to me that at times I might find it frustrating to work in a team. This emphasises how important it will be for me to use supervision, peer support and my outside social support to cope with this. I think that the helpful aspects of working in a team for me will be that it will moderate my pragmatic approach and give me confidence to be innovative. For example, although our presentation was very creative, I don't know if I would have the confidence to do something similar alone.

Learning Points for Myself and Others Arising from the Task

During the task, I learned to cope with my annoyance and frustration by talking to my peers. This is something that could be helpful in the future. I think that one issue that needs to be addressed by our group as a whole is that we are all quite perfectionistic. This meant that we spent a lot of time planning and practicing the presentation, and by the end, were slightly lacking in energy and enthusiasm. I think that we need to learn to do a bit less and accept that the outcome will not be perfect.

SYNTHESIS

This reflection has elucidated for me that one of the most important aspects of the task was working together as a group. I think that we were working quite well by the end, but that some improvements could be made next time. For example, we have sometimes found it hard to compromise and value each other’s views. This might be something to discuss. Also, although I am aware that my proclivity is be pragmatic, I think that our case discussion group does need to be more practical in its approach.
Another helpful aspect of reflecting was to think about how the task relates to our work. It helped me to observe the links between work and the course more clearly. For example, in terms of team work in general, I think it is important for me to see that even if a group does not appear to be functioning well at first, this can improve. One of the factors that enabled this to happen was that we were open with each other about the difficulties in the group. I was also able to think about my own role in relation to group work and I thought about some strategies that would enable me to develop this. Overall, I have found it useful to think about what I have learned and how it will be useful in the future.
REFERENCES


Problem-Based Learning Reflective Account

March 2007

Year 2

Word Count - 1990
THE TASK

The task was a vignette about Mr. and Mrs. Stride and their children. Social services were considering having the children adopted, due to concerns about the Strides' parenting. Their concerns related to Mrs. Stride having a learning disability, domestic violence in the parental relationship, their non-attendance at parenting classes and the family's poverty. They were referred to the psychology department for a risk assessment and rehabilitation plan. We were asked to make a presentation about this.

We initially considered making the presentation a fly-on-the-wall expose of poor practice in child protection cases. We decided against this because it would only provide a negative view of child protection and we wanted to demonstrate the complex dilemmas involved. Therefore, we decided to do the presentation in the style of 'Newsnight' in order to have a debate about the issues. We wanted to set the programme in the future when the children had grown up so that all parties could discuss the outcome.

I think we were able to produce such an original idea because of how we discussed the task. We initially stated any ideas we could think of and then added to each other's suggestions. In this way, we were able to work as a team rather than a collection of individuals (as we had in our last problem-based learning [PBL] task). The group ownership of ideas enabled us to make decisions about what to do in a rational, non-personal, way. I think that this represents a positive development of the group, which will hopefully be maintained.

I think that another strength of our group was our pragmatism. We seemed to have a sense of proportion about the importance of the task and how much time to spend on it. I think we learned from the last PBL exercise, when we took lots of
time over it. This was probably because it was the first exercise we did on the course and we were keen to impress the tutors.

An example of our practical approach was that, near the beginning, we planned the structure of the presentation and time allocated to each part. This enabled us to realise that we had less time for each section than we thought. Overall, I think we managed our time well, and I hope that we can use the same planning skills in our next task.

In terms of weaknesses, some of our group members were more dominant than others. I have noticed that the less dominant people, including myself, tend to defer to the more dominant ones and seek their opinion. In this way, we are all responsible for maintaining the inequality. However, towards the end of the task, the less dominant people seemed more able to state their views. Maybe this was because we had become aware of the imbalance. This led to decisions being made more fairly. I hope that we will continue to do this.

The main limitation of the actual presentation was that we could have emphasised more of the dilemmas of the decision about the children's care in our presentation. We could have had the professionals portrayed be more specific about the reasons for their views. We also could have included more material about the risks of removing a child from their parents.

**RELEVANCE OF THE TASK TO CLINICAL PRACTICE**

The task was highly relevant to my learning disabilities placement. It made me consider how cognitive impairment relates to functioning, in particular, parenting and accessing services. This encouraged me to include aspects of functioning in my formulations of clinical work. The task also helped me to think about how to resolve ethical issues. When an ethical issue arose in my work, I was able to use
some of the methods I had learned to resolve it, for example, consulting guidelines and convening the team.

The task also enabled me to learn more about resilience. In the presentation, I played one of the children, who was intended to demonstrate resilience. The literature revealed some of the factors that increase resilience, for example, social support in school, religion or the community (Smith & Pryor, 1995) and being willing to seek support (Alvord & Grados, 2005). I hope that this will help me to consider how to increase resilience, particularly as I am now working in a child service, which the literature related to. An example of this is that it may be possible to elucidate ways in which the child could increase their support network.

Another aspect of the task that was relevant to clinical practice was the literature about children witnessing domestic violence. Margolin and Gordis (2000) described how this can lead to internalising difficulties such as depression and anxiety, or externalising difficulties, such as aggression and crime. I found this a helpful way of thinking about different responses to the same situation.

I also think the task highlighted how services may not always consider the diversity of their clients. In the vignette, there were diversity issues such as learning disability, poverty and having twins in the family. These issues may have affected the assessment of Mr. and Mrs. Stride's parenting. It seemed that any aspect of their parenting that was different to the perceived norm was viewed negatively. However, I think it is likely that not many parents adhere to the 'norms' set out by social services. It also seemed that failure to recognise diversity might have affected the interventions offered to Mr. and Mrs. Stride. It appeared that they were offered mainstream parenting courses and were sent letters even though they could not read. This prompted me to ensure that my own communication with clients was appropriate.
I also think that this task raised issues related to service users. One of these was that it emphasised that service users may feel unable to refuse interventions, leading to non-attendance instead. I think that this may have happened with one of the clients I saw on placement. It highlighted the importance of seeking consent regularly, especially with groups that may be particularly dis-empowered. Another way in which the task related to service user issues was that a carer and service user watched the presentations. One member of our group was concerned about this, as some of the presentations were comic. This made me aware of the views people may hold about service users, for example, that they do not have a sense of humour. I also think that the presence or absence of service users or carers should not affect how respectful we are. This increased my awareness of the resistance that still exists to service user and carer involvement. Personally, I think it would be helpful to have more feedback on our academic work from service users, as I believe this would emphasise a different perspective.

Having now worked in a learning disabilities service, I can reflect on how we could have done the task differently. The service I worked in was made up of many different professionals using their specific skills to work with clients. This was more evident than when I worked in adult mental health. I think that if we were to do the task now, we could emphasise more about the roles of different professionals in relation to the ethical dilemma. An example of this is that the case manager could have talked about their role in arranging a case conference. A further point I learned from my clinical practice was that some people with learning disabilities have a strong desire to be autonomous but may feel restricted by the services working with them, which may want to protect them. I think that we could have included this in the portrayal of Mrs. Stride, in order to demonstrate this issue.
At some points during the task, I found it difficult to express my opinions. An example of this was that there was a discussion about who played what character. Someone else ended up playing the character that I wanted to, partly because I was not very assertive in stating my preferences.

I think that finding it difficult to state my views was due to the hierarchy I perceived in the group. Through personal therapy, I have become aware that I am particularly sensitive to hierarchies, which is probably why I noticed it in the first place. The background to this is that some of the older members of my family were in military organisations, and encouraged a hierarchical structure in the family, where older generations are more senior. There is also strong endorsement of military-type beliefs in my family, for example, that senior members will make all the decisions and that more junior members are not allowed to question these.

In the CDG, I am aware that there is not an actual hierarchy, as we are all peers. However, some group members had more dominant personalities, for example, they stated their views with certainty, they made statements about what we should do rather than suggestions, and they generally presented themselves in a confident manner. I think that once I noticed that there were more dominant people, I became one of the less assertive members of the group because I feared that if I challenged one of the more dominant people, they would get angry with me, and possibly reject me.

Through writing my reflective journal, I became aware of how my personal history was affecting my contribution to the group, and I decided to try to speak out more. An example of this was that I suggested that we plan what we would do with the time we had. The other group members said they appreciated this idea.
This encouraged me to continue being more assertive, because it was well received by the rest of the group, and my fears about their reaction were not realised.

My reflections above have made me think about how finding it difficult to be assertive may affect how well I can carry out the role of a Clinical Psychologist. I am aware that team working and leadership are an essential part of the role, and this reflection has made me aware of the difficulty I may have in achieving this. Therefore, I need to take responsibility for my lack of assertion and ensure that my views are heard. This will be a challenge; However, I think that the more I do it, the easier it will get. One strategy that may help me to do this may be to build relationships with team members, so that I will feel less anxious about making suggestions. Another possible strategy could be to elicit the support of my supervisor in helping me to achieve this.

The task also made me think about how my clinical work may be affected by my personal attitudes. An example of this is that I made the character I was playing a portrayal of resilience because I am interested in people's strengths and coping. This is probably because my parents have always encouraged me to notice the positive aspects of a difficult situation. When working with clients, this means that I tend to acknowledge resilience factors that may be present. This can help me to facilitate clients to elucidate what their resources are; however I also have to be aware of the need to explore their difficulties.

SUMMARY

In summary, the task helped me to gain knowledge about clinically relevant topics such as child protection procedures and how to manage ethical and risk-related issues. During the process of carrying it out, I developed skills in the areas of time management and making presentations. Finally, the task and this
reflection helped me to understand more about relationships and my role in them, which should help me when working in teams, with clients, and in my personal life. I was able to think about what I have to contribute to a group and how I can ensure that my views are heard.
REFERENCES


Problem-Based Learning Reflective Account

February 2008

Year 3

Word Count - 1999
INTRODUCTION

This reflective account will explore three areas – how our group approached the problem-based learning (PBL) task, the relevance of the task to professional practice, and the relationship between the task and my personal development. This structure is used for clarity, but overlap between these areas will be demonstrated.

THE TASK

The task was a vignette about Mr. Khan, a 72 year-old Pakistani man who has lived in England for approximately 35 years. His wife recently died but he has two adult daughters, Shazia and Maya. Shazia had an arranged marriage and lives in Pakistan, while Maya married a European and lives in England. Maya has approached social services with concerns about Mr. Khan's memory, physical health and daily living skills. We were asked to make a presentation about this.

Our group decided to focus the presentation on culture because it is a topic that we feel is often difficult to discuss. However, due to this very issue, we found it difficult to develop the presentation. We therefore decided to make our presentation a reflection about our difficulties in discussing the task.

Through this, our group demonstrated a strength in reflection. Our reflecting skills have developed throughout the course, probably facilitated by our reflective accounts. However, reflecting in a presentation was challenging because of a conflict between wishing to reflect honestly and knowing that our tutors, who evaluate us, would be watching. It was difficult to resist presenting ourselves as we thought trainee clinical psychologists should be – empathic, interested in other cultures and politically correct. However, we were able to reflect somewhat
openly. These reflecting skills will be invaluable to us when working with clients, as part of a team or as consultants, and will hopefully continue to develop.

Another strength of our group was that we were able to reflect on our own cultural identities, as white people, and how this may contribute to our difficulties in discussing culture. I think that this was possible partly because some of us had had placements where cultural awareness was emphasised. Additionally, now that the group has been together for three years, sufficient trust has been established for us to discuss more personal issues. One group member felt that there is a taboo about white people discussing culture. I told the others about an article (Gushue & Constantine, 2007) about white identity being associated with shame due to white peoples' contribution to racism through constructing other groups as the 'other' and therefore inferior. This may help to explain our difficulty in discussing cultural issues, which could inhibit us when working with clients, supervisors and colleagues. Awareness of this may help us to overcome it.

One weakness of our approach was that many ideas were developed then discarded. This seemed to be due to perfectionism and competitiveness with other groups doing the task. These characteristics are probably fairly typical of trainees, as they are presumably required in order to gain a training place. However, this vastly increased the amount of time spent on the task. When we are qualified, we will have limited time for developing presentations and will need to be more realistic.

Another limitation was that we took an overly cautious approach to the presentation. The tutors had recently informed our year group that some trainees in the year had felt offended by what others had said or done. This made some members of our small group feel anxious about offending others. This helped me to realise that it is important to balance being sensitive with being able to tackle difficult issues. I was concerned about reflecting upon the difficulties between
trainees in the year group in this assignment, as I am aware that regional psychologists sometimes mark the assignments. I am reluctant for people outside the course to know about it as I think that it reflects badly on our year group. However, I recognise that it had an impact on how we approached the task and I acknowledge that for reflection to be helpful, I sometimes need to take risks even though it feels exposing.

The main limitation of the actual presentation was that we did not address the vignette. We decided not to, as we wanted to explore our difficulties in discussing culture instead. If we had focussed on the vignette, we could have presented how Mr. Khan's culture might have impacted upon the assessment and intervention, for example, whether standardised tests would have been valid (Allen, 1997).

RELEVANCE OF THE TASK TO CLINICAL PRACTICE

The task highlighted the importance of acknowledging cultural diversity in clinical psychology, which is one of the ten Essential Shared Capabilities (Hope, 2004). This represents an ethical position, particularly in the context of a largely white profession, with which people from other groups may have difficulty engaging. I shared an experience with the group of working in a service where cultural differences were routinely acknowledged, possibly facilitated by high ethnic diversity of the clients and the team. This helped me to understand the possible impact of cultural differences between therapist and client. Another group member shared an experience of a team that did not acknowledge cultural differences. Gushue and Constantine (2007) stated that this could contribute to racism through not recognising difference. This team might have denied difference because, like us, they felt uncomfortable about discussing culture.
These discussions helped us to recognise the importance of acknowledging cultural differences.

Although we did not present this, the group discussed the potential challenges of providing 'culturally competent' services (Whaley & Davies, 2007), for example, how to determine what is appropriate for any given individual. In Mr. Khan's case, he may not consider himself culturally different from English people since he has lived in England for a long time. Also, even if he does feel that he is from a different culture, this does not necessarily imply that he would like a specialised service. It must also be acknowledged client choice is limited and the multidisciplinary team is powerful in determining what services Mr. Khan can access. This discussion reminded me to ensure I do not make assumptions about appropriate interventions for clients based on my view of their culture.

Another service user issue raised by this task was that the potential client might not be the person who is most keen for the referral. Others may seek help on their behalf because they are dis-empowered by prejudice, emotional state or cognitive impairment. This has implications for ethical practice, consent, and engagement. It highlights the importance of ascertaining the service user's view of the referral. During my older adult placement, I hope to gain experience of managing such situations.

The task was useful in my psychodynamic placement. I worked with a woman from an Asian background who had an arranged marriage. I noticed that she frequently explained certain cultural concepts to me. Although this was helpful, it made me aware of the need to pay attention to how clients may perceive me as different from them. Our different backgrounds also affected how confident I felt about formulating her difficulties because I felt uncertain about the impact of her cultural background. An article I read for the task, by Amodeo and Jones (1997), suggested conceptualising culture in terms of an individual within a family belief
system within a cultural belief system. This was helpful in understanding this client. However, I still struggled with the formulation and discussed it with my supervisor. This was useful and encouraged me to consider the role of culture more in my formulations.

My current placement also made me reflect on how we could have done the task differently. The service I work in is made up of therapists of different professions and therapeutic orientations. Through my own experiences and attending team meetings, I have been able to recognise the differences between those approaches and the relative strengths and weaknesses of each. Since Mr. Khan was likely to be seen within a multi-disciplinary team, it might have been interesting to have focused the presentation on how the different professions would have understood and managed his difficulties, and the strengths and weaknesses of each perspective. This might have helped us to understand the viewpoints of other professionals and to critique our own position as psychologists.

PERSONAL LEARNING FROM THE TASK

The task helped me to consider my feelings about discussing culture. During one discussion about whether we should role-play the family, I became concerned that we might stereotype them as they were from an unfamiliar culture. I reflected on why I was more worried about this than other role-plays. I concluded that it was because I grew up in a place where there were few people from other cultures, which makes me fear that my lack of knowledge might lead me to inadvertently offend someone from another culture, especially since cultural difference can be a particularly sensitive topic. In my work with clients, I need to ensure that this does not prevent me from discussing issues of culture.
More generally, I learned that I tend to get annoyed by slow progress on tasks. Our group spent a lot of the time allocated to the task discussing irrelevant topics or unable to make a decision about the focus of the presentation, which I felt was inefficient. I commented on this, and while some group members agreed with me, others felt that we should spend as much time as necessary. However, my comment did effect a change in the group, in that we came to a compromise decision about the focus of the presentation and subsequently managed to work more quickly. This helped me to realise the importance of providing feedback in order to contribute to the group's approach to a task. However, I also sought to understand my irritation about how the group approached the task by discussing it with my personal therapist. This made me aware that part of the reason I was annoyed was that I thought that there was a better way to do the task and that I should ensure it was done in this way. I think this is probably because I was brought up to think that there are 'right' ways to do things. Also, in my family, I often felt responsible for others and situations. I think that this has led me to believe that I should 'manage' everything, and tend to either completely take responsibility for other people or completely expect other people to take responsibility for themselves. An example of the latter is that when one of the group members wanted the rest of us to tell her what to say in the presentation, I thought that she should think of something to say for herself. This tendency is something that I would like to address, particularly as I realise that it could affect how I work with clients and staff. I will therefore spend more time exploring this issue with my therapist.

Using my therapist to understand my irritation in the PBL task helped me to understand that being able to get support can affect how I am able to manage and learn from a situation. I have often found it helpful to use support systems outside the immediate professional environment to discuss difficulties and try to process it helpfully, for example, my supervisor, my therapist, reflective journal, these assignments, a friend, or the mentor we have been allocated. This has
demonstrated to me the importance of having a range of potential sources of support, which will be helpful at different times.

SUMMARY

This assignment has enabled me to see my progress in reflecting. This has been encouraged by feedback given by assignment markers and supervisors, particularly in my psychodynamic placement, where I have been reflecting on counter-transference. However, I realised in writing this assignment that I tend to reflect quite critically on myself and others, and need to balance this with self-acceptance and understanding. I hope that I will further develop my reflective skills in order to benefit me both professionally and personally.
REFERENCES


Summaries of Process Accounts of Case Discussion Group

July 2008

Year 3

Word Count - 554
Structure of the Group

First, the group was structured around the problem-based learning (PBL) task, then case presentations, then a combination of discussion topics and case presentations. I think that I learned from listening to other peoples’ experiences. However, sometimes I did not think that issues were discussed in sufficient depth.

Group Processes

Initially, the group did not compromise much. Then, making the video for our PBL presentation helped us to bond and become more considerate towards each other. However, later there was another period of difficulty. Our facilitator helped us to reflect on this and we become more cohesive. I saw the importance of feedback and reflection in groups, which is also relevant to multi-disciplinary teams. I began to view diversity and conflict as potentially helpful and creative.

My Contribution

I tried to bring structure to the group’s discussions, which I think the other group members appreciated. However, I was anxious about presenting clients, being sensitive to other group members’ feelings, and not interrupting others, which meant that my views were often not heard. After reflecting on this, I was more able to talk in the group. My experience raised my awareness that some people in therapeutic groups they may find it difficult to contribute.
Learning

In terms of client work, discussing a client in the group made me aware of my assumptions about the client, and helped me to think of new approaches. In terms of working in groups, our group eventually managed to use our diversity in a constructive way, which was helpful to reflect on in relation to multi-disciplinary teams. Finally, in terms of personal learning, I realised that it takes me a long time to feel part of a group and I need to explore the reasons for this more fully.

YEAR TWO

Structure of the Group

Initially, we did case presentations, but there was often little meaningful content. I think that this was because of the personalities of group members, difficult interpersonal relationships, and fear of the reactions of others. The facilitator encouraged us to reflect on this and we decided to make the sessions topic based, which I think was more helpful.

Group Processes

Initially, there was a power imbalance in the group. I think that group members, including myself, reflected on this, which led to more equality of contributions. The facilitator sometimes highlighted the lack of enthusiasm and reflection in the group, and the group tried to respond to this. However, the group seemed largely unable to reflect upon it's own difficulties.
My Contribution

I found it difficult to say what I thought in the group, which contributed to the lack of reflection by the group as a whole. Reflecting on this made me decide to try to speak up more, which I did. This also enabled me to contribute more at team meetings. I think that I formed better relationships with the other group members, which further facilitated my contribution.

Learning

A discussion about how to manage a high workload on placement enabled me to form a plan about how to manage this and to feel more confident about being assertive. I also discussed an ethical issue in relation to a client, and developed a strategy to manage this. Also, through the group and this reflective account, I have developed my reflecting skills.
CLINICAL DOSSIER
Summary of Placements
ADULT MENTAL HEALTH

Settings

Two Community Mental Health Teams (CMHT), a Primary Care Psychology and Counselling Service and an inpatient psychiatric ward.

Models

Cognitive Behavioural, Humanistic/Explorative, Integrative, Neuropsychological.

Clients

Clients were 19 to 56 years old and were diverse in terms of employment, disability and socio-economic status. Presenting problems were mild to severe and included cognitive impairment.

Types of Work

Work included individual and group therapy, cognitive assessment, service development, carrying out an audit, attending meetings, liaison and joint work.

Assessments

Assessments included interviews with the client and, when appropriate, staff members, and the use of standardised measures.

Interventions

Interventions included psycho-education, thought challenging, behavioural activation, graded exposure, behavioural experiments, assertiveness training and humanistic/exploratory approach.
LEARNING DISABILITIES

Settings

Community learning disability team base, residential settings, an inpatient ward, client's homes, day centres.

Models

Behavioural, systemic, neuropsychological, bereavement, life review.

Clients

Clients were 20 to 64 years old and were diverse in various ways. Presenting problems ranged from mild to severe and included challenging behaviour.

Types of Work

Work included individual therapy, behavioural analysis, cognitive assessment, facilitating care staff discussions, attending meetings and joint work.

Assessments

Assessments included interviews with the client and, when appropriate, staff or family members, standardised measures, behaviour charts, and observations.

Interventions

Interventions included life review, psycho-education, bereavement counselling, behavioural interventions, making recommendations and risk management.
CHILDREN AND FAMILIES

Setting

Child and adolescent mental health team base and local schools.

Models

Cognitive Behavioural, Systemic, Social Learning.

Clients

Clients were 4 to 14 years old and were diverse in various ways. Presenting problems ranged from mild to severe and included behavioural difficulties.

Types of Work

Work included individual or systemic therapy, cognitive assessment, making recommendations, care planning, making presentations and joint work.

Assessments

Assessments included interviews with the client, parents and teachers; standardised measures, feeling thermometer, feeling pie and observations.

Interventions

Interventions included psycho-education, graded exposure, relaxation training, thought challenging, anger management, parenting training, solution-focused therapy, externalisation, network meetings, and making recommendations.
SPECIALIST PLACEMENT – BRIEF PSYCHODYNAMIC THERAPY

Setting

Primary care clinic.

Model

Psycho-dynamic, particularly object relations approach.

Clients

Clients were 18 to 63 years old and were diverse in terms of family configuration, religion, culture, and socio-economic status. Presenting problems ranged from mild to severe and included acute problems.

Types of Work

Work involved individual therapy, and attending meetings and making a presentation in a primary care therapy team.

Assessments

Assessments involved interviews with clients and standardised tests.

Interventions

Interventions included using an analytic frame, mirroring affect, interpretations (including transference interpretations), and use of the therapeutic relationship to modify object relations.
OLDER ADULT PLACEMENT

Setting

Community Mental Health Team for older people.

Model

Behavioural, Cognitive Behavioural, Integrative

Clients

Clients were 63 to 86 years old and were diverse in terms of religion, culture, and socio-economic status. Presenting problems ranged from mild to severe and included clients with dementia and adjustment to adverse circumstances.

Types of Work

Work involved individual and group therapy, cognitive assessment, behavioural analysis and writing care plans, attending meetings and making presentations as part of a multi-disciplinary team.

Assessments

Assessments involved interviews with clients and carers, standardised measures, cognitive assessments and observation.

Interventions

Interventions included psycho-education, thought challenging, behavioural activation, counselling/psycho-dynamic approach.
Summaries of Case Reports

July 2008

Year 3

Word Count – 1234
ADULT MENTAL HEALTH 1

Reason for Referral

Paul was a 56 year-old white British man. After seeing a psychiatrist in the Community Mental Health Team (CMHT) for anxiety for two years, he had benefited little from medication, and was therefore referred for psychological input.

Assessment

Assessment methods used were interview, standardised questionnaires and reading previous case notes. Paul reported anxiety and depression related to thoughts of incompetence, and avoided people and activities. He attributed this to the stress of his last job. Paul said that he had good relationships with his parents and brother.

Formulation

The precipitant to Paul's difficulties was stress at work and leaving his job. He started worrying about his competency and felt anxious about tasks, so avoided them. This confirmed his belief that he was incompetent, maintaining his anxiety and depression. The lethargy accompanying his depression further reduced his ability to do tasks.

Intervention

Interventions were cognitive behavioural. I provided Paul with psycho-education, which normalised his experiences. I also shared the formulation to help him to understand his difficulties. I attempted to teach him thought challenging, but it
made him feel incompetent so used positive self-talk instead. We also did behavioural activation, which was partly successful.

**Outcome**

Paul was unsure whether therapy was helpful. However, he said that positive self-talk alleviated his depression and he was able to increase his activities slightly. I also thought he was better able to understand his difficulties. Standardised questionnaires showed an improvement.

**ADULT MENTAL HEALTH 2**

**Reason for Referral**

Emily was a 33 year-old white British woman. She visited her General Practitioner because of anxiety about travelling. He referred her to the primary care psychology service.

**Assessment**

The assessment involved an interview and standardised questionnaires. Emily reported having panic attacks on transport and when on trips away. She worried about going mad and others rejecting her. She avoided these situations. She had her first panic attack 4 years previously at a stressful time in her life on a plane. Emily reported that she was abused as a child.

**Formulation**

Stress probably triggered Emily’s first panic attack, which she associated with transport and being away. Her sexual abuse might have contributed to fear of
losing control and others' responses, which were activated after the panic attack, causing a fear of panic attacks and these situations. Her avoidance of the situations maintained anxiety by preventing extinction.

**Intervention**

Interventions were cognitive behavioural. Emily and I constructed a formulation to help her understand her difficulties. I provided psycho-education to normalise anxiety. I taught her thought challenging and graded exposure. We devised a behavioural experiment to test other peoples' responses to her anxiety.

**Outcome**

Emily thought she had made some progress in managing anxiety. She seemed less self-critical about it, trusted people more and felt more confident. She re-evaluated previous relationships in which she felt rejected. Emily was able to go on trains, visit other parts of England for a weekend, and use riverboats with little anxiety.

**LEARNING DISABILITIES**

**Reason for Referral**

Jan was a 52 year-old man living in a National Health Service home for people with learning disabilities. He was referred to the psychology service because of verbal and physical aggression.
Assessment

Jan communicated non-verbally. His key-worker said that staff responded to his aggression by asking him about it. The home manager said that he was 'intelligent' and 'manipulative', and had to do certain activities due to normalisation and lack of staff. ABC charts suggested aggression occurred when Jan was asked to do something, after which the request was withdrawn.

Formulation

The functions of Jan's behaviour seemed to be to gain social interaction or communicate that he did not want to do something. The perception of Jan as intelligent and manipulative seemed to derive from an uneven cognitive profile. Staff shortages and lack of training influenced unhelpful ways of working with Jan.

Interventions

I recommended that staff increase non-contingent interaction and stop interaction after aggression. I recommended that they reduce demands, but they were reluctant so we agreed to have a 'best interests' meeting. I helped Jan to make a communication tool. I facilitated network training for staff to re-frame Jan's behaviour.

Outcome

Jan communicated that he liked his communication tool. Staff said they were disappointed that we did not tell them exactly what to do but thought they understood Jan more. Subjective reports and behaviour charts suggested that
Jan's challenging behaviours had decreased. Staff seemed to have improved perceptions of Jan.

CHILDREN AND FAMILIES

Referral

Kal was an eleven year-old boy referred to the Child and Adolescent Mental Health Service by a paediatrician for assessment for autistic spectrum disorder.

Assessment

Kal's mother reported that he could not understand others' emotions, had poor social skills, and inflexible routines. She and Kal's brother had autistic spectrum disorders and his father had a drinking problem. Observation suggested that Kal's social skills were poor with peers but appropriate with adults. His WISC-IV scores ranged from 'Average' to 'Very superior' at an age equivalence of at least 16 years old, with equivalent achievement levels. His BDI-youth score was 'Mildly Elevated'.

Formulation

Kal's test profile, social abilities with adults, communication, range of interests and reactions to unexpected events were not consistent with autism. His social difficulties with peers could have been due to poor attachments and modelling, high abilities, and a genetic predisposition to social difficulties. Also, Kal might have been experiencing some emotional distress, possibly due to his home situation.
Recommendations

I recommended that Kal attend a social skills group, join a youth club or scouts, join a buddy system at school, and be linked with a mentor or Young Carers organisation. I made Kal’s teachers aware of his strengths and difficulties. I recommended that Kal’s school and Anna investigate the usefulness of the National Academy for Gifted Children.

Outcome

Kal agreed with the outcome of the assessment. Anna seemed validated by our observations of Kal’s social difficulties and was in agreement with the recommendations.

SPECIALIST – BRIEF PSYCHODYNAMIC THERAPY

Reason for Referral

Lorraine was a thirty-two year-old woman referred to the primary care therapy service by her General Practitioner with postnatal depression.

Assessment

Lorraine did not show much emotion in sessions and seemed not to expect me to respond. She reported that she resented providing emotional care to her son and wished he was less dependent. She was also depressed after her second child and as a teenager. Lorraine said that both her parents drank excessively and described them as emotionally unavailable, unpredictable and aggressive.
Formulation

Lorraine's core anxiety was about acknowledging her dependency needs, probably because these were not met as a child. She tended to deny these and project them into others. She was probably reminded of her dependency needs by her baby. To avoid turning all her hostility towards him, she directed some of it towards herself leading to depression.

Intervention

A therapeutic space was established. Specific interventions included interpretations, affect mirroring, and modifying object relations through the therapeutic relationship and transference interpretations.

Outcome

Lorraine reported finding the sessions beneficial. At the end, she no longer felt depressed, was more able to tolerate her children's dependency, and had begun asking others for support. I think that Lorraine improved her capacity to reflect. She was able to re-integrate her dependency, could allow herself to feel and show emotions more, and her thoughts and feelings seemed more reality-based. Lorraine's score on the GHQ had reduced from 15 to 7.
RESEARCH DOSSIER
Service-Related Research Project

Audit of Mental Health Promotion in Primary Care in a National Health Service Trust

Louise Hamill

July 2006

Year 1

Word count – 2954
Title: Audit of Mental Health Promotion in Primary Care in a National Health Service Trust. Objective: Mental Health Promotion (MHP) is advocated as part of the National Service Framework (NSF) for Mental Health and the stepped-care approach to treatment in the National Institute of Clinical Excellence (NICE) guidelines. This study aimed to investigate understanding and implementation of MHP in Primary Care in a London Borough. Design: This was a cross-sectional study. Participants: Participants were all General Practitioners (GPs) and therapists working in the primary care service (n=30; response rate=28%). Main outcome measures: A questionnaire was designed to measure understanding of MHP, the level of MHP in the service currently, and the perceived barriers to implementing MHP. This was based on discussions with therapists working in primary care. Feedback was provided from a research tutor at the University of Surrey. Results: The data show that most practitioners knew what MHP was (n=27, 85%) and provided MHP information to patients/clients (n=29, 97%). However, there was a lack of MHP events being offered. The difficulty in implementing these was partly ascribed to a lack of therapist time to carry out such activities. Conclusions: Several recommendations were suggested to ameliorate the situation, for example, raising awareness of MHP and clarifying the roles of the different professionals.

ACKNOWLEDGEMENTS

I would like to thank my Field Supervisor (anon), Course Supervisor (Vicky Senior), The Psychological Therapies in Primary Care service, the Director of Psychological Therapies at the NHS Trust (anon), and Director of PRIMHE (Chris Manning).
INTRODUCTION

What is MHP?

According to the Department of Health (DOH) guideline ‘Making it Happen – A Guide to Delivering Mental Health Promotion’ (2000), MHP involves ‘any action to enhance the mental well-being of individuals, families, organisations or communities’. A variety of models have been suggested for MHP (e.g. Flay 1992). However, ‘Mental Health Promotion in Primary Care’ (DOH; 2002), conceptualises it as both increasing protective factors and decreasing risk factors. It says that MHP includes activities as diverse as voluntary work, relaxation advice and service user groups.

Context

The context of this project is the NSF for Mental Health, which advocates MHP. This is complemented by several National Institute for Clinical Excellence (NICE) guidelines advocating the stepped-care approach to treatment of mental health difficulties (for example, ‘Depression: Management of depression in primary and secondary care’, 2004). The first 2 stages in this approach could be viewed as MHP. They involve providing access to self-help, support groups, and sleep management.

Implementing MHP

‘Mental Health Promotion in Primary Care’ states that MHP is a primary care activity for a number of reasons; mental health and physical health are related, primary care is non-stigmatising and accessible, and the General Practitioner’s (GPs) surgery is part of the community. It emphasises taking a broad perspective to implementing MHP, targeting both individuals and the community, for example,
giving benefits advice in surgeries, and having employment links and friendship groups. Secker (1998), in a discursive paper, says that MHP should also aim for wider change, for example, health services should make links with anti-poverty organisations. However, Whitehead (1995), in his discussion, says that this rarely happens.

Related Research

A literature search revealed little previous research in this area. A survey (Monarch and Spriggs, 1995) of professionals in primary care, found that most respondents defined MHP in terms of raising awareness of mental health issues, and had limited knowledge of what activities might be considered MHP. They found that the majority of respondents saw MHP as an essential part of their work. However, a significant number were indifferent or hostile to it, usually on budgetary grounds. Only a quarter of the respondents said they were currently involved in MHP activities. A key difficulty identified was a lack of training. Humphris (1992) also conducted a study that found that GPs had a relatively poor attitude towards MHP. Finally, Ross and Stark (1995) conducted a survey of Health Authorities to find out how many had MHP strategies, and this was found to be only 3%.

Local Context

The Psychological Therapies in Primary Care service consists of Clinical Psychologists, Counselling Psychologists and Psychotherapists. The topic of MHP was chosen after discussion with some of the therapists in the service. This was for several reasons. MHP is a non-stigmatising and normalising way to improve mental health, which could increase client choice and access. The therapists were aware that they had long waiting lists and felt that some of their clients could benefit from MHP while waiting. This might be the only intervention
required or it might form part of the overall intervention. However, the therapists felt that there is a lack of knowledge about MHP and the therapists' role in it. They were keen to elucidate what MHP is currently being done so that the methods could be disseminated.

OBJECTIVES

The objectives were therefore: (1) to elucidate primary care professionals' understanding of MHP, (2) to ascertain the level of MHP currently available and what it consists of, and (3) to elucidate the perceived obstacles to implementing MHP.

METHOD

Participant Selection and Characteristics

GPs and therapists working in primary care were the primary professional stakeholders in MHP. All 96 GPs and 11 therapists in the borough were asked to take part.

Measures

There are no measures currently available that would address the objectives set. Therefore, two questionnaires were designed, one for therapists (Appendix 1) and one for GPs (Appendix 2). They addressed the following: what MHP is, what kind of MHP work is done currently, and barriers to carrying this out. The questions were yes/no, open-ended, likert scales, or tick boxes.

The questionnaires had face validity as they were devised according to what information was required. Some of the questions were drawn from 'Mental health promotion in primary care' (DOH, 2002). Two clinicians and a research tutor at
Surrey University provided feedback on them. The clinicians could be regarded as 'experts', and this therefore contributes to ensuring content validity. However, no other assessment of validity or reliability was made.

Procedure

The methodology was designed in conjunction with the field supervisor. It was a cross-sectional study. The therapist questionnaires were given to the therapists at their regular meeting. The GP questionnaires were posted to GPs with a covering letter (Appendix 3) and a self-addressed envelope to return it in. Despite a good initial response rate (22 participants), a second mail shot was done to increase sample size, and yielded one further participant (Appendix 4).

ANALYSIS

The questionnaire data were both qualitative and quantitative. The quantitative data were analysed in terms of percentages and means because this was what was required to address the objectives set. A form of inductive analysis was carried out on the qualitative data, which produced themes and sub-themes for the data. This was carried out by two people separately and the differences discussed to compile the final themes. This approach was used to explore the participants' personal views and experiences.

GPs' Responses

23 GPs returned their questionnaires, representing 24% of the population. This is a reasonable response rate for a postal survey.
Understanding of MHP

Four GPs (17%) did not know what MHP was. For those who did define MHP, the main themes were: approach to mental health, effect of MHP on mental health, responding to mental health problems and examples of MHP activities (see Table 1).

Table 1. Definition of MHP by GPs.

<table>
<thead>
<tr>
<th>MASTER THEME AND EXAMPLE</th>
<th>SUB-THEMES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Raising awareness of mental health e.g. GP 4</td>
<td></td>
</tr>
<tr>
<td>'Raising awareness of mental health'.</td>
<td>Raising awareness of symptoms</td>
</tr>
<tr>
<td></td>
<td>Targeting patients, carers and staff</td>
</tr>
<tr>
<td>Effect of MHP on mental health e.g. GP 14</td>
<td></td>
</tr>
<tr>
<td>'Improve patients mental health'.</td>
<td>Improving mental health</td>
</tr>
<tr>
<td></td>
<td>Maintaining mental health</td>
</tr>
<tr>
<td></td>
<td>Preventing mental health problems</td>
</tr>
<tr>
<td>Responding to mental health problems e.g. GP 4</td>
<td></td>
</tr>
<tr>
<td>'Improve care of people with mental health problems'.</td>
<td>Diagnosis</td>
</tr>
<tr>
<td></td>
<td>Treatment</td>
</tr>
<tr>
<td>Methods of MHP e.g. GP 1 'Posters, leaflets, books'.</td>
<td>Education/self-help</td>
</tr>
<tr>
<td></td>
<td>Opportunistic</td>
</tr>
<tr>
<td></td>
<td>Non-confrontational</td>
</tr>
</tbody>
</table>

MHP in the Waiting Room

The most frequent professions GPs (n=22) cited as having some or all responsibility for information in the waiting room were nurses (10; 45% of GPs cited them), receptionists (6; 27%) and practice managers (5, 23%; Figure 1).
Seven GPs (32%; n=22) did not know how the information in the waiting room was selected.

MHP Events

Only one GP had held a MHP event in their surgery. For those who had not, the most common reason given for not doing this was that no one had thought of it. Fifteen GPs (65%) cited this factor (Figure 3).
Figure 3. Factors Preventing MHP Events at the Surgery

Only 1 GP had held a MHP event outside the surgery. Again, for those who had not, the most common reason for this not occurring was that no one had thought of it (15, 68%; Figure 4).

Figure 4. Factors Preventing MHP Events in the Surgery
Of those who answered (n=21), 12 (57%) GPs said they provided MHP information to patients at least once per week, however 3 (14%) never provided it. Seventeen (81%) GPs said that they recommended self-help books to clients. Most commonly (n=15) this was about 1-3 times per month (8; 53%). For those who did not recommend books (n=5), the most common reason was that the GP did not know what to recommend (4; 80%). Fifteen (65%) GPs said that they did not offer any other intervention prior to referring to a therapist. The most common reason given (n=16) was a lack of resources (5, 31%; Figure 5).

Figure 5. Factors Preventing GPs from Carrying out Interventions Prior to Referral to a Therapist
When asked in what circumstances they would refer to a therapist without other intervention, the most common response was that other options had been exhausted (Table 2).

Table 2. Reasons for Referring Directly to Therapist Without Other Intervention.

<table>
<thead>
<tr>
<th>REASON</th>
<th>PERCENTAGE OF GPS CITING REASON</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Aptitude</td>
<td>15</td>
</tr>
<tr>
<td>Severe Difficulty</td>
<td>15</td>
</tr>
<tr>
<td>Reduced Functioning</td>
<td>8</td>
</tr>
<tr>
<td>Other Options Exhausted</td>
<td>23</td>
</tr>
<tr>
<td>Recurrence of Difficulty</td>
<td>8</td>
</tr>
<tr>
<td>Patient Request</td>
<td>15</td>
</tr>
<tr>
<td>High Risk</td>
<td>15</td>
</tr>
<tr>
<td>Certain Types of Difficulty</td>
<td>15</td>
</tr>
<tr>
<td>To assess and refer on</td>
<td>8</td>
</tr>
</tbody>
</table>

General Comments

In terms of additional comments made, themes were: views on services provided by the mental health trust and concerns about MHP (see Table 3).
Table 3. Additional comments from GPs.

<table>
<thead>
<tr>
<th>MASTER THEME AND EXAMPLE</th>
<th>SUB-THEMES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Views on services provided by the mental health trust</td>
<td>People fall between primary care and community mental health team criteria</td>
</tr>
<tr>
<td>e.g. GP 4 ‘Problems...which are not serious enough for the psychiatrists to accept’.</td>
<td></td>
</tr>
<tr>
<td>Concerns about MHP</td>
<td>Need for full assessment</td>
</tr>
<tr>
<td>e.g. GP 4 ‘The main problem is the waiting for the therapist”.</td>
<td>Lack of resources/therapists</td>
</tr>
<tr>
<td></td>
<td>Lent items not being returned</td>
</tr>
<tr>
<td></td>
<td>Training</td>
</tr>
</tbody>
</table>

Therapists’ Responses

The majority of therapists responded (7 out of 11). These 7 therapists worked in 12 surgeries.

Understanding of MHP

All therapists attempted to define MHP. The main themes were: examples of MHP activities, effect of MHP on individual’s mental health, and effect of MHP on the system around the individual (see Table 4).
Table 4. Definition of MHP According to Therapists.

<table>
<thead>
<tr>
<th>MASTER THEME AND EXAMPLE</th>
<th>SUB-THEMES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Examples of MHP activities</td>
<td>Education/self-help</td>
</tr>
<tr>
<td>e.g. therapist 3 ‘Making information about all aspects of mental health available’.</td>
<td>Linking patients to mental health professionals</td>
</tr>
<tr>
<td></td>
<td>Raising awareness</td>
</tr>
<tr>
<td>Functions of MHP</td>
<td>Improving/maintaining mental health</td>
</tr>
<tr>
<td>e.g. therapist 3 ‘Improve their emotional well-being’.</td>
<td>Increase understanding of mental health</td>
</tr>
<tr>
<td>Effect of MHP on system around individual</td>
<td>Reducing stigma</td>
</tr>
<tr>
<td>e.g. therapist 4 ‘reducing stigma’.</td>
<td>Sharing knowledge with other professionals</td>
</tr>
<tr>
<td></td>
<td>Educating carers</td>
</tr>
</tbody>
</table>

*MHP in the Waiting Room*

Most surgeries (n=11) had 1-3 MHP leaflets (7) and 1-3 MHP posters (9) in the waiting room. In terms of how responsible therapists felt for information in the waiting room on a scale of 1-5 (where 1 is not at all, 3 is shared and 5 is completely) all therapists scored 1 or 2.

*MHP Events*

Only one therapist had held a MHP event at a surgery. The most common factor cited as preventing this was lack of time (4; Figure 6).
Figure 6. Factors Preventing MHP Events in Surgery.

Only 2 therapists carried out MHP outside the surgery. For those who did not (n=5), again the factor most commonly cited as preventing this was lack of time (3).

*MHP While on the Waiting List to See a Therapist*

Most therapists said that they provided information to clients on their waiting list sometimes. When asked what influenced their decision on whether to send information, the most commonly cited factor was the length of time the client would have to wait (5; Table 5).
Table 5. Factors Influencing Therapists Decision as to Whether to Send Information to Clients on the Waiting List.

<table>
<thead>
<tr>
<th>FACTOR</th>
<th>NUMBER OF THERAPISTS CITING FACTOR AS INFLUENCING WHETHER THEY SEND INFORMATION TO CLIENTS ON THE WAITING LIST</th>
</tr>
</thead>
<tbody>
<tr>
<td>Length of wait</td>
<td>5</td>
</tr>
<tr>
<td>Therapist time to send them</td>
<td>4</td>
</tr>
<tr>
<td>Clarity of referral issue</td>
<td>3</td>
</tr>
<tr>
<td>Availability of materials</td>
<td>2</td>
</tr>
<tr>
<td>Severity of difficulty</td>
<td>1</td>
</tr>
<tr>
<td>Type of difficulty</td>
<td>1</td>
</tr>
<tr>
<td>Client/GP request</td>
<td>1</td>
</tr>
<tr>
<td>Therapist view on need for assessment</td>
<td>1</td>
</tr>
</tbody>
</table>

On average therapists estimated that 25% (SD=18.3) of their referrals could have benefited from using self-help materials instead of therapy and 51% (SD=18.4) of their referrals could have benefited from them in addition to therapy.

Additional Comments

Additional comments made by therapists could be grouped under the themes: support for MHP, concerns about MHP, and the role of other professionals (see Table 6).
Table 6. Additional Comments Made by Therapists.

<table>
<thead>
<tr>
<th>MASTER THEME AND EXAMPLE</th>
<th>SUB-THEMES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Support for MHP</td>
<td>Prevent future difficulties</td>
</tr>
<tr>
<td>e.g. Therapist 2 ‘It’s a good chance to help more people at an earlier stage’.</td>
<td>Examples of feedback about MHP</td>
</tr>
<tr>
<td>Concerns about MHP</td>
<td>Not enough time</td>
</tr>
<tr>
<td>e.g. Therapist 1 ‘Some of my clients struggle with reading’.</td>
<td>Difficult to locate/select materials</td>
</tr>
<tr>
<td>Role of other professionals</td>
<td>Client reading difficulties</td>
</tr>
<tr>
<td>e.g. Therapist 2 ‘The role of psychologist in our service has always been just individual therapy’.</td>
<td>Support from GPs</td>
</tr>
<tr>
<td></td>
<td>Need graduate mental health workers to carry out MHP</td>
</tr>
</tbody>
</table>

Summary

Overall, both GPs and therapists had a good understanding of what MHP was. It was evident that written MHP information was being provided but there was a lack of MHP events for clients to attend. An issue cited by GPs and therapists as affecting MHP was the lack of therapist time.

DISCUSSION

The definitions of MHP provided by therapists and GPs were broadly consistent with the definition offered by the DOH. GPs appeared to be more sceptical about MHP. Only therapists mentioned that MHP involved influencing systems as well as individuals, and it could be hypothesised that this was due to their training.

One of the aims of the study was to ascertain the level of MHP currently available in primary care in the borough. The most active area of MHP appeared to be in
written information-giving, which was mostly available without needing to access a health care professional. The least active area seemed to be that of facilitated events providing information. This was less than in the Monarch and Spriggs (1995) study.

Self-help is advocated in the stepped-care approach in the NICE guidelines and it was evident that a large number of GPs recommended it, but this did not appear to be done frequently. The most common reason for not doing this was a lack of knowledge about what to recommend. There could therefore be a role for therapists in providing lists of useful self-help books. There is also a need to increase how often self-help is suggested to clients.

It also appears that GPs are attempting to implement the stepped-care approach around who to refer to a therapist. They report referring patients with more severe difficulties. However, therapists are still reporting that a significant proportion of their referrals could use self-help instead of therapy.

Another aim of the study was to elucidate the obstacles to implementing MHP. It is notable that, despite the emphasis on MHP as a primary care activity, a significant proportion of GPs did not know what it was, and, possibly as a consequence, had not thought of implementing it. The most frequently reported obstacle to therapists carrying out MHP was lack of time. These responses partly fitted with an article by McCullogh & Boxer (1997) listing common negative attitudes about mental health promotion. These are: that it is too broad and too theoretical, it is beyond the scope of healthcare or is already being carried out, it is expensive, it cannot be evaluated but achieves little, and that professionals do not have the skills or time for it.
In terms of strengths and weaknesses of the study, one of the strengths was that several stakeholders were consulted in the design process. One of the limitations of the study was that GPs were not consulted in the design. A further difficulty was that there might have been a difference between those who responded and those who did not; for example, those who responded may have been more interested or involved in MHP. Another limitation was that it was evident from the data that some of the questions asked were vague. For example, when asking about possible reasons for not carrying out MHP, 'Lack of resources', could have had a number of meanings. This made it difficult to interpret.

If a similar study was to be carried out again, these issues could be addressed by consulting with all stakeholders, including potentially, service users, and perhaps piloting the questionnaire. The audit could be repeated following changes implemented after the service review in order to evaluate the impact of these.

A further aim of the study was to share the results with people working in primary care. Therefore, the results will be disseminated to the GPs and therapists and learning points considered (Appendix 5). In addition the following recommendations will be discussed.

**Recommendations**

- One aim of the study was to find out what MHP is being done. Some specific feedback was provided which could be implemented across the service. For example, placing MHP materials in waiting rooms and on the back of toilet doors, gathering MHP materials for therapists and GPs to access, asking GPs to state a clear referral issue if possible to facilitate sending information to clients on the waiting list.
- There is a need to clarify who is responsible for the information in waiting rooms.
- As GPs and therapists both mentioned lack of time as a factor preventing MHP, there should be consideration of increasing therapist hours.
- Consider having more MHP events, perhaps by a therapist who is not tied to a particular surgery.
REFERENCES


APPENDIX 1

THERAPIST QUESTIONNAIRE
QUESTIONNAIRE FOR THERAPISTS

1. What do you understand by the term 'mental health promotion'?

2. Do you hold/have you held any mental health promotion events at the surgery?
   Yes / No (please circle).
   If yes, please list these and say how often they occur.

3. If no, what has prevented it?
   - Lack of time □
   - Lack of information □
   - Lack of resources □
   - Theoretical orientation □
   - Have not thought of it □
   - Other □ Please specify_____________________

4. Do you do any mental health promotion outside the surgery?
   Yes / No (please circle).
   If yes, please list these and say how often they occur.

5. If no, what has prevented it?
   - Lack of time □
   - Lack of information □
   - Have not thought of it □
   - Other □ Please specify_____________________

6. How many different mental health leaflets do you have in your waiting room? Please circle.
   0 1-3 4-6 7-9 >9

7. If applicable, please list them.
   ____________________________________________________________
8. How many different mental health posters do you have in your waiting room? Please circle.

0  1-3  4-6  7-9  >9

9. If applicable, please list them.

________________________________________________________________________
________________________________________________________________________

10. Which, if any, leaflets or posters have you personally added to the waiting room?

________________________________________________________________________
________________________________________________________________________

11. If none, what has prevented it?

   Lack of time □
   Lack of information □
   Lack of resources □
   Theoretical orientation □
   Have not thought of it □
   Other □ Please specify________________________

12. How responsible do you feel for material in your waiting room? Please circle.

1  2  3  4  5
Not at all  Shared  Completely
13. Please say how often you send the following information to clients on your waiting list. If applicable, please specify what these are about, e.g. depression, Carers UK, bereavement.

<table>
<thead>
<tr>
<th>INTERVENTION</th>
<th>HOW OFTEN DO YOU SEND THESE? (PLEASE TICK)</th>
<th>WHAT ARE THESE ABOUT?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Information/psycho-educational leaflets</td>
<td>NEVER</td>
<td>SOMETIMES</td>
</tr>
<tr>
<td>List of self-help books</td>
<td></td>
<td></td>
</tr>
<tr>
<td>List of websites</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Information on services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Information on self-help groups</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

14. Do you offer any other intervention to clients on the waiting list? Please circle.

Yes  No  Sometimes

15. If yes or sometimes, what do you offer?

________________________________________________________________________
________________________________________________________________________

16. What influences your decision to send or not send information/use interventions?

________________________________________________________________________
________________________________________________________________________

17. What percentage of your referrals do you think could have benefited from using self-help materials from the GP at point of consultation *rather than* referral to a therapist?

________________________________________________________________________

18. What percentage of your referrals do you think could have benefited from using self-help materials from the GP at point of consultation *as well as* referral to a therapist?

________________________________________________________________________

Thank you for your help.
APPENDIX 2

GP QUESTIONNAIRE
QUESTIONNAIRE FOR GPS ON MENTAL HEALTH PROMOTION

1. What do you understand by the term 'mental health promotion'?

______________________________________________________________________________

2. What is the first point at which a patient could have access to mental health information (either written or verbal) in the surgery where you work?
   - Waiting room □
   - Consultation with GP □
   - Consultation with therapist □
   - Don't know □

3. Do you/have you held any mental health promotion events at the surgery?
   Yes / No (please circle).
   If yes, please list these and say how often they occur.

______________________________________________________________________________

4. If no, what has prevented it? (tick all that apply)
   - Lack of time □
   - Lack of information □
   - Have not thought of it □
   - Other □  Please specify________________________

5. Do you do any mental health promotion outside the surgery?
   Yes / No (please circle).
   If yes, please list these and say how often they occur.

______________________________________________________________________________

6. If no, what has prevented it?
   - Lack of time □
   - Lack of information □
   - Have not thought of it □
   - Other □  Please specify________________________

7. Who has responsibility for the leaflets and posters in the waiting room?
8. How are the leaflets and posters in the waiting room chosen (if known)?


9. Do you ever give mental health promotion information to patients? If yes, what is this about?

<table>
<thead>
<tr>
<th>TOPIC</th>
<th>PLEASE TICK IF PROVIDED</th>
</tr>
</thead>
<tbody>
<tr>
<td>Depression</td>
<td></td>
</tr>
<tr>
<td>Bereavement</td>
<td></td>
</tr>
<tr>
<td>Anxiety</td>
<td></td>
</tr>
<tr>
<td>Stress</td>
<td></td>
</tr>
<tr>
<td>Self-esteem</td>
<td></td>
</tr>
<tr>
<td>Physical activity</td>
<td></td>
</tr>
<tr>
<td>Childcare</td>
<td></td>
</tr>
<tr>
<td>Employment</td>
<td></td>
</tr>
<tr>
<td>Domestic violence</td>
<td></td>
</tr>
<tr>
<td>Safety</td>
<td></td>
</tr>
<tr>
<td>Parenting</td>
<td></td>
</tr>
<tr>
<td>Learning</td>
<td></td>
</tr>
<tr>
<td>Housing</td>
<td></td>
</tr>
<tr>
<td>Social support</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
</tr>
</tbody>
</table>

10. How often does this happen? Please circle.

Never 1-3 times a month Once a week More often

11. Do you ever recommend patients mental health self-help books/leaflets?

Yes / No (please circle).

If yes, please specify which.


12. What are these about?

- Depression □
- Bereavement □
- Anxiety □
- Stress □
- Other □ Please specify________________________
13. If no, what has prevented it?

Lack of time □
Lack of knowledge □
Have not thought of it □
Other □ Please specify____________________

14. How often does this happen? Please circle.

Never 1-3 times a month Once a week More often

15. Do you have self-help books/leaflets available for patients to borrow/keep? Yes / No (please circle). What, if any, other interventions you would make before referring to a therapist?

________________________________________
________________________________________

16. If you do not make any interventions before referring to a therapist, what stops you?

Lack of time □
Lack of information □
Lack of resources □
Have not thought of it □
Other □ Please specify____________________

17. In what circumstances in which you would refer to a therapist immediately?

________________________________________
________________________________________

Thank you for your help.
APPENDIX 3

COVERING LETTER TO GPS
PROJECT ON MENTAL HEALTH PROMOTION

I am a trainee clinical psychologist working with the Primary Care Psychology and Counselling Service. As part of my training, I am carrying out an audit in the service.

There is currently a re-organisation of services taking place in the borough. As part of this, we are interested in finding out about the role of mental health promotion in primary care. I would be grateful if you would complete the enclosed questionnaire, which should take no more than 5 minutes. You can remain anonymous and your responses will be kept confidential.

Please return the questionnaire in the envelope provided by 12th May.
APPENDIX 4

SECOND MAIL SHOT LETTER
HEALTH PROMOTION QUESTIONNAIRE

I am a Trainee Clinical Psychologist working in the Psychological Therapies in Primary Care Service. You may recall that I recently sent you a questionnaire on mental health promotion. As this was anonymous, I have no way of knowing whether you returned it.

If you have already returned you questionnaire, I would like to thank you for taking part. If you have not yet sent it back, I would like to encourage you to take the opportunity to allow your views to be taken into account in the review of the Psychological Therapies in Primary Care Service. The results of this survey will be used in the review to think about how the counsellor or psychologist in your surgery can improve their service to you.

If you did not receive your questionnaire or have mislaid it, I can send you an electronic version if you email me at L.S.Hamill@surrey.ac.uk. The questionnaire can be returned up until 12th May.

Thank you for your help,

Louise Hamill
Trainee Clinical Psychologist
APPENDIX 5

LETTER REGARDING THE PRESENTATION OF THE PROJECT
26 June 2006

University of Surrey
Guildford
Surrey GU2 5XH

To Whom it May Concern

I am writing to confirm that Louise gave an excellent presentation to our psychology department on 21st June 06. She spoke about her research on mental health promotion. This is a topic relevant to national guidance and our local redesign of psychological therapy service delivery. We hope to use Louise's work in our service redevelopment in the coming weeks.

Louise has been a real asset to our department and we hope that we can continue to work with University of Surrey trainees to produce more projects of an equal standard.

Yours sincerely

Clinical Team Coordinator
Primary Care
Major Research Project

The Role of Schema Avoidance in Substance Misuse

Louise Hamill

July 2008

Year 3

Word count – 19,997
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ABSTRACT

Introduction: Little research has been carried out in relation to the links between schemas, avoidance and substance misuse. Aims: This study examined whether there is a relationship between schema avoidance and substance misuse, choice of substance, severity of use and anxiety/depressed mood. It also included a factor analysis of the Young-Rygh Avoidance Inventory (YRAI). Design: This was a cross-sectional questionnaire-based study. Setting: The setting was several substance misuse services within a National Health Service trust. Participants: The participants were people attending a substance misuse service whose primary substance of choice was alcohol, stimulants or opiates (N=145). There was also a control group of people not attending a substance misuse service (N=57). Procedure: Participants completed the YRAI, the Hospital Anxiety and Depression Scale and a demographic questionnaire. Results: An association was found between schema avoidance and substance misuse, and anxiety was found to be related to schema avoidance. Conclusion: It is possible that interventions focusing on schema avoidance could be helpful in substance misuse services, with high anxiety potentially indicating a need for assessment of schema avoidance. However, the concept of schema avoidance remains hypothetical and requires empirical validation.

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INTRODUCTION

1. Background

1.1 What is Substance Misuse?

Substance misuse has been defined in a number of ways. West (2006) described it as impaired control over substance-related behaviour, leading to significant difficulties, for example, poor physical health, homelessness, low mood or committing crimes to fund use. Similarly, Wanigaratne et al. (1990) defined it as a compulsion to engage in substance-related activities, causing distress to the individual. The two major classification systems for psychiatric disorders (Pocket Guide to the International Classification of Diseases 10 [ICD-10], Cooper [1994]; Diagnostic and Statistical Manual IV [DSM-IV], American Psychiatric Association [APA, 2000]) each provide criteria for two types of substance misuse disorder (Table 1). Although similar, these criteria and the definitions above differ on some details.

Table 1. Summary of ICD-10 and DSM-IV Criteria for Substance Misuse

<table>
<thead>
<tr>
<th>ICD-10</th>
<th>DSM-IV</th>
</tr>
</thead>
<tbody>
<tr>
<td>Harmful Use</td>
<td>Substance Abuse</td>
</tr>
<tr>
<td>A. The substance causes harm.</td>
<td>A. One or more of the following occurring within a 12-month period:</td>
</tr>
<tr>
<td>B. The harm is identifiable.</td>
<td>1. Recurrent use resulting in failure to fulfil obligations.</td>
</tr>
<tr>
<td>C. Use has persisted for at least one month or repeatedly within a 12-month period.</td>
<td>2. Recurrent use in hazardous situations.</td>
</tr>
<tr>
<td></td>
<td>4. Persistent interpersonal problems related to use.</td>
</tr>
<tr>
<td></td>
<td>B. Symptoms do not meet criteria for substance dependence.</td>
</tr>
</tbody>
</table>
Dependence Syndrome
A. Three or more of the following occurring together for at least one month or repeatedly within a 12-month period:
   1. Compulsion to take the substance.
   2. Impaired capacity to control substance use.
   3. Withdrawal when substance use is reduced or ceased.
   4. Increasing amounts of the substance needed to achieve the desired effect.
   5. Preoccupation with substance use.
   6. Persistent substance use despite harm.

Substance Dependence
Three or more of the following within a 12-month period:
A. Tolerance.
B. Withdrawal.
C. The substance is taken in larger amounts and for longer than intended.
D. Desire to cut down substance use.
E. Large amount of time spent on substance-related activities.
F. Social, occupational or recreational activities affected by use.
G. Persistent substance use despite harm.

Part of the difficulty in defining substance misuse is that to some extent it is socially defined. Therefore, to provide a definition that applies across historical time and different cultures is difficult. There are also subtle differences between terms used, for example, both the ICD-10 (Cooper, 1994) and DSM-IV (APA, 2000) make a distinction between harmful use and physical dependence. Another differentiation is made between 'substance use' and 'substance misuse'. Bauman and Phongsavan (1999) stated that 'substance use' refers to any use ranging from recreational to dependent while 'substance misuse' specifically refers to harmful use. There is also a distinction made between legal and illegal substance use, as defined by the Misuse of Drugs Act 1971. Some theorists suggest that illegal substance use is more problematic, as it represents a progression along the developmental continuum of substance use (see, for example, Wagner & Anthony, 2002). In practice, services do not adhere to strict definitions of substance misuse, and tend to work with individuals who request help with their substance use.

1.2 Impact of Substance Misuse

Substance misuse is a significant problem in England (Department of Health [DOH], 2001). It is strongly linked to crime, probably due to factors such as the income required to maintain substance use, physiological effects of substances
such as increased arousal, and the anti-social tendencies of some people misusing substances (Robins, 1998). A longitudinal study (Gossop et al., 1998) following 1,100 people into treatment for substance misuse found that 664 of them had committed a total of 70,000 crimes in the three months before entering treatment. Substance misuse also has a considerable impact on the individual using the substance. It is associated with social problems, such as financial, housing and forensic issues; various physical health problems, depending on the substance; psychological problems, including low self-esteem; and interpersonal difficulties (Gossop, 1993). The Home Office Drugs Strategy Directorate (2004) has made the development of effective substance misuse interventions a key priority.

1.3 Substances Used by People Attending Substance Misuse Services

Alcohol, opiates and stimulants are the most common substances used by people attending substance misuse services. A brief description of each of these follows.

The term ‘opiate’ refers to a number of controlled drugs such as diamorphine, morphine, methadone, buprenorphine and street heroin (Emmett & Nice, 2006). Opiates are analgesics and sedatives (Ghodse, 1995). According to Emmett and Nice (2006), desired effects of use are euphoria and freedom from worry, pain, hunger and cold. Possible adverse effects are depressed breathing and, if injected, infections, collapsed veins and abscesses. Another unwanted consequence of regular use can be physical dependence, which results in an unpleasant withdrawal syndrome when the drug is not used. A common intervention services offer to manage physical dependence is stabilising the client on a pharmaceutical opiate, such as methadone, which can then be gradually reduced to prevent withdrawal. According to Emmett and Nice (2006),
the average heroin user in the United Kingdom (UK) needs £14,560 per year to fund their use.

Stimulants are substances such as cocaine, crack and amphetamine. They rapidly stimulate the central nervous system producing increased energy, euphoria, confidence and social interaction. People might use them for the feeling of power they provide (Wade, 1994), to stay awake or to enhance activity (Boys et al., 2001). According to Winger et al. (2004), possible adverse effects are paranoia, aggression and, if smoked, lung problems. Also, immediately after use, the user experiences depression, low energy and possible craving for more of the drug. Excessive or long-term use can lead to substantial weight loss, problems with the nasal passages if taken intra-nasally (Emmett & Nice, 2006), stroke and overdose (Winger et al., 2004).

Alcohol is a depressant and anaesthetic (Emmett & Nice, 2006). It reduces anxiety in the short term, reduces co-ordination, promotes sleep and relieves pain. Like opiates, a physical withdrawal syndrome occurs when high, regular usage is abruptly stopped. This may include tremors, seizures and hallucinations, and can be fatal. Winnington and Rasool (1998) stated that alcohol produces more health problems than illicit drugs, particularly digestive problems. According to the DOH (1993), alcohol is a significant factor in many presentations to accident and emergency departments. Raskin and Daley (1991) stated that 3% of deaths are recorded as directly linked to alcohol, although the actual figure may be much higher.

1.4 Substance Misuse and Mental Health

Many studies show an association between substance misuse and psychiatric diagnoses, which is much higher than chance (for example, Farrell et al., 2001).
Marsden et al. (2000) found that one in five people attending a substance misuse service had previously received help for a psychiatric problem.

There are several possible models for understanding the high co-occurrence of psychiatric symptoms and substance misuse. Mueser et al. (1998) described a model that assumes common risk factors. They reported that one possible common risk factor is genetic predisposition, as there is strong evidence that genetics contribute to both psychiatric disorders and substance misuse. Another possible common risk factor is anti-social personality traits, as there is evidence that these are associated with both psychiatric disorders and substance misuse, although there is some uncertainty about the validity of the anti-social personality concept (Mueser et al., 1998).

The self-medication model, described by West (2006), purports that the co-occurrence of psychiatric symptoms and substance misuse may be due to the use of substances to 'treat' psychological symptoms. Eissenberg (2004) stated that this model emphasises the role substances can have in reducing negative affect. Evidence for this model comes from studies showing that psychiatric disorders often begin before substance misuse (Kessler et al., 2003) or those showing an association between negative affect and using substances to cope (Wills et al., 1999). In a review, Greely and Oei (1999) concluded that the evidence for the self-medication model of substance misuse is inconsistent, probably because it only applies to certain cases.

A further model, described by Mueser et al. (1998), is the secondary psychiatric disorder model, which proposes that substance misuse precipitates psychiatric symptoms in people who would not otherwise develop them. Research evidence for this model appears to be limited to the development of psychotic symptoms (for example, Arseneault et al., 2007).
Finally, the bi-directional model (Popkin & Tucker, 1992) proposes a two-way relationship between psychiatric disorders and substance misuse. It purports that substances may be used to manage mental health problems and also contribute to the development and exacerbation of psychological difficulties (Popkin & Tucker, 1992). Additionally, substance misuse may impair ability to cope with psychological difficulties, as it can affect frontal lobe functioning (Lingford-Hughes et al., 2003), thereby reducing problem solving skills (Delis et al., 1992).

According to Ana et al. (2007), people with co-occurring substance misuse and psychiatric disorders tend to engage less in treatment than those with substance misuse problems alone. Additionally, Kessler (2004) stated that treatment is less effective for these clients. Therefore, the Models of Care (National Treatment Agency1 [NTA], 2006) emphasised the importance of addressing the mental health of people misusing substances.

1.5 *Psychological Approaches to Substance Misuse*

Several psychological interventions are currently used in the substance misuse field (for a review, see Wanigaratne et al., 2005). The evidence suggests that all these interventions have potential for benefiting a client, but also some limitations (Appendix 12). The approach that seems most effective is Twelve-Step (Table 2), with medium to large effect sizes up to 12 months post-treatment (Crits-Cristophe et al., 1999). Effectiveness might be increased further by involving the client's partner, if applicable (Fals-Stewart et al., 2006). However, effectiveness of Twelve-Step probably depends on the client accepting the assumptions of lack of control over substance use and abstinence as a goal (Walters, 2002), as well as

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1 The National Treatment Agency is an authority set up by the government to increase the availability and effectiveness of drug treatment in England.
2 Only studies with sufficient information to calculate effect size were included in this review.
regular attendance (Gossop *et al.*, 2003). More studies using control groups are needed.

Table 2. Psychological Interventions for Substance Misuse

<table>
<thead>
<tr>
<th>INTERVENTION</th>
<th>DESCRIPTION</th>
</tr>
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<tbody>
<tr>
<td>Motivational Interviewing</td>
<td>Motivational interviewing does not propose a model of addiction, but is underpinned by behaviour change theories. It aims to enhance motivation to change.</td>
</tr>
<tr>
<td>Twelve-step Approach</td>
<td>The twelve-step approach purports that the client must accept lack of control over their substance misuse and abstinence as the solution.</td>
</tr>
<tr>
<td>Cue Exposure</td>
<td>Classical conditioning suggests that substance misuse is maintained through association between triggers and substance use. Cue exposure involves gradually exposing the client to triggers without using substances.</td>
</tr>
<tr>
<td>Contingency Management</td>
<td>Operant conditioning suggests that substance misuse is maintained through association between substance use and its rewarding effects. Contingency management involves giving rewards for non-substance-using behaviours.</td>
</tr>
<tr>
<td>Behavioural Couples Therapy</td>
<td>Behavioural couples therapy uses behavioural and communication strategies to change one partner's substance misuse by working with the couple.</td>
</tr>
<tr>
<td>Cognitive Behavioural Therapy (CBT)</td>
<td>The cognitive behavioural model of substance misuse suggests that substance misuse is driven by beliefs, such as, 'I need heroin to block things out'. CBT aims to modify unhelpful beliefs and behaviours.</td>
</tr>
<tr>
<td>Relapse Prevention</td>
<td>Relapse prevention is based on CBT principles and focuses on the maintenance of progress.</td>
</tr>
<tr>
<td>Dialectical Behaviour Therapy (DBT)</td>
<td>DBT is aimed at people with a diagnosis of borderline personality disorder. It teaches strategies for managing emotions that do not involve substances.</td>
</tr>
<tr>
<td>Family Therapy</td>
<td>Family therapy aims to improve family relationships, which are assumed to influence symptoms, such as substance misuse.</td>
</tr>
<tr>
<td>Psychodynamic Therapy</td>
<td>Psychodynamic approaches aim to ameliorate underlying difficulties that may be contributing to substance misuse.</td>
</tr>
</tbody>
</table>
There is evidence for some effectiveness of Cue Exposure (Table 2), with medium to large effect sizes up to 6-month follow-up (Carter & Tiffany, 1999; Sitharthen et al., 1997). This is based on a meta-analysis of 41 studies (Carter & Tiffany, 1999). One study showed that effect sizes for Cue Exposure were larger than CBT under the same conditions (Sitharthen et al., 1997), although this was based on only 42 participants. Cue Exposure seems less effective for people misusing alcohol (Carter & Tiffany, 1999).

There is evidence for the effectiveness of CBT (Table 2; Beck et al., 1993), with medium to large effect sizes, up to 12 months follow-up (Sitharthen et al., 1997; Winters et al., 2002). Effect size increases with the addition of the Twelve-Step approach (Crits-Cristophe et al., 1999) or Couples Behavioural Therapy (Winters et al., 2002). However, CBT might be less effective than cue exposure under the same conditions (Sitharthen et al., 1997). Additionally, one study suggested that men might benefit less than women, achieving better outcomes with counselling (Pollack et al., 2002), although this was based on only 23 participants. The National Institute for Clinical Excellence (NICE) guideline for Drug Misuse (2007) advocated CBT for co-morbid depression or anxiety, rather than routinely using it to address substance misuse itself.

There is evidence that Contingency Management (Table 2) is somewhat effective for substance misuse, with medium to large effect sizes by the end of treatment (Higgins et al., 2003; Petry et al., 2007; Silverman et al., 1998). Two studies showed that it was more effective than control interventions (Higgins et al., 2003; Silverman et al., 1998). One study suggested that follow-up outcomes were mixed, which may be partly dependent upon the particular reinforcement schedule (Silverman et al., 1998). However, this was based on only 59 participants, with three groups compared. Research is also currently limited to the United States and has mostly been conducted with stimulant or opiate users. Therefore, more research is needed with other substances. Despite this,
Contingency Management is recommended in the NICE guideline for Drug Misuse (2007).

There is evidence for some effectiveness of Behavioural Couples Therapy (Table 2), with medium effect sizes up to 12-month follow up (Walitzer & Dermen, 2004; Winters et al., 2002; Fals-Stewart et al., 2006). These effects seemed to increase with the addition of individual therapies (Winters et al., 2002; Fals-Stewart et al., 2006). However, one study suggested that partner involvement in individual treatments might be as effective as Behavioural Couples Therapy (Walitzer & Dermen, 2004), although this was based on only 64 participants, with three groups. Also, Behavioural Couples Therapy would probably only be suitable for a small proportion of the substance misusing population, as it could only be considered when the client has a long-term drug-free partner (Heather et al., 2006).

Motivational Interviewing (Table 2) has some evidence for short-term effectiveness, with medium to large effect sizes (Burke et al., 2003; Ana et al., 2007). This is based on a meta-analysis involving 5611 participants and is therefore strong evidence (Burke et al., 2003). One study also suggested that Motivational Interviewing compared favourably to a control condition (Ana et al., 2007). However, effect sizes reduce to small at 67-week follow-up, according to the same meta-analysis (Burke et al., 2003).

Finally, Relapse Prevention (Table 2) has been found to ameliorate substance misuse. However, effect sizes are small (Irvin et al., 1999), unless it is combined with other interventions (Irvin et al., 1999; Petry et al., 2007). This is based on a meta-analysis involving 9504 participants (Irvin et al., 1999). Studies using a control group are needed.
In addition to these specific interventions for substance misuse, there are some general interventions, not directly aimed at reducing substance misuse, that might contribute to addressing it, for example, Dialectical Behaviour Therapy (DBT; Linehan et al., 2002), Family Therapy, and Psychodynamic Therapy (Table 2). As these are not specific interventions for substance misuse, there is little research on their effectiveness with adults misusing substances. The NICE guideline for Drug Misuse (2007) did not include DBT or Family Therapy, and recommended that Psychodynamic Therapy should not be used as an intervention for substance misuse, but only for other co-morbid difficulties. Many psychotherapists view substance misuse as a counter-indication for Psychodynamic Therapy (Lemma, 2003).

In summary, there is evidence for some effectiveness of Twelve-Step, Cue Exposure, CBT, Contingency Management and Behavioural Couples Therapy, with some limitations about which groups of clients are likely to benefit. There is evidence of low effectiveness of Motivational Interviewing and Relapse Prevention when follow-up is considered. Little research has been conducted on the impact of DBT or Family Therapy on substance misuse, and Psychodynamic Therapy is probably counter-indicated. Models of Care (NTA, 2006) emphasised that substance misuse services should provide a range of evidence-based psychosocial interventions to meet the needs of all clients.

2. Schema Therapy

2.1 Schema Theory

One intervention that might be helpful for people misusing substances is schema therapy. It is a relatively new therapy, developed by Young (1990). It is an extension of CBT, and attempts to address some of its limitations. Although there is evidence of the general effectiveness of CBT, it appears to be less effective for people whose symptoms are related to characterological difficulties (McGinn &
Young, 1996), for example, those diagnosed with antisocial or borderline personality disorder. Therefore, in fields where there seem to be high levels of people with these difficulties, such as substance misuse, there is less strong evidence for the use of CBT. One reason CBT might be less effective for people with characterological difficulties is that CBT focuses more on the present than on childhood experiences and personality development, which might be particularly relevant to the ongoing difficulties of this group. Schema therapy is specifically designed to help this group of people (Young, 1990). It extends CBT by exploring and understanding the impact of childhood experiences on maladaptive beliefs, and focusing on deep-level beliefs formed in childhood, which Young (1990) calls schemas. One potential criticism of schema theory and therapy is that it has been primarily developed by Young.

The main assumption of schema theory is that everyone has schemas (Young et al., 2003). Young et al. (2003) defined schemas as life-long, pervasive themes about the self and relationships that a person has, which originate from childhood experiences. They consist of cognitive, emotional, behavioural and relational elements and may be helpful or unhelpful. Young (1990) has identified at least 16 specific unhelpful schemas. These are emotional deprivation, abandonment, mistrust/abuse, social isolation/alienation, defectiveness, social undesirability, failure to achieve, dependence/incompetence, vulnerability, enmeshment, subjugation, self-sacrifice, emotional inhibition, unrelenting standards, entitlement and insufficient self-control. These have been regularly amended and added to, which is a challenge to the validity of these categories.

Young (1990) devised the Young Schema Questionnaire (YSQ), a self-report questionnaire, to identify which, if any, of the sixteen unhelpful schemas a person has. It has long and short forms and is the only available clinical measure of schemas. Factor analyses of the short form have yielded different results, for example, Cecero et al. (2004) found only fourteen factors, while Hoffart et al.
(2005) found fifteen. The mixed results of the factor analyses undermine the validity of the YSQ. However, Cecero et al. (2004) demonstrated the predictive validity of the YSQ for attachment style. They found that low overall YSQ scores predicted secure attachment, high scores on the abandonment schema predicted preoccupied attachment, high ratings on the social isolation/alienation and emotional deprivation schemas predicted dismissive attachment, and high ratings on the mistrust/abuse schema predicted fearful attachment.

Another assumption of schema theory is that schemas are formed in childhood as a response to early experiences (Young et al., 2003). They are usually initially adaptive, and therefore are reinforced, but can become less adaptive as the environment changes. Young and Klosko (1994) believe that there is a link between certain experiences in childhood and each of the particular schemas identified above. An example of this is that the origins of the defectiveness schema (feeling worthless), may be related to having a critical or punitive parent, being rejected or abused by a parent, being blamed for everything that went wrong, or being compared unfavourably with siblings (Young & Klosko, 1994)3. Sheffield et al. (2005) conducted a study that found a link between poor parenting and negative schemas. However, they did not find direct relationships between certain styles of parenting and specific schemas, which is contrary to what the theory would predict. More research needs to be done to elucidate whether there are links between specific childhood experiences and particular schemas.

A further assumption of schema theory is that schemas impact considerably on a person’s life because they affect how people feel, think, act and relate to others (Young & Klosko, 1994). Young et al. (2003) stated that unhelpful schemas could help to explain the occurrence and maintenance of difficulties in a person’s life. There is some evidence to support this. Nordahl et al. (2005) and Rijkeboer et al.

3 The defectiveness schema will be consistently used to provide examples.
(2004) carried out studies, which found that people with more unhelpful schemas had greater symptomatic distress.

A final assumption of schema theory is that a person may attempt to cope with their negative schemas in a number of ways. These coping strategies are known as schema processes and include schema surrender, schema compensation and schema avoidance (Young & Klosko, 1994). Different people or the same person at different times may respond to a certain schema using different strategies. All of these strategies have a role in maintaining the schemas. Schema surrender means responding as if the schema was true. An example of this is that someone with the defectiveness schema may think, feel and act as though they are defective and (mis)interpret situations so that the schema is reinforced (Young & Klosko, 1994). They may do this by choosing critical, abusive or disinterested partners, being critical of people who like them, comparing themselves unfavourably to others, putting themselves down or paying selective attention to information that supports the schema. Alternatively, a person may engage in schema compensation, which means doing the opposite of what a schema suggests. An example of this is that a person with the defectiveness schema may act, feel and think as if they are special, superior or perfect (Young & Klosko, 1994). This in turn may result in isolation and lack of intimacy, thus reinforcing the defectiveness schema. Finally, a person may use schema avoidance to escape or block out their schemas, including the associated unpleasant thoughts and emotions. The avoidance could be cognitive, for example, trying to think about other things; or behavioural, for example, drinking a lot, withdrawing socially or working excessively (Young & Klosko, 1994). One potential difficulty with the concept of schema avoidance is how it could be ascertained exactly what the individual is avoiding - whether it is the schema itself or, for example, a painful memory not directly related to a schema.
Schema avoidance is measured using the Young-Rygh Avoidance Inventory (YRAI; Young & Rygh, 1994). Brotchie et al. (2006) hypothesised that the YRAI measures secondary avoidance of affect. They defined secondary avoidance as attempting to block affect after it has been triggered, as opposed to primary avoidance, which is avoiding affect being triggered in the first place.

One potential challenge to Young's (1990) schema theory is that other, similar theories, exist. In the field of social psychology, social cognition theorists postulate that a person develops schemas about themselves, others, and situations, for example, 'I'm adventurous'. These influence information processing towards a confirmation bias and possibly drive behaviour (Baldwin, 1992). In the field of clinical psychology, in relation to CBT, Padesky (1994) proposes that schemas are deep-level, underlying beliefs, for example, 'I'm incompetent'. These are referred to by other CBT theorists as 'core beliefs'. Both social cognition theory and Padesky (1994) conceptualise schemas as entirely cognitive, in contrast to Young's theory, in which schemas also include emotional, behavioural and image elements. However, Beck et al.'s (2004) theory, similarly to Young's, conceptualises schemas as deep psychological structures that represent styles of thinking, feeling and behaving according to a particular theme, for example, 'I'm worthless'. The similarity of these theories might provide some validation for them. However, Beck et al.'s (2004) theory is more directly related to CBT, as Beck et al. (2004) postulated that core beliefs in CBT, which are the deep-level, underlying cognitions, represent the cognitive component of schemas. Young et al. (2003) stated that Beck et al.'s (2004) theories and Young's are not incompatible, but have different emphases, for example, Young (1990) placed much greater emphasis on ways of responding to schemas and outlined these in detail (schema avoidance, schema surrender, schema compensation). Young's theory also seems more detailed in relation to delineating specific schemas, how they might link to childhood experiences and
their impact on the individual. He also explicitly links schemas to personality development (Young, 1990).

2.2 Schema Therapy

Young’s schema theory (1990) helps clinicians develop a formulation of a client’s difficulties that can form the basis for using schema-focused therapy. Young (1990) stated that this therapy is primarily aimed at people described as having a personality disorder. It could potentially be helpful for those people using substance misuse services who have characterological aspects to their difficulties, and are therefore likely to only partially benefit from CBT (McGinn & Young, 1996).

Schema focused therapy assumes that unhelpful schemas can be ameliorated (Young and Klosko, 1994). It aims to reduce the client’s belief in and adherence to unhelpful schemas, and replace them with more helpful schemas. This would be expected to lead to behavioural changes and better quality of life for the individual. It might be difficult for some people to achieve this without therapy, as schema processes could maintain the schemas.

Some of the techniques used to modify unhelpful schemas are similar to those used in CBT to challenge negative thoughts. They involve helping the client to identify their unhelpful schemas and challenge their validity and utility, using a number of strategies (Young and Klosko, 1994). Behavioural techniques can also be used, such as reducing schema-related avoidance. Other interventions include helping the client understand the origins of their unhelpful schemas, encouraging emotional expression as a means of catharsis, and using empathic confrontation and the therapeutic relationship to modify unhelpful schemas. Young (1990) also said that therapists should be aware that schemas and schema processes could adversely affect therapy. Examples of this are that
schema avoidance may make identifying and addressing a schema difficult or a person with the emotional inhibition schema may find it difficult to engage in a therapeutic process focusing on emotions. Also, a person with the mistrust/abuse schema might find it difficult to engage in a therapeutic alliance.

As schema-focused therapy is relatively new, the development of an evidence-base is in its infancy and therefore fairly minimal. However, there is some evidence for the effectiveness of schema-focused therapy. Giesen-Bloo et al. (2006) conducted a randomised control trial using participants diagnosed with borderline personality disorder. They found that three years of schema-focused therapy was effective in reducing difficulties related to the disorder, as well as other difficulties. They also found that it was more effective than transference-focused psychotherapy and had a lower dropout rate. The main limitation of this study is the absence of a natural course control group, which would have clarified the rate of spontaneous improvement.

A second randomised controlled trial was conducted by Ball (2007). This compared schema therapy to the twelve-step approach for people diagnosed with a personality disorder and opiate misuse. Both approaches were associated with reductions on several measures of severity, with those receiving schema therapy having faster reductions in substance use. However, reductions in low mood were greater for those receiving the twelve-step approach.

Several non-controlled studies have also explored the effectiveness of schema therapy. Nordahl et al. (2005) studied 82 clients diagnosed with personality disorders who were having schema therapy. They found that reductions in unhelpful schemas predicted symptom improvement by the end of therapy. Nordahl and Nysaeter (2005) reported on a single case series of six clients with borderline personality disorder who received schema-focused therapy. Large effect sizes were reported, which were perceived as clinically meaningful for five
of the six clients. Half of the clients no longer fulfilled criteria for borderline personality disorder by the end of therapy. Finally, Ball and Young (2000) reported on a single case series of three clients who misused substances and were also diagnosed with personality disorders. All clients experienced some improvements in areas such as substance use, psychiatric symptoms and mood. More research is needed about the effectiveness of schema therapy with a greater range of populations.

2.3 Schema Theory and Substance Misuse

With regards to substance misuse, schema theory suggests that early negative life experiences, for example, child abuse (which is particularly common amongst people misusing substances; Fleming et al., 1998) or other adverse experiences, may lead to the development of unhelpful schemas. These may make a person vulnerable to using substances (Liese & Franz, 1996) as a form of schema avoidance.

The above theory has been partly tested by a study that examined schemas in a substance misusing population (Brotchie et al., 2004). The participants were three groups of people using a substance misuse service: people using alcohol, people using opiates, or people using both. There was also a control group of people not using substance misuse services. All groups completed the YSQ (Young, 1990). The results demonstrated that all three clinical groups had more unhelpful schemas than the control group. The researchers postulated that the findings were compatible with the hypothesis that substances are used to cope with schemas. The two groups using alcohol had more unhelpful schemas than those who used opiates alone. The authors advocated more research with people using other substances.
2.4 Previous Studies Related to Schema Avoidance or Substance Misuse

Little research has been conducted regarding schema avoidance in substance misuse. However, two studies have examined schema avoidance in eating disorders. This is of particular interest, since eating disorders and substance misuse are thought to serve similar functions in terms of managing difficult emotions (Lacey, 1993) and similar studies have been conducted in both populations. In the first study, Spranger et al. (2001) compared the schema avoidance, measured using the YRAI, of women with bulimia with a control group. They found that the women with bulimia showed much higher schema avoidance than the controls. More detailed analyses were somewhat inconclusive. However, the clinical group only consisted of 19 participants and therefore the study may have lacked the power to detect effects.

In the second eating disorder study, Luck et al. (2006) conducted a factor analysis of the YRAI (Young & Rygh, 1994), and concluded that it had two factors – behavioural/somatic avoidance and cognitive/emotional avoidance. However, this only included 18 of the 40 YRAI items (Young & Rygh, 1994). They also compared the schema avoidance, measured by the YRAI, of people with different types of eating disorder (anorexia nervosa restrictive sub-type, anorexia nervosa binge purge sub-type, bulimia nervosa) and a non-clinical control group. They found that all clinical groups scored significantly higher than the control group. There were no significant differences between the clinical groups, except that the anorexia nervosa binge purge sub-type group scored significantly higher on the behavioural/somatic factor of the YRAI (Young and Rygh, 1994), possibly indicating that this aspect of schema avoidance is particularly relevant for this group.

A few previous studies have examined the role of general (as opposed to schema) avoidance in substance use. Avoidant coping style, measured using the Cope Inventory (Carver et al., 1989), has been found to be associated with
drinking in non-problem-drinking adolescents (Catanzaro & Laurent, 2004) and adult men (Cooper et al., 1992). Avoidant coping was also found to be linked with alcohol misuse in adolescents (Laurent et al., 1997) and older adults (Shutte et al., 1998). In the only study examining a substance other than alcohol, Blair (2005) found that the primary reason for using heroin was to avoid negative mood states.

One study was found that specifically examined the role of schema avoidance in substance misuse. Brotchie et al. (2006) measured the schema avoidance of people misusing alcohol and opiates using the YRAI. In concordance with the Brotchie et al. (2004) study, which showed that people misusing alcohol had higher levels of unhelpful schemas than those misusing opiates, they hypothesised that people misusing alcohol would also have higher levels of schema avoidance. However, they found no difference in schema avoidance between the two groups, which conflicts with the earlier study. However, Brotchie et al. (2006) did find that in people misusing alcohol, schema avoidance increased with increasing severity of alcohol use, measured by units drunk per week. They suggested that this indicates that alcohol is used to block out negative emotional states. One limitation of this study was the lack of a non-clinical control group, which would have clarified whether people misusing substances have higher levels of schema avoidance than the general population. A thorough literature search revealed no other directly relevant studies.

To summarise, little research has been carried out in the area of schema avoidance and substance misuse. Research that has been conducted has clarified possible areas of interest, for example, differences between people misusing substances and the general population, differences between people misusing different substances, the relationship between severity of misuse and schema avoidance, and factors of the YRAI (Young & Rygh, 1994). However, most of the preceding research relates to alcohol or opiates and some of it has
been carried out with non-clinical populations. There is an absence of research with stimulant users. Also, where clinical populations were used, some studies recruited relatively small numbers of participants, and in some cases no control group was used. It was intended that the current study would contribute to filling these research gaps.

3. The Current Study

3.1 Aims of Study

1. Firstly, the current study was designed to help to test the theory that substance misuse is related to avoidance. Many psychological therapies used in the substance misuse field, for example, DBT, are based on the hypothesis that people may misuse substances as an avoidance strategy (Linehan et al., 2002). However, very little research could be found about the relationship between avoidance and substance misuse. One of the aims of this study is to inform psychological formulations of substance misuse and possibly provide support for interventions based on this premise.

2. Secondly, the current research aims to inform theories of schema avoidance and substance misuse. It aims to test whether schema avoidance is related to substance misuse, as suggested by schema theory (Young et al., 2003). No previous research has explored this. If support was found for this, it might suggest that therapeutic interventions addressing schema avoidance would be helpful for people misusing substances. Another area of interest, following from the study by Brotchie et al. (2006), is whether level of schema avoidance is related to substance of choice. They found no relationship, which is surprising in the light of previous research (Brotchie et al., 2004). It would be helpful to clarify this. If there was a difference in schema avoidance between people misusing different substances, this could inform theories of the
psychological function of different substances, and point towards particular interventions for different substances. Brotchie et al.'s (2006) study also found a relationship between level of schema avoidance and severity of use in alcohol misuse. The current study further investigates possible links between schema avoidance and severity of use in relation to alcohol as well as stimulants and opiates. Further to this, this study explores links between schema avoidance and levels of anxiety and depression, to help test the assumption that schemas and therefore, presumably, schema avoidance would be related to distress (Young and Klosko, 1994). Finally, a factor analysis of the YRAI (Young & Rygh, 1994) might lend support to the factor solution proposed by Luck et al. (2006), and potentially lead to the development of categories of schema avoidance, measured by the YRAI. It was hoped that these investigations might contribute to theories of schema avoidance and substance misuse.

3.2 Research Questions

In order to achieve these aims and extend previous research several research questions were devised.

1. Is there a link between schema avoidance and substance misuse? Previous literature and research assumes a link between schema avoidance and substance misuse (Young et al., 2003; Brotchie et al., 2006). The proposed study attempted to test this hypothesis.

⇒ H1: Schema avoidance will be higher among people using substance misuse services than those who do not.

2. Do people misusing alcohol use more schema avoidance than those misusing opiates? Brotchie et al. (2004) found that people who misuse alcohol, either alone or in combination with opiates, had more unhelpful schemas than those
using opiates alone. Brotchie et al. (2006) hypothesised that people misusing alcohol would therefore also have higher schema avoidance than those misusing opiates. However, this hypothesis was not supported by their study. Therefore, the current study aims to replicate this comparison in order to help to clarify this. As with Brotchie et al. (2006), it was hypothesised that people using alcohol would use more schema avoidance than those using opiates.

⇒ H2: People using alcohol will have greater schema avoidance than those using opiates.

3. Do people misusing stimulants use less schema avoidance than those misusing alcohol or opiates? In order to extend the study by Brotchie et al. (2006), the current research compared the schema avoidance of stimulant users as well as those using alcohol and opiates. Through clinical observation, it is hypothesised that use of stimulants will be less associated with schema avoidance than use of either opiates or alcohol. This may be related to stimulants being more commonly used to fulfil a different function to that of alcohol and opiates, namely, staying alert or enhancing activity (Boys et al., 2001) rather than managing difficult feelings.

⇒ H3: People misusing stimulants will have lower schema avoidance than people using opiates or alcohol.

4. Is schema avoidance related to severity of substance misuse? The study by Brotchie et al. (2006) found that among people misusing alcohol, severity of use increased with schema avoidance. It is hypothesised that this may apply to all substances. Therefore, it is expected that higher levels of schema avoidance will be associated with greater severity of use for alcohol, opiates and stimulants.

⇒ H4: Severity of use will increase with schema avoidance.
5. Is there a relationship between schema avoidance and levels of depression and anxiety in people misusing substances? Young (1990) stated that higher levels of maladaptive schemas are associated with greater difficulty for the individual (Young et al., 2003). It is assumed that there would be a positive correlation between levels of schemas and level of schema avoidance (Brotchie et al., 2006). Therefore, it is hypothesised that in people using substance misuse services, higher schema avoidance would be associated with higher levels of anxiety and depression.

⇒ H5: Schema avoidance will increase with levels of anxiety and depression.

6. What factors emerge from the YRAI? Luck et al.’s (2006) factor analysis of the YRAI with an eating disorder population yielded two factors: behavioural/somatic and emotional/cognitive. It is hypothesised that the same factors will be found for a substance misuse population. This is because schema avoidance is considered a universal concept.

⇒ H6: The YRAI will have two factors: behavioural/somatic and emotional/cognitive.

The present study assumes that all participants have maladaptive schemas and therefore only measures schema avoidance. This is for several reasons. Firstly, schema theory suggests that everyone has maladaptive schemas to some degree. Secondly, Brotchie et al. (2004) have already found that people in substance misuse services have maladaptive schemas. Thirdly, Spranger et al. (2001), Luck et al. (2006) and Brotchie et al. (2006) did similar studies to that proposed and only measured schema avoidance. Finally, pragmatically, it was thought that requiring participants to complete the YSQ (Young, 1990) in addition to other questionnaires would have increased the time required of each participant to a degree that might have prevented the recruitment of sufficient participants.
METHOD

1. Participants

1.1 Clinical Group

All participants were over 17 years old and lived in the United Kingdom (UK). Clinical group participants were people using substance misuse services in a National Health Service (NHS) trust, which was the group to which it was hoped to apply the findings of the research. The three sub-groups within the clinical group were people primarily using (1) alcohol, (2) opiates, or (3) stimulants. These substances were chosen to extend previous research and because they are the most common substances used by people attending substance misuse services.

In this study, substance group was determined by participants' self-report of their primary substance, which was similar to a methodology used by Conway et al. (2002). One hundred and thirty-one (90.3%) clinical group participants were able to choose a primary substance. Those who could not, or who used something other than alcohol, stimulants or opiates, were not included in analyses comparing these three groups, but were included in other analyses.

1.2 Control Group

The control group consisted of people not using substance misuse services. To ensure this, control group participants had to complete a question confirming that they did not attend a substance misuse service (Appendix 2). Additionally, an attempt was made to ensure that they did not have a possible substance misuse problem by checking substance use reported in the demographic questionnaire. Despite this, it is acknowledged that people might under-report substance use (for example, see Dackis et al., 2005), and therefore it is not possible to be...
completely certain that a control group participant did not have a substance misuse problem.

1.3 Number of Participants Needed

A power calculation was used to clarify how many participants were needed. For the study to detect a medium effect (F=0.25) with an alpha of 0.05 and a power of 80% for four groups a total of 180 participants were required - 45 primarily misusing alcohol, 45 primarily misusing opiates, 45 primarily misusing stimulants, and 45 for the control group.

2. Setting

The clinical group came from three outpatient and two inpatient substance misuse services. The three outpatient services had approximately 500 clients each, at any one time. The inpatient services had a total of 37 beds, with turnover approximately once per month. The control group were approached online.

3. Design

A cross-sectional between-groups design was used. The groups were: people primarily using (1) alcohol, (2) opiates, (3) or stimulants, and (4) a control group. As there is a questionnaire to measure schema avoidance (YRAI; Young & Rygh, 1994), a questionnaire method was employed. The Hospital Anxiety and Depression Scale (HADS; Milne, 1992) and a demographic questionnaire were also used. The independent variables were using or not using a substance misuse service, primary substance group, amount of substance used, and anxiety and depression levels. The dependent variable was level of schema avoidance.
4. Questionnaires

4.1 YRAI

The YRAI (Young & Rygh, 1994) measures level of schema avoidance (Appendix 3). It is a self-report questionnaire with 40 statements to be rated on a six-point Likert scale indicating how much they describe the respondent. It was designed for clinical use, but has been previously used in research (Brotchie et al., 2006; Luck et al., 2006).

Karaosmanoglu et al. (2005) found that the YRAI's (Young & Rygh, 1994) internal consistency was 0.738, which is acceptable (Nunnally & Bernstein, 1994). There are no norms for the YRAI (2003). Further research is needed and the current study will involve a factor analysis to clarify the structure of the measure.

4.2 HADS

The HADS (Milne, 1992) measures levels of anxiety and depression (Appendix 4), but is not a diagnostic tool. It does not focus on physical symptoms (Johnston et al., 2000), which might be a confounding factor in people misusing substances. The HADS (Milne, 1992) is a self-report questionnaire with 7 anxiety and 7 depression items, rated on a four-point scale. Milne (1992) stated that its content validity was ensured by basing items on other scales and research. Johnston et al. (2000) found that the internal consistency of the HADS was greater than 0.7, which is acceptable (Nunnally & Bernstein, 1994). Bjelland et al. (2002) found that convergent validity, measured by correlating the HADS (Milne, 1992) with similar questionnaires, was 0.49 to 0.83, and that most factor analyses yielded the expected factors - anxiety and depression. However, some
studies have found other factor solutions, for example, Ravazi et al. (1990) found one factor, and Lewis (1991) found three factors, although with poor fit.

4.3 Demographic Questionnaire

A self-report questionnaire was used to collect information about demographics and substance use. This would determine which group participants belonged to and monitor demographic differences between the clinical and control groups. If large disparities were found, the recruitment strategy could have been adjusted to rectify it, but this was not considered necessary.

No existing questionnaire was entirely suitable. A demographic questionnaire was devised, partly based on the Alcohol Use Disorders Identification Test (AUDIT; Saunders et al., 1993). Several studies have shown good internal consistency for the AUDIT at about 0.8 (Allen et al., 1997). However, its convergent validity is uncertain, with studies finding varying results (Bohn et al., 1995; Rigmaiden et al., 1995; Barry & Fleming, 1993).

The demographic questionnaire consisted of closed and open-ended questions (Appendix 5). General conventions for questionnaire design were followed, such as placing the most threatening questions at the end (Barker et al., 1994), and gradually getting narrower in focus. The control group version included a question about whether the respondent was attending a substance misuse service. No pilot was conducted due to limited time. However, a service user representative provided feedback, which resulted in changes to enhance clarity.
5. Procedure

5.1 Preparation

A contract was agreed between the researcher, field supervisor and academic supervisor (Appendix 6) to clarify roles. Two university reviewers approved the research proposal (Appendix 7) and a protocol was written. The University of Surrey approved funding for questionnaires, using a questionnaire-hosting website and stationery. Ethical approval was granted by the Regional Ethics Committee (Appendix 8), the Research and Development Ethics Committee for the NHS trust (Appendix 9) and the Faculty of Arts and Human Sciences Ethics Committee (Appendix 10). An honorary contract was agreed with the NHS trust (Appendix 11).

5.2 Access to Participants for the Clinical Group

The field supervisor negotiated access to the clinical group. The researcher met each service manager to discuss timing and frequency of data collection, location of communal areas, procedures if a participant became upset and the provision of a private room. The researcher offered to introduce the research to staff by making a presentation (Appendix 12), which two managers accepted. All staff members were given an information sheet explaining the research (Appendix 13).

5.3 Approach to Potential Participants for Clinical Group

Data collection took six months (Appendix 14). The clinical group came from outpatient or inpatient services. Outpatient services were visited weekly for one to three hours and potential participants were approached in the waiting room. Inpatient services were visited fortnightly for one hour and potential participants
were approached in communal areas to comply with service protocols and maintain the researcher's safety. They were visited less frequently due to lower turnover of potential participants.

5.4 Consent and Questionnaire Completion for Clinical Group

Potential participants were given an information sheet (Appendix 15) and, if they agreed to take part, completed a consent form (Appendix 16). In compliance with university guidelines, they could retain the information sheet and a copy of the consent form. They could also receive the results of the study if they provided contact details. Participants were asked to complete three questionnaires and return them to the reception desk of the service they attended within the following two weeks. However, most participants completed and returned the questionnaires immediately.

5.5 Approach to Potential Participants for Control Group

Potential participants for the control group were approached using an email snowballing technique (Fischbacher et al., 2000). This provided access to a large population, which helped to recruit the number of participants required for statistical power. It also had ethical advantages, in that participants could withdraw easily (Sternberg, 1994). The email sent to potential participants stated that participants needed to be over 17 years old and based in the UK. It contained a link to a questionnaire-hosting website.

5.6 Consent and Questionnaire Completion for Control Group

The questionnaire-hosting website contained information about the research (Appendix 17) and a consent section (Appendix 18) which participants needed to accept before continuing to the questionnaires. They could receive the results of
the study if they emailed the researcher to request this. Participants completed
the questionnaires on-line. The responses were stored in a password-protected
part of the website, accessible only to the researcher. Two participants reported
technical difficulties and needed the researcher’s assistance. It is possible that
others experienced difficulties, which may have prevented them from taking part.

6. Ethical considerations

6.1 Potential Participants with Language/Literacy Difficulties

Due to limited resources and the use of validated questionnaires, it was not
possible to translate the questionnaires. Therefore, two potential participants who
did not speak English were excluded. Additionally, some participants in the
clinical group either spoke English as a second language or had poor literacy.
The researcher usually became aware of this quickly because the information
sheets were in written English. Such people were not excluded, and instead the
researcher facilitated them to understand the information sheet and complete the
questionnaires. This could be done in private.

6.2 Informed Consent

Participants were not expected to directly benefit from participation in this study,
and there was a need to gain informed consent, so that they understood the
purpose of the research and that it would not directly benefit them. Information
sheets and consent forms were devised to achieve this. They were designed to
be as clear as possible, with headings to add structure and emphasise main
points. A service user representative provided feedback on them, after which
some technical language was removed and the wording made less formal to
facilitate understanding. The service user representative was also concerned that
the information sheets should not over-emphasise risk and unduly alarm potential
participants. Therefore, statements about risks, insurance and complaints were worded to convey the message that harm was not expected to occur. Potential participants would have been excluded if it was considered that they could not provide informed consent, but this did not occur.

6.3 Confidentiality

It was essential that confidentiality was assured, as participants would potentially state that they were taking illegal substances (Appendix 19). Therefore, all questionnaires were anonymous and after use, the data, questionnaires and consent forms will be stored in a locked cabinet at the University of Surrey. In addition, the data will be reported anonymously.

6.4 Potential Harm to Participants

It was possible that participants would find the questionnaires upsetting. This was not thought likely. However, participants could complete the questionnaires privately. Additionally, if any participant was upset, they could have seen the duty worker at their substance misuse service on the same day or their key-worker if it was less urgent. For the control group, a list of non-statutory contacts for support and advice was provided in the information sheet because it was assumed that they would not have rapid access to the NHS. In practice, it did not appear that any participant required any of these.

7. Data Entry

7.1 Amount of Primary Substance Used

The statistical program Statistical Package for the Social Sciences was used for data entry and analysis. There were three issues in entering amount of substance used. First, amount of substance used was calculated per week for
alcohol and per day for other substances. This was to facilitate comparison between the alcohol use of the clinical and control groups. Also, it was not necessary for alcohol, stimulant and opiate use to be measured the same way because the study did not aim to compare them. Second, some participants stated money spent on the substance, rather than amount used. This was converted into amount used using substance prices provided by Daly (2007). Third, participants in detoxification used no substances. However, this might not have been a valid representation of their use, as they were unable to use substances in detoxification. Therefore, their amount used was entered as missing.

7.2 Whether Multiple Substances were Used

The questionnaire item about whether multiple substances were used allowed responses of 'yes', 'no' or 'sometimes'. These values were entered as 'yes' or 'no', with 'sometimes' entered as 'yes', to simplify interpretation.

7.3 Scoring the YRAI and the HADS

There are no formal procedures for scoring the YRAI (Young & Rygh, 1994). Therefore, item scores were summed to achieve the YRAI score (range 40-240). All items were weighted positively and given equal weightings. The anxiety and depression items from the HADS (Milne, 1992) were summed separately to give a depression score and an anxiety score (range 0-21), because they are different conceptually, which might have been relevant in the analyses.

8. Statistical analyses

The questionnaires leant themselves to quantitative statistical analysis. Parametric tests were used, when their assumptions were met, because they are
more powerful rather than non-parametric tests (Sheskin, 2004). Parametric assumptions are that data are independent, at least interval and normally distributed and comparisons have homogeneity of variance (Field, 2005).

8.1 Samples Used

For the first hypothesis, which involved comparing people who use substance misuse services and those that do not, the overall sample was used. Hypotheses two to five related to people misusing substances, so only the clinical group was used. The factor analysis of the YRAI used the overall sample because schema avoidance is assumed to be universal.

8.2 Comparisons of Two Categorical Variables

When comparing two categorical variables, a Pearson chi-square test was used when the assumption of expected frequencies more than five was met (Field, 2005).

8.3 Comparisons of the Clinical and Control Group

When comparing the clinical and control group on a continuous variable, t-tests were used, when parametric assumptions were met (Field, 2005). This was because the independent variable had two categories. If parametric assumptions were not met, the Mann-Whitney test would have been used (Field, 2005).

8.4 Comparisons of the Alcohol, Opiate and Stimulant Groups

When comparing the alcohol, opiate and stimulant (clinical) groups on a continuous variable, analysis of variance (ANOVA) was used when parametric assumptions were met (Field, 2005). This is because the independent variable
had three categories. If the parametric assumptions were not met, the Kruskal-Wallis test would have been used (Field, 2005).

8.5 Comparisons of Two Continuous Variables

Two continuous variables were compared using a Pearson’s correlation (Field, 2005), when parametric assumptions were met. If they were not met, a Spearman’s correlation would have been employed.

8.6 Regressions

Two regressions were conducted:

1. If there was a significant result for the comparison between the clinical and control group on YRAI scores, a regression would be conducted including any potentially confounding demographic variables. This would show the contribution of different variables to predicting schema avoidance when the others are controlled for, within the overall sample.

2. After testing hypotheses two to five, all variables found to be related to schema avoidance would be included in a regression, along with any potentially confounding demographic variables. This would highlight the variables that predict schema avoidance when the others are controlled for, within the clinical group.

8.7 Factor Analysis

Each YRAI item was represented by a variable containing its scores. The factor analysis used principal component analysis, because Field (2005) stated that this is the most theoretically sound procedure. An oblimin rotation was employed.
because it was likely that the factors in the questionnaire would correlate (Field, 2005).

9. Criteria for Evaluating Study

It was planned to evaluate the study in terms of contribution to psychological theory, methodology (including measures used, sampling and ability to control extraneous variables) and power.

RESULTS

1. Refusal/Drop Out Rates

1.1 Refusal Rates

Three hundred and thirty-five potential participants were approached. Two hundred and thirty-six (70.4%) agreed to take part, and 99 (29.6%) refused. Of the 259 people approached for the clinical group, 85 (32.8%) did not take part. Of the 76 people approached for the control group 14 (18.4%) did not take part. As it was not possible to measure how many potential control group participants received the email but did not open the link, actual refusal rates for this group were probably higher.

1.2 Drop-out Rates

Of those who agreed to take part, only 205 (86.9%) completed all questionnaires. The other 31 (13.1%) completed some questions and then dropped-out. It is not possible to know whether there was a systematic bias in those who did not take part or dropped-out, for example, whether they were more depressed, or their substance use was more severe.
2. Rate of Difficulties Reading English in Clinical Group

Nineteen (10.9%) clinical group participants needed the information and questionnaire read to them, either because of poor literacy or because English was their second language. It is possible that some people that refused to participate were unable to read English but did not wish to say this.

3. Excluded Participant

One participant was excluded from the control group because they responded yes to the question, ‘Do you use a substance misuse service?’. This participant was not included in the clinical group as it was unclear whether this response was accidental or whether they used one of the services for which ethical approval was granted.

4. Data Screening

4.1 Missing Data

Where only one or two pieces of data were missing for a participant’s depression, anxiety or YRAI score (Young & Rygh, 1994), mean substitution was used, rounded up if necessary (Schafer & Graham, 2002).

4.2 Outliers

Field (2005) advocated screening dependent and independent variables. The following were screened for outliers: age, units of alcohol per week, grams of heroin per day, rocks of crack per day, anxiety score, depression score, YRAI score. As recommended by Field (2005), z-scores were used to locate outliers, with any z-score over 3.29 indicating a possible outlier.
Two scores in the YRAI score variable (Young & Rygh, 1994) were possible outliers. The raw data suggested an unusual response pattern for these participants, as they had answered 'Describes me perfectly' to almost every question. Therefore, these cases were removed.

The age variable had three possible outliers. However, these cases were not removed for two reasons. First, in clinical research outliers in the age variable are unlikely to represent errors in sampling, but rather demonstrate genuine variations in the studied population. Second, removing these outliers would have left too few participants in the alcohol group, according to the power calculation. Therefore, this variable was transformed (see below).

The variable units of alcohol per week had one possible outlier. Again, it was not possible to remove this case, as it would have left too few participants in the alcohol group, so it was transformed (see below). No other outliers were found.

4.3 Distribution

To assess the parametric assumption of normally distributed data, Field (2005) recommended using tests of skewness and kurtosis and the Kolmogorov-Smirnov test. According to Field (2005), a z-score above 3.29 on tests of skewness and kurtosis indicates abnormality, and the Kolmogorov-Smirnov test suggests abnormality if it is significant. The variables screened for outliers were also screened for normality.

The variables grams of heroin, anxiety and YRAI score (Young & Rygh, 1994) were normally distributed on all tests. The other variables had abnormal distributions (Table 3). The age variable, in addition to having three outliers (see above), was positively skewed. The variable units of alcohol per week, in addition to one outlier (see above), had abnormal distribution (Kolmogorov-Smith z=2.67,
p<0.00), and was positively skewed and leptokurtic (31.50; SE=0.62; z-score=50.56). The variable number of rocks of crack per day was positively skewed and platykurtic (5.64; SE=0.94; z-score=6.03). Additionally, the depression variable was abnormally distributed, as demonstrated by the Kolmogorov-Smirnov test (Kolmogorov-Smirnov z=1.47, p<0.03). All these variables were transformed (Field, 2005).

Table 3. Skewness of Age, Alcohol Per Week and Crack Per Day

<table>
<thead>
<tr>
<th>VARIABLE</th>
<th>SKEWNESS</th>
<th>STANDARD ERROR</th>
<th>Z-SCORE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>0.82</td>
<td>0.17</td>
<td>4.78</td>
</tr>
<tr>
<td>Alcohol Per Week</td>
<td>5.25</td>
<td>0.32</td>
<td>16.63</td>
</tr>
<tr>
<td>Crack Per Day</td>
<td>2.10</td>
<td>0.48</td>
<td>4.37</td>
</tr>
</tbody>
</table>

4.4 Transforming Data

The variables age, crack rocks per day and depression score were transformed using a square root transformation (Field, 2005). The variable units of alcohol per week was transformed using a logarithm. Following transformation, all variables had no outliers, skewness, kurtosis or abnormality of data.

4.5 Homogeneity of Variance

There are two ways of assessing the parametric assumption that comparisons have homogeneity of variance, depending on the type of data (Field, 2005). For between group comparisons, Levene’s test was used (Field, 2005), in which non-significance indicates homogeneity of variance. It showed homogeneity of variance when comparing clinical/control group with age, anxiety and depression; when comparing clinical primary substance group (alcohol, opiate or stimulant) with age, anxiety, depression and YRAI score (Young & Rygh, 1994); and when comparing sex with YRAI score. Therefore, parametric tests could be used for these. The comparisons between the clinical and control groups on units of
alcohol and YRAI responses (Young & Rygh, 1994) did not have homogeneity of variance. Transformations did not change this (Field, 2005). Therefore, only parametric tests that can tolerate lack of homogeneity of variance or non-parametric tests could be used for these comparisons.

For correlational comparisons, a scatterplot is used to assess homogeneity of variance (Field, 2005). Age, units of alcohol per week, grams of heroin per day, rocks of crack per day, level of depression and level of anxiety were each plotted against YRAI (Young & Rygh, 1994) score. These suggested reasonable homogeneity of variance, so it was possible to use parametric tests.

5. Number of Participants

After data screening, 202 cases remained (Figure 1). The overall sample consisted of the clinical and control group. The clinical group was divided into those primarily using alcohol, opiates, or stimulants. The power calculation suggested that each of the four groups (alcohol, stimulant, opiate and the control group) should have at least 45 participants. All groups except the stimulant group met this target.

Figure 1. Number of Participants
6. Demographic Characteristics of Sample

The demographic characteristics of the sample were analysed in relation to the clinical and control groups, as well as the clinical primary substance groups (alcohol, opiates, stimulants) to reflect the groups compared in the main analyses. Any demographic characteristics that were significantly different between these groups might have been confounding variables, and were included in the main analyses to evaluate their impact on the dependent variable, schema avoidance.

6.1 Sex

The clinical group consisted mostly of men and the control group mostly women (Table 4). To assess whether this was significant, sex and clinical/control group were compared. As both variables were categorical, a Pearson chi-square test was used (Field, 2005). The participant who chose the category ‘other’ for sex was excluded in order to meet the assumption that expected frequencies for any group should be over 5.

The chi-square test was significant (chi-square [1]=30.72, P<0.00), suggesting a relationship between clinical/control group and sex. Cramer’s V was also significant (Cramer’s V=0.39, p<0.00), indicating that the strength of this relationship was significant (Field, 2005). Field (2005) suggested calculating effect size using an odds ratio. Frequencies suggested that the largest difference was between number of males in the clinical group and number of males in the control group. The odds ratio indicated that a participant in the clinical group was 6.04 times more likely to be a man than a participant in the control group. As sex might influence schema avoidance, it was controlled for when comparing the clinical and control groups.
Sex was analysed in relation to the clinical primary substance groups using a chi-square test, but no difference was found.

6.2 Age

Mean age was higher for the clinical group than the control group (Table 4). To see whether this was significant, age and the clinical/control group variable were compared. As assumptions for t-tests were met, an independent t-test was used (Field, 2005). This was significant (t [200]=5.31, p<0.00), suggesting a relationship between clinical/control group and age. Age might affect schema avoidance, for example, older people could have developed more adaptive coping strategies. Therefore, this was controlled for when comparing the clinical and control groups.

Table 4. Demographic Characteristics of Sample

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<thead>
<tr>
<th>DEMOGRAPHIC</th>
<th>CLINICAL GROUP</th>
<th>CONTROL GROUP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Frequency Female</td>
<td>30 (20.7%)</td>
<td>35 (61.4%)</td>
</tr>
<tr>
<td>Frequency Male</td>
<td>114 (78.6%)</td>
<td>22 (38.6%)</td>
</tr>
<tr>
<td>Frequency Other</td>
<td>1 (0.7%)</td>
<td>0 (0.0%)</td>
</tr>
<tr>
<td>Average Age (range)</td>
<td>39.952 (19-75)</td>
<td>31.597 (21-66)</td>
</tr>
</tbody>
</table>

The mean ages of the clinical primary substance groups were different (Table 5). To see whether this was significant, age and clinical primary substance group were compared. As assumptions for parametric tests were met, an ANOVA was used (Field, 2005). This showed that there was a significant difference in age between the groups (F [2,124]=4.88, p<0.01). Post-hoc analysis using Tukey HSD showed that the main difference was between the opiate and alcohol groups (p<0.01), with means indicating that the alcohol group were older. Therefore, age was included in comparisons of the clinical primary substance groups.
Table 5. Mean Ages of the Clinical Primary Substance Groups.

<table>
<thead>
<tr>
<th></th>
<th>ALCOHOL</th>
<th>OPIATE</th>
<th>STIMULANT</th>
</tr>
</thead>
<tbody>
<tr>
<td>AGE (range)</td>
<td>44.11 (26-75)</td>
<td>38.33 (21-62)</td>
<td>38.91 (22-55)</td>
</tr>
</tbody>
</table>

6.3 Educational Level

It was planned to compare educational level to clinical/control group and the clinical primary substance groups using a chi-square test, as the variables were categorical (Field, 2005). However, some expected frequencies when comparing education level to primary substance group were less than 5, violating an assumption of the test (Field, 2005). Therefore, the education level variable was split into two groups – those with further education (more than GCSE level) and those without.

Educational level seemed lower in the clinical group than the control group (Figure 2), with 44 (31.9%) clinical group participants achieving no educational qualifications. To assess whether this was significant, educational level and clinical/control group were compared. The chi-square test was significant (chi-square [1]=33.65, p<0.00), suggesting a relationship between clinical/control group and educational level. Cramer’s V was also significant (Cramer’s V=0.42, p<0.00), indicating that the strength of this relationship was significant (Field, 2005). An odds ratio suggested that a participant in the control group was 14.04 times more likely to have had further education than one in the clinical group (Field, 2005). Education level was therefore entered into comparisons of the clinical and control groups, as it was possible that achievement and schema avoidance would be related.
A chi-square test of educational level in relation to clinical primary substance group found no significant difference between groups (Figure 3).

Figure 3. Educational Level of Alcohol, Opiate and Stimulant Groups

6.4 Ethnicity

Ethnic diversity among the clinical and control groups was similar (Figure 4), although there were no Black British people in the control group, while this group represented about one fifth of the clinical group. It was not possible to conduct a
chi-square test on this as several expected frequencies were less than five (Field, 2005).

Figure 4. Ethnic Origins of Clinical and Control Group

Ethnic diversity among the clinical primary substance groups was also quite similar (Figure 5). However, the stimulant group had a higher proportion of Black British people and a lower proportion of White British people, which probably represents the ethnic diversity of the geographical area that stimulant participants were primarily recruited from. Field (2005) stated that only variables expected to affect the dependent variable should be included in a regression. As it was not thought that ethnicity would influence schema avoidance this was not included in further analyses. Additionally, the nature of this data made it unsuitable for analysis.
6.5 Anxiety and depression levels

T-tests showed that the clinical group had significantly higher levels of anxiety ($t_{199}=5.20$, $p<0.00$) and depression ($t_{200}=9.38$, $p<0.00$) than the control group (Table 6). Therefore, these were included in analyses comparing the clinical and control groups as they might have a confounding effect.

Table 6. Mean Levels of Anxiety and Depression for Clinical and Control Groups

<table>
<thead>
<tr>
<th>GROUP</th>
<th>ANXIETY</th>
<th>DEPRESSION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical</td>
<td>10.07 (SD=4.23)</td>
<td>7.87 (SD=4.33)</td>
</tr>
<tr>
<td>Control</td>
<td>6.67 (SD=4.05)</td>
<td>2.58 (SD=2.56)</td>
</tr>
</tbody>
</table>

The anxiety and depression levels of the clinical primary substance groups were compared using an ANOVA (Field, 2005). The overall comparison of the groups on anxiety level was not significant (Table 7). Planned comparisons compared the stimulant group to the other groups and the alcohol group to the other
groups, reflecting the hypotheses about differences between the groups (H2 and H3). These showed that the stimulant group had lower anxiety levels than the other groups \((t [123]=-2.05, p<0.03 \text{ [one-tailed]})\), representing a small effect size \((r=0.11)\) and the alcohol group had higher anxiety levels than the other groups \((t [123]=1.96, p<0.03 \text{ [one-tailed]})\), representing a small effect size \((r=0.17)\).

Although these effects need to be interpreted with caution since they did not emerge in the overall analysis (Tybout and Sternthal, 2001), anxiety level was included in comparisons of the primary substance groups.

Table 7. Mean Levels of Anxiety and Depression for Primary Substance Groups

<table>
<thead>
<tr>
<th>GROUP</th>
<th>ANXIETY</th>
<th>DEPRESSION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol</td>
<td>10.89 (SD=4.32)</td>
<td>8.02 (SD=4.22)</td>
</tr>
<tr>
<td>Opiate</td>
<td>9.98 (SD=4.50)</td>
<td>7.59 (SD=4.73)</td>
</tr>
<tr>
<td>Stimulant</td>
<td>8.63 (SD=4.01)</td>
<td>7.88 (SD=4.11)</td>
</tr>
</tbody>
</table>

The overall ANOVA analysis and planned comparisons of depression levels in relation to primary substance group were not significant, suggesting that depression levels were quite similar across groups.

6.6 Substance Use

Differences in substance use characteristics were found between the clinical and control groups. This was expected and therefore it was not felt necessary to include these characteristics in further comparisons of the clinical and control groups to control for their effects. One difference between the two groups was substance used (Table 8). One hundred and twenty-seven \((87.0\%)\) clinical group participants' primary substance was alcohol, stimulants or opiates, which was expected as these were the substances being studied. Four \((2.8\%)\) named another substance and 14 \((9.7\%)\) named multiple primary substances (classified 'polysubstances'). In the control group, most \((50, 87.7\%)\) participants' primary substance was alcohol (Table 8) and 5 \((8.8\%)\) did not use any substance.
The clinical alcohol group drank more mean alcohol units per week than the control group. As this comparison met all assumptions for parametric tests except homogeneity of variance, a t-test was used, which can manage lack of homogeneity of variance. Participants recruited from detoxification were excluded, because their zero usage was not regarded as valid. The t-test showed that the difference in units of alcohol drunk per week between the clinical and control groups was significant (t [10.33]=3.33, p<0.00).

Table 8. Primary Substances and Amount Used

<table>
<thead>
<tr>
<th>PRIMARY SUBSTANCE</th>
<th>CLINICAL GROUP</th>
<th>CONTROL GROUP</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Frequency Citing as Primary Substance</td>
<td>Mean Amount Used</td>
</tr>
<tr>
<td>Alcohol</td>
<td>45 (31.0%)</td>
<td>109.63 units per week (SD=142.391)</td>
</tr>
<tr>
<td>Opiates</td>
<td>49 (33.8%)</td>
<td>Heroin: 0.32g per day (SD=0.117). Methadone: 63mls per day (SD=61.40). Diamorphine: 252.50mg per day (SD=208.07). Dihydrocodeine: 150.00mgs per day (n=1). Opium: 2.50g per day (n=1).</td>
</tr>
<tr>
<td>Stimulants</td>
<td>33 (22.8%)</td>
<td>Cocaine: 1.50g per day (SD=1.23) Crack: 6.09 rocks per day (SD=5.49) Amphetamine: 0.50g per day (n=1).</td>
</tr>
<tr>
<td>Cannabis</td>
<td>2 (1.4%)</td>
<td>Missing</td>
</tr>
<tr>
<td>Benzodiazapines</td>
<td>2 (1.4%)</td>
<td>Missing</td>
</tr>
<tr>
<td>Polysubstances</td>
<td>14 (9.7%)</td>
<td>Not Applicable</td>
</tr>
<tr>
<td>None</td>
<td>0 (0%)</td>
<td>Not Applicable</td>
</tr>
<tr>
<td>Missing</td>
<td>0 (0%)</td>
<td>Not Applicable</td>
</tr>
</tbody>
</table>
Mode frequency of primary substance use for the control group was 'two to three times per week', while for the clinical group it was 'never', probably because fifty-five clinical group participants (37.9%) were recruited from detoxification. Clinical group participants were more likely to use additional substances than control group participants (Table 9).

Table 9. Frequency Using Additional Substances for Clinical and Control Groups

<table>
<thead>
<tr>
<th>Frequency Using Additional Substances</th>
<th>CLINICAL GROUP</th>
<th>CONTROL GROUP</th>
</tr>
</thead>
<tbody>
<tr>
<td>94 (65.3%)</td>
<td>10 (18.2%)</td>
<td></td>
</tr>
</tbody>
</table>

Differences in substance use characteristics were also found between the three clinical primary substance groups, as expected due to the different nature of each substance. One difference was mode frequency of use. For the opiate group, mode frequency of use was 'four or more times per week', probably due to the need to use opiates every day to avoid withdrawal symptoms (Emmett & Nice, 2006). The group using stimulants, which are not physically addictive (Emmett & Nice, 2006), mostly used 'two to three times per week'. Finally, the alcohol group's mode frequency of use was 'never', probably due to the high proportion of that group recruited from detoxification (Table 10).

The alcohol group was least likely to use additional substances (Table 10). To assess whether this was significant, a comparison between primary substance group and whether additional substances were used was conducted. As both variables were categorical and expected frequencies were above 5, a chi-square test was used (Field, 2005). This was significant (chi-square [2]=7.53, p<0.02), suggesting a significant difference between the clinical primary substance groups in their use of additional substances. Cramer's V was also significant (Cramer's V=0.24, p<0.02), indicating that the strength of this relationship was significant.

---

4 The percentage using multiple substances includes those who mentioned...
The effect size was calculated using an odds ratio (Field, 2005). Percentages suggested that the largest difference in the use of additional substances was between the alcohol and opiate groups. The odds ratio suggested that an opiate group participant was 2.86 times more likely to use additional substances than an alcohol group participant. Alcohol users might have been less likely to use multiple substances because some did not wish to use illegal substances.

There were differences in the percentage of each clinical primary substance group recruited from detoxification (Table 10). To assess the significance of this, clinical primary substance group was compared to the variable recruited from detoxification/not recruited from detoxification. As both variables were categorical and expected frequencies were over 5, a chi-square test was used (Field, 2005). This showed a significant relationship between clinical primary substance group and recruited from detoxification/not recruited from detoxification (Chi Square=45.53, p<0.00). Cramer's V was also significant (Cramer's V=0.60, p<0.00), indicating that the strength of this relationship was significant (Field, 2005). Percentages suggested that the largest difference in recruitment from detoxification was between the alcohol and stimulant groups. The odds ratio (Field, 2005) suggested that an alcohol group participant was 45.38 times more likely to be recruited from detoxification than a stimulant group participant. It was felt that the differences in recruitment from detoxification between the substances did not represent intrinsic differences between the substances but was an anomaly related to data collection. As recruitment from detoxification was a potentially confounding variable that could affect schema avoidance, it was included in analyses comparing the three clinical primary substance groups to assess its impact.
Table 10. Substance Use Characteristics of Clinical Primary Substance Groups

<table>
<thead>
<tr>
<th></th>
<th>ALCOHOL</th>
<th>OPIATES</th>
<th>STIMULANTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Frequency Recruited</td>
<td>33 (73.3%)</td>
<td>10 (20.4%)</td>
<td>2 (6.1%)</td>
</tr>
<tr>
<td>from Detoxification</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Frequency Using</td>
<td>16 (35.5%)</td>
<td>30 (61.2%)</td>
<td>20 (60.6%)</td>
</tr>
<tr>
<td>Multiple Substances</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

7. Hypothesis Testing

7.1 Schema avoidance will be higher among people using substance misuse services than those who do not (H1)

The clinical group had higher mean schema avoidance than the control group (Table 11). This was assessed using a t-test, which can manage the lack of homogeneity of variance associated with this comparison. This found that the difference in schema avoidance was significant (t=7.53, p<0.00). A calculation provided by Field (2005) revealed that the effect size was medium to large (r=0.48).

Table 11. Mean YRAI Scores of Clinical and Control Groups

<table>
<thead>
<tr>
<th>GROUP</th>
<th>MEAN YRAI SCORE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical</td>
<td>135.10 (SD=24.33)</td>
</tr>
<tr>
<td>Control</td>
<td>115.56 (SD=12.30)</td>
</tr>
</tbody>
</table>

The variable clinical/control group was entered into a regression with the potentially confounding variables from the demographic analyses - sex, age, education, anxiety and depression. This would assess the impact of these on schema avoidance, and the effect of the variable clinical/control group when the other variables are controlled for (Field, 2005). The analysis met the assumptions that predictor variables are categorical or continuous, the outcome variable is continuous, there is variance, and the values of the outcome variable are independent (Field, 2005). The assumption of independent errors was confirmed
by checking that the Durbin-Watson statistic was more than 1 and less than 3 (Field, 2005). The assumption of no multicollinearity was confirmed by checking that VIF values averaged more than 1, with none greater than 10, and tolerances were above 0.2 (Field, 2005). Plots showed that the assumptions of homoscedasticity and a linear relationship were met. All assumptions of parametric tests were met, except that the comparison between clinical/control group and schema avoidance did not have homogeneity of variance. Bobko and Russell (1990) argued that including homogeneity of variance as an assumption of regressions is inappropriate as heterogeneity of variance might represent a legitimate effect, which the regression could explain. Due to this, and the lack of another method to conduct the analysis (Field, 2005), the regression was conducted.

The regression used block-wise entry. Sex, age, education level, depression and anxiety were in the first block because they were covariates of the clinical/control group variable, and it was necessary to control for their effects. Depression and anxiety levels were in the second block because, although they were also covariates of the clinical/control group variable, it was a specific hypothesis of this study that they are related to schema avoidance, so it was necessary to assess their impact separately from the other covariates. Clinical/control group was in the third block to elucidate the effect of this variable when the other variables were controlled for.

R squared values suggested that age, sex, and education level explained 5.5% of the variance in schema avoidance; depression and anxiety levels explained an additional 13.9%; and clinical/control group an additional 4.8%. These were all significant (Fchange=3.74, p<0.01; F change=16.19, p<0.00; F change=12.07, p<0.00). The F-values showed all three blocks significantly increased the prediction of schema avoidance above chance (Field, 2005). The regression equation was: total R squared=0.242 (F [6,188]=10.01, p<0.00), which indicates
that 24.2% of the variance was accounted for when all the above variables were entered. The Beta values allow comparison of the contribution of each variable to predicting schema avoidance when the other variables are held constant (Field, 2005; Table 12). They showed that anxiety level was the most important predictor of schema avoidance, followed by clinical/control group. Both of these variables made a significant contribution (p<0.00) when the others were held constant, while the others did not. Although this suggested that anxiety level was a more important predictor than clinical/control group, the regression was not re-run with the variables in this order, because there were theoretical reasons for the original order, which is important in block-wise entry (Field, 2005).

Table 12. Beta Values of Regression

<table>
<thead>
<tr>
<th></th>
<th>B</th>
<th>STANDARD ERROR OF B</th>
<th>BETA</th>
<th>T</th>
<th>SIGNIFICANCE</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>STEP 1</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CONSTANT</td>
<td>104.62</td>
<td>14.34</td>
<td>7.30</td>
<td>0.00</td>
<td></td>
</tr>
<tr>
<td>AGE</td>
<td>2.83</td>
<td>1.98</td>
<td>0.10</td>
<td>1.43</td>
<td>0.15</td>
</tr>
<tr>
<td>SEX</td>
<td>-2.99</td>
<td>3.50</td>
<td>-0.06</td>
<td>-0.85</td>
<td>0.40</td>
</tr>
<tr>
<td>EDUCATION LEVEL</td>
<td>8.18</td>
<td>3.42</td>
<td>0.17</td>
<td>2.39</td>
<td>0.02</td>
</tr>
<tr>
<td><strong>STEP 2</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CONSTANT</td>
<td>96.78</td>
<td>13.39</td>
<td>7.23</td>
<td>0.00</td>
<td></td>
</tr>
<tr>
<td>AGE</td>
<td>1.88</td>
<td>1.88</td>
<td>0.07</td>
<td>1.00</td>
<td>0.32</td>
</tr>
<tr>
<td>SEX</td>
<td>-2.92</td>
<td>3.30</td>
<td>-0.06</td>
<td>-0.89</td>
<td>0.38</td>
</tr>
<tr>
<td>EDUCATION LEVEL</td>
<td>5.45</td>
<td>3.23</td>
<td>0.11</td>
<td>1.69</td>
<td>0.09</td>
</tr>
<tr>
<td>ANXIETY SCORE</td>
<td>2.10</td>
<td>0.50</td>
<td>0.40</td>
<td>4.23</td>
<td>0.00</td>
</tr>
<tr>
<td>DEPRESSION SCORE</td>
<td>-0.77</td>
<td>2.16</td>
<td>-0.04</td>
<td>-0.36</td>
<td>0.72</td>
</tr>
<tr>
<td><strong>STEP 3</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CONSTANT</td>
<td>133.68</td>
<td>16.80</td>
<td>7.96</td>
<td>0.00</td>
<td></td>
</tr>
<tr>
<td>AGE</td>
<td>0.31</td>
<td>1.88</td>
<td>0.01</td>
<td>-0.17</td>
<td>0.87</td>
</tr>
<tr>
<td>SEX</td>
<td>0.13</td>
<td>3.32</td>
<td>0.00</td>
<td>0.04</td>
<td>0.97</td>
</tr>
<tr>
<td>EDUCATION LEVEL</td>
<td>1.60</td>
<td>3.33</td>
<td>0.03</td>
<td>0.48</td>
<td>0.63</td>
</tr>
<tr>
<td>ANXIETY SCORE</td>
<td>2.18</td>
<td>0.48</td>
<td>0.42</td>
<td>4.53</td>
<td>0.00</td>
</tr>
<tr>
<td>DEPRESSION SCORE</td>
<td>-3.71</td>
<td>2.26</td>
<td>-0.17</td>
<td>-1.64</td>
<td>0.10</td>
</tr>
<tr>
<td>CLINICAL/CONTROL GROUP</td>
<td>-15.66</td>
<td>4.51</td>
<td>-0.31</td>
<td>-3.47</td>
<td>0.00</td>
</tr>
</tbody>
</table>
7.2 People using alcohol will have greater schema avoidance than those using opiates (H2) and people using stimulants will have lower schema avoidance than people using opiates or alcohol (H3).

The schema avoidance of the clinical primary substance groups was compared using an ANOVA (Table 13), which was not significant (F [2,124]=1.61, p<0.20). However, planned comparisons revealed that people whose primary substance was a stimulant had lower schema avoidance than those using alcohol or opiates (t [124]=-1.79, p<0.04). The effect size for this, using Field's (2005) calculation, was small (r=0.16). As this effect was not found in the overall analysis, this result must be interpreted cautiously (Tybout and Sternthal, 2001).

Table 13. Mean YRAI Scores of the Clinical Primary Substance Groups

<table>
<thead>
<tr>
<th>GROUP</th>
<th>AVERAGE YRAI SCORE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol</td>
<td>137.51 (SD=22.99)</td>
</tr>
<tr>
<td>Opiates</td>
<td>137.69 (SD=26.61)</td>
</tr>
<tr>
<td>Stimulants</td>
<td>128.73 (SD=22.92)</td>
</tr>
</tbody>
</table>

7.3 Schema avoidance will increase with amount of substance used for each substance (H4)

Participants recruited from detoxification were excluded from analyses of the relationships between amount of each substance used and schema avoidance. Since these comparisons met the assumptions for parametric statistics, Pearson's correlations were used (Field, 2005). These revealed that the relationships between amount used and schema avoidance were non-significant for alcohol (r=0.13, p<0.36 [n=10]), crack (r=0.20, p<0.18 [n=23]) and heroin (r=0.12, p<0.33 [n=16]).
7.4 Schema avoidance will increase with levels of anxiety/depression (H5)

The comparison of anxiety level and schema avoidance met the assumptions for parametric tests, so a Pearson's correlation was used (Field, 2005). The correlation was significant ($r=0.34$, $p<0.00$), representing a medium effect ($R^2=0.114$). This indicated that 11.4% of the variance in schema avoidance was accounted for by anxiety level.

The comparison of depression level and schema avoidance met parametric assumptions, so a Pearson's correlation was used (Field, 2005). The correlation was significant ($r=0.14$, $p<0.04$), representing a small effect ($R^2=0.02$). This indicated that depression score accounted for 2% of the variance in schema avoidance.

7.5 Variables Contributing to Schema Avoidance for the Clinical Group

A regression was conducted to clarify the impact of the variables found to predict schema avoidance (primary substance used, anxiety level, and depression level) when the other variables were controlled for. Only the clinical group was included, as this was the group for whom the variables were originally found to be important. The variables detoxification/not and age were also included because they co-varied with primary substance, so their impact needed to be assessed.

Regressions require categorical variables with two groups. As the variable primary substance used contained three groups, it was split into two dummy variables (Field, 2005), one with the categories stimulant and alcohol/opiates and the other containing the categories alcohol and opiates/stimulants. The third possible comparison of opiates and alcohol/stimulants was not included to avoid violating the assumption of no multicollinearity (Field, 2005). This organisation
reflected the hypothesised differences between the substances (H2 and H3) and
differences found between the substances in previous comparisons.

The analysis met all assumptions for a regression. Parametric assumptions were
met (Field, 2005). The assumption of independent errors was assessed by
confirming that the Durbin-Watson statistic was not lower than 1 or greater than 3
(Field, 2005). The assumption of no multicollinearity was assessed by confirming
that the average VIF score was not below 1 and no score was above 10 and that
no tolerance score was below 0.2 (Field, 2005). Finally, plots showed that the
assumptions of homoscedasticity and linearity were met.

Variables were entered block-wise. Detoxification/not and age were entered in
block one to control for their impact. The two primary substance variables were
controlled for in block two, because earlier analyses suggested that primary
substance might have a small effect on schema avoidance. Depression (block
three) was entered before anxiety (block four) to clarify the effect of anxiety if
depression is controlled for, as anxiety was important in the regression for the
overall sample.

R squared values showed that detoxification/not and age accounted for 3.8% of
the variation in schema avoidance (Field, 2005), alcohol vs stimulants/opiates
and stimulants vs opiate/alcohol 2%, and depression level 2.6%. None of these
were significant. Anxiety level accounted for 6.9% of the variance, which was
significant (F change=9.732, p<0.00). The regression equation was: total R
squared=0.15, F (6,119)=3.586, p<0.00, which shows that when all the above
variables were included in the regression, they accounted for 15% of the
variance in schema avoidance. The Beta value, which represents the degree to
which each variable predicted schema avoidance when the others were held
constant (Field, 2005), confirmed that anxiety level was the most important and
only significant predictor (Table 14). The F-ratio value showed that the model
including only anxiety level significantly improved prediction of schema avoidance above chance (Field, 2005; F [6,119]=3.586, p<0.00).

Table 14. Beta Values of the Regression

<table>
<thead>
<tr>
<th></th>
<th>B</th>
<th>STANDARD ERROR OF B</th>
<th>BETA</th>
<th>T</th>
<th>Significance</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>STEP 1</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CONSTANT</td>
<td>169.58</td>
<td>20.57</td>
<td>8.24</td>
<td>0.00</td>
<td></td>
</tr>
<tr>
<td>AGE</td>
<td>-2.95</td>
<td>2.80</td>
<td>-0.10</td>
<td>-1.05</td>
<td>0.30</td>
</tr>
<tr>
<td>DETOX/NOT</td>
<td>-9.65</td>
<td>4.59</td>
<td>-0.19</td>
<td>-2.10</td>
<td>0.04</td>
</tr>
<tr>
<td><strong>STEP 2</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CONSTANT</td>
<td>170.87</td>
<td>20.80</td>
<td>8.21</td>
<td>0.00</td>
<td></td>
</tr>
<tr>
<td>AGE</td>
<td>-2.80</td>
<td>2.87</td>
<td>-0.09</td>
<td>-0.98</td>
<td>0.33</td>
</tr>
<tr>
<td>DETOX/NOT</td>
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<td>5.61</td>
<td>-0.17</td>
<td>-1.58</td>
<td>0.12</td>
</tr>
<tr>
<td>ALCOHOL VS OPIATES/STIMULANTS</td>
<td>-3.59</td>
<td>5.95</td>
<td>-0.07</td>
<td>-0.60</td>
<td>0.55</td>
</tr>
<tr>
<td>STIMULANTS VS ALCOHOL/OPIATES</td>
<td>-8.71</td>
<td>5.56</td>
<td>-0.16</td>
<td>-1.57</td>
<td>0.12</td>
</tr>
<tr>
<td><strong>STEP 3</strong></td>
<td></td>
<td></td>
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<td></td>
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<tr>
<td>CONSTANT</td>
<td>163.26</td>
<td>21.00</td>
<td>7.77</td>
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<tr>
<td>AGE</td>
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<td>-0.12</td>
<td>-1.17</td>
<td>0.24</td>
</tr>
<tr>
<td>DETOX/NOT</td>
<td>-9.18</td>
<td>5.56</td>
<td>-0.18</td>
<td>-1.65</td>
<td>0.10</td>
</tr>
<tr>
<td>ALCOHOL VS OPIATES/STIMULANTS</td>
<td>-4.14</td>
<td>5.89</td>
<td>-0.08</td>
<td>-0.70</td>
<td>0.48</td>
</tr>
<tr>
<td>STIMULANTS VS ALCOHOL/OPIATES</td>
<td>-9.04</td>
<td>5.51</td>
<td>-0.16</td>
<td>-1.64</td>
<td>0.10</td>
</tr>
<tr>
<td>DEPRESSION SCORE</td>
<td>4.48</td>
<td>2.41</td>
<td>0.16</td>
<td>1.86</td>
<td>0.07</td>
</tr>
<tr>
<td><strong>STEP 4</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CONSTANT</td>
<td>148.96</td>
<td>20.79</td>
<td>7.17</td>
<td>0.00</td>
<td></td>
</tr>
<tr>
<td>AGE</td>
<td>-1.88</td>
<td>2.79</td>
<td>-0.06</td>
<td>-0.67</td>
<td>0.50</td>
</tr>
<tr>
<td>DETOX/NOT</td>
<td>-7.93</td>
<td>5.38</td>
<td>-0.16</td>
<td>-1.47</td>
<td>0.14</td>
</tr>
<tr>
<td>ALCOHOL VS OPIATES/STIMULANTS</td>
<td>-5.07</td>
<td>5.70</td>
<td>-0.10</td>
<td>-0.89</td>
<td>0.38</td>
</tr>
<tr>
<td>STIMULANTS VS ALCOHOL/OPIATES</td>
<td>-5.82</td>
<td>5.42</td>
<td>-0.10</td>
<td>-1.07</td>
<td>0.29</td>
</tr>
<tr>
<td>DEPRESSION SCORE</td>
<td>-2.44</td>
<td>3.22</td>
<td>-0.09</td>
<td>-0.76</td>
<td>0.45</td>
</tr>
<tr>
<td>ANXIETY SCORE</td>
<td>2.09</td>
<td>0.67</td>
<td>0.37</td>
<td>3.12</td>
<td>0.00</td>
</tr>
</tbody>
</table>

The regression showed that when anxiety level was controlled for, depression level did not significantly influence schema avoidance. This led to the hypothesis that a correlation between anxiety and depression levels might explain the relationship between depression and schema avoidance, with anxiety as a confounding variable. To assess this, a Pearson’s correlation was used (Field,
2005) to compare anxiety and depression levels, as assumptions for parametric tests were met. This revealed a significant relationship between depression and anxiety levels ($r=0.67$, $p<0.00$ [one-tailed]), which represented a large effect. This supported the hypothesis that anxiety level might have accounted for the apparent relationship between depression and schema avoidance.

The relationship between anxiety and schema avoidance also required further clarification. It was possible that this relationship only occurred in the clinical sample, but was found in the overall sample because the clinical sample made up most of the overall sample. To clarify whether the relationship between anxiety and schema avoidance occurred in the control group, anxiety and schema avoidance were compared for this group. A Pearson's correlation was used, as assumptions for parametric tests were met. This was significant ($r=0.353$, $p<0.004$ [one-tailed]), representing a medium effect ($R^2=0.125$), which suggested that anxiety accounted for 12.5% of the variance in schema avoidance for the control group.

7.6 The YRAI will have two factors: behavioural/somatic and emotional/cognitive (H6)

A factor analysis of the YRAI was conducted. Field (2005) stated that in factor analysis variables should correlate well but not perfectly, and suggested methods to test this. Firstly, he advised correlating each variable with the others and deleting any variable with either most of the significance values over 0.05 or any correlation coefficient greater than 0.9. This resulted in the removal of the variables for items 2, 5, 6, 10, 16, 17, 19, 21, 23, 26, 39, and 40, then re-running the analysis. Secondly, Field (2005) suggested assessing that variables are not over-correlated by checking that the determinant of the correlation matrix is greater than 0.0001, which it was. Thirdly, Field (2005) recommended using
Bartlett's test of sphericity to test for under-correlation of variables. This was significant ($p<0.00$) showing that the data are not under-correlated.

Field (2005) recommended two methods for assessing the adequacy of the data for factor analysis. One of these was the Kaiser-Meyer-Olkin test. This score was 0.81, showing that the adequacy of the data was very good. Field (2005) also recommended checking the diagonal elements of the anti-image correlation matrix and deleting variables with a value below 0.5. Following this, the variables for questions 11, 20, 29, and 34 were removed and the analysis re-run. The previous checks were re-done using the new set of variables. The determinant of the correlation matrix remained acceptable (0.002), Bartlett's test of sphericity remained significant ($p<0.00$), the Kaiser-Meyer-Olkin test still showed that the adequacy of the data was very good (0.81) and the diagonal elements of the anti-image correlation matrix all had values above 0.5.

There are different methods for deciding how many factors to extract (Field, 2005). Kaiser's criterion (Kaiser, 1960), to extract all factors with an eigenvalue of more than 1, resulted in six factors. However, Field (2005) did not recommend using this when the average communality after extraction is under 0.6, as it was with this data. Joliffe's (1972) criterion recommends extracting factors with eigenvalues greater than 0.7, which would result in 13 factors for these data. This was not particularly helpful, as there were only 24 variables. Field (2005) also suggested using the scree plot to assess how many factors to extract. The curve tailed off after six factors. Therefore, six factors were extracted, as indicated by Kaiser's (1960) criterion and the scree plot.

The pattern matrix (Table 15) showed that the six factors seemed to represent: 1/ social withdrawal, 2/ not acknowledging difficult feelings, 3/ distraction, 4/ numbing painful feelings, 5/ avoiding upsetting thoughts/somatising, and 6/ trying to remain emotionally neutral. Items 22, 33, and 38 did not load onto any factor.
The structure matrix showed that several variables loaded onto more than one factor (Field, 2005), probably because of correlations between variables 1 and 5 \((r=0.35)\) and variables 4 and 5 \((r=-0.26)\). These correlations suggested that using oblique oblimin rotation was probably appropriate (Field, 2005). Field (2005) recommended assessing that the model is acceptable by checking that differences between correlations of the variables in the observed data and those predicted by the model are small, with less than 50% greater than 0.05. In this data, 39% of these values were less than 0.05, which is acceptable.

Table 15 Pattern Matrix for Principal Component Analysis

<table>
<thead>
<tr>
<th>FACTOR</th>
<th>QUESTION</th>
<th>FACTOR LOADING</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>I withdraw when I'm angry</td>
<td>0.75</td>
</tr>
<tr>
<td></td>
<td>I spend a lot of time daydreaming</td>
<td>0.67</td>
</tr>
<tr>
<td></td>
<td>I withdraw when I'm sad</td>
<td>0.73</td>
</tr>
<tr>
<td>2</td>
<td>I rarely feel sad or blue</td>
<td>0.48</td>
</tr>
<tr>
<td></td>
<td>I cannot intensely dislike anyone</td>
<td>0.42</td>
</tr>
<tr>
<td></td>
<td>I try not to think about painful memories from my past</td>
<td>0.52</td>
</tr>
<tr>
<td></td>
<td>People say I'm like an ostrich with my head in the sand</td>
<td>0.52</td>
</tr>
<tr>
<td></td>
<td>I tend not to think about loses and disappointments</td>
<td>0.73</td>
</tr>
<tr>
<td>3</td>
<td>I am happy most of the time</td>
<td>-0.49</td>
</tr>
<tr>
<td></td>
<td>Sticking to the task at hand keeps me from feeling upset</td>
<td>-0.76</td>
</tr>
<tr>
<td></td>
<td>I feel better if I keep myself constantly busy, not leaving much time</td>
<td>-0.59</td>
</tr>
<tr>
<td></td>
<td>to think</td>
<td></td>
</tr>
<tr>
<td></td>
<td>I find myself buying things that I don’t need, to improve my mood</td>
<td>-0.60</td>
</tr>
<tr>
<td>4</td>
<td>I use drugs to feel better</td>
<td>0.67</td>
</tr>
<tr>
<td></td>
<td>I don’t feel much when I remember my childhood</td>
<td>0.78</td>
</tr>
<tr>
<td></td>
<td>I smoke when I’m upset (overlap with 5)</td>
<td>0.49</td>
</tr>
<tr>
<td>5</td>
<td>I try not to think about things that upset me</td>
<td>-0.47</td>
</tr>
<tr>
<td></td>
<td>I smoke when I’m upset (overlap with 4)</td>
<td>-0.47</td>
</tr>
<tr>
<td></td>
<td>I often get headaches</td>
<td>-0.77</td>
</tr>
<tr>
<td></td>
<td>I don’t have as much energy as most people my age</td>
<td>-0.42</td>
</tr>
<tr>
<td></td>
<td>I suffer from muscular aches and pains</td>
<td>-0.62</td>
</tr>
<tr>
<td>6</td>
<td>I try to stay emotionally neutral most of the time</td>
<td>-0.77</td>
</tr>
<tr>
<td></td>
<td>I try not to put myself in situations that are difficult or make me</td>
<td>-0.73</td>
</tr>
<tr>
<td></td>
<td>uncomfortable</td>
<td></td>
</tr>
</tbody>
</table>
DISCUSSION

1. Main Findings and their Contribution to Psychological Theory

This study contributes to substance misuse theories and schema theory.

1.1 Differences Between Substances

Research about the differences in schemas and schema avoidance between people using different substances has been equivocal. Brotchie et al. (2004) found that alcohol users had higher levels of schemas than opiate users. In a later study, Brotchie et al. (2006) found no difference between alcohol and opiate users on levels of schema avoidance. In the current study, it was hypothesised that, due to the proposed relationship between levels of schemas and levels of schema avoidance, alcohol users might have higher levels of schema avoidance than opiate users. Clinical observation also led to the hypothesis that stimulant users would have lower schema avoidance than alcohol or opiate users.

This study found no overall difference in schema avoidance between people using different substances. This is concordant with current theory and practice in substance misuse, which are becoming more 'transdiagnostic' - a model that has also influenced recent research on eating disorders (for example, Fairburn et al., 2003). 'Trandiagnostic' refers to the theory that presenting problems within a particular spectrum might be maintained by common underlying psychological processes (Fairburn et al., 2003). In eating disorders, this implies that different eating disorders, such as anorexia and bulimia, have similar underlying maintaining factors. In substance misuse, this suggests that people misusing different substances might actually have similar underlying processes maintaining the substance misuse.
One example of a 'transdiagnostic' approach to substance misuse is the stages of change model (Prochaska et al., 1992), which does not differentiate between substances. This postulates that all substance misuse is influenced by motivation to change. They describe five stages of motivation: pre-contemplation, where there is no intention to change substance use; contemplation, when changes are considered; preparation, where a decision is made to change; action, when significant changes are made; and maintenance, where an attempt is made to avoid relapse. Another example of the 'transdiagnostic' approach to substance misuse is West's (2006) synthetic theory of addiction. This hypothesises that all substance misuse is a symptom of abnormalities in the motivational system, which are caused and maintained by factors such as psychological difficulties, the effects of the substance, underlying psychological mechanisms and a negative environment. Gossop (1993) emphasised that an individual might not choose a particular substance, but rather the substance used is incidental and due to social factors such as availability, the wider culture, and sub-cultures to which the individual belongs. Although the analysis found no difference in schema avoidance between people using different substances, the insufficient number of participants in the stimulant group might have affected power, so this result should be treated cautiously (Field, 2005). It is possible that, as with the Brotchie et al. (2006) study, with sufficient numbers a significant result would be found.

In contrast to the overall finding of no difference in schema avoidance between groups, simple comparisons between specific groups in this study found that stimulant users had lower schema avoidance than alcohol or opiate users. This may suggest that stimulant use is less linked to schema avoidance than other substances, possibly because it is more related to factors such as wanting to feel confident (Emmett & Nice, 2006), stay awake or enhance activity (Boys et al., 2001). However, this finding must be treated cautiously, as the overall effect was
not significant (Tybout & Sternthal, 2001), so it might represent a spurious result or a very small effect.

1.2 Relationship Between Amount Used and Schema Avoidance

Brotchie et al. (2006) found that amount of alcohol used positively correlated with schema avoidance. The current study aimed to replicate this, and also hypothesised that amount of stimulant and opiate used would correlate positively with schema avoidance. These hypotheses were not supported, as schema avoidance was not found to correlate with amount used for any substance. This contradicts Brotchie et al.'s (2006) study, which found that schema avoidance and amount used correlated for alcohol users. However, the current analyses had low numbers, partly due to exclusion of those in detoxification, which led to lack of power and biased the results towards non-significance (Field, 2005). Also, how this study measured severity of use (current amount used) may not have been valid, which could explain the lack of relationship with schema avoidance.

1.3 Relationship Between Substance Misuse and Anxiety and Depression

Numerous studies have found that substance misuse tends to co-occur with psychological distress (Farrell et al., 2001; Wills et al., 1999). In this study, a relationship was found between substance misuse and levels of depression and anxiety. Mean HADS scores for anxiety and depression were both within 'borderline' range for the clinical group and 'normal' range for the control group (Milne, 1992), suggesting that the difference might be clinically as well as statistically significant.

The finding that substance misuse is associated with anxiety and depression potentially supports theories that hypothesise that substances are used to manage difficult emotions (for example, DBT, self-medication model, CBT).
However, while this study suggests a relationship between levels of anxiety and depression and substance misuse, it does not imply causation. Indeed, it is generally accepted that increased anxiety and depression can also be a consequence of using substances (Bonomo and Proimos, 2005; Emmett & Nice, 2006; and Glauser, 1995). Therefore, the current study could have been measuring the consequences of substance use. This was minimised as far as possible by using the HADS, which focuses less on physical symptoms. This finding highlights the importance of including experiences of anxiety and depression in formulations and interventions, acknowledging a potential two-way interaction with substance misuse, and addressing them if necessary.

1.4 Relationship Between Schema Avoidance and Substance Misuse

It is a hypothesis of schema theory that schema avoidance is associated with substance misuse, because substance misuse is considered a method of schema avoidance (Young and Klosko, 1994; Young et al., 2003). However, this has not been empirically tested. Brotchie et al. (2006) had no control group and therefore did not test whether people using substance misuse services had higher schema avoidance than the general population. The current study aimed to investigate this.

The findings of this study suggested that schema avoidance might be related to substance misuse. This relationship was found to be independent of sex, age, education level, level of anxiety and depression level. However, the regression analysis employed to control for these other factors did not have homogeneity of variance, meaning that one of the usual assumptions of a regression was violated and the findings might need to be viewed cautiously (Field, 2005; Bobko & Russell, 1990). The findings of the current study potentially support the theory that substance misuse is a method of schema avoidance, by showing an apparent association between the two. This complements other research which
has found that substance misuse might represent a way of blocking negative thoughts and feelings (Laurent et al., 1997; Shutte et al., 1998; Blair, 2005). Additionally, it could be hypothesised that substance misuse may increase schema avoidance by activating schemas, thereby creating further need for schema avoidance. An example of this is that someone with the defectiveness schema might view their substance misuse as evidence of their defectiveness, activating this schema, and leading to greater schema avoidance. The finding that schema avoidance might be related to substance misuse potentially lends support to schema theory.

1.5 Relationship Between Schema Avoidance and Anxiety and Depression

An assumption of schema theory is that schemas are associated with psychological distress (Young ad Klosko, 1994; Young et al., 2003). Studies by Nordahl et al. (2005) and Rijkeboer et al. (2004) supported this, by showing relationships between higher levels of schemas and higher scores on measures of distress. In this study, it was hypothesised that schema avoidance would be related to anxiety and depression.

This study suggested that schema avoidance might be related to anxiety for both the clinical and control groups. This implies that the relationship between schema avoidance and anxiety could apply to the general population. Therefore, schema avoidance and its interaction with anxiety could be universal, with the difference between clinical and non-clinical populations relating to severity.

The purported relationship between anxiety and schema avoidance is unsurprising, as anxiety and avoidance are generally related (Anthony & Rowa, 2005). In the CBT model of anxiety (Wells, 2005), there is a two-way relationship between anxiety and avoidance, in which anxiety and related fears lead to avoidance, and avoidance maintains anxiety by preventing disconfirmation of
specific fears. It is hypothesised that the relationship between anxiety level and schema avoidance could be explained in a similar manner to the CBT model of anxiety (Wells, 2005). It is hypothesised that there might be a two-way relationship between anxiety and schema avoidance, in which schema-related anxiety leads to schema avoidance as a way of coping, and schema avoidance maintains anxiety by not allowing the schemas' veracity to be tested.

Although levels of depression and schema avoidance were initially found to be related, when levels of anxiety were controlled for, depression level was not related to schema avoidance. It seems that the apparent relationship between depression and schema avoidance could be accounted for by the high correlation between levels of depression and anxiety, where anxiety was primarily responsible for the relationship with schema avoidance. It is hypothesised that depression is not linked to schema avoidance because it is more associated with schema surrender, where the person accepts their negative schema. This is because if a person surrenders to their negative schema, for example, the defectiveness schema, this might lead to hopelessness and depression. This hypothesis requires further research.

1.6 The YRAI Might Measure Different Types of Schema Avoidance

Luck et al. (2006) found that the YRAI had two factors: behavioural/somatic and emotional/cognitive. It was hypothesised that this factor structure would be replicated in this study. However, this study yielded a different factor solution with six factors, in comparison to Luck et al.'s (2006) two. This undermines the YRAI's (Young & Rygh, 1994) validity and suggests that a factor structure cannot be confidently used to interpret its results.

As with the Luck et al. (2006) study, the factor analysis in the current study suggested that the YRAI might measure different types of schema avoidance.
Brotchie et al. (2006) did not factor analyse the YRAI, but they hypothesised that it measures secondary avoidance of affect (blocking affect after it has been triggered). They did not believe that it measured primary avoidance (stopping affect from being triggered to begin with). Contrary to Brotchie et al.'s (2006) hypothesis, the factor analysis in this study suggested that the YRAI might measure both primary and secondary avoidance, as they defined it. The factors 'Not acknowledging difficult feelings', 'Avoiding upsetting thoughts/somatising' and 'Trying to remain emotionally neutral' could be examples of primary avoidance. The factors 'Social withdrawal', 'Distraction' and 'Numbing painful feelings' could be examples of secondary avoidance. This suggests that the YRAI has wider scope than Brotchie et al. (2006) hypothesised.

Other categories of avoidance have been suggested, for example, emotional avoidance, which involves avoiding emotions (Feldner et al., 2002); cognitive avoidance, which relates to blocking thoughts (Lavy & Van Den Hout, 2006); and behavioural avoidance, which consists of behavioural activities aimed at avoiding emotional pain (Waddell et al., 1993). The current factor structure found for the YRAI (Young & Rygh, 1994) seems to fit these, which lends some validity to the factors found. The factors 'Not acknowledging difficult feelings' and 'Trying to remain emotionally neutral' could represent emotional avoidance; 'Avoiding upsetting thoughts/somatising' could represent cognitive avoidance; and 'Social withdrawal', 'Numbing painful feelings', and 'Distraction' could represent behavioural avoidance (Waddell et al., 1993).

1.7 Problems with the Validity of The YRAI

This study revealed difficulties with the YRAI (Young & Rygh, 1994) which could affect its validity. Sixteen out of 40 items had to be excluded to conduct the factor analysis, which might suggest difficulties with the YRAI's factor structure. Furthermore, the following three items did not load onto any factor, which might
undermine their presence in the inventory. The item 'I take naps or sleep a lot during the day' was not closely related to any of the YRAI factors found, and could be related instead to other factors, such as depression (Breslau et al., 1996), lifestyle, and the effects of substances (Stark & Payne-James, 2003). The item 'Often I don't feel anything, even when the situation seems to warrant strong emotions' probably requires some objectivity, because to agree the respondent needs to be aware that although they do not feel much about a certain situation, most other people would. This might have led to unusual responding on this item, due to some inaccurate responses. The item 'I get physically ill when things aren't going well for me' also requires some self-awareness because to agree the participant would need to link two separate past events – being ill and things going badly. Again, this might have led to some inaccurate responses. The validity of the YRAI might be improved if these items were removed.

Another difficulty with the validity of the YRAI (Young & Rygh, 1994) is that there is no official scoring method. As it was initially devised for clinical use, Young (2003) recommended that any item receiving a response of 5 or 6 should be explored with the client. This is not appropriate for quantitative research, so in this study an overall score was achieved by summing each item score. It is possible that there other ways to score the YRAI (Young & Rygh, 1994), and that the validity of the scoring method used in this study could be questioned. This potentially undermines the utility of this measure as a research tool.

There were also difficulties with the self-report nature of the YRAI (Young & Rygh, 1994), which could affect validity. Firstly, a self-report format assumes literacy skills. This was addressed in this study by the researcher reading the YRAI to some participants, however this might have increased socially desirable responding. Secondly, self-report assumes that peoples' responses and behaviours are transparent to them (Barker et al., 1994). However, this could be questioned, particularly when measuring avoidance, as the nature of avoidance
may mean that there is reduced awareness of what is avoided. Despite this, there are some advantages to self-report methodology, especially the reduced amount of time the researcher needs to spend with each participant and the reduction in socially desirable responses compared to interview methods.

Another validity issue for the YRAI (Young & Rygh, 1994) is how much it measures schema avoidance specifically, as opposed to avoidance in general. Further research is needed to investigate this, for example by studying the relationship between levels of schemas and levels of schema avoidance as measured by the YRAI, and convergent and divergent validity of the YRAI with measures of general avoidance.

2. Implications for Clinical Practice

2.1 Use of the YRAI

In addition to the above issues regarding the validity of the YRAI (Young & Rygh, 1994), the study revealed some difficulties for participants in understanding YRAI items (Young & Rygh, 1994). Clinicians need to be aware of this, and the possible need to provide help. Difficulty in understanding YRAI items was usually due to items containing double negatives, more than one proposition, relatively complex language, or the word 'withdrawing', which has a double meaning for people misusing substances. It is acknowledged that these difficulties may have been exacerbated for the clinical group studied, due to their low overall academic level. However, the difficulties for participants in understanding the YRAI (Young & Rygh, 1994) and the problems with its validity, suggest that caution needs to be exercised when using it and interpreting the results.

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5 The results and implications of this study will be disseminated (Appendix 20).
2.2 Schema Therapy for People Misusing Substances

This study suggests that it is possible that therapeutic work focusing on schema avoidance could potentially be helpful for substance misuse. Additionally, as the present study indicated that anxiety might be associated with schema avoidance, the presence of high anxiety could indicate a particular need to assess schema avoidance in this client group, and possible therapeutic work around this. The suggested way of conceptualising the relationship between anxiety level and schema avoidance could facilitate formulation of individual clients' difficulties, and indicate suitable interventions. This does not necessarily imply that people with low anxiety could not benefit from schema therapy.

2.3 Other Therapies for Substance Misuse

The finding that schema avoidance might be related to substance misuse also potentially provides support for the theory behind interventions predicated on the idea that substance misuse is related to avoidance in general. DBT, for example, assumes that people may misuse substances to avoid difficult feelings (Linehan et al., 2002). CBT (Beck et al., 1993) also assumes that substances may be used to block out thoughts or feelings. Very little research has tested whether there is a relationship between avoidance and substance misuse. This study therefore potentially provides support for the theory behind such therapies.

2.4 Low Educational Levels of People Using Substance Misuse Services

This study highlighted the relatively low educational levels and English literacy of people using substance misuse services. Davis et al. (1993) similarly found low literacy levels among clients using substance misuse services. They also found that the written materials provided by the service their participants attended required a literacy level well above that of the clients. It might be helpful for
professionals to be aware of the likelihood of low educational and literacy levels and to consider the language and construction of written materials, or whether there are alternative methods to convey the information.

3. Evaluation of Study

3.1 Strengths

One strength of this study was that it was related to previous research and aimed to extend it to contribute to psychological knowledge in the fields of schema theory and substance misuse. The use of a control group enabled comparisons with the general population, which had not previously been done. Also, the inclusion of stimulant users extended previous research, of which little was conducted with stimulant users. Furthermore, a service user representative provided feedback during the development phase of the study on procedure, information sheets and questionnaires. This led to changes, which probably improved the clarity and appropriateness of the written information.

Another strength of the study was that the overall sample was relatively large given the time-scale. This was partly because the proportion of potential participants agreeing to participate was relatively high. This enabled the results to be meaningful because they were potentially more representative of the population and most analyses had sufficient power to detect effects (Field, 2005).

A further strength of the study was the use of the HADS (Milne, 1992) to measure levels of anxiety and depression. As stated earlier, this is particularly helpful to use with the substance misusing population as it is designed to measure anxiety and depression without confounding by physical symptoms (Milne, 1992), which people misusing substances are more likely to have because of their substance use (Johnston et al., 2000). In addition, it is widely
used and has good validity and reliability (Milne, 1992; Johnston et al., 2000; Bjelland et al., 2002).

A final strength of the study is that the results make a contribution to psychological theory and practice in the fields of schema theory and substance misuse. In particular, the possible relationship between anxiety and schema avoidance has helped to develop hypotheses about the relationship between ways of responding to schemas and psychological symptoms. Furthermore, the study suggests that there is potential for therapy focusing on schema avoidance to be helpful for substance misuse. The findings were strengthened by the inclusion of potentially confounding variables in the analyses, which enabled clearer interpretation of the results.

3.2 Limitations

This study had several limitations. The most significant were the limitations of the YRAI (Young & Rygh, 1994) as a research tool, which mainly related to its questionable reliability and validity. In particular, the concept it purports to measure, namely schema avoidance, is a hypothetical construct which itself lacks empirical validation. The validity of the YRAI depends upon the validity of the schema avoidance concept, which is currently uncertain. Furthermore, the face validity of the YRAI is debatable. Firstly, as mentioned above, it is possible that it measures general avoidance rather than schema avoidance specifically. Secondly, particular items may not reliably measure schema avoidance, for example, the items relating to somatic symptoms may measure physical illness unrelated to schema avoidance. A further limitation of the use of the YRAI in research is the lack of statistical norms and few reliability and validity studies. This limits the current utility of the measure for research, because its quality is unknown. Further, as mentioned above, there are several other limitations of the YRAI, for example, poor item construction leading to completion difficulties,
which further undermine the validity and utility of this measure in research. Specific to this study, the items, ‘I drink alcohol to calm myself’, and, ‘I use drugs to feel better’, should have been removed as they probably disproportionately increased the YRAI scores of the clinical group.

There were other limitations relating to the use of questionnaires. In general, using questionnaires means that it is potentially difficult to detect whether a participant misunderstood a question or is answering in a socially acceptable manner. Specifically, it is acknowledged that the HADS (Milne, 1992) is not diagnostic and measures levels of depression and anxiety rather than specifying diagnosis. However, it was used because it had other advantages, as mentioned above. Additionally, it was not possible to pilot the demographic questionnaire due to lack of time. This meant that some minor difficulties were not addressed. One issue was that some participants did not understand the word ‘ethnicity’, which might have been resolved by providing examples of responses.

Another limitation related to the sampling of the clinical group. Firstly, the stimulant group had 12 fewer participants than the number suggested by the power calculation. This was because there were less stimulant users, in comparison to those using other substances, accessing services, and therefore fewer potential participants to approach. Additionally, although this was not recorded, they appeared less likely to participate. Having insufficient participants for this group adversely affected statistical power for comparisons involving this group, increasing the probability of failing to detect an effect when one existed (Type II error; Field, 2005). This meant that the non-significant results for analyses involving this group had to be viewed cautiously. This might suggest that future research with stimulant users should incorporate the potentially lower numbers of participants into the study design and time-scale. Secondly, there were not enough participants for the comparisons of amount used with schema avoidance, mostly because participants from detoxification were excluded due to
their zero responses. This could be improved by asking people in detoxification to state their levels of substance use prior to admission (and in-community prior to any community detoxification). Thirdly, 202 participants is not many for a factor analysis. Comrey and Lee (1992) stated that 300 participants is good and 100 is poor. Therefore, 202 is on the lower range of what is acceptable for a factor analysis, which might affect its validity. Fourthly, the responses of people misusing substances that did not participate in the study or did not attend services at all might have been different to those who did. Recruiting participants not attending services is a common problem in research. Future studies could investigate these more difficult to engage populations, possibly by enlisting the help of some service users and using snowballing techniques to access people who might not otherwise take part or do not use services.

There were also some limitations related to the sampling of the control group. Firstly, the email snowballing method used to recruit them might have introduced a sampling bias, as certain groups may have been over or under represented, for example, it excluded people not using the internet (Sternberg, 1994). An attempt was made to monitor sampling biases and differences between the clinical and control groups by collecting some demographic data. Another method of recruiting control group participants would be through local facilities or organisations. Secondly, although the email sent to potential control group participants requested that only those over 17 and living in the UK take part, this was not monitored. This could have been achieved by adding questions about age and country of residence.

One methodological limitation of the study was that clinical group participants were recruited at different stages of treatment. The treatment they were receiving may have influenced schema avoidance. Ideally, all participants would have been recruited when entering treatment. Due to time limitations of this study, it was not possible to do this.
Another limitation related to how participants were classified into primary substance groups. Firstly, many people attending substance misuse services use more than one substance (for example, see Hopfer et al., 2002). Excluding these would have made it unlikely that enough participants would be recruited to have sufficient power to detect effects (Field, 2005). Additionally, this could have reduced generalisability as many substance users use multiple substances, so to exclude them would have meant that the participants did not represent clients that present to services clinically. Therefore, for the purposes of this study, participants were asked to identify the primary substance they used. Secondly, this study determined primary substance by participant self-report, which was a method used by Conway et al. (2002). However, other studies have categorised people into primary substance groups by diagnosis (Conway et al., 2002), or most 'serious substance of dependence' ever used, as judged by the researchers (Conway et al., 2003). For this study, it was felt appropriate for participants to choose their primary substance rather than the researcher.

A further limitation was that schema levels were not measured in the study. This was partly due to the theoretical assumption that schemas and schema avoidance would be related and partly due to the prohibitive amount of time that would be required of each participant to complete the YSQ (Young, 1990) in addition to the other questionnaires.

Another limitation is that lack of translated material, which led to the exclusion of non-English speakers, was not satisfactory, as it prevented people from participating and reduced the generalisability of the findings. However, before translated versions of the questionnaires could be used confidently, it would be necessary to ascertain whether the different versions were comparable, and some work needs to be done in this area.
A final limitation is that this study has not examined all factors that may contribute to substance misuse or schema avoidance. Other factors have been found to be associated with substance misuse, for example, socio-economic status (Koppel & McGuffin, 1999), work-place drinking cultures (Ames & Rehhun, 1996) and trauma (Brabant et al., 1997). Other factors that might influence schema avoidance are psychological difficulties, levels of schemas, and the use of other ways of coping with schemas, such as schema surrender or schema compensation.

4. Further Work

4.1 YRAI

This study raised questions about the validity and construction of the YRAI (Young & Rygh, 1994), especially in the light of conflicting factor analyses. Little previous work has been conducted on the reliability and validity of the YRAI, and this needs to be carried out. Further studies could help to improve the YRAI (Young & Rygh, 1994) by identifying the most relevant items, clarifying the factors and perhaps comparing versions with different language and construction. It might also be useful to identify an appropriate cut-off for clinical significance, in order to help assess the clinical significance of research findings.

4.2 Schema Theory and Substance Misuse

This study suggested that people using substance misuse services might have greater schema avoidance than the general population. It could be helpful to further explore the role of schema processes in substance misuse. People using substance misuse services and the general population could be compared on the other schema processes of schema surrender and schema compensation.
This study provided some evidence that stimulant users might have lower schema avoidance and anxiety levels than alcohol and opiate users. Not much research has been conducted with stimulant users. Taking account of the difficulties in recruiting stimulant users in this study, it could be helpful to conduct exploratory research into reasons for using stimulants, perhaps through qualitative interviewing, which requires far fewer participants (Marshall, 1996).

Another possible piece of research would be to replicate the current study but recruiting all participants at the beginning of treatment. Finally, there are other factors that may influence substance misuse and schema avoidance, and it might be productive to explore these, for example, childhood trauma.

4.3 Schema Theory

Schema theory is relatively new. It continues to be developed and there is limited research in this area. This study did not explore whether schemas and schema avoidance are related and no other study was found that did this. Therefore, this needs to be done. Research linking schema content to ways of coping with schemas, such as schema avoidance, schema surrender, and schema compensation would provide further support for schema theory. Also, this study suggested a relationship between schema avoidance and anxiety, which led to a hypothesis that there might be a link between depression and schema surrender. This hypothesis remains to be tested. At a clinical level, this could help to make clearer hypotheses based on schema theory. Finally, more outcome studies of schema therapy are required to evaluate its effectiveness with different populations.
5. Conclusions

This study found that, as suggested by schema theory, substance misuse could potentially be related to schema avoidance. It is possible that clinical work focusing on schema avoidance, and the underlying schemas driving it, could be helpful in substance misuse services. However, the concept of schema avoidance (and its measurement using the YRAI) remains hypothetical and requires empirical validation. As there is currently little research on schema theory and therapy, much more is needed, including testing of the main assumptions of the theory, outcome studies, and evidence relating to which populations are most likely to benefit.
REFERENCES


versus non-clinical population. *Journal of Behaviour Therapy and Experiemental Psychiatry* 36 (2), 129-144.


APPENDIX 1

EFFECTIVENESS OF PSYCHOLOGICAL INTERVENTIONS FOR SUBSTANCE MISUSE
<table>
<thead>
<tr>
<th>AUTHOR</th>
<th>INTERVENTION</th>
<th>POPULATION</th>
<th>DESIGN</th>
<th>OUTCOME</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ana et al. (2007)</td>
<td>Group Motivational Interviewing or Therapist Activity Attention Control Intervention</td>
<td>Psychiatric inpatients misusing substances (n=101)</td>
<td>Randomised Controlled Trial. Measure: number of days of use on the previous month</td>
<td>Days of use were lower at 1-month follow up for group motivational interviewing than control group for both alcohol (d=0.70) and drugs (d=0.81)</td>
</tr>
<tr>
<td>Burke et al. (2003)</td>
<td>Motivational Interviewing</td>
<td>Substance misuse, eating disorders, risk-taking behaviours (30 studies, total n=5611)</td>
<td>Meta-analysis</td>
<td>Improvement from Intake to post-treatment (d=0.82). Improvement from intake to 67 weeks follow up (d=0.11).</td>
</tr>
<tr>
<td>Carter and Tiffany (1999)</td>
<td>Cue Exposure</td>
<td>People misusing substances (41 studies)</td>
<td>Meta-analysis</td>
<td>Cravings reduced across all substances (d=0.92), although people misusing alcohol benefited less (d=0.53)</td>
</tr>
<tr>
<td>Crits-Cristoph et al. (1999)</td>
<td>Group drug counselling alone or group drug counselling plus one of the following: twelve-step drug counselling, cognitive therapy, or supportive-expressive therapy.</td>
<td>People misusing cocaine (n=487)</td>
<td>Randomised Controlled Trial. Measure: Drug Use Composite Score from the Addiction Severity Index (McLellan et al., 1992)</td>
<td>Days of use were lower for all treatments from intake to 12 months post-intake (d=0.98).</td>
</tr>
<tr>
<td>Fals-Stewart et al. (2006)</td>
<td>Individual 12-Step Counselling alone or Individual 12-Step Counselling plus one of the following: Behavioural Couples Therapy or Psycho-education for couples</td>
<td>Heterosexual couples where the female was entering treatment for alcohol misuse (n=138)</td>
<td>Randomised Controlled Trial. Measures: percentage of days abstinent, The Drinker Inventory of Consequence (Miller et al., 1995)</td>
<td>There was an increase in the number of days abstinent from intake to 12-months post-treatment for those receiving Individual 12-step plus Behavioural Couples Therapy (d=1.084), Individual 12-Step Counselling alone (d=0.703) and Individual 12-Step Counselling plus Psycho-education for couples (d=0.714)</td>
</tr>
<tr>
<td>Authors</td>
<td>Methodology</td>
<td>Population</td>
<td>Measures</td>
<td>Findings</td>
</tr>
<tr>
<td>------------------</td>
<td>------------------------------------------------------------------------------</td>
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</tr>
<tr>
<td>Gossop et al. (2003)</td>
<td>Twelve-Step Approach as an Adjunct to Inpatient Treatment</td>
<td>People misusing alcohol (n=150)</td>
<td>Longitudinal outcome study Measure: Frequency and quantity of drinking over the previous month.</td>
<td>Greater reductions in quantity of drinking for those regularly attending twelve-step groups than those not attending or attending sporadically (d=1.05).</td>
</tr>
<tr>
<td>Higgins et al. (2003)</td>
<td>Contingency Management or non-contingent rewards</td>
<td>Outpatients misusing cocaine (n=100)</td>
<td>Randomised Controlled Trial Measures: urinalysis and alcohol breath test.</td>
<td>Those receiving contingency management produced more negative urinalyses than those receiving non-contingent rewards (d=0.59).</td>
</tr>
<tr>
<td>Irvin et al. (1999)</td>
<td>Relapse Prevention</td>
<td>People misusing substances (26 studies total n=9504)</td>
<td>Meta-analysis</td>
<td>There was improvement from intake to post-treatment (r=0.14). Improvement when using medication in conjunction with relapse prevention was greater (r=0.48) than without (r=0.09).</td>
</tr>
<tr>
<td>Petry et al. (2007)</td>
<td>Group Psycho-education and Relapse Prevention alone or with Contingency Management</td>
<td>People misusing cocaine (n=393)</td>
<td>Randomised Controlled Trial Measure: urinalysis</td>
<td>Number of weeks of abstinence achieved during treatment was greater for those who received contingency management than those who did not (d=0.613).</td>
</tr>
<tr>
<td>Pollack et al. (2002)</td>
<td>Cognitive Behavioural Therapy or Counselling</td>
<td>People misusing opiates who have not responded to other interventions (n=23)</td>
<td>Randomised Controlled Trial Measure: urinalysis.</td>
<td>More drug-free urine screens were produced by women receiving cognitive behaviour therapy than counselling (d=0.61). More drug-free urine screens were produced by men receiving counselling than cognitive behaviour therapy (d=0.77).</td>
</tr>
<tr>
<td>Study</td>
<td>Intervention</td>
<td>Participants</td>
<td>Randomised Controlled Trial</td>
<td>Measures</td>
</tr>
<tr>
<td>------------------------------</td>
<td>------------------------------------------------------------------------------</td>
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<tr>
<td>Silverman et al (1998)</td>
<td>Methadone and counselling plus one of the following: Escalating Reinforcement or Escalating Reinforcement with Bonuses for abstinence initiation, or Non-contingent Reinforcement</td>
<td>People in methadone maintenance treatment (n=59)</td>
<td>Randomised Controlled Trial</td>
<td>Measure: Urinalysis</td>
</tr>
<tr>
<td>Sitharthan et al. (1997)</td>
<td>Cue Exposure or Cognitive Behavioural Therapy</td>
<td>People misusing alcohol who want to reduce their drinking rather than achieve abstinence (n=42)</td>
<td>Randomised Controlled Trial</td>
<td>Measures: Problem Drinking Questionnaire (Kavanagh et al., 1996)</td>
</tr>
<tr>
<td>Walitzer and Dermen (2004)</td>
<td>Behavioural Couples Therapy or Partner Involvement focusing on alcohol use or Individual Drug Counselling</td>
<td>Males misusing alcohol and their partners (n=64)</td>
<td>Randomised Controlled Trial</td>
<td>Measures: Amount of alcohol per day in the previous month, The Drinker Inventory of Consequence (Miller et al., 1995)</td>
</tr>
<tr>
<td>Winters et al. (2002)</td>
<td>Individual Cognitive Behavioural Therapy alone or Individual Cognitive Behavioural Therapy plus Couples Behavioural Therapy</td>
<td>Heterosexual couples in which the female partner was entering substance misuse treatment (n=75)</td>
<td>Randomised Controlled Trial Measures: urinalyses, percentage of days abstinent in the previous month, Addiction Severity Index (McLellan et al, 1980)</td>
<td>Percentage of days abstinent in the previous month increased from intake to 12-months post-treatment for the Individual Cognitive Behavioural Therapy group (d=0.743) and the Individual Cognitive Therapy plus Couples Behavioural Therapy group (d=1.241).</td>
</tr>
</tbody>
</table>
APPENDIX 2

CONTROL GROUP DEMOGRAPHIC QUESTIONNAIRE
Information About You

This information is essential to the research. It will be kept confidentially and only the researcher will see it.

1. Are you: Male_______ Female_______ Other_______ (please tick)

2. How old are you?_______

3. What is the highest level educational qualification you have? E.g. GCSE, degree, none.

4. How would you describe your ethnicity?

5. What, if any, do you see as the main substance you use (including alcohol)?

6. How often do you use this substance? (please tick)
   Never_______
   Monthly or less_______
   2-4 times a month_______
   2-3 times a week_______
   4 or more times a week_______

7. How much of this substance do you have in a typical week?

8. Do you take any other substances, including prescribed substances? (please tick)
   Yes_______ No_______ Sometimes_______

9. If yes, what other substances do you use? Please write beside each substance how much you currently use per week.

<table>
<thead>
<tr>
<th>OTHER SUBSTANCES USED</th>
<th>AMOUNT PER WEEK</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

10. Do you attend a service for help with substance problems? (please tick)
   Yes_______ No_______
APPENDIX 3

YOUNG-RYGH AVOIDANCE INVENTORY
INSTRUCTIONS: Listed below are statements that a person might use to describe himself or herself. Please read each statement and decide how well it describes you. Then choose the highest rating from 1 to 6 that best describes you and write the number in the space before the statement.

RATING SCALE:
Completely untrue of me = 1
Mostly untrue of me = 2
Slightly more true than untrue = 3
Moderately true of me = 4
Mostly true of me = 5
Describes me perfectly = 6

EXAMPLE:
A. 4 I try not think about things that bother me.

1. _____ I try not to think about things that upset me.
2. _____ I drink alcohol to calm myself.
3. _____ I am happy most of the time.
4. _____ I rarely feel sad or blue.
5. _____ I value reason over emotions.
6. _____ I believe that I should not get angry, even at people I don’t like.
7. _____ I use drugs to feel better.
8. _____ I don’t feel much when I remember my childhood.
9. _____ I smoke when I’m upset.
10. _____ I suffer from gastrointestinal problems (e.g. indigestion, ulcers, colitis).
11. _____ I feel numb.
12. _____ I often get headaches.
13. _____ I withdraw when I’m angry.
14. _____ I don’t have as much energy as most people my age.
15. ______ I suffer from muscular aches and pains.
16. ______ I watch a lot of TV when I'm alone.
17. ______ I believe that one should use reason to keep emotions under control.
18. ______ I cannot intensely dislike anyone.
19. ______ My philosophy when something goes wrong is to put it behind me as soon as possible and move on.
20. ______ I withdraw from people when I feel hurt.
21. ______ I don't remember much about my childhood years.
22. ______ I take naps or sleep a lot during the day.
23. ______ I am happiest when I'm roaming or traveling around.
24. ______ Sticking to the task at hand keeps me from feeling upset.
25. ______ I spend a lot of time daydreaming.
26. ______ When I'm upset, I eat to feel better.
27. ______ I try not to think about painful memories from my past.
28. ______ I feel better if I keep myself constantly busy, not leaving much time to think.
29. ______ I had a very happy childhood.
30. ______ I withdraw when I'm sad.
31. ______ People say I'm like an ostrich with my head in the sand. (In other words, I tend to ignore unpleasant thoughts)
32. ______ I tend not to think about losses and disappointments.
33. ______ Often I don't feel anything, even when the situation seems to warrant strong emotions.
34. ______ I was fortunate to have such good parents.
35. ______ I try to stay emotionally neutral most of the time.
36. ______ I find myself buying things that I don't need, to improve my mood.
37. ______ I try not to put myself in situations that are difficult or make me uncomfortable.
38. ______ I get physically ill when things aren't going well for me.
39. ______ When people have left me or died, I didn't feel too upset.
40. ______ What others think of me does not bother me.
APPENDIX 4

HOSPITAL ANXIETY AND DEPRESSION SCALE
Doctors are aware that emotions play an important part in most illnesses. If your doctor knows about these feelings he will be able to help you more.

This questionnaire is designed to help your doctor to know how you feel. Read each item and place a firm tick in the box opposite the reply which comes closest to how you have been feeling in the past week.

Don’t take too long over your replies; your immediate reaction to each item will probably be more accurate than a long thought-out response.

**Tick one box only in each section**

<table>
<thead>
<tr>
<th>Item</th>
<th>Description</th>
<th>Options</th>
<th>Ticks</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>I feel tense or ‘wound up’:</td>
<td>Most of the time</td>
<td>Not at all</td>
</tr>
<tr>
<td>2</td>
<td>I don’t enjoy the things I used to enjoy:</td>
<td>Definitely as much</td>
<td>Hardly at all</td>
</tr>
<tr>
<td>3</td>
<td>I get a sort of frightened feeling as if something awful is about to happen:</td>
<td>Very definitely and quite badly</td>
<td>Not at all</td>
</tr>
<tr>
<td>4</td>
<td>I can laugh and see the funny side of things:</td>
<td>As much as I always could</td>
<td>Not at all</td>
</tr>
<tr>
<td>5</td>
<td>Worrying thoughts go through my mind:</td>
<td>A great deal of the time</td>
<td>Only occasionally</td>
</tr>
<tr>
<td>6</td>
<td>I feel cheerful:</td>
<td>Not at all</td>
<td>Most of the time</td>
</tr>
<tr>
<td>7</td>
<td>I can sit at ease and feel relaxed:</td>
<td>Definitely</td>
<td>Not at all</td>
</tr>
<tr>
<td>8</td>
<td>I feel as if I am slowed down:</td>
<td>Nearly all the time</td>
<td>Not at all</td>
</tr>
<tr>
<td>9</td>
<td>I get a sort of frightened feeling like ‘butterflies’ in the stomach:</td>
<td>Not at all</td>
<td>Occasionally</td>
</tr>
<tr>
<td>10</td>
<td>I have lost interest in my appearance:</td>
<td>Definitely</td>
<td>Not at all</td>
</tr>
<tr>
<td>11</td>
<td>I feel restless as if I have to be on the move:</td>
<td>Very much indeed</td>
<td>Not very much</td>
</tr>
<tr>
<td>12</td>
<td>I look forward with enjoyment to things:</td>
<td>As much as I ever did</td>
<td>Only occasionally</td>
</tr>
<tr>
<td>13</td>
<td>I get sudden feelings of panic:</td>
<td>Very often indeed</td>
<td>Not at all</td>
</tr>
<tr>
<td>14</td>
<td>I can enjoy a good book or radio or TV programme:</td>
<td>Often</td>
<td>Very seldom</td>
</tr>
</tbody>
</table>
APPENDIX 5

CLINICAL GROUP DEMOGRAPHIC QUESTIONNAIRE
Information About You

This information is essential to the research. It will be kept confidentially and only the researcher will see it.

11. Are you: Male_______ Female_______ Other_______ (please tick)

12. How old are you?_______

13. What is the highest level educational qualification you have? E.g. GCSE, degree, none.

14. How would you describe your ethnicity?

15. What do you see as your main substance?

16. How often do you use this substance now? (please tick)
   Never_______
   Monthly or less_______
   2-4 times a month_______
   2-3 times a week_______
   4 or more times a week_______

17. If applicable, how much of this substance do you have in a typical week when using?

18. Do you use any other substances, including prescribed substances, e.g. methadone, benzodiazapines? (please tick) Yes_______ No_______ Sometimes_______

19. If yes, what other substances do you use? Please write beside each substance how much you currently use per week.

<table>
<thead>
<tr>
<th>OTHER SUBSTANCES USED</th>
<th>AMOUNT PER WEEK</th>
</tr>
</thead>
</table>
APPENDIX 6

CONTRACT BETWEEN THE RESEARCHER, FIELD SUPERVISOR AND UNIVERSITY SUPERVISOR
MAJOR RESEARCH PROJECT:
CONTRACT BETWEEN TRAINEE, UNIVERSITY RESEARCH SUPERVISOR AND FIELD SUPERVISOR

This contract is to be completed at a meeting between the trainee and their supervisor(s) which should be held as soon as is practicable after the project has been approved. All parties should retain a copy of this contract. A copy should also be sent to the trainee's research tutor, who should be notified of any changes. This contract can be renegotiated at any point with the agreement of all parties.

This contract covers the responsibilities of the trainee and the university research and field supervisors (where applicable). It also includes a projected timetable for the completion of the research project and any subsequent submission for publication, as well as agreement about authorship/ownership of the research.

Generating the research proposal

*Traine*ee
- Will prepare initial research proposal
- Will respond to changes requested.

*Academic supervisor*
- Will read through a draft of the initial proposal and give feedback

Obtaining ethical and research governance approval

*Traine*ee
- Will prepare LREC/MREC proposal

*Academic supervisor*
- Will advise in the preparation of the LREC/MREC proposal and read through one draft

*Field supervisor*
- Will support trainee with NHS Trust R&D procedures

Obtaining access to participants

*Traine*ee
- Will liaise with field supervisor

*Field supervisor*
- Will meet with trainee to arrange access to participants

Collecting and interpreting data

*Traine*ee
- Will collect data as agreed in research proposal under direction of supervisors
Academic supervisor
☐ Will meet trainee at regular and appropriate intervals to gauge process of work (Please specify whether fortnightly/monthly/as required).

Field supervisor
☐ Will oversee data collection
☐ Will remind trainee of the responsibility to carry out research in an ethical manner and to protect the anonymity, confidentiality and integrity of collected data.
☐ Will meet trainee regularly to gauge progress of work. (Please specify whether fortnightly/monthly/as required).

Analysing data

Trainee
☐ Will undertake data analysis

Academic supervisor
☐ Will oversee data analysis
☐ Will meet trainee regularly to check on progress

Writing the thesis

Trainee
☐ Will prepare one draft of the complete thesis within the agreed period
☐ Will revise the thesis under the direction of the academic supervisor

Academic supervisor
☐ Will meet trainee regularly to assess progress of work
☐ Will read through one draft of the complete thesis and give feedback in written form

Field supervisor
☐ Will meet with trainee to discuss final draft of thesis

Submission for publication and authorship

This part of the contract concerns the preliminary expectations of all parties regarding the preparation and submission of the thesis for publication, including contingencies if the expectations set out in the contract are not met. This part also covers expectations regarding authorship [e.g. see Game and West (2002) “Principles of Publishing”. The Psychologist, 15 (3), 126-129].

Will the research be submitted for publication  Yes ☐ No ☐

Will a first draft be prepared post-submission/pre viva Yes ☐ No

Target date by which submission will occur 12/1/2023
Where will the data be stored after submission?

UNIVERSITY

Rationale for authorship if target is met.

LEVEL OF INVOLVEMENT

Order of authorship if target is met

1. 

2. 

3. 

4. 

5. 

Action plan if target is not met

SUBMIT LATER.

Rationale for authorship if original target date is not met

AS ABOVE

Order of authorship if original target date is not met

AS ABOVE
<table>
<thead>
<tr>
<th>Trainee</th>
<th>Address &amp; email</th>
<th>Signature</th>
</tr>
</thead>
<tbody>
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<td></td>
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<tr>
<td>University research</td>
<td></td>
<td></td>
</tr>
<tr>
<td>supervisor</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Date:</td>
<td>14.06.07</td>
<td></td>
</tr>
<tr>
<td>Field supervisor:</td>
<td></td>
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<tr>
<td>Date:</td>
<td>15/06/07</td>
<td></td>
</tr>
</tbody>
</table>
APPENDIX 7

APPROVAL FOR PROPOSAL
**MRP Proposal Result Sheet**

<table>
<thead>
<tr>
<th>Trainee Name:</th>
<th>[Redacted]</th>
</tr>
</thead>
<tbody>
<tr>
<td>URN Number:</td>
<td>3535932</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>RESULT</th>
<th>Accepted</th>
</tr>
</thead>
</table>

**Proposal resubmission date:**

**FEEDBACK NOTES:**
APPENDIX 8

REGIONAL ETHICS COMMITTEE APPROVAL
28 August 2007

Trainee Clinical Psychologist
University of Surrey
Guildford
Surrey GU2 7XH

Dear [Name],

Full title of study: The Role of Schema Avoidance in Substance Misuse and Choice of Substance in People using Substance Misuse Services

REC reference number:

Thank you for your letter of 13 August 2007, responding to the Committee's request for further information on the above research and submitting revised documentation.

The further information has been considered on behalf of the Committee by the Joint-Chair.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised.

Ethical review of research sites

The Committee has designated this study as exempt from site-specific assessment (SSA). There is no requirement for other Local Research Ethics Committees to be informed or for site-specific assessment to be carried out at each site.

Conditions of approval

The favourable opinion is given provided that you comply with the conditions set out in the attached document. You are advised to study the conditions carefully.

Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

<table>
<thead>
<tr>
<th>Document</th>
<th>Version</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Application</td>
<td>1</td>
<td>29 June 2007</td>
</tr>
<tr>
<td>Investigator CV</td>
<td></td>
<td>19 June 2007</td>
</tr>
</tbody>
</table>

This Research Ethics Committee is an advisory committee to London Strategic Health Authority. The National Research Ethics Service (NRES) represents the NRES Directorate within...
R&D approval

All researchers and research collaborators who will be participating in the research at NHS sites should apply for R&D approval from the relevant care organisation, if they have not yet done so. R&D approval is required, whether or not the study is exempt from SSA. You should advise researchers and local collaborators accordingly.


Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

Feedback on the application process

Now that you have completed the application process you are invited to give your view of the service you received from the National Research Ethics Service. If you wish to make your views known please use the feedback form available on the NRES website at:

https://www.nresform.org.uk/AppForm/Modules/Feedback/EthicalReview.aspx

We value your views and comments and will use them to inform the operational process and further improve our service.

Please quote this number on all correspondence
With the Committee's best wishes for the success of this project

Yours sincerely

Chair

Email:

Enclosures: Standard approval conditions

Copy to: University of Surrey
         University of Surrey
         R&D
SSI Cover Sheet

This cover sheet is required for projects where resources, staff or patients are being used and submitted with your SSI form. Guidance notes on the completion of this form can be found on the R&D website.

Please complete this form once funding has been agreed and before your research begins.

1. **Investigator:** (as it appears on other documentation eg NRES (COREC) ethics form)

<table>
<thead>
<tr>
<th>Full Name:</th>
</tr>
</thead>
</table>

2. **Project title:** (as it appears on other documentation eg NRES (COREC) ethics form)

| The role of schema avoidance in substance misuse and choice of substance in people using substance misuse services. |

3. **Project type**

<table>
<thead>
<tr>
<th>Type of Project</th>
<th>Tick all that apply</th>
<th>Further Instructions</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) Own account (no formal funding received)</td>
<td></td>
<td>Peer review required see section 6</td>
</tr>
<tr>
<td>b) Externally funded (Non-commercial funding body – e.g. Charity)</td>
<td>✔</td>
<td></td>
</tr>
<tr>
<td>c) Externally funded (Commercial Company)</td>
<td></td>
<td>Please contact the R&amp;D Office to discuss potential NHS Costs &amp; peer review</td>
</tr>
<tr>
<td>d) Student project</td>
<td>✔</td>
<td>Students Name (if not PI above)</td>
</tr>
<tr>
<td>e) Clinical trial (Medicinal or Non-Medicinal)</td>
<td></td>
<td>Please contact the R&amp;D Office for advice at an early stage</td>
</tr>
</tbody>
</table>

4. **Service Directorate involvement & approval**

Please tick all Directorates likely to be involved in the research project. Please send a brief e-mail to each service directorate manager including a short outline of your study. Please attach each service directorate manager’s e-mail response to this cover sheet and submit with your SSI form.

<table>
<thead>
<tr>
<th>Directorate</th>
<th>Tick those that apply</th>
<th>Service Directorate Manager</th>
<th>Service Directorate contact details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Borough</td>
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<td></td>
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<tr>
<td>Child &amp; Adolescent</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Specialist - Addictions</td>
<td>✔</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Specialist - Learning disabilities &amp; National</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
5. Pharmacy Arrangements
If your project involves the dispensing of medication please list which Pharmacy(ies) will be involved in the dispensing. Please send a brief e-mail to each pharmacy including a short outline of your study. Please attach each pharmacy(ies) e-mail response to this cover sheet and submit with your SSI form.

<table>
<thead>
<tr>
<th>Site</th>
<th>Pharmacist Involved</th>
</tr>
</thead>
<tbody>
<tr>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>

6. Peer review (Commercial and own account projects only)
Please propose 3 people who are independent to the project who could review your project. The R&D Office will select one of these. If you are unable to suggest names the R&D office will be able to arrange this for you.

<table>
<thead>
<tr>
<th>Name and full contact address</th>
<th>Involved with the Project</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) N/A</td>
<td>Y / N</td>
</tr>
<tr>
<td>2) N/A</td>
<td>Y / N</td>
</tr>
<tr>
<td>3) N/A</td>
<td>Y / N</td>
</tr>
</tbody>
</table>

Please complete and return this form together with:
1. Evidence of e-mail exchange/s from relevant service directorate managers and pharmacy departments as appropriate.
2. A signed paper original SSI Form, and corresponding completed NRES (COREC) ethics form for sponsor signature if you require to sponsor your research.
3. If the project is own account, commercially sponsored and/or a Clinical Trial we also require a copy of your protocol.

To

Tel: [redacted]

E-mail: [redacted]

Approved 15 Oct 2007

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APPENDIX 10

FACULTY OF ARTS AND HUMAN SCIENCES ETHICS COMMITTEE
APPROVAL
Dr Mark Cropley  
Chair: Faculty of Arts and Human Sciences Ethics Committee  
University of Surrey

Department of Psychology - Clinical Trainee  
University of Surrey

29th October 2007

Dear [Name],

Reference: [Redacted]

Title of Project: The Role of Schema Avoidance in substance Misuse and Choice of Substance in People Attending Substance Misuse Services

Thank you for your submission of the above proposal.

The Faculty of Arts and Human Sciences Ethics Committee has given favourable ethical opinion.

If there are any significant changes to this proposal you may need to consider requesting scrutiny by the Faculty Ethics Committee.

Yours sincerely

[Signature]

Dr Mark Cropley
APPENDIX 11

CONTRACT WITH NHS TRUST WHERE THE RESEARCH TOOK PLACE
14 August 2007

PRIVATE & CONFIDENTIAL

Dear [Name],

I am pleased to inform you on behalf of the [Director/Manager] that your application for an honorary contract with the Trust has been accepted.

Please accept this letter as an honorary contract with the [Department] for the honorary post and duration listed below:

Post Title: Trainee Clinical Psychologist
Start Date: 30th August 2007
End Date: 30th September 2008
Supervisor: Head of Clinical Psychologist (Addition Division)

You are reminded that permission to involve patients in research must be sought on a per research project basis from the individual(s) directly responsible for the patients’ care.

This does not constitute an employment contract and the terms of this honorary contract may be subject to change.

You are required to work in accordance with all Trust clinical, operational and personnel policies and are responsible for ensuring you work to the standards required by the Trust. The [Department] handbook for holders of Honorary Contracts will be available shortly for details of Trust policies, in particular in relation to the nature of your honorary contract. In the mean time Trust policies are available on the Trust Intranet or you can request a hard copy from your supervisor or the Human Resources Department.

The contract will last for the tenure of your substantive employment contract. Should the Trust wish to terminate this honorary contract, you will be given 2 weeks notice. The Trust may, at its discretion require you not to access Trust patients or resources during this notice period or may relieve you of your activities relating to the Trust. If your level of contact with NHS patients changes during this period please notify the Human Resources Department so that your honorary contract can be...
amended appropriately. If your employment with the Trust is terminated, this honorary contract will also be terminated.

Where research is undertaken which involves the use of human research participants, you are required to read and undertake your responsibilities under the Research Governance Framework for Health and Social Care, noting in particular ‘Responsibilities of Researchers’ (para 3.5) and ‘Responsibilities of Principal Investigators’ (para 3.6). The Research Governance Framework Document is available at www.doh.gov.uk/research/rd/nhsrandd/researchgovernance.html or hard copies can be obtained through the Human Resources Department.

You are required to ensure that all work involving the use of human research participants adheres to the 1998 Data Protection Act.

It is our policy that all new staff, including those with Honorary Contracts, attend a health review. Upon your start date please can you contact our Occupational Health Department by telephoning either [redacted] or [redacted] to make an appointment at whichever O H Department is most convenient for you.

Please confirm that you accept this offer by signing and returning one copy of this letter to the address above.

Yours sincerely

Human Resources Department

Enc.

I hereby accept, on the conditions specified, the terms of your letter dated 14 August 2007.

Signed: .................................................. Date: ............................................
«FirstName» «LastName»
APPENDIX 12

PRESENTATION MADE TO STAFF TEAMS TO INTRODUCE THE STUDY
Schemata

Schemata of negative schemata and/or replace them with more helpful
Young (1994) - Schemata focused therapy helps to reduce the impact
using substances (Young, 2003).
Schemata avoidance is when a person finds ways to escape or block
(Younig, 2003).
Unhelpful schemata can help to explain difficulties in a person's life
(Younig, 1994).
Feel, think, act and relate to others (Young, 2003). They affect how people
develop in childhood and can be helpful or unhelpful e.g. I am
relationships, that a person experiences (Young, 1990). They
Schemata are life-long pervasive themes about the self and
Previous Studies

2006: With increasing severity of alcohol misuse (Broatch et al., 2006) - but study had few opiate users (Broatch et al., 2006). People misusing alcohol had more unhappy unhelpful schemas than those who used opiates.

People misusing substances seem to have more heroin was to block out negative mood states. (Bier et al., 2005). Found that the primary reason for use of opiate, 1997; Cooper et al., 1992.

No difference in schema avoidance between alcohol and

previous studies (Catanza and Laurent, 2004; Laurent

Avoidant coping seems to be related to levels of alcohol
Objectives of Study

- To explore whether there is a relationship between schema avoidance and levels of depression and/or anxiety in people misusing substances.

- To examine whether schema avoidance is related to severity of substance misuse across different substances.

- To clarify whether schema avoidance between people misusing substances is a difference in phenomenology.

- To examine whether there is a link between schema avoidance and substance misuse.
H1: Schema avoidance will be higher among people using substance misuse services than those who do not.

H2: People using alcohol will have greater schema avoidance than those using opiates or stimulants.

H3: People using stimulants alone will have lower schema avoidance across substances.

H4: Schema avoidance will increase with severity of substance misuse.

H5: In people with a substance misuse problem schema avoidance will increase with increasing levels of depression and/or anxiety.
misuse services and 45 for the control group.

A power calculation revealed that a total of 180 participants is required - 75 from the substance
or primarily using stimulants,
primarily using alcohol, primarily using opiates,
health trust. The three sub-groups will be people
substance misuse services in a large mental

Participants

- A control group will be made up of people who
do not use substance misuse services.
- A control group will be made up of people who

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Method

There will be regular follow-up visits to the services to collect the questionnaires.

- In order to ensure support for the research a brief description of the project will be given to each team.
- Questionnaires to clients.
- Clients in the waiting rooms and/or posting the questionnaires in each service. Possible methods of recruitment may involve the researcher approaching psychologists in each service. Possible methods of initially with the managers and/or consultant.

The best way to approach participants will be discussed.

- Demographic questionnaire.
- HADS (to measure depression and anxiety).
- Questionnaires - VRAL (to measure schema avoidance).
Ethical Considerations

Participants may find completing the questionnaires upsetting - arrangements made to manage this.

Although I am able to read questionnaires and write responses for participants with literacy difficulties, they cannot be translated due to the nature of the research.

Participants may not directly benefit from taking part in this research - need to be aware of this.

Anonymity of data - will be kept in a locked cabinet in the university.
How Will This Study Help?
APPENDIX 13

STAFF INFORMATION SHEET
RESEARCH ON COPING STRATEGIES AND SUBSTANCE MISUSE

INFORMATION ABOUT THE RESEARCH

Why are we doing this research?
I am a Trainee Clinical Psychologist at the University of Surrey. I am working with the substance misuse service on a piece of research. This research is about how people might use substances to deal with difficult thoughts or feelings. There is not much research about this. The purpose of it is to enable better understanding of substance misuse and what strategies might best help clients.

Who do we need to take part?
We need 135 people who use alcohol, opiates or cocaine (possibly along with other substances) to take part. We are asking people attending different substance misuse services across [REDACTED] if they would like to be involved.

How will people consent?
The researcher will give the potential participants a research pack. This will consist of an information sheet, two consent forms and three questionnaires. If the person wants to take part, they should sign the consent forms to show they have agreed. The participant should keep one consent form and the information sheet, and the other consent form should be handed in with the questionnaires within the next two weeks. If a potential participant has questions, they should be asked to leave their contact details at reception so that I can contact them.

What will they have to do?
The research will involve completing three questionnaires. This will take about 20 minutes in total. After participants have done this, they can give them to me. The questionnaires should be completed and returned within two weeks of the participant receiving them.

Are there any risks of taking part in the research?
We do not think the questionnaires will be upsetting. However, participants will be informed that if they are upset, they can speak to the duty worker, or, if it is less urgent, they could wait until they see their keyworker. If a participant makes
Is the information kept private?

All information will be kept entirely confidential. Participants do not have to put their names on the questionnaires. When we write a report on the research, it will be a summary of all the questionnaires. No-one will know who took part or what they said. After ten years the questionnaires will be shredded.

Who can find out the results of the research?

1. The service will have the opportunity to have a presentation about the outcome of the research.
2. Participants can ask for a summary to be sent to them.

Who has approved the research?

The research has been approved by the

Where can you get more information?

If you want to know more or you have questions at any time during the research, please e-mail me or call

Yours sincerely

Trainee Clinical Psychologist
APPENDIX 14

FLOWCHART OF PROCEDURES
FLOWCHART

Approach by Researcher

Participant Reads Consent Form

Participant Can Ask Researcher Questions

Participant Consents and Signs Form

Participant Completes Questionnaires and Puts them in Sealed Box with Consent Forms

Participant requests Feedback and Provides Contact Details

Participant Does Not Consent

Participant Does Not Request Feedback

End of Involvement

Summary Results Provided in Approximately July 2008.
RESEARCH ON SUBSTANCE MISUSE

INFORMATION ABOUT THE RESEARCH

I am a Trainee Clinical Psychologist at The University of Surrey. I am working with the substance misuse service on a piece of research. I would like to ask you to take part in this research, but before you decide it is important for you to understand why the research is being done and what it will involve. Please take your time to read this sheet. If you need any help understanding this sheet or have any questions, please tell me or leave a message at reception for me to contact you.

Why are we doing this research?

This study is about how people might use substances to deal with difficult thoughts or feelings. The purpose of it is to help people who work in substance misuse to understand it better and know more about what strategies might best help their clients.

Why would we like you to take part?

We need 135 people who use alcohol, opiates or cocaine (possibly along with other substances) to take part. We are asking people attending different substance misuse services across if they would like to be involved.

Do you have to take part?

No, you do not have to take part. It is up to you to decide after reading this sheet and it is completely voluntary. If you want to take part, please sign the attached consent forms to show you have agreed. You can change your mind at any time, without giving a reason. If you do not want to take part it will not affect the service you get here.

What will you have to do?

The research will involve completing three questionnaires. This will take about 20 minutes in total. After you have done this, you can give them to me. The questionnaires have to be completed and returned within the next two weeks.
Are there any risks of taking part in the research?

We do not think the questionnaires will be upsetting. However, if they do upset you, you can ask to speak to the duty worker today, or, if it is less urgent, you could wait until you see your key worker. If you want to complain about how you have been approached or treated during this study, the normal NHS complaints mechanisms are available to you.

Is the information kept private?

All information will be kept entirely confidential. You do not have to put your name on the questionnaire. When we write a report on the research, it will be a summary of all the questionnaires. No-one will know you took part or what you said. After ten years the questionnaires will be shredded.

Are you able to find out the results of the research?

You can get a summary of the results of the research. To do this:
1. You can give me your contact details on a separate sheet of paper.
2. You can watch for posters telling you that the results are available and then collect them from reception.

Who has approved the research?

The research has been approved by:

Where can you Get More Information?

If you want to know more, please give your details to a member of staff, so I can contact you, or speak to me directly when you see me in the waiting rooms or communal areas. If you want advice about whether you should take part, you can speak to the Research and Development Department or the Patient Advisory and Liaison Service. If you are concerned about anything related to the research and feel you cannot talk to me about it, in the first instance please contact my supervisor.

Many thanks for your help in this research.

Trainee Clinical Psychologist
APPENDIX 16

CLINICAL GROUP CONSENT FORM
CONSENT FORM

Title of Project: Coping and Substance Misuse
Name of Researcher: (ANONYMISED)

1. I confirm that I have read and understand the information sheet dated 05.08.07 (version 2) for the above study. I have had the opportunity to consider the information and ask questions.

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

3. I agree to take part in the above study.

Name of participant: Date: Signature:

If you wish to receive a summary of the results of the research please write your email or postal address here.

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________
APPENDIX 17

CONTROL GROUP INFORMATION PROVIDED
I am a Trainee Clinical Psychologist at The University of Surrey. I would like to ask you to take part in a piece of research, but before you decide if it is important for you to understand why the research is being done and what it will involve. Please take your time to read this. If you need any help understanding this or have any questions, please email me at (anonymised).

Why are we doing this research?

This study is about how people might use substances to deal with difficult thoughts or feelings. The purpose of it is to help people who work in substance misuse to understand it better and know more about what strategies might best help their clients.

Why would we like you to take part?

We need 135 people who go to a substance misuse service and 45 people who do not go to a substance misuse service to take part, so that we can compare them. That is why we are asking you to take part.

Do you have to take part?

No, you do not have to take part. It is up to you to decide after reading this and it is completely voluntary. If you want to take part, please continue to the questionnaire. You can change your mind at any time.

What will you have to do?

The research will involve completing a questionnaire. This will take about 20 minutes.

Are there any risks of taking part in the research?

We do not think the questionnaires will be upsetting. However, if they do upset you, I have attached a list of contact numbers where you may be able to gain support. If you want to complain about how you have been approached or treated during this study, please speak to me or my supervisor, (anonymised), on (anonymised).
Is the information kept private?

All information will be kept entirely confidential. You do not have to put your name on the questionnaire. When we write a report on the research, it will be a summary of all the questionnaires. No-one will know you took part or what you said. After ten years all data will be destroyed.

Are you able to find out the results of the research?

You can get a summary of the results of the research. To do this, please email me at (anonymised).

Who has approved the research?

The research has been approved by (anonymised).

Where can you get more information?

If you want to know more, please email me at (anonymised). If you want advice about whether you should take part, you can speak to my supervisor, (anonymised), on (anonymised).

Many thanks

(anonymised)
Trainee Clinical Psychologist
SUPPORT AVAILABLE

Samaritans 08457 909090
Available 24 hours a day for emotional support if stressed or in despair.

Frank 0800 776600
Available 24 hours for advice.

Narcotics Anonymous 08453 733366
Helpline.

Drinkline 08009178282
For help and advice.

Mind 08457 660163
Monday to Friday 915 to 515pm for information on mental health.

Depression Alliance 08451 232320
Leave a message to receive an information pack.

Rethink 020 8974 6814
Available 10-3pm for people with schizophrenia and their families.

Parentline Plus 0808 8002222
Available 24 hours for anyone parenting a child.

Lesbian and Gay Switchboard 020 7837 7324
Support for gay and bisexual people.
APPENDIX 18

CONTROL GROUP CONSENT STATEMENT
CONSENT

Title of Project: Coping and Substance Misuse
Name of Researcher: *(ANONYMISED)*

1. I confirm that I have read and understand the information for the above study. I have had the opportunity to consider the information and ask questions.

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

3. I agree to take part in the above study.
APPENDIX 19

RISK MANAGEMENT PLAN
RISK ASSESSMENT

Participants

Hazards

1. Questionnaires.
2. Breach of confidentiality.

Risks

The potential risks to participants are:

1. That they may find the questionnaires in the study upsetting.
2. That their personal data is not kept confidentially.

Researcher

Hazard

Being alone with participants.

Risk

The potential risk to the researcher is:

Risk to personal safety from one of the participants.

Risk Management Plan

1. The research will be carried out only within the service where participants receive treatment or, for the control group in other public places. As these are public places where other people will be present, this will minimise the risk to the researcher.
2. Questionnaires have been chosen that are not thought to have high potential for causing distress to the participants.
3. If participants do experience distress when completing the questionnaires, the information sheet and/or myself tells them where they can get support.
4. The questionnaires, which contain personal information, will be kept in a locked cupboard at the University. These will be destroyed after ten years.
5. Each participant's questionnaires will be given a code and this is how the data will be recorded on computer for analysis. After analysis, the data will be stored on a university computer and destroyed after ten years.
6. The results will be reported in such a way that no one could know who had taken part.
APPENDIX 20

DISSEMINATION OF THE RESULTS
DISSEMINATION

The results of the study will be presented or given to the services that provided access to participants. Any participants that asked for feedback will be provided with summaries of the results. It is also intended to publish the results in a peer-reviewed journal.
Research Log Checklist
## RESEARCH LOG CHECKLIST

<table>
<thead>
<tr>
<th></th>
<th>Activity</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Formulating and testing hypotheses and research questions</td>
<td>Y</td>
</tr>
<tr>
<td>2</td>
<td>Carrying out a structured literature search using information technology and literature search tools</td>
<td>Y</td>
</tr>
<tr>
<td>3</td>
<td>Critically reviewing relevant literature and evaluating research methods</td>
<td>Y</td>
</tr>
<tr>
<td>4</td>
<td>Formulating specific research questions</td>
<td>Y</td>
</tr>
<tr>
<td>5</td>
<td>Writing brief research proposals</td>
<td>Y</td>
</tr>
<tr>
<td>6</td>
<td>Writing detailed research proposals/protocols</td>
<td>Y</td>
</tr>
<tr>
<td>7</td>
<td>Considering issues related to ethical practice in research, including issues of diversity, and structuring plans accordingly</td>
<td>Y</td>
</tr>
<tr>
<td>8</td>
<td>Obtaining approval from a research ethics committee</td>
<td>Y</td>
</tr>
<tr>
<td>9</td>
<td>Obtaining appropriate supervision for research</td>
<td>Y</td>
</tr>
<tr>
<td>10</td>
<td>Obtaining appropriate collaboration for research</td>
<td>Y</td>
</tr>
<tr>
<td>11</td>
<td>Collecting data from research participants</td>
<td>Y</td>
</tr>
<tr>
<td>12</td>
<td>Choosing appropriate design for research questions</td>
<td>Y</td>
</tr>
<tr>
<td>13</td>
<td>Writing patient information and consent forms</td>
<td>Y</td>
</tr>
<tr>
<td>14</td>
<td>Devising and administering questionnaires</td>
<td>Y</td>
</tr>
<tr>
<td>15</td>
<td>Negotiating access to study participants in applied NHS settings</td>
<td>Y</td>
</tr>
<tr>
<td>16</td>
<td>Setting up a data file</td>
<td>Y</td>
</tr>
<tr>
<td>17</td>
<td>Conducting statistical data analysis using SPSS</td>
<td>Y</td>
</tr>
<tr>
<td>18</td>
<td>Choosing appropriate statistical analyses</td>
<td>Y</td>
</tr>
<tr>
<td>19</td>
<td>Preparing quantitative data for analysis</td>
<td>Y</td>
</tr>
<tr>
<td>20</td>
<td>Choosing appropriate quantitative data analysis</td>
<td>Y</td>
</tr>
<tr>
<td>21</td>
<td>Summarising results in figures and tables</td>
<td>Y</td>
</tr>
<tr>
<td>22</td>
<td>Conducting semi-structured interviews</td>
<td>N</td>
</tr>
<tr>
<td>23</td>
<td>Transcribing and analysing interview data using qualitative methods</td>
<td>N</td>
</tr>
<tr>
<td>24</td>
<td>Choosing appropriate analysing analyses</td>
<td>Y</td>
</tr>
<tr>
<td>25</td>
<td>Interpreting results from quantitative and qualitative data analysis</td>
<td>Y</td>
</tr>
<tr>
<td>26</td>
<td>Presenting research findings in a variety of contexts</td>
<td>Y</td>
</tr>
<tr>
<td>27</td>
<td>Producing a written report on a research project</td>
<td>Y</td>
</tr>
<tr>
<td>28</td>
<td>Defending own research decisions and analyses</td>
<td>Y</td>
</tr>
<tr>
<td>29</td>
<td>Submitting research reports for publication in peer-reviewed journals or edited book</td>
<td>Y</td>
</tr>
<tr>
<td>30</td>
<td>Applying research findings to clinical practice</td>
<td>Y</td>
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</tbody>
</table>
Abstract for Qualitative Research Project
Title

Dr Stereotype?: A Interpretive Phenomenological Analysis of a groups views of therapists and psychologists in film.

Aim

The aim of this current study was to examine people's perceptions and thinking about psychologists in films, particularly whether they viewed psychologists as being stereotyped.

Method

Participants

Five participants (2 male, 3 female, aged between 20-32 years) took part in a focus group. Selection criteria: participants were non-psychologists and had not studied psychology at degree level.

Focus Group

The five participants met together with two facilitators to talk about their experience of psychologists in film, within a private, distraction-free room at the university. The focus group aimed to elicit the subjective experience of the participants, and a semi-structured schedule was used. The interview style was based around the principles of the counselling interview (Coyle, 1998). The focus group was recorded using audiotapes, and lasted approximately 60 minutes. The tape was then transcribed verbatim.
Analytic Strategy

An interpretive phenomenological analysis (IPA) approach (Smith et al., 1999) was used to analyse the data. This approach captured participants' perceptions as opposed to empirically 'perfect' data. The content of transcript was analysed using the method described by Smith et al. (1999), which involves examining the transcript for master themes and sub themes.

Analysis

Five master themes were identified following analysis of the transcript:

- General stereotype of the shrink;
- Movies vs. Reality (themes relating to participants' awareness that the portrayal of psychologists in film is not realistic);
- Therapeutic Relationship;
- Difficulty identifying psychologists in films;
- Performance anxiety of participants.

Limitations

There were some limitations to our study. A number of assumptions were made by the researchers on conducting this research e.g. that psychologists are stereotyped in films, and that this is an opinion shared by other psychologists, and this assumption may have affected how the research was conducted. One methodological limitation was that the study used a small, convenience sample.

Further research

To determine whether psychologists in films shape people's views of real-life psychologists and how this may influence the likelihood of people seeking
psychological help. To investigate representations of psychologists in other forms of media, for example, books, television programmes, newspapers.

References
