A PORTFOLIO OF STUDY, PRACTICE AND RESEARCH

Submitted for the Doctor of Psychology (PSYCHD) in Clinical Psychology

CONVERSION PROGRAMME

by

Caron Elizabeth Gaw

Department of Clinical Psychology
University of Surrey
Guildford

September 1996
ACKNOWLEDGEMENTS.

During the year that I have spent working on this portfolio family, friends, and professional colleagues have offered immeasurable amounts of help and support. To all of them I offer my thanks and gratitude.

I would particularly like to thank the members of the Psychological Therapies Service at Warlingham Park Hospital, who have been very involved in the high points and low points of the last year, for their patience and support. I would specially like to thank Liv Schonfield, John Revell, Catherine O'Shea, and those who helped with the collection of data.

I would also like to thank the CMHT managers and all the CPNs who collected data, especially Rosa May and her team.

Special thanks to Barbara Ashley, librarian at W.P.H. who spent hour after hour pursuing elusive references.

I am forever grateful to John Addy for his support and undying good humour; without his help, support, and patience, this portfolio would, most certainly, have remained incomplete.

My thanks to Robert Edelmann, for supervising the more recent research project presented in the portfolio. His sound advice, help, support, patience, and encouragement helped more than words can express. Thank you.

Deserving of my gratitude is Sonia Nagi, psychology assistant, who helped with the never ending processing of data and showed me the secrets of SPSS for Windows.

I would also like to thank Professor M.J. Power for his help getting to grips with the Significant Others Scale (SOS) and its scoring; Dr Geraldine Strathdee for her helpful advice; Dr. E. Williams and his colleagues for their time; and Paul Devonshire for his helpful comments.

I would like to thank my family for their continued interest in my progress and their support during the last year. Finally I would like to thank my partner, Richard, who has ‘survived’ during the completion of this portfolio.
SECTION ONE: Professional Audit

1. Overall Aims and Objectives

2. Academic
   2.2 Aims
   2.3 Objectives
   2.3 Rationale
   2.4 Plan

3. Clinical
   3.1 Aims
   3.2 Objectives
   3.3 Rationale
   3.4 Plan

4. Research
   4.1 Aims
   4.2 Objectives
   4.3 Rationale
   4.4 Plan

5. Summary of Clinical Training and subsequent professional development

5.1 Outline of training programme leading to MSc. in Abnormal Psychology, Queens University Belfast, 1979.
5.2 Professional experience since qualification

5.2.1 Basic Grade Clinical Psychologist (1979-1982) 10
5.2.2 Senior Grade Clinical Psychologist (1982-1986) 10
5.2.3 Principal Grade Clinical Psychologist (1986-1989) 12
5.2.4 Top Grade Clinical Psychologist (1989-1990), from 1990 onward Grade B (Consultant) Clinical Psychologist 14

6. Post qualification training events attended 16

6.1 1979-1994 17
6.2 October 1994-September 1995 17

SECTION TWO: Academic Audit

Critical Review One

Critical Review Two
A Critical Review on Significant Variables Within the Therapeutic Process. 38

Critical Review Three
A Critical Review on Needs Assessment: How is ‘need’ assessed and the implications for Clinical Psychology as a profession. 57

SECTION THREE: Clinical Audit

The Development of a Primary Care Counselling Service for Adults Within the London Borough of Croydon. 73

1. Introduction 74
<table>
<thead>
<tr>
<th>Section</th>
<th>Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.</td>
<td>Literature review</td>
<td>76</td>
</tr>
<tr>
<td>2.1</td>
<td>Models of formal psychiatric services links with GPs</td>
<td>77</td>
</tr>
<tr>
<td>2.2</td>
<td>‘Talking therapies” and primary care</td>
<td>81</td>
</tr>
<tr>
<td>3.</td>
<td>The Organisation of Local Mental Health Services</td>
<td>85</td>
</tr>
<tr>
<td>3.1</td>
<td>The context of local services</td>
<td>85</td>
</tr>
<tr>
<td>3.2</td>
<td>Operational issues</td>
<td>88</td>
</tr>
<tr>
<td>3.3</td>
<td>The Psychological Therapies Service (PTS)</td>
<td>92</td>
</tr>
<tr>
<td>4.</td>
<td>The development of a Primary Care Counselling Service</td>
<td>95</td>
</tr>
<tr>
<td>4.1</td>
<td>The birth of the service</td>
<td>95</td>
</tr>
<tr>
<td>4.2</td>
<td>Implementing the new service</td>
<td>98</td>
</tr>
<tr>
<td>4.2.1</td>
<td>The service model</td>
<td>98</td>
</tr>
<tr>
<td>4.2.2</td>
<td>Identification of primary care settings</td>
<td>102</td>
</tr>
<tr>
<td>4.2.3</td>
<td>Recruiting personnel</td>
<td>103</td>
</tr>
<tr>
<td>4.2.4</td>
<td>Establishing the service</td>
<td>105</td>
</tr>
<tr>
<td>5.</td>
<td>Critical Review</td>
<td>106</td>
</tr>
<tr>
<td>6.</td>
<td>Postscript</td>
<td>111</td>
</tr>
<tr>
<td>6.1</td>
<td>Evaluating the new service</td>
<td>111</td>
</tr>
<tr>
<td>6.2</td>
<td>Future development of the service</td>
<td>111</td>
</tr>
</tbody>
</table>

**SECTION FOUR: Research Audit**

**Study One**  
A Test of the Reformulated Learned Helplessness Model of Depression in terms of Attribution Theory.  

**Abstract**  

<table>
<thead>
<tr>
<th>Section</th>
<th>Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Introduction</td>
<td>122</td>
</tr>
<tr>
<td>1.1</td>
<td>Background</td>
<td>123</td>
</tr>
<tr>
<td>1.2</td>
<td>Learned helplessness as a model of human depression (1975)</td>
<td>130</td>
</tr>
<tr>
<td>1.2.1</td>
<td>Symptoms</td>
<td>131</td>
</tr>
<tr>
<td>1.2.2</td>
<td>Cause</td>
<td>134</td>
</tr>
<tr>
<td>1.2.3</td>
<td>Treatment</td>
<td>137</td>
</tr>
<tr>
<td>1.2.4</td>
<td>Prevention</td>
<td>139</td>
</tr>
</tbody>
</table>
1.2.5 Summary

1.3 Inadequacies of the learned helplessness model of depression (1975)
1.3.1 Symptoms
1.3.2 Cause
1.3.3 Treatment
1.3.4 Prevention
1.3.5 Further inadequacies

1.4 The reformulated learned helplessness model (1978)

1.5 The present study

1.6 Hypotheses to be tested

2. Method

2.1 Design

2.2 Subjects

2.3 Test materials
2.3.1 Test booklet
2.3.2 Personal information questionnaire

2.4 Procedure
2.4.1 Administration of test booklet
2.4.2 Personal Information questionnaire
2.4.3 Self-esteem ratings from the B.D.I.
2.4.4 Determinants of social class using occupation
2.4.5 Determinants of diagnostic category

3. Results

3.1 Population characteristics

3.2 Hypothesis number one

3.3 Hypothesis number two

3.4 Hypothesis number three
3.5 Hypothesis number four

3.6 Hypothesis number five

3.6.1 Determinants of Beck Depression Inventory scores:
whole population

3.6.2 Determinants of Beck Depression Inventory scores:
psychiatric subpopulation

3.6.3 Determinants of Beck Depression Inventory scores:
normal subpopulation

3.6.4 Summary

3.7 Hypothesis number six

3.7.1 Discrimination between normal and depressed groups

3.7.2 Discrimination between depressed and other psychiatric groups

3.7.3 Discrimination between all three diagnostic groups

3.7.4 Summary

4 Discussion and conclusions

4.1 Discussion of results

4.1.1 Failure vs. success outcomes

4.1.2 Self-esteem and attribution

4.1.3 The relationship between depression and attribution style

4.2 Conclusions

Bibliography

Appendices

1 Test Booklet - Title Page
2 Test Booklet - B.D.I.
3 Test Booklet - Rotter’s Internal-External locus of control
   questionnaire
4 Test Booklet - Seligman’s Attribution Questionnaire
5 Personal Information Questionnaire
6 B.D.I. obtained from Beck (1967).
7 Population Descriptive Statistics
8 Thesis Proposal
Study Two
Primary care referrals to local mental health services: Patient characteristics and the direction of referral.

Abstract

1. Introduction

1.1 The detection of mental health problems by general practitioners

1.2 Factors identified to operate at the primary care level to allow patients to pass through the filters.

1.2.1 The second filter; the detection of a mental health problem by the GP.

i) Characteristics of the GP.

ii) Characteristics of the patient.

iii) Interaction between doctor and patient.

1.2.2 The use of the GHQ to improve detection

1.3 The third filter: the decision to refer the patient to a mental health professional.

1.4 Factors influencing direction of referral

1.5 The present study

1.6 The local context

1.7 Aims and hypotheses

2. Methodology

2.1 Research design

2.2 Subjects

2.2.1 Gender

2.2.2 Age

2.2.3 Ethnic origin
2.3 Measures  
2.3.1 The GHQ-12: The General Health Questionnaire  
2.3.2 The IIP: Inventory of Interpersonal Problems  
2.3.3 The SOS: Significant Others Scale  
2.3.4 The CRI: Coping Responses Inventory  
2.3.5 Patient questionnaire  
2.3.6 Therapist questionnaire  

2.4 Method  
2.4.1 Procedure  
2.4.2 Data analysis  

3. Results  
3.1 Problem type reported by patient  
3.2 Number of patients that have previously received counselling for their problem  
3.3 Hypothesis one  
3.3.1 Subscale correlations between the measured variables  
3.3.2 Conclusion from the Pearson product-moment analysis of data  
3.4 Hypothesis two  
3.4.1 Conclusions from the Kruskal-Wallis one-way anovas  

4. Discussion  
4.1 Patient characteristics measured by the SOS, IIP, CRI  
4.2 Patient characteristics and relationship between the SOS, IIP and CRI  
4.2.1 The relationship between AEM with the five subscales of the Inventory of Interpersonal Problems (IIP) specifically ASS, INT, RES, SOC, and SUB  
4.2.2 The relationship between LA and two subscales of the Significant Others Scale (SOS), specifically, DEM and DPR  
4.2.3 The relationship between SUB (a subscale of the IIP) and AR (a subscale of the CRI)  
4.2.4 The relationship between SUB (a subscale of the IIP) and ED (a subscale of the CRI)  
4.2.5 The relationship between SOC (a subscale of the IIP0 and APR (a subscale of the SOS)
4.3 The relationship between measures of psychological distress (GHQ-12 and Distress) and other patient characteristics 338
4.3.1 Similarities between GHQ-12 and DIS profiles 339
4.3.2 Differences in the profile of the GHQ-12 scores and the variable DIS 340
4.4 The relationships between DUR, PRE, and all other reported variables 341
4.5 Summary: Characteristics of patients referred to all three specialist mental health services by local GPs 343
4.5.1 Conclusion: Characteristics of the group of patients referred to all three specialist mental health services by local GPs 345
4.6 Referral direction 345
4.6.1 Conclusion: Referral direction 348
4.7 Methodological limitations 348

4.7 Suggestions for future research 351

References 354

Appendices 359

Appendix A Patient questionnaire 360
Appendix B Therapist questionnaire 361
Appendix C Explanatory letter sent to patients with the GHQ-12, IIP, SOS, CRI and patient questionnaire 362
Appendix D Data summary sheet returned to therapists 363
SECTION ONE:

PROFESSIONAL AUDIT
PERSONAL STUDY PROGRAMME

Psych D in Clinical Psychology:
Conversion Programme

Name: Caron Elizabeth Gaw.  Date of Registration: 1. October 1994
Registration Number: 3414922

1. OVERALL AIMS AND OBJECTIVES

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

1.2 To raise awareness of training and professional developments within clinical psychology amongst my colleagues with different professional backgrounds.

1.3 To pursue areas of interest relevant to my current responsibilities.

2 ACADEMIC

2.1 Aims

2.1.1 To enhance academic competence in three specialist areas of clinical psychology so as to develop the services offered by the department and the profession.

2.1.2 To gain knowledge and understanding of the processes by which purchasers of mental health services assess need.

2.1.3 To gain knowledge and understanding of the means by which services are evaluated.

2.1.4 To increase understanding of the significant processes that occur within a therapeutic encounter.
2.2 **Objectives**

2.2.1 To complete three critical reviews, one from each of three specialist areas.

2.2.2 To complete three extensive literature searches in the three specified areas.

2.2.3 To communicate the knowledge gained to members of the Psychological Therapies Service by verbal presentation, documentation, and discussion.

2.2.4 To use the knowledge gained to assist in the development of relevant service outcome measures.

2.2.5 To use the knowledge gained to inform the process of identifying 'need' in respect of psychological therapies.

2.2.6 To use the knowledge within therapy sessions, to inform and improve clinical skills.

2.3 **Rationale**

2.3.1 The health service has undergone many changes over recent years in respect of the philosophical underpinnings of service delivery, and the political direction. The requirements on providers and purchasers to have greater information about these services, how they operate, and the quality of the resulting interventions, have greatly increased. As the head of the Psychological Therapies Service, with a responsibility to develop these services in line with current thinking, it is important to understand and appreciate how psychological interventions are, or could be, evaluated so that a clinically meaningful system of outcome evaluation can be introduced.

2.3.2 A new service has recently been supported, and funded, following the identification of 'need' by the Commissioning Agency. The process of identifying 'need' is undertaken by purchasers, and, partly on the basis of these 'needs assessment', local health services are funded. How the process of needs assessment is undertaken, and the implications of this process to the delivery and future development of Clinical Psychology, is significant in the present day health service, and relevant to the future development of services.

2.3.3 The question of cost effectiveness is high on the agenda of managers of health services. Within clinical psychology this has resulted in suggestions that specific therapeutic interventions can be as effectively undertaken by members of a different professional group, at less cost. As the distinguishing feature between these professional groups is the level of training received, it seems reasonable to speculate that the process within the therapeutic encounter may discriminate
between therapists rather than the unsophisticated therapy outcome measures currently available. It is important to understand what these process variables are, how they are measured, and what they ultimately tell us how people are best helped.

2.4 Plan

2.4.1 A critical review on Outcome Measurement and Service Evaluation

2.4.2 A critical review on Significant Variables Within the Therapeutic Process.

2.4.3 A critical review on Needs Assessment: How is ‘need’ assessed and the implications for Clinical Psychology.

3. CLINICAL

3.1 Aims

3.1.1 To develop the range of services offered by the Psychological Therapies Service by the development of a Primary Care Counselling service.

3.1.2 To develop a service appropriate to the local context.

3.1.3 To fulfil the designated role of service project leader.

3.2 Objectives

3.2.1 To extensively search the literature to gain knowledge of existing service models.

3.2.2 To determine the local context within which the new service will operate.

3.2.4 To introduce a service, acceptable to local stakeholders, by the first quarter of 1995.

3.2.5 To produce a written report on the development and operation of the service for local service users.
3.3 **Rationale**

3.3.1 In October 1993, local providers, from both voluntary and statutory sectors, were requested by the local health commissioning agency (at that time Croydon District Health Authority), to submit proposals for funding to the local LIZ (London Initiative Zone) steering group. This local steering group would evaluate the proposals, in terms of local need, and forward the successful projects to the London Implementation Group (LIG). This larger group would then agree the funding available for the suggested projects. The money to fund these initiatives had been identified following the review of hospital services within London.

3.3.2 Projects submitted for funding had to meet various criteria set by the LIG. These included a focus on community based services, an enhancement of the services available within the primary care setting, and an emphasis on preventing hospital admission.

3.3.3 A bid was submitted by the present author to fund a primary care counselling service that had been identified as a service ‘need’ by both service users and local general practitioners.

3.3.4 Funding of this proposal was provisionally agreed in December 1993, but confirmation was not received by local commissioners until July 1994. Following the confirmation of funding for the primary care counselling service, the service outline required translation into an operationally viable service consistent with the existing, and changing, context of local mental health services.

3.4 **Plan**

3.4.1 To review relevant existing literature.

3.4.2 To review the context of local mental health services.

3.4.3 To develop a model consistent with existing local mental health services.

3.4.4 To introduce the model to local primary health care teams.

3.4.5 To recruit appropriately trained staff.

3.4.6 To operationalize the service by the end of the first quarter of 1995.

3.4.7 To make available a report of this service development to local stakeholders by the last quarter of 1995.
4. **Research**

4.1 **Aims**

4.1.1 To increase research competence to develop the services offered by the Psychological Therapies Service.

4.1.2 To increase the knowledge available to the service and the profession.

4.1.3 To increase the knowledge available to professional colleagues within local mental health services.

4.1.4 To increase the knowledge available to local commissioners on the newly established primary care counselling service.

4.2 **Objectives**

4.2.1 To produce a piece of research which when added to previous research amounts to a total of some 40,000 words.

4.2.2 To complete an extensive search of the literature in the area of study to enhance the level of knowledge in this field.

4.2.3 To disseminate the knowledge gained to local stakeholders via a written report.

4.2.4 To provide local commissioners with evaluative information on the newly established LIG funded primary care counselling service.

4.3 **Rationale**

4.3.1 Following the success of a bid to the London Implementation Group (LIG) to fund a primary care counselling service, many concerns were raised by local stakeholders relating to the ‘value’ of the service. Some of these concerns were voiced by the commissioners in terms of service outcome - how could they judge the value of such a service and would it be worthwhile purchasing ‘more’ if significant outcomes were achieved?

4.3.2 In May 1994 local commissioners requested bids, from provider units, for consideration. These bids would be considered on the basis of stated criteria for submission to the South West Thames Primary Care Development Fund. Successful bids would receive funding for a twelve month period for a small scale research project.
4.3.4 A bid was successfully submitted by the present author, in association with a general manager within the mental health service, to evaluate the LIG funded primary counselling service. This would include outcome evaluation, referral criteria to the service and prescribing practices.

4.4 Plan

4.4.1 To introduce to concept of service evaluation to general practitioners during the development of the primary care counselling service.

4.4.2 To develop short questionnaires to collect information relevant to the evaluation.

4.4.3 To identify existing psychometric tools that appropriately quantify patient characteristics.

4.4.4 To discuss the project with service managers and relevant professionals and obtain necessary approval.

4.4.5 To learn how to use SPSS for Windows.
Signed........................................................ Participant

Signed........................................................ Line Manager

Signed........................................................ Course Director
5. Summary of Clinical Training and subsequent professional development

5.1 Outline of training programme leading to MSc. in Abnormal Psychology, Queens University Belfast, 1979.

5.1.1 Academic component; October 1977 - September 1979.

A range of lectures, workshops (including video taped feedback sessions) and seminars were attended during the two year course. These sessions covered psychiatric classification systems and diagnosis; psychological theory, problem analysis and therapeutic approaches to problems presented by children, adults, and the elderly; neuroanatomy; family therapy; and statistics and psychometrics. Examinations were held at the end of the second academic year on theoretical perspectives and on the application of treatment approaches via vignettes. A separate examination in neuroanatomy was taken at the end of the first academic year, and various items of course work were required by supervisors including two essays on neurological problems.

5.1.2 Clinical Component.

- one four month placement in Adult Mental Health
- one four month placement Student Health and Counselling
- one four month placement with a District Department of Clinical Psychology in England. Referrals from a variety of sources including primary care and medical specialities, of a variety of different age groups, including children, adult and elderly, were received by this service. Experience in this setting encompassed all the above groups.
- one four month placement in Child Psychology
- one four month placement in Neuropsychology
- one four month placement Mental Handicap (Learning Disabilities)

5.1.3 Research component.

A research study was undertaken and a thesis submitted to the university at the end of the second year, entitled;

'A test of the reformulated learned helplessness model of depression in terms of attribution theory.'
5.2 Professional experience since qualification

5.2.1 Basic Grade Clinical Psychologist (1979-1982)
Provided a clinical service to two localities within the Northern Health and Social Services Board. The service was available to adults over 16 years no longer in full time education. Referrals were received for inpatients and outpatients from psychiatrists and general practitioners. Two weekly clinics were held in general practice setting, one in each locality. Population characteristics resulted in a large percentage of referrals being for people over the age of 65 years. This lead to the development of a special interest in this age group, specifically in the process, and consequences for the individual and carers, of intellectual deterioration caused by dementia.

5.2.2 Senior Grade Clinical Psychologist (1982-1986)
A specialist post; 70% Elderly and 30% General Adult services. This was a newly established post, the author being the first post holder. A wide range of problems were referred from, and a number of different ways of working were developed for, both the adult and elderly services including;

Clinical
- development of behaviour therapy programmes for inpatients. Problem areas addressed included incontinence, aggression, fire-setting, 'wandering', daily living skills, property destruction, and anti-social behaviour of various types.
- an advisory capacity to ongoing behaviour therapy programmes, some of which had been implemented by nursing staff
- individual inpatient referrals from Elderly Services and the Special Care Unit (difficult and offender patients)
- outpatient referrals for elderly and adult groups. Elderly referrals were received from the whole district while adult referrals were received from one locality. Referrals were received from local Part II and Part III accommodation for the elderly
- assessment/treatment of patients on geriatric and medical wards at the District general Hospital
- establishment of relative support groups in 3 day hospitals, one day centre, and a further group through the Local Alzheimer's disease society
- provision of group therapies (mainly anxiety management and loss) within the day hospitals
- input to the Occupational Therapy/Physiotherapy Department at the local District General hospital advising staff on the assessment of cognitive deficits following CVAs, and emotional issues of loss.
Teaching/training
• seminars were regularly provided to ward and day hospital staff
• lectures provided to student RMNs on psychological theories and treatment approaches
• planning and teaching (elderly component) on the local training scheme in Clinical Psychology
• supervision of Clinical Psychology trainees and student nurses on placement.
• lectures to local social services staff (e.g. home care attendants)
• jointly produced a ‘Question and Answer’ booklet for nursing staff on the administration of C.A.P.E.; an assessment procedure for the elderly
• lectures on pre-retirement courses

Management
• involved in the planning of elderly services within the district as a member of the Elderly Services Committee
• founder member, and committee member, of the Redhill branch of the Alzheimer’s Disease Society.
• chairperson of the S.W. Thames Regional Special Interest Group of Psychologists Working with the Elderly (PSIGE) 1985-1986. Chairing this group resulted in membership of the Regional Psychologists Advisory Committee and the Joint Management Subcommittee (University of Surrey)
• chairperson and founder member of the Community Liaison Group (1984-1986). This group aimed to reduce the social stigma and isolation associated with mental illness by establishing links with the local community. Improved links were established with the local Police training college at Guildford as a result of this groups activities.
• director of ‘LIFT’ (1985-1986), a charitable organisation, based in Redhill, Surrey, for people with a Mental Health Problem. The focus of the group is self help, work, social rehabilitation, and mutual support. Most users of this service had a long term psychiatric problem.

Research
• accommodation survey. Undertaken by the rehabilitation committee to determine the dependency level of each patient and their consequent accommodation needs. I was responsible for designing the questionnaire.
• supervising research of Clinical Psychology trainee and RMNs on ENB courses requiring submission of a research project involved with nursing staff in a research project on Dependency Level and Nursing Practice. This project was abandoned due to the key players leaving their posts
5.2.3 Principal Grade Clinical Psychologist (1986-1989)

District responsibility for providing an autonomous and systematic Clinical Psychology service, identifying service priorities and initiating service developments to the local population. This was a newly established post, the author being the first post holder.

Clinical

- Providing a Clinical psychology Service to people over the age of sixty-five years. Referrals were received from general practitioners, psychogeriatrics, physicians, neurologists, and on a consultancy basis from nursing staff (including CPNs), social services staff (residential and day care), and the voluntary sector.
- Clinical work (assessment, treatment, consultation) was undertaken in residential settings, day care settings, inpatient hospital settings, and at outpatient clinics. Treatment was provided through individual or group sessions and via patient focused workshops with care staff.
- ‘Out’ of district transfers back. A total of more than 60 patients was transferred ‘back’ to their district of origin from surrounding districts. This transfer process involved individual patient assessments, and the development of a schedule of transfer based on examples of good practice recorded in the literature. This involved a major training programme for the staff involved in the new service in which the present author played a significant part.

Teaching/training

- A large number of teaching/training seminars on psychological aspects of ageing, psychological approaches to problems, and specific treatment techniques, to carers and staff in the voluntary and statutory sectors. A number of day workshops were provided to Social Services staff in adjoining districts.
- Lectures on Management of Behavioural Problems presented by people with dementia to the SSD (Social Services Diploma) course at Lewes technical College
- Assistant team leader at a P.A.S.S. workshop evaluating local learning disability services
- Case Reports Tutor, S.E.Thames In-Service training Scheme in Clinical psychology (1988-89)
- Supervisor of a S.W. and a S.E.Thames Trainee in Clinical Psychology (Older Adult placement)
- Part of the advisory group (1988-1989) developing the syllabus, and written submission for consideration by the awarding body of ‘City and Guilds 325-3 Advanced Management for Care (Special)’. Lectured to the existing 325-2 course
• Member of the Joint Training and Development Group, a subgroup of the Joint development Team (services for the Elderly). This group had a brief to recommend training initiatives for those (a) caring for the elderly in institutional settings and (b) caring for people in their own homes (including voluntary and self-help groups).

Management
• To advise and inform the Manager of Services for the Elderly Mentally Ill (EMI), and the District Psychologist, on clinical matters relating to this group, and to identify implications and options for strategic and operational planning within this service
• Member of the Steering Group (5 members) involved in the commissioning, appointment of key staff, philosophy and operational policy specification of a new service for people over the age of sixty-five, which included inpatient, day hospital care, community services, liaison with social services and primary health care teams etc.
• Member of the Steering group involved in commissioning a Social Services day Centre/Sheltered Housing Facility (Housing Association)
• Chairperson of the Clinical review Group 1985-1986. This group was established to address issues of quality assurance
• Member of the Senior management Group E.M.I. Services 1986
• Member of the E.M.I. Services Planning Group considering options for future service development. Recommendations accepted by the District Priority Care Groups Committee
• Managerially, and professionally responsible for one Senior Grade Clinical Psychologist and one Psychology Assistant

Research
• Supervision of the research project on Consumer Consultation undertaken by psychology assistant
• Small scale research project on the environment within one of the elderly admission and assessment wards. This project was undertaken by the author and an Occupational Therapist
• A number of small scale projects were undertaken under the aegis of the Clinical Review Group. I left this post before these were reported
• Research advice to the local hospital pharmacy on 'Drug Compliance Following Discharge in a sample of Elderly people'. Advice and individual feedback were given to the pharmacy staff on the development of interviewing skills
5.2.4 Top Grade Clinical Psychologist (1989-1990), from 1990 to date Grade B (Consultant) Clinical Psychologist

The responsibilities of this post are to provide Clinical psychology Services to those with Mental Health Problems, including children and adolescents, within the unit's catchment area. This was a newly established post and Head of the Department that included 5.0 w.t.e. Senior Grade and 1.0 w.t.e. Basic Grade Clinical Psychologists. The author has experienced many organisational changes in this post due to local restructuring and reorganisation of services. These changes divide roughly into two the time periods: 1989-1992 and 1992 to the present (October 1995). The next section will follow this chronological division.

The early years: 1989-1992

Clinical
• Providing a Clinical Psychology input to one sector of the district
• Specialist input to brain damaged, behaviourally disturbed inpatients
• Individual and group sessions provided via the local MIND to self-referred patients (mainly depressives and obsessionals)
• Providing support and supervision to Clinical psychologist employed by the local authority
• Facilitating staff support groups on an acute admission ward and in a social services day centre

Teaching/training
• Lectures to ENB 998 on Perception, Motivation and Learning
• Workshops for ‘ENB 298: Care of the Elderly’ on ‘The Behavioural Management of Difficult Behaviours resulting from Dementias’
• DCP lecture (local group) on The Psychology of Retirement
• Various lectures to student nurses (RMN) on aspects of psychology and treatment approaches
• Trained as a ‘Set Adviser’ within a Self Managed Learning framework. Operated as a set adviser to a group of mental health professionals on a CMS course
• Lectures on the foundation management course provided by the District Continuing Education Department on Learning an attitude change
• Number of lectures to local GPs via seminars to their locality groups and post qualification training meetings. Topics ranged from the management of depression and stress, to the role of the psychologist
• Number of training sessions to local GP receptionists
Management

• To manage the Department of Clinical psychology (mental Health Unit) on a day-to-day basis, being responsible for training, guidance, direction, appraisal, development and discipline as appropriate, in consultation with the Unit General Manager and Personnel Manager, and in accordance with established policies and procedures
• To advise and inform the Unit General manager, and Unit management Group on clinical Psychology matters within the Mental health Unit, and to identify implications and options for strategic and operational planning within the Unit and District
• To control the delegated budget
• Member of the Mental Health Unit's planning group (strategic direction)
• Member of the Age Concern Day Centre Management Group

Miscellaneous

During 1991-1993 the author work, on a self-employed basis, for one of the local GP practices. This allowed the development of positive relationships with influential GPs and increased the author's skills, and knowledge, in relation to work within the primary care setting and the concerns of local GPs.

The latter years: 1992 onwards

Until the end of 1992 a variety of reviews of local Mental Health Services were undertaken. These reviews were driven by financial and/or management agendas. During this time the department of psychology was disbanded and psychologists managerially sectorised. This resulted in a number of local problems, and culminated, at the end of 1992, in the identification, by the purchasers, of a problem in the provision of psychological therapies within the district. This issue was examined during the Strategic Review of Mental Health Services undertaken by local commissioners during 1993.

As a consequence of the Strategic Review, the present author was appointed Head of the Psychological Therapies Service (PTS), in charge of a delegated budget, with management accountability for Clinical psychologists, Counselling Psychologists, Counsellors, Art Therapists, and secretarial staff.

While still providing a comprehensive clinical service, and supervision of Clinical Psychology Trainees, the responsibilities of the post now encompass marketing clinical psychology, producing bids and service specifications, service audit and evaluation and fulfilling the responsibilities of being part of the unit’s management team.
The PTS has grown as a result of various initiatives, and there are now two specialist Grade B posts, four Grade A posts (with one further in the pipeline), two Counselling Psychologists, a part time Counsellor, two Art Therapists, and two secretaries accountable to the author. Additional money has recently been obtained for further service developments.

6. Post qualification training events attended

6.1 1979-1994
During this period various training events were attended. These included:

- Three conferences of the British Psychological Society
- Two Summer Schools of the Division of Clinical Psychology
- Training Events organised by the local branch of the BPS Clinical Division
- Basic management skills for Clinical Psychologists
- Training in the provisions of The Mental Health Act (1983), The Children’s Act (1991), Caring for Patients, Health of the Nation etc.
- Annual Conference of PSIGE (Psychologists Specialist Interest Group for the Elderly)
- Training events organised by the local branch of PSIGE
- Variety of lectures and workshops on problems of the Elderly and their carers organised by voluntary and statutory bodies
- Multidisciplinary team working
- Workshops for new, and experienced, clinical supervisors
- Two PASS (Programme Analysis of Service Systems) residential workshops
- Residential workshops held at David Salomons Centre (now Salomons Centre) by the post qualification training committee on a variety of topics.
• Variety of post qualification training committee organised workshops on psychometric measurement and therapeutic applications.

• Workshop on service outcome and evaluation

• Uses of the ‘single case’ research design

• Managing and Leading Change in the Health Service (course of lectures, workshops and seminars over a six month period)

• Training in the use of the Care Programme Approach and Supervision Register

6.2 October 1994- September 1995

• Cognitive Therapy for More Difficult Problems (follow up workshop)  
  Ruth Williams

• Risk Assessment and Analysis  
  Bridie Asquith

• Interface Between Neuropsychology and the Specialties  
  Paul Devonshire

• Systematic Way of Getting Things Done  
  Phillip Messinger

• Negotiating for contracts  
  Eva Lauermann

• But it’s only an inkblot! Rorschach Workshop 1  
  Kari Carstairs

• But it’s only an inkblot! Rorschach Workshop 2  
  Kari Carstairs

• Measurement in Major Psychiatric Disorder  
  Paul Devonshire

• Medico-legal Aspects  
  Nigel Eastman

• Cognitive Models of Depression  
  John Teasdale

• Evaluation of Psychotherapies  
  Paul Devonshire

• Statistics: refresher  
  Sean Hammond
SECTION TWO:

ACADEMIC AUDIT
A Critical Review on Service Evaluation and Outcome Measurement
1. Introduction

During the late nineteenth century mental health services were evaluated in terms of economic and organisational efficiency (e.g. cost per patient). In the early twentieth century admission rates for various categories of disorder, average length of hospitalisation and re-admission rates were reported to indicate the effectiveness of treatment (Satorius and Harding, 1983). With the increasing range of services provided to the mentally ill since the 1950s, government legislation (e.g. Working for Patients, 1989) and the move to ‘care within the community’, monitoring and evaluating health care has become more complex.

The ability to define and measure quality in mental health services is not well developed. If clinicians, commissioners and directors of public health are to appropriately monitor and evaluate mental health care then a comprehensive system of outcome indicators is needed (Jenkins, 1990). An ‘indicator’ is defined as a measure that summarises information relevant to a particular phenomenon, or is a reasonable proxy for such a measure (Jenkins 1990). The indicators of ‘success’ currently used (e.g. shorter waiting times) do not relate to outcome, effectiveness or appropriateness of the care provided (Radical Statistics Health Group, 1995). Appropriate quantitative monitoring of outcomes would provide a rational basis for modifying clinical practice as well as informing the decisions of commissioners (Popkin, 1991).

Service commissioners are responsible for assessing the needs of the local population and allocating available resources to achieve the best services for the lowest cost (Parry, 1992). The drive to obtain the best ‘value for money’ is now evident in all areas of the NHS
(Stevens, 1989; Turpin, 1994). Services evaluation is now crucially important to both providers and commissioners (Wilde and Svanberg, 1990).

As a consequence of the above, there has been a growth in the number of projects evaluating service provision commissioned both locally, and nationally (Turpin, 1994). Service evaluation is concerned more with the outcome of the service intervention and less with the process by which a service operates (Parry, 1992).

The following review will seek to examine some methodological issues and difficulties faced by evaluative research, some methods currently in use to measure service outcome and, finally to identify a way forward for Clinical Psychology.

2. Evaluative research: issues to be addressed

Evaluative research differs in many ways from research undertaken within an academic context. Distinctions can be drawn in terms of the purpose of the research, the topic, the setting, the measurement tools, the applicability of findings, and the replicability of results (Turpin 1994). The objective of evaluative research is not to build theories, establish truth, and improve ‘understanding’. Instead, facts and evidence are sought to inform and direct service planning processes, and ultimately improve the service and the care provided for patients (Stevens, 1989).

The manner in which facts and evidence are gathered to achieve these objectives often includes a ragbag of measuring tools instead of the standardised instruments more commonly used in academic research (Turpin, 1994). Rigorous experimental control is
difficult to achieve in evaluative research due to the demand to provide a service to those referred for help. This obviously results in a less rigorous set of research findings, open to subjective bias.

As with all forms of research, service evaluation requires resources to be undertaken successfully. The problems of resourcing are not encountered quite so clearly in the academic field. Turpin (1994) raised a number of ethical issues pertaining to the funding of evaluative research. Firstly, if the service evaluation has been commissioned by an NHS trust (or an employing body), service staff may be placed into conflicting roles, those of service provider and service evaluator, without choice. It is important that the evaluative work is owned by the staff involved if the best results are to be achieved (see for example Culverwell et al., 1994) Secondly, the need for a high compliance rate from patients to achieve valid samples and meaningful results, might result in undue pressure being used on patients to comply with the research programme (Turpin, 1994). Thirdly, there may be concerns about confidentiality from users who may be involved with the service in the future, that any information given may be used subsequently and have a detrimental effect on their care. This is particularly relevant to users of mental health services. Reports of a recent study by National MIND indicated that consumer’s views on mental health services may be generally less positive than those reported by ‘internal’ studies (Williams and Wilkinson 1995). This result adds weight to Turpin’s (1994) concerns.

These three ethical issues (Turpin, 1994) add to present a strong case for the establishment of independent, externally controlled, service evaluation programmes. However, evaluation
by external agencies can lead to problems implementing recommendations (Parry, 1992). Knowledge alone rarely leads to a change in clinical practice (Sheldon, 1994). The history of change and improvements in the health services suggests that innovation in patient care tends to take place at a local level (Ovretveit, 1994). Furthermore, the results obtained from any service evaluation may only be applicable and directly relevant to that specific programme, and setting, and not generalisable to any similar service (Turpin, 1994). For all these reasons, service evaluation is best undertaken as an integral part of the planning, and future development, of the service. If this is achieved then the outcome is more likely to be ‘owned’ by the professional’s involved if the service and the desired aim of improving patient care will be achieved. It would appear that undertaking service evaluation requires a balance to be struck between external, independent evaluation, and local ownership and innovation.

Before commencing an evaluative process, clear statements are required about what is to be evaluated. Unfortunately there is frequently a lack of stated service goals with broad, general, aims (e.g. making patients better) being used to describe the ‘goal’ of the service. Without clearly defined, measurable goals, or objectives, a programme simply cannot be evaluated meaningfully (Milne, 1987a). ‘Fuzzy’ goals are often stated which need to be replaced with clearly stated, specific, observable events, which are measurable, if any evaluation is to proceed. Services are not standardised; different people are involved. Identifying, and defining, the specific goals of the service or programme usually involves several professional groups, administrators/managers and clients, politicians and members of the general public. Each of these will have their own separate perspective adding to the complexity of the research design.
As a consequence of the difficulties discussed above, evaluative research is difficult to execute, interpret and repeat (Milne, 1987a). A possible partial solution to the problem of defining service goals may lie in the six service dimensions listed by Maxwell (Parry, 1992). These dimensions include service relevance, equity, accessibility, acceptability, effectiveness and efficiency. Targets can be set using these six dimensions as a framework. These targets can then be evaluated and a judgement made as to whether they are met by the service.

3. Measuring service outcome

A number of different approaches have been suggested and developed under the aegis of evaluative research. Medical audit can be viewed as a form of service evaluation undertaken by practitioners as a routine aspect of service delivery (Parry, 1992). Peer review of this kind is obviously open to bias and may not stand objective scrutiny. Quality assurance (QA) procedures measure the process by which therapy is delivered setting standards for performance and inspecting whether or not they are achieved. Consequently QA programmes can operate as a form of service evaluation. Innovations like audit and quality assurance have a poor track record and a bad image among some clinical staff (Barnes, 1994) and have failed, so far, to develop into comprehensive service evaluative systems. Some alternative procedures have yielded information that has informed and directed planning processes. These techniques include the measurement of psychotherapy outcome (Culverwell et al., 1994), consumer feedback (Stallard and Chadwick, 1991), TQM (total quality management), goal attainment scaling (Øvretveit, 1994; Gillies, 1993; Parry, 1992; Stallard and Chadwick, 1991) and quality of life (Fallowfield, 1993). These will be briefly examined in the following sections.
Clinicians are frequently concerned with how a better, more effective service can be delivered (Popkin, 1991). Psychotherapy research has mainly focused on a comparison of different therapy outcomes and/or an understanding of the therapy process by which outcomes are achieved (Parry, 1992). This type of research has rarely been done under routine service conditions, having instead involved carefully selected clients and specific treatment approaches (Milne, 1987b). Experimental designs of this type are often of little use in real clinical settings (Ottenbacher and Cusick, 1990), the experimental paradigm more closely fitting the pure research model discussed earlier.

Linden and Wen (1990) suggested that this type of outcome research could be improved by more replication studies, enhanced comparability across studies, enhance clinical relevance to real life circumstances and more attention to cost issues. For example, Culverwell et al. (1994) undertook to replicate, within an NHS setting, the research findings that cognitive-behavioural yielded better outcomes than psychodynamic-interpersonal therapies (see Shapiro and Firth, 1987; Shapiro et al., 1994). Although the original experimental results were effectively replicated, the authors reported a change in the working practice of those therapists who took part in the study with all therapists adopting time limited therapies. Equally, therapists who did not routinely evaluate their service prior to the research programme began to do so as part of their standard NHS practice. Culverwell et al. (1994) concluded that the active involvement in evaluative research, of professionals within the service delivery system, resulted in a positive attitude and behaviour change towards the value of evaluation. Although outcome research of this type more appropriately fits the pure
academic model discussed earlier, the changes in the manner in which therapist's offered their services, following involvement with, and the results of, the outcome study, meet with the aims of service evaluative research. In their study Culverwell et al. (1994) successfully balanced the demands of pure research with the demands of a real-life service. Although significant changes occurred in service delivery following this research project, many aspects of the service were not evaluated. The purpose of the study was not to develop an ongoing service evaluation system that could function as an integral part of the service. An effective, integral, service evaluative system requires a broader focus and different aims.

3.2 Consumer feedback an evaluation

The involvement of the consumer in the evaluation of health care has been highlighted by a number of policy documents e.g. The White Paper, Working for Patients (DoH, 1989). Patients' views of their care, summarised as satisfaction, are the most widely used global measures of outcome (Stevens, 1989). Patients are the recipients of care, and therefore, it can be argued that they are the best judges of how it effects them (Davies and Crombie, 1994). It is assumed within governmental policy documents, that consumer evaluation and feedback, will lead to service change. Service evaluation by consumers, which in the case of mental health services includes patients and referrers, can range from service satisfaction to service outcome.

Gathering information from consumers is frequently undertaken by the use of consumer questionnaires. There are serious limitations with this research methodology and many
problems have been identified. For example, consumer surveys traditionally report high rates of satisfaction, usually in the range 70-90% (Stallard and Chadwick, 1991; Davies and Crombie, 1994). The responses obtained may be an artifact of questionnaire design. Stakeholders may not be represented, and the sample actually used may not be sufficiently representative (Satorius and Harding, 1983). The client may be unable to complete the questionnaire due to their clinical problem (Milne, 1987a). The questionnaire may not be wide ranging enough to give information on all aspects of service delivery (Evans and Wright, 1987). Literacy problems and the suitability of this type of tool for ethnic minorities also limit the use of questionnaires (Culverwell et al., 1994). Statistical reliability and validity measures are rarely made (Stallard and Chadwick, 1991). Finally, the relationship between user’s views and the quality of care they receive is not simple. An individual's satisfaction with a service is determined by a complex interaction of at least four factors; the environment, the nature of the interpersonal exchange and the personal characteristics of both patient and carer (Davies and Crombie, 1994). Using the information obtained from consumer surveys, to alter the pattern of service delivery, without a serious consideration of the interplay of these factors, may be ill-advised.

Williams and Wilkinson (1995) suggest that the diversity of findings from patient surveys is the result of unstable assumptions about the concept of satisfaction. Satisfaction studies are often undertaken on the assumption that they are cheap and easy to conduct, that evaluations require quantitative data of a type that can be readily reported, and addressing patient satisfaction demonstrates a concern for the patient. There is frequently a failure to gather information that is specific and focused on an important area where deficiencies in care are expected, or known, to occur. Although there are many problems with customer survey data,
a greater attention to the tools (measures) used could significantly improve the quality of information. The development of qualitative research techniques (see for example Breakwell et al. 1995) has much to offer evaluate research seeking to obtain feedback from consumers.

In commercial organisations the emphasis is on giving the customer what they want. Griffey (1989), an educational psychologist, advocated a public service orientation, that is, the quality of a service should be judged by the customers' standards rather than by organisational or professional standards.

While this approach may be appropriate within Education it would seem to be simplistic and potentially dangerous approach to health care. In health services, customers may not know what they need and/or may potentially ask for treatments that are inappropriate or even harmful (Øvretveit, 1990; Davies and Crombie, 1994). Therefore, in the realm of health services, there is a need to include a professional definition of what the customer needs. A further element is introduced as a consequence; how well does the customer feel their perceived need has been recognised and met by the professional’s definition. The evaluation process has again becomes value-laden and one of balancing possible differences between consumer and provider. It is important to take the views of all relevant parties into consideration to gain a true picture of the service (Parry, 1992). A service that succeeds and meets a customer’s need (as perceived by professional and customer), can still be wasteful of resources. A true quality service is not only one that meets the customers needs but also one that involves using resources in the most efficient way (Øvretveit, 1990) implying that a systems approach, taking into account multiple perspectives on the evaluation is required (Parry, 1992).
3.3 TQM: total quality management

Total quality management (TQM) assumes that poor quality arises from bad systems not bad people. The concept moves away from a model of standards and inspection (quality assurance) towards an emphasis on creating a facilitative climate within the organisation. This climate consists of people who are enthusiastic to identify deficiencies in quality and to work together to rectify them (Parry, 1992). TQM has been described an organisation-wide attitude of doing the right things, right first time, at the right time with the systems to support staff in doing this (Øvretveit, 1994). The concept of 'fully meeting customer requirements' is also central.

TQM programmes have proved extremely successful in commercial companies but have so far failed to deliver the promised benefits of reducing costs and making services more responsive to patients within the NHS. Øvretveit, (1994) suggested that this is largely because TQM does not take account of the differences between public care and commercial services. The political nature of the NHS means that there are frequent changes of policy and directives that demand immediate management attention. Pursuing sustained long-term strategies is difficult, if not impossible, in the constantly changing climate of the NHS. TQM systems are also expensive (Øvretveit, 1994) A lack of the financial resources necessary to adequately implement a TQM programme hinders their development within the NHS. The simplicity and power of the 'fully meeting customer requirements' concept has to be modified in the NHS. The NHS customer is a complex mix of patients, carers, purchasers,
referrers and other interested groups. The TQM concept of customer satisfaction as the only measure of service quality, and evaluation, appears absurdly simple in this complicated environment.

3.4 Goal attainment scaling

Goal attainment scaling has a distinct advantage over the techniques used to evaluate services discussed to date. The goals of a therapeutic intervention, and what the service is seeking to achieve, are clearly specified. Goal attainment scaling involves goal setting procedures and assessment techniques that are practice-based and practitioner-oriented (Ottenbacher and Cusick, 1990). Without the specification of an objective (goal) it is impossible to determine whether the intervention process has been successful.

Goal attainment scaling as a method of evaluating a programme’s impact, requires two basic steps. Firstly, the construction of a plan, or goal attainment guide, based on the desired or expected level of performance of a patient. Secondly, this guide is used to rate the client’s performance at a predetermined time after intervention (Ottenbacher and Cusick, 1990). Numerical values can be assigned to the goals set and the achievement obtained. The technique can be used in psychotherapy, mental health, education and mental retardation, and general rehabilitation services. The process of evaluation is largely based on single case studies. Combining together these basic building blocks with data on the characteristics of the treatment, therapist, problem and client and correlating these with outcome measures allows the identification of differential effectiveness and efficient, and effective, service evaluation (Benbenishty 1989).
The technique of goal attainment scaling starts with the therapist and patient (Benbenishty 1989) and is an integral part of the service. As a technique it meets many of the desirable features of an evaluative system; 'owned' by professionals and an integral part of how the service operates on a day to day basis. Information obtained by adding single case data together provides a basis for service planning processes. However the process is not a research/service evaluative tool. Scores obtained at the end of treatment are influenced by the reliability of predictions and assessments made at the beginning. Although the process has much to offer in terms of specificity and measurement of outcome, the process is subjective, based on the clinical judgement of the therapist and the patient's agreement.

3.5 QOL: quality of life as an evaluative measure

A patient's level of satisfaction with the services received is an important part of that person's quality of life (Davies and Crombie, 1994). The quality of life (QOL) concept may offer a broad perspective for assessing health needs and clinical outcomes (Wilde and Svanberg, 1990) relevant to all areas of health care. The measurement of QOL has stimulated considerable interest in medical circles with the development of approaches to the measurement of the quality of life in cancer, Aids, cardiovascular disease, arthritis, and the elderly (Fallowfield, 1993)

Kaasa (1992) suggests that information on a patient's quality of life will give a more comprehensive evaluation of the treatment outcome than measures of tumour response and survival in cancer patients. Conceptually, quality of life is a somewhat vague term (Fallowfield, 1993). QOL has been defined in two different ways: firstly, a psychosocial
definition encompassing a subjective well being of how people feel about their own life, and secondly, a medical/health related definition encompassing performance status, reduction in symptom level, improved mood and sense of well-being in addition to objective response. Fallowfield (1993) views the QOL concept as a multi-faceted phenomenon covering four primary domains; psychological, social, occupational, and physical. Kaasa (1992) suggests that a holistic view of the individual is important and consequently the measured outcome variable should be related to psychological, physical and social functioning. Measures of psychosocial functioning could provide routine outcome data of more significance and relevance to the patient. Wilde and Svanberg (1990) proposed that a QOL model must include variables such as physical functioning, mental health, performance of social roles, social relationships, morale, satisfaction with life, well being and happiness. While there is general agreement on the areas to be included in any assessment of QOL, there are differences of emphasis.

Quality of life considerations are likely to constitute an increasingly important set of criteria by which to evaluate the effectiveness of interventions (Wilde and Svanberg, 1990). QOL as a concept and an investigative tool is of value in measuring the effects of interventions, in assessing the quality of care, in estimating population needs, in improving clinical decision making, and in researching the causes and consequences of health status. There is, however a need for greater clarification and definition of the facets involved.

4. Conclusions

The art of outcome/evaluative research is one of creative compromise. Practical constraints preclude the perfect study. As yet no fully comprehensive system of service evaluation exists.
The need to evaluate services to determine how the assessed needs of the population can be met, with the best services for the lowest cost (Parry, 1992), will remain a challenge for service commissioners in the near future.

Turpin, (1994) summarised specific skills and methods which psychologists need to learn alongside their existing research competencies in order to undertake successful evaluation work.

- organisational and political skills. The health service is a large organisation subject to many competing agendas.
- knowledge of research methods (measurement and design), ability to compromise and understand the implications. Indeed, Shapiro (1989), pointed out that there is no perfect outcome study and the choice of research design is a 'creative compromise'.
- to gain credibility it is helpful if the psychologist has proved of value to the service both clinically and organisationally
- knowledge of sources and ability to secure additional funds. Many evaluative studies and initiatives have been abandoned due to a lack of resource
- ability to present data appropriately and at appropriate times
- ability to secure support from colleagues

This list is certainly comprehensive and challenging. Service evaluation is a growing area and cannot be ignored by Clinical Psychology if service funding is to be secured. However, structural changes within organisations, the increasing number of service level agreements requested (numbers of patients seen), the appointment of nurses to positions of 'quality
manager’ suggests that Clinical Psychologists may lack sufficient ‘power’ within the organisation to establish the networks advocated by Turpin (1994). There is, however scope to use the research skills frequently neglected by applied psychologists in the context of evaluative research with both individual cases (e.g. therapy research, goal attainment scaling QOL) and the organisation (e.g. consumer surveys, TQM). As Parry (1992) concluded, it is perhaps time to accept as a profession that:–

‘......in the interests of the many patients who need but do not obtain high quality psychotherapeutic help, unmonitored practice is no longer defensible.’

(Parry, 1992; page 14)
References.


A Critical Review on Significant Variables Within the Therapeutic Process.
1. Introduction.

Research into the process of therapy has developed substantially in recent years (Orlinsky et al., 1994). This is due, perhaps, to a recognition that research aiming to demonstrate the superiority of one therapeutic model over another has failed to find robust evidence that significant differences in outcome occur (Frank, 1979; Stiles et al., 1986; Shapiro & Firth, 1987; Llewelyn, 1988; Horvath and Luborsky, 1993).

Process research investigates what therapy is, and seeks to develop an understanding of the process of change in a manner that is clinically meaningful. It is not driven by a theoretical perspective (Parry et al., 1986). In contrast, outcome research evaluates what therapy achieves, while process-outcome studies aim to identify the variables that, singly, or in combination, bring about what therapy achieves (Orlinsky et al., 1994). To effectively investigate the process of therapy, the detail of what occurs has to be systematically and objectively described and related to information about effectiveness (Parry et al., 1986).

Many research strategies have been developed and used in process research (Hill and Corbett, 1993), including case studies, sequential analysis of sessions, significant events (helpful and hindering), task analysis, discovery-orientated approaches, and qualitative approaches.

The following review will critically examine research on the significant variables within the therapeutic process by looking at firstly, the contribution of three theoretical perspectives to the development of process research; secondly some of the significant processes that have been identified and the importance of the observational perspective; and finally the development of a generic model of psychotherapy.
2. The development of process research.

The Client Centred Therapy of Carl Rogers in the 1940s and 1950s generated a proliferation of studies on the facilitative conditions within therapy (Hill and Corbett, 1993). Necessary and sufficient conditions for therapy were summarised by therapist characteristics of empathy and congruence (genuineness), and unconditional positive regard (respect and warmth). If these conditions were available then clients would grow towards fully functioning persons understanding their inner experiences (Rogers, 1976). Although research evidence could be seen to support the importance of the therapist facilitative conditions in helping clients change (e.g. Lafferty et al. 1989), their sufficiency is questionable. Within this perspective no account is taken of the involvement of the patient or his/her characteristics, the style of the therapist alone being the ingredient producing change (Hill and Corbett, 1993; Horvath et al., 1993). In addition, as pointed out by Traux (1971), an empathic, warm and genuine therapist is not the exclusive product of any particular theoretical orientation. The lack of attention to variables brought into the therapy setting by the patient is a serious omission as the patient is not a passive recipient of the therapist's behaviour. Despite this, the Rogerian approach has yielded much information about the significance within therapy of the facilitative conditions.

The development of cognitive therapies in the 1960s and 1970s (Bandura, 1977; Beck et al., 1979) provided a framework that recognised overt (observable) and covert (thoughts, internal reactions) behaviours within a therapy session. Thus the therapist and the patient were seen as contributing in a more equal fashion by overt and covert behaviours to the process of therapy. Process researchers began to study the covert behaviours of therapy
participants and the process of therapy was re-interpreted as an evolving interaction based on
a repeating cycle of covert, and overt, behaviours of the therapist and client in turn (Hill and
Corbett, 1993). Process research began to take account of the personal experience of both
participants a necessary development if a full appreciation of the variables involved in the
change process is to be obtained (Elliot et al. 1985).

Psychodynamic, Existential, Gestalt, and Person Centred therapies all propose that the
therapeutic relationship is an important determinant of treatment outcome (Corey, 1991). All
see the therapist’s degree of caring, their interest, ability to help the client, and their
genuineness, as factors that influence the relationship. The manner in which the therapeutic
relationship has been interpreted by psychodynamic theory has lead to a significant amount
of research (e.g. Geslo and Carter, 1985; Horvath and Symonds, 1991) and consequently
contributed much to a greater understanding of the processes operating within therapy.

Geslo and Carter (1985), working within a psychodynamic model, divided the therapeutic
relationship into three components; the working alliance, transference and
countertransference, and, finally the ‘real’ relationship (i.e. the relationship in the present).
Most research has focused on the concept of a working alliance, which may have resulted
from the often found relationship between a positive alliance and a positive therapy outcome
(Crits-Christoph et al., 1993; Horvath and Symonds, 1991; Horvath and Luborsky, 1993)
and possibly from the similarity between this concept and that of the necessary and sufficient
conditions defined by Rogers. Bordin (1979) conceptualised the working alliance as
consisting of three distinct parts; bond, agreement on tasks, and agreement on goals. The 'bond' includes trust, acceptance, confidence, and positive attachment between therapist and client; 'tasks' relate to behaviours and cognitions that form the counselling process; and 'goals' the desired outcome of intervention. The goal chosen will vary with the theoretical approach used and may range from 'restructuring personality' to 'reducing anxiety' (Corey, 1991). The process of therapy is obviously multifaceted as reflected in the above breakdown into increasingly more detailed, and specific, defining of concepts. It is perhaps worth questioning how useful such a detailed hierarchical structure is in allowing the separation of any specific factor from another as there is an inherent relationship and interaction. On the other hand such an analysis allows attention to be specifically focused on a single variable that may lead to improved understanding.

Although the origin of the working alliance concept lies in psychoanalytic theory, research findings (see Orlinsky et al., 1994) have lead to an acceptance of the construct as pantheoretical. The wide applicability of this concept suggests that, despite differences, all therapies share a common core of processes responsible for a large part of the client's improvement (Stiles et al. 1986). If a common core is indeed present within all therapies, and this has been accepted widely for approximately ten years (e.g. Stiles et al. 1986; Orlinsky et al., 1994), it is perhaps worth commenting that the consequences of this communality do not appear to have significantly altered the manner in which therapists operate with many still espousing one theoretical framework in opposition to another, seeking to prove the superiority of one over another (e.g. Shapiro and Firth, 1987). Perhaps the answer to this conundrum lies within other variables, or factors, operating within the therapy process.
3. Significant process variables and the observational perspective.

3.1 Therapist/client factors.

Schulte-Bahrenberg et al. (1993) working on the cognitive-behavioural treatment of phobias, found that changes of strategy during therapy resulted from therapist factors (hopes, apprehensions and disappointments) as much as changes in the client, and correlated negatively with a outcome. Positive and negative goal changes also appeared to relate to positive or negative therapy outcomes. It was hypothesised that the behaviour of the therapist when setting therapy goals that have a negative effect on the therapeutic process, may lead to the patient developing a sense of a lack of therapist competence. 'Competence' has been recognised as a therapist characteristic correlated with a positive outcome (Bennun and Schindler, 1988). Perhaps therapists feel more 'competent' when reassured by the security of a detailed knowledge of a specific theoretical perspective that guides intervention. Failure to accept and develop the identified common core within all theories, may be a consequence of a lack of therapist 'confidence' outside an experienced and tested framework.

Lafferty et al. (1989) found a number of measurable differences between more and less effective trainee psychotherapists, effectiveness being measured by changes in symptomology during the course of therapy. Less effective therapists were revealed to have lower levels of empathic understanding, to rate their patients as more involved in treatment and to rate themselves as more supportive than more effective therapists. These finding are not
unexpected as the therapist’s ability to communicate empathy and concern to a client is of significance in the establishment of the therapeutic alliance (Herman, 1993) which has been shown to correlate with more favourable outcomes (e.g. Crits-Christoph et al., 1993). This study raises the issue of how the therapist perceives him/herself, and the client, and suggests that less successful therapists rate themselves as more skilled than effective therapists. Perhaps more attention should be paid by those involved in the training of new therapists to the measurement, or assessment, of specific personality variables such as self-confidence, self-awareness, self-perception and self-image.

The manner in which the therapist and the patient interact was examined in a study by Bennun and Schindler (1988). When examining the therapeutic process in the behavioural treatment of a phobia, three therapist variables, (conveying positive regard and interest in the patient, showing competency and experience, offering direct guidance to the patient) and three patient factors (positive regard toward the therapist, self-disclosure and engagement, co-operation and goal operation) highly correlated with outcome were identified. The process dimension most consistently reported to predict therapy outcome is patient involvement in therapy (Gomes-Schwartz, 1978; Orlinsky et al., 1994). The distinction between ‘patient involvement’ in therapy and ‘patient motivation’ has not been examined. Motivation is frequently referred to as the activating force within the individual that stimulates behaviour directed towards the achievement of a desired goal (Maslow, 1954). It could be supposed that patient involvement and motivation are causally related and that strategies to increase, or measure, patient motivation, prior to therapy, may have a significant effect on therapy outcome.
Herman (1993) suggested that non-specific factors, such as a therapist’s personal characteristics, may be primary determinants of successful therapy outcome. Trends from a simulated clinical evaluation task seem to suggest that when values are highly relevant to a clinician, he or she may be more likely to reveal or reinforce that value in a therapy context. While this proposition takes no account of the patient’s characteristics, it would tend to suggest that having, or having the possibility of developing, shared values is significant. This makes logical sense in the context of research findings as opposing values would lead to a lack of positive regard and co-operation between the patient and therapist, factors which have been shown (see above) to be significant within the process of therapy.

The significance of the therapist’s behaviour has to be considered in light of the research finding (Luborsky et al., 1986; Horvath and Luborsky, 1993; Schulte-Bahrenberg et al., 1993) that it is the client’s perceptions of the therapist’s behaviour, rather than how the therapist actually behaves, that correlates most closely with therapy outcome. This finding suggests (in direct opposition to the Rogerian position) that the necessary and sufficient conditions, provided by the therapist's behaviour, are irrelevant if the patient misperceives or misinterprets the therapists' intentions. A strong case would appear to be made for explicit communication with the patient, with the therapist stating specifically his/her intentions which should, in turn, reflect the variables that have been found to be significant within therapy. An approach to therapy, based on this proposition would, contradict many of the fundamental therapist behaviours specified in various therapeutic approaches e.g. psychodynamic psychotherapy, client-centred therapy.
3.2 The therapeutic alliance

The therapeutic alliance, that is the bond, agreement on tasks and agreement on goals, between the therapist and client, has been shown to fluctuate throughout the process of therapy (Horvath and Luborsky, 1993). Two important phases are evident. The development of a therapeutic alliance early in therapy appears to be a powerful prognosticator of a good outcome (Horvath and Luborsky, 1993). During this early phase, the alliance appears to be related to patient variables (Crits-Christoph et al., 1993). Good pre-treatment interpersonal relationships, demographic similarities between the patient and therapist, pre-treatment social adjustment, low levels of pre-treatment symptomatology and lower pre-treatment patient defensiveness all appear to predict the development of a positive alliance (Crits-Christoph et al., 1993; Horvath and Luborsky, 1993).

The second phase of development of the alliance occurs when the therapist challenges old patterns of responding (Horvath and Luborsky, 1993). The extent to which the alliance continues to be positive, or an initial negative alliance becomes positive, seems to depend on how the therapist responds to the patient. It would seem that as therapy progresses, the working alliance becomes more intimately linked to evolving interactions between the therapist and client. Mitchell (1993) reported that therapist’s values influence what happens during treatment and clients who benefited from therapy have tended to adopt their therapists' values.

Empirical research suggests that negative characteristics of the patient and therapist influence the formation of the therapeutic alliance and consequently the outcome of therapy (Eaton et
al. 1993). Negative indicators were reported to include patient personal qualities and attitudes; therapist personal qualities and attitudes; errors in therapeutic technique; and patient/therapist interaction. The strong correlation found between the alliance and these negative indicators was suggested by Eaton et al. (1993) to indicate the presence of an underlying construct, relating to the state of the therapist-patient relationship (Eaton et al., 1993).

The above studies would appear to suggest that predetermined patient, and therapist, characteristics are highly significant in determining the outcome of therapy. A complicated interaction takes place with the therapist and client adopting different roles within the relationship. The adoption of these roles appears to follow some logical sequence but the rules governing this process have not yet been made clear.

3.3 Therapy impact.

The immediate impact of a therapist's intervention, or the therapy session itself, has been addressed as a means of assessing the significant aspects of the therapeutic process from the client's perspective. As mentioned above, research has shown that it is how the client perceives the therapist's behaviour, rather than the actual behaviour that is most closely related to outcome. During therapy the impact of therapist intervention can be immediate or delayed, observable or covert (Elliot et al., 1985). The immediate impact of any event is of considerable significance as the client response observed by the therapist, is likely to guide, or change, the intervention strategies subsequently chosen. Changes in strategy have been shown to correlate negatively with outcome (Schulte-Bahrenberg et al., 1993) and a
mechanism is suggested here whereby changes in strategy by the therapist may be a result of how the therapist perceives therapy impact within the client. Once again it seems impossible to separate the interaction of patient and therapist responses within therapy sessions.

Immediate impact has been studied in two ways; observable client behaviour (e.g. topic change, vocal quality) and clients' descriptions of their experiences. Elliot et al. (1985) presented a framework based on different types of therapeutic impact describing significant therapy events. Eight types of helpful events and six types of hindering events were identified. Helpful events were found to group into two larger clusters; task and interpersonal events. The ‘task’ cluster involved progress towards solving clients' problems; finding a new perspective; problem solution; problem clarification; and focusing awareness. The ‘interpersonal’ cluster involved helpful interpersonal contact between the client and therapist including a strengthening of the therapeutic alliance, identified as understanding, reassurance, involvement and personal contact. Llewelyn et al. (1988) found that during treatment the most commonly occurring helpful events were problem solving, awareness and reassurance. Problem solving and reassurance impacts were found more often in prescriptive therapies while awareness and personal contact events where more prevalent in exploratory treatments. It would seem that the therapeutic impacts reported reflect the expected mode of change in the different types of therapeutic intervention. Bearing in mind previous findings (e.g. Horvath and Luborsky, 1993) it would seem that this result may again point to the interaction between therapist and client and the ‘sharing’ of values that appears to be of significance within the context of therapy.
The six unhelpful events (Elliot et al., 1985) were identified as misperception; negative therapist reaction; unwanted responsibility; repetition; misdirection; and unwanted thoughts. Llewelyn et al. (1988) found the most commonly occurring hindering impact, which correlated negatively with outcome, was that of 'unwanted thoughts' (e.g. guilt).

Elliot et al. (1985) argued that the analysis of therapeutic impacts provided an eclectic framework for analysing the change process in therapy. The impacts identified as finding a new perspective, awareness, unwanted thoughts, and negative therapist reaction correspond to the psychoanalytic concepts of insight, working through, warding off and transference/countertransference. Involvement and personal contact impacts correspond to Bordin's (1979) previously mentioned division of the psychoanalytic therapeutic alliance concept into task and emotional bonding aspects. The reassurance, understanding and personal contact impacts correspond to the Client Centred conditions of perceived therapist warmth, empathy, and genuineness. Finally, the problem clarification and problem solution impacts parallel the behavioural processes of goal setting/contracting and rehearsal/prescription. The analysis presented by Elliot et al. (1985), while reinforcing the value of different theoretical perspectives, does not progress the search for significant variables within therapy further.
3.4 Observational perspective

The observational perspective used to collect information during process research has developed a significance due to the consistently found lack of correlation amongst the information reported from three main sources, the therapist, client and independent observer (Orlinsky et al. 1994).

Horvath and Luborsky (1993) examined at least eleven methods of assessing the therapeutic alliance. Each method was found to be available in several versions, adapted as an observer rating scale or a self-report measure. Using these tools, clients' and observers' ratings of the working alliance appear to be more correlated with all types of outcome than the therapist's ratings (Horvath and Symonds, 1991; Horvath and Luborsky, 1993). Elliot et al. (1985) reported the lack of a relationship between the 'experienced impact' reported by the client and the client's behaviour independently observed. This failure to find a relationship may provide an explanation for the low levels of agreement frequently found between the client and the therapist's perceptions of the therapy process. The therapist's perception of significant events may be based on observable client behaviour and this does not reliably correlate with the client's internal experiences. How internal experiences, which appear to be of greater significance to therapy, can be more efficiently assessed within a therapy session, has not been addressed.

When examining therapist perspectives of therapy process, Llewelyn (1988) found that therapists reported clients gaining cognitive and affective insight as the most significant helpful event. Clients on the other hand, reported reassurance/relief and problem solving events most frequently. It would seem that different aspects of the therapeutic process have
different salience for therapists and clients (Parry et al., 1986; Llewelyn, 1988). For example, clients would appear to be interested in a solution to their problems and feeling better whereas therapists are more concerned with the aetiology of the problem and its transformation through insight. Little evidence has been found so far that events seen as helpful by therapist are also those seen as helpful by patients (Elliot et al. 1985). From the above it would appear that, in general, therapists can be helpful by focusing their interventions on patient problems, and, with caution on patient’s affective responses during sessions (Orlinsky et al., 1994). In contrast, patients seem to do best when focusing their therapeutic conversations on life problems and core personal relationships (Orlinsky et al., 1994). The state of the therapeutic relationship in general and the working alliance in particular seem worthy of particular attention by the therapy participants as does the impact of the therapist’s interventions on the client. Finally, it would seem essential to understand observational phenomena if aspects of the therapeutic process are to be more effectively used to improve therapy.

They way forward would seem to be the development of a new approach to therapy by developing a process that takes account of, and combines all variables shown by research findings to be of significance.

5. A generic model of psychotherapy

The increasing body of empirical evidence indicating the relevance of process variables to therapy and therapy outcome can not be overlooked. How can process research be used to inform clinical practice? Hill and Corbett (1993) postulated that there were identifiable
process elements common to all theories and suggested seven from arousing emotions, providing new learning experiences, enhancing a sense of self-efficacy to obtaining an external perspective on the self and the world. Elliot et al. (1985) also identified elements common to all psychological theories suggesting a total of four namely insight, reassurance/relief, problem solution and personal contact. Perhaps the conclusion to be drawn from the process research reported above is that a generic model of psychotherapy emphasising commonalties (Stiles et al. 1986), within therapeutic models, would provide a way forward in the quest to understand the significant processes within therapy and, ultimately, how to do it better.

Orlinsky et al. (1994) proposed a generic model in which the therapy system receives inputs, works through processes and produces outputs. Inputs are the pre-treatment characteristics of the persons who practice or receive therapy. Processes are the characteristics of actual treatment and possible interactions, while output relates to treatment outcome and effectiveness both in themselves and with respect to other treatments (comparative outcome research). This type of model can be seen as an attempt to bring together what research has shown to be significant in a clinically meaningful way.

The generic model proposed distinguished six aspects of the therapeutic process. Firstly, a formal aspect (therapeutic contract) which relates to an understanding about the goals and conditions for engaging each other as patient and therapist. Secondly, a technical aspect (therapeutic operation) which relates to the technical procedures that patients and therapists commit themselves to perform under the therapeutic contract. These operations always
involve some form of problem presentation, expert understanding, therapist intervention and patient co-operation. Thirdly, an interpersonal aspect (therapeutic bond) which can support (positive) or interfere (negative) with therapy. Fourth, an intrapersonal aspect (self-relatedness) which relates to the way patient and therapist experience and respond to their internal arousal e.g. thoughts, and emphasises the importance of both client and therapist contributions to the therapy process. Fifth, a clinical aspect (in-session impact). Favourable in-session impacts on patients include insight, catharsis, softening of interpersonal conflict, reinforcement of hope and enhancement of self efficacy while negative in-session events include confusion, anxiety, or embarrassment. Finally, a temporal aspect (sequential flow) which relates to the finding that there appears to be an orderly pattern of flow both within and across therapy sessions. This model brings together the empirical evidence presented to date. To prove of use the model must inform clinical practice and be shown to enhance therapy outcome. This remains a task to be achieved and it is difficult to see how such a model can be developed without a substantial increase in the level of exposure amongst therapists than is presently observed.

6. Summary and conclusions

Hill and Corbett (1993) conclude that the overall goal of process and outcome research should be to determine the effective components within therapy and to build a treatment approach from this starting point. Research suggests that it is not the therapist's theoretical orientation and knowledge, and clinical experience (two aspects of therapist competence) that are the primary determinants of therapy outcome. Shapiro et al. (1989), reporting on the Sheffield Psychotherapy Project, concluded that therapist characteristics may have a different
impact on therapy depending upon which theoretical approach is employed. Perhaps therapists are drawn to, and use, a particular theory successfully because it fits their value system and their own personality. Imagining Carl Rogers and Albert Ellis switching theories in their treatment of patients (Shapiro, 1986), conveys the sense of this proposition admirably!

Training programmes for therapists, based on the empirical results of what works in therapy, would significantly alter our concepts of what determines quality and therapist competence. Firstly, there would be a distancing from theoretical perspectives to 'qualities that make a good therapist', and perhaps, more arguably, qualities that make a good patient! Theoretical perspective would become a vehicle which 'best fits' the therapist providing a framework within which the process of therapy, a complex interaction of variables, occurs. Secondly, training, and therapy sessions, would emphasise the various processes identified in an integrated, generic, theory with particular attention to the quality of the therapeutic relationship in general and the alliance in particular. Thirdly, there would be significantly more attention paid to the fit between therapist and client in terms of personality characteristics and value systems. A system in which the right therapist, engages in therapy with the right patient, using the right vehicle to facilitate change. Certainly a system far removed from that provided currently.

Process research to date provides a way forward for psychological therapies. As yet there is still a long way to journey before the therapy process is fully understood and before an attempt can be made to integrate the process variables, empirically demonstrated to be significant, into a clinically useful model.
References


Psychological theories have often used the concept of 'need' as a basis for understanding a course of action (Slade, 1994). Maslow's hierarchy of need (Maslow 1954), for example, often being used to explain human motivation and action. In contrast 'need' is defined within the National Health Service and Community Care Act (1990) as:–

"the requirements of individuals to enable them to achieve, maintain or restore an acceptable level of social independence or quality of life".

A further definition has been suggested by Thornicroft et. al. (1992) for mental health needs as:–

'problems for which state of the art solutions exist'.

The two definitions firmly relate the concept of need to the availability of a solution to a problem that adversely affects an individual's quality of life or social independence.

Conway (1995) pointed out that, despite the new emphasis on need assessment, it has been left unclear how 'need' should actually be assessed. The lack of reference to methodological issues, has led to a process of 'learning by doing' by commissioning authorities who are increasingly basing their purchasing decisions on systematic, epidemiologically informed, assessments of the health needs of their local populations (Shanks et al. 1995). The process by which information is provided on the most efficient and effective health policies and interventions, is need assessment. This process is usually
undertaken under the aegis of Public Health Medicine, a discipline in which disease prevention is seen as taking precedence over a curative orientation (Jablensky 1990).

The following review will look at how needs are assessed, methodological and conceptual issues, and implications for the future of Clinical Psychology.

Prior to the publication of The Health of the Nation White Paper (1992), health services were provided on the basis of what had been available historically, or simply on what had been offered by local providers of services. The White Paper proposed that a national health strategy based on improving health outcomes should be developed. This government initiative was aimed at generating a more rational, and scientific, approach to the provision of health care, than the prior system of ‘same as last year plus or minus five percent for pressure groups’ (Hopton and Dlugolecka, 1995). Central to the initiative was the concept of ‘needs assessment’ and the recognition that there is only a need where there is evidence that an intervention and/or the care setting is effective. This immediately raises the question of what constitutes ‘evidence’ and how strong this has to be before a need can be recognised.

To fully understand the health needs of the community it is essential to take account of local demography (population characteristics), epidemiology, evidence on the effectiveness of treatments, and the views of local people (Hopton and Dlugolecka, 1995) and relevant subgroups within it. Thus, the measurement of need cannot be objective (Slade 1994). Need becomes a socially negotiated concept arising from negotiation
amongst user, provider and purchaser (Kat 1992) and can be significantly influenced by organised lobbying, politics and media images. This creates a potential difficulty due to the possibility of irreconcilable differences between professional and public views.

Epidemiology is the scientific study of the occurrence, transmission and control of disease, within groups. Epidemiological studies, therefore, can significantly inform need assessment. A major strength of epidemiology is an ability to look beyond patients who already demand health care to those who do not, but need it, and perhaps provides a means of resolving some of the inadequacies in health care reported in the Black Report (Black et al. 1982). Mortality statistics are routinely collected and are believed to be the best available proxy for morbidity within a population (Williams 1995). However these statistics do not provide adequate or sufficient information as the impact of many diseases is underestimated in these figures. For example, diseases such as heart failure can have a major impact on the health status of a population, often resulting in hospital admission, but as they are not often recorded as cause of death their impact is often underestimated (Majeed 1995). Equally, information on the needs of a population, e.g. substance misuse, may be actively hidden by those involved, due to social and/or legal consequences of identification. The Public Health Common Data Set provides basic epidemiological data about districts and is used by Directors of Public Health (Kat 1992). The data set also contains an analysis of the underlying national policies for health to which the information relates.

Information concerning health status is of central importance to need assessment, and new information systems are being developed within public health medicine to assist health and
local authorities determine resource allocation. Shanks et al. (1995) suggest that there is a vast, untapped, data base within primary health care settings. Many practices now keep detailed data bases on their patients including illnesses and risk behaviours. This information could be used to identify all the conditions that have a major impact on health.

There are two main research strategies used to gather epidemiological data (Kat 1992, Conway 1995). Firstly, those concerned with describing the frequency or distribution of disease or disorder, and secondly, those concerned with the relationship between the occurrence of disease or disorder and the exposure to some factor that causes or increases the risk of that condition. Both require data. The means of gathering it include surveys, unstructured or semi-structured interviews, the focus group discussion, public meetings and informal quasi methods such as patient advocates, liaison officers and advisory/special interest groups (McIvor 1991). All of these methods have inherent methodological or conceptual limitations.

Conway (1995) points out that user perspectives have been placed at the centre of needs assessment with the incorporation of their views into the planning and development of services by government policy (Health of the Nation, 1992). The aim of user involvement is to obtain accurate and useful information, collected in ways that enables providers to make changes and improve the quality of services (McIvor 1991). However, the use of surveys, public meetings, and focus groups, has delivered a range of qualitative information, often anecdotal, which is difficult to make meaningful to the commissioning process (Conway, 1995). Users' views will be influenced by the culture and society in which they exist and what is perceived as acceptable. Equally users may simply not
understand the purpose or implications of the study and may be unable to give valid comments on services when they do not have any conceptual framework within which to judge alternative services (Hopkin and Dlugolecka, 1995). Further problems are introduced by the tendency of members of the public to define their state of health in subjective terms encompassing the effect on their everyday quality of life including their relationships with family, friends, and ability to work, while medicine defines health in terms of presence or absence of disease (Slade 1994). Hopton and Dlugolecka (1995) investigating the possibility of using users' perceptions of the need for primary care services to develop priorities, found that assessments of need based on the popularity of the help or advice offered, differed vastly from assessment of need based on ill health or distress. They found that some opinions have to be given a greater weight than others to promote equity. Equality is different from equity and giving everyone an equal say may be at odds with equity. Slade (1992) adds to this issue by pointing out the distinction between need, what people benefit from, and demand, what they ask for. Perhaps a contrast between outcome and satisfaction. Need assessment has to be developed to the point where a prediction can be made concerning the amount that an individual will benefit from a particular intervention if purchasers are to retain credibility in the face of the possible range of identified needs (demands?) from users.

The perceptions of users and providers are particularly significant within mental health services where professionals' views often differ vastly from lay perspectives (Mitchell 1993). An American study assessing the treatment needs, via clinicians' perspectives, of a state-wide random sample of Missouri's young adult psychiatric patients (Holcomb and Ahr, 1986) demonstrated the discrepancies that can be found between the two groups.
The objective of the study was to determine the types of services that should be available to this population and the level of engagement, or compliance, that was likely to be achieved. The results showed that the most impaired patients were thought to be in greatest need of medication and crisis intervention by service providers. Service users, on the other hand, were found to be most likely to comply with recommendations for outpatient counselling and psychotherapy. Producing a balanced view on services required, taking into account both perspectives, appears, in this case to move the service model away from medical/crisis interventions to the ‘talking therapies’ with a basis in psychological theory.

Mclvor (1991) raised a number of additional methodological and conceptual issues. Identified problems include obtaining a representative sample of users, asking the right questions in an appropriate manner, and interpreting the data correctly.

Obtaining a representative sample is hindered by the use of questionnaires. This form of data collection assumes that potential respondents can see, read a written language, use their hands and understand and feel comfortable with this formal and stylised format. With users of mental health services the issue of a representative sample is particularly problematic. Fear, hostility and vulnerability may make users less likely to respond particularly while still under treatment (Mclvor, 1991). Indeed beliefs about the nature of mental illness encourage service providers to discount the views and opinions of patients as part of their illness.
Mental health is a difficult area in which to assess need due to the considerable variation in diagnoses (Williams 1995). Mitchell (1993) referring to mental health, advocates that what people say they need is often a good indicator of what would promote their mental health. From a study of people attending a day centre it appeared that need of other people is central. Love, self-esteem, confidence, more money, a job and personal determination featured highly. Just meeting people who are accepting of their mental health problem would seem to have an enormous impact on their mental health and quality of life. If users' views are taken seriously, the identified needs would produce services with a very different structure from the services presently provided focusing on interpersonal contact and experience rather than illness.

Problems can be found when assessing need within specific target groups. Wilson (1994) reported such individualised reactions to spinal cord injuries that it is difficult to establish psychological needs via research to date. Social engagement appears to enhance adaptation to injury as does a sense of internal control with less reliance on multiple coping strategies. Wilson (1994) argues that the psychological needs of these patients require identification along with the treatment to match. It would appear that the social context, the relationship between social context and coping, other factors affecting coping and the role of drugs and alcohol abuse provide areas for psychological study of this group.

Brewin (1992) reviewed available need assessment schedules (mental health) dividing these into three types respectively measuring a lack of health, a lack of action, and a lack of access to services. The tools considered included the Stirling County study, the Eastern
Baltimore Mental Health Survey, Lehtinen's epidemiological study, SNAPOR (services Needed, Available, Planned, Offered, and Rendered), and the MRC needs for care assessment. This latter tool was considered by Brewin (1992) to be the most comprehensive instrument available to assess the needs of the long term mentally ill. All of these tools were considered lacking in their ability to appropriately assess need reporting instead symptom level; available institutional service provision; and measures of the effectiveness of a specific intervention. Part of the problem may reside in a failure to take on the definition of 'need' outlined in the Health of the Nation (1992).

Burton and Watson (1994) reported that psychological care is now perceived to be an essential element of good patient management in oncology and an integral part of any comprehensive cancer service within the USA. There are often psychological and psychiatric sequelae among cancer patients at all stages of the disease. Cancer pain can be exacerbated by mental state with depressed and anxious patients more likely to report pain or pain-related problems. Furnish (1994) further points out that there appears to be a neglect of the older citizen possibly due to negative stereotypes in this area. As a group they do not speak loudly and their voice is not heard yet three-quarter of all diagnoses of cancer are made in the over seventy-fives. There is evidence to suggest (Burton et al. 1994) that appropriate psychological care may help to reduce the number of medical and outpatient visits and, in a minority of patients, the length of inpatient stay. They advocate the need to develop psycho-oncology as a specialism to support the significant needs of the cancer patient and their family. In could be argued that evaluation of the most effective interventions has resulted in the development of a new specialism within Clinical Psychology.
Most forms of ill health are multi-factorial with multiple interacting causes. Aspects of personal behaviour or lifestyle, an exposure to an environmental event, or an inborn or inherited characteristic which epidemiological research has shown to be related to some form of ill health, all constitute risk factors (Kat, 1992; Niaura & Goldstein, 1992; Marks, 1992). Need assessment aims to establish what services should be provided in order to enabled individuals to achieve, maintain or restore an acceptable level of social independence or quality of life. Variations in risk factors lead to the specification of health need for a population. By ameliorating risk factors health status will be influenced by reducing the incidence of targeted health problems.

Wright (1994) working with patients suffering from end-stage renal failure identified a variety of issues applicable to any form of chronic illness including anxiety and depression. If psychology is to contribute significantly to risk assessment, these factors need to be linked to improvements in outcome i.e. if you provide treatment for symptoms of anxiety/depression which have been identified as a risk factor associated with a poor outcome, does that mean a better health outcome, or less need, for these patients?

Jablensky (1990) states that mental health problems can be understood, and are amenable to intervention, within a public health framework. A significant portion of mental morbidity in the community is preventable through socially organised effort aimed at eliminating or reducing pathogens (e.g. psychosocial stress), or risk factors (e.g. maternal deprivation in childhood). Indeed there are many examples of the interplay between health and social/ psychological factors. An example of this interplay is available when examining variations in child health status. Child health status has been shown to be influenced by
factors around the time of birth. Examining infant mortality and morbidity figure yields four risk factors - low birthweight, young mothers, births outside marriage, and maternal smoking (Williams 1992). These four factors have been combined into an index called the Multiple Risk Factor Index (MRFI) which gives a practical guide for distributing resources appropriately and a convenient way of monitoring changes in child health status. The risk factors identified, with the exception of a measured low birth weight that may indeed be correlated with other psychological factors, are largely determined by maternal behaviours. The possibility of psychologically altering risk behaviour in pregnant women (e.g. smoking behaviour), and investigating further psychological factors within young, unmarried mothers, is perhaps an area worthy of psychological investigation.

Carr-Hill et al. (1995) reported the results of a study on health behaviour and health status in black and ethnic minority communities. One of their major conclusions was that for significant proportions of the different black and ethnic minority communities, traditional health concerns such as diet, physical activity, or smoking, targeted risk factors for the reduction of coronary heart disease, had to be seen in the wider context of social and environmental stress factors, areas of interest to Clinical Psychology.

Williams (1993) reported that while it is difficult to gather complete information on drug misuse because those taking drugs wish to conceal their habit and do not contact services, there are some identifiable risk factors. Links exist with regular smoking and drinking, and teenage drug users tend to be absent from school more often. The report concludes that the best strategy for reducing the incidence of drug misuse is to reduce the number of young people who experiment with drugs. While this conclusion is valid from the
information presented, it fails to take account of the social context within which teenagers function. The most effective approach to the problem is to offer positive lifestyle messages (Williams 1993), suggesting, once again, a strong link between preventative measures and an area of interest to clinical psychology, that of attitude and behaviour change.

National concern (Health of the Nation 1992) has been expressed about the increasing number of suicides amongst young men (15-44 years). The reasons are unclear but may be related to changing social support, breakdown of marriages, unemployment and the use of alcohol and illicit drugs, factors relevant to psychological interventions. The role of men in society has been changing rapidly especially in relation to the certainties of gender roles. Men at risk are difficult to identify as they are unlikely to be known to health services or to seek help from mental health services. Social services staff, social security benefit staff and the police and probation services may be in a position to help those who need it (Williams 1995). The user friendliness of primary care based counselling services may prove more acceptable to this group, and may provide a means by which some of the needs of this group could be addressed. Attitudes, beliefs and value systems have also been associated with a risk of suicide. These personality characteristics are of relevance to the field of clinical psychology where change in these areas is a prime focus of therapy intervention (see, for example, Kanfer and Goldstein 1980).

The decisions of commissioners of health services determine the quantity and quality of a wide range of health and community services. All aspects of these decisions, the choice of outcomes, priorities, analysis of needs and the specification of services are infused with psychological issues (Kat 1992). Indeed, almost every aspect of health and community
care is permeated by processes and problems arising from human thoughts, feelings and actions as demonstrated by the examples above. The assessment of need is presently undertaken by Public Health where the focus is frequently 'medical'. Appropriate and adequate methodology is still in the process of development, and the results are frequently influenced by a political agenda. Only a few psychologists are involved in the responsibilities of public health departments and the influence of the profession is limited. Kat (1992) suggested that the profession, Clinical Psychology, may have lost opportunities to become involved in the process despite an apparent readiness to develop community based and prevention orientated services.

The author goes on to state that:

'At present the initiative is with Public Health Medicine. Very few psychologists are actively involved in the purchasing functions yet they have much to contribute. It is to be hoped that the contribution will be sought, welcomed and made in a spirit of mutual respect and co-operation.'

Kat (1992) argues that there is a conceptual fit between psychology and public health medicine. The above review points to substantial evidence that psychological needs have often been overlooked in health care. In addition, many of the identified risk factors fall within the domain of psychology.

Perhaps, as a profession, it is time to pursue co-operative initiatives.
References.


SECTION THREE:

CLINICAL AUDIT
THE DEVELOPMENT OF A PRIMARY CARE COUNSELLING SERVICE FOR ADULTS WITHIN THE LONDON BOROUGH OF CROYDON.
1. Introduction

Historically Clinical Psychology Services within Croydon have been poorly resourced with the demand for clinical services far in excess of availability (see Croydon Health Commissioning Agency, 1994). Part of my role as the head of the Psychological Therapies Service is to advise, and develop, the psychology service in line with the strategic direction adopted by the local Mental Health Service.

In October 1993, service providers within Croydon, from both voluntary and statutory agencies, were requested by the local health commissioning agency (at that time Croydon District Health Authority), to submit service development proposals to the local LIZ (London Initiative Zone) steering group for possible funding. The local steering group would evaluate the proposals, in terms of local need, and forward selected projects to the London Implementation Group (LIG) for consideration. This larger group would then determine which of the projects, submitted by agencies within the London zone, would be funded. The money to fund these initiatives had been identified following the review of hospital services within London (Tomlinson, 1992).

Projects submitted for funding had to meet criteria set by the LIG. These included a focus on community based services, an enhancement of the services available within the primary care setting, and an emphasis on preventing hospital admission.
A bid was submitted, by the present author, to fund a primary care counselling service. A service of this general type had been identified as a service ‘need’ by service users, local voluntary sector organisations, the local mental health service and local general practitioners. This Clinical Audit outlines relevant literature, the organisation of local services and the development of the new service from the initial service proposal to establishment of the service.

The aims of this Clinical Audit are:

♦ To develop the range of services offered by the Psychological Therapies Service by the development of a Primary Care Counselling service
♦ To develop a service appropriate to the local context of mental health services
♦ To fulfil the designated role of service project leader and operationalize the service

These aims will be addressed by achieving the following objectives:

◊ To extensively search available literature to gain knowledge of existing service models.
◊ To determine the local context within which the new service will operate.
◊ To introduce a service, acceptable to local stakeholders and consistent with existing local mental health services, by the first quarter of 1995.
◊ To produce a written report on the development and operation of the service for local service users.
2. Literature review

The extensive work of Shepherd et al. (1966) established that the majority of patients with mental health problems are seen within the primary care setting by general practitioners. Approximately 14% of patients were found to consult their GP for a condition that was largely, or entirely psychological or psychiatric in nature.

Strathdee and Sutherby, in a more recent, but undated report, estimated that between 1/5 and 1/4 of all GP consultations have a significant mental health component. Based on estimates of mental health morbidity in primary care (1981-1982), Strathdee and Sutherby estimated the following rates of various mental health problems in the primary care setting to be as shown in Table A.

<table>
<thead>
<tr>
<th>DIAGNOSIS</th>
<th>cases per 1000</th>
</tr>
</thead>
<tbody>
<tr>
<td>depression</td>
<td>28.0</td>
</tr>
<tr>
<td>anxiety and other neuroses</td>
<td>35.7</td>
</tr>
<tr>
<td>situational disturbance/other diagnoses</td>
<td>26.7</td>
</tr>
<tr>
<td>affective psychosis</td>
<td>3.0</td>
</tr>
<tr>
<td>schizophrenia</td>
<td>2.0</td>
</tr>
<tr>
<td>organic dementias</td>
<td>2.2</td>
</tr>
<tr>
<td>drug/alcohol disorder</td>
<td>2.7</td>
</tr>
<tr>
<td>personality disorder</td>
<td>1.1</td>
</tr>
</tbody>
</table>

Table A data from an unpublished paper by Strathdee and Sutherby.
For many years professionals (psychiatrists, psychologists, CPNs) within mental health services have been moving their services to bases within the community and providing services within primary care health centres. Kendrick et al. (1993) reported that about 20% of psychiatrists, 22% of community psychiatric nurses and 27% of clinical psychologists spend some part of their time working within a general practice setting. This move has been motivated by many different factors the most significant of which is a change in the accepted philosophy of care for the mentally ill. Despite this, community mental health services in many areas are still very poorly developed (Thornicroft et al. 1995).

Thornicroft et al. (1995) argue that mental health care services should follow three essential principles if community care is to be fully developed. These three essential principles are summarised by firstly continuity, secondly co-ordination and lastly integration of care. The way that services are arranged and integrated at the primary-secondary care interface determines whether these three principles are upheld.

A number of models of psychiatric services have been developed by various workers in an effort to progress the move into the community. These are summarised in the following section.

2.1 Models of formal psychiatric services links with GPs

Four models of informal links between mental health services and GPs are identified within the briefing paper produced by the Centre for mental Health Services Development (1994).
(i) The lunchtime meeting is the most informal model in which a senior mental health professional, usually a psychiatrist, attends one of the regularly held GPs lunchtime meetings. The meeting is informal, normally without an agenda, and discussion revolves around the management of individual patients.

(ii) The consultation model is more formalised and involves a regular meeting during which the GP presents specific cases for discussion. The patient continues to be seen by the primary health care team with advice on management and when necessary diagnosis, being given by the mental health professional.

(iii) The shifted outpatient model involves the mental health team moving into the primary care setting. Mental health professionals (psychiatrists, psychologists, and CPNs) hold their clinics in the surgery with the aim of providing ease of access and a less stigmatising environment for attendees. Long term management remains with the GP. This model has been extensively developed with some CMHTs having named link workers (usually CPNs) for each practice in their catchment area. These link workers may undertake initial screening and act as the gatekeeper to other mental health services.

(iv) The final model is that of liaison-attachment team. This model advocates a comprehensive network of general practice mental health clinics for psychiatrists and other mental health professionals, with an emphasis on informal liaison with general practitioners,
and others, in the primary care team. In parallel to these developments, is a reduction in secondary care psychiatric outpatient clinics. The specific aim is to train the primary care team to develop skills in the assessment and management of people with mental health problems. Once this aim has been achieved the team move on to another practice.

In addition to the above Tyrer et al. (1990) outlined a comprehensive model in which collaboration between the primary care and psychiatric teams are the key element. The main features of this model include;

a) patients are seen at a clinic or GP practice of choice
b) regular liaison takes place at clinics between psychiatrist and GP
c) emergency clinic role for psychiatrist in general practice
d) regular clinics for CPNs
e) liaison between other workers in primary care and psychiatric teams
f) joint educational ventures to update both general practitioners and psychiatrist

The advantages of providing psychiatric assessment within the primary care setting are seen to include, improved communication between the psychiatrist and GP; a reduction in stigma for the patient and improved satisfaction; continuing care is enhanced by the close relationship; and improved follow-up is available for the long term mentally ill patients reluctant to attend hospital.
Other service models have been developed e.g. the 'hive' model (Tyrer, 1985), and the Nunhead 'integrated model' (Strathdee, 1993) in response to the assessed needs of specific groups or in response to local factors.

The above models of community mental health services are dominated by the roles of psychiatry and 'psychiatric' services. This emphasis is reflected in many areas of mental health care and arises from the concern (e.g., Thornicroft et al. 1995), that the first priority of community mental health teams (CMHTs) should be to target the most severely disabled patients. The second priority, is the support, through GP practice attachments, of primary care staff with the other 90% of mentally ill patients who are not referred on to specialist teams. The information presented from the Strathdee and Sutherby report (see Table A), gives an indication of the number of cases presenting to general practitioners that could be regarded as falling outside the priority group of patients with severe mental health problems.

It has been argued that the early identification of emotional problems (the lower priority group) and referral to an appropriate mental health worker for therapeutic intervention, may prevent more serious disturbances and the need to refer on to specialist secondary care mental health, or psychiatric, services (McLeod, 1988) Services for the 90% of patients with a less severe mental health problem identified by Thornicroft et al. (1995), have received a substantial amount of attention due to their popularity with GPs and service users and it is to this area of clinical service that we will turn to next.
2.2 ‘Talking therapies’ and primary care.

Models of mental health services are increasingly emphasising the provision of services for the most severely mentally ill. In contrast to the work of Tyrer et al., (1990), and Thornicroft et al. (1995), counselling, or “talking” therapies have focused on offering services to the group identified as ‘the worried well’, neurotic, relationship or life adjustment problems. Psychological therapies have been grouped together as “talking therapies” by local service users within Croydon to emphasise the contrast between them and drug therapies, the desire to receive treatment in a non-medical manner involving talking and listening, and to avoid the use of frequently confused terms such as psychology, counselling, client-centred therapy, psychodynamic therapy etc. Interestingly this definition applies to patients in both priority groups identified by Thornicroft et al. (1995).

General practitioners are aware that a great proportion of their time at work is spent dealing with patients whose problems are related to situations beyond the doctors' control (Anderson and Hasler, 1979). Rowland and Hurd (1991) report that as many as 1/3 of people who approach their GP have a problem that relates to the stresses of daily life which have lead to feelings of illness. Concern about the efficacy, safety, and cost of psychotrophic drugs has increased the level of interest in non-drug treatments such as behaviour therapy and counselling (Sibbald et al., 1993). One solution has been for members of mental health services to work alongside GPs within the primary care setting. The professionals normally involved in this type of problem solution are Community Psychiatric Nurses (CPNs), Nurse Therapists, and Clinical Psychologists. Strathdee and Sutherby (undated) reported that a survey of links between individual practices and health professionals in 1991 showed that;
<table>
<thead>
<tr>
<th>Percentage</th>
<th>Professional</th>
</tr>
</thead>
<tbody>
<tr>
<td>48%</td>
<td>CPN</td>
</tr>
<tr>
<td>21%</td>
<td>Social worker</td>
</tr>
<tr>
<td>17%</td>
<td>Counsellor</td>
</tr>
<tr>
<td>15%</td>
<td>Clinical psychologist</td>
</tr>
<tr>
<td>16%</td>
<td>Psychiatrist</td>
</tr>
</tbody>
</table>

From Strathdee and Sutherby (undated).

The data reported requires careful interpretation as there is a tendency for some practices to have many links while other have few (Strathdee and Sutherby, undated).

An alternative option to the use of mental health professionals, has been to add practice based counsellors to the primary health care team, employed directly by the practice. Indeed here has been a considerable increase in the number of counsellors working in general practice with King (1994) reporting that about one third of practices in England and Wales employ a counsellor with no other task.

Jenkins (1995) reported in a review of published and unpublished research, that specific psychotherapeutic interventions, used by appropriately trained counsellors, with sufficient experience have been shown to have beneficial effects on patients referred to them in general practice. General research findings indicated that, 80-90% of patients report that they find the experience helpful or very helpful; 2-6% report the experience unhelpful; about 1/3 of patients referred to counsellor are taking psychotropic drugs but after counselling 20-50% of this group report that the have either discontinued or reduced their medication; 2-6%
increase the dose of their prescribed drugs; and consultation rates with GPs fall, and remain reduced, for as long as six months although some studies report a small rise (Jenkins, 1995; Corney, 1990; Anderson and Hasler, 1979). Additional benefits have been reported, for example, some practices employing counsellors report a considerable fall in referrals to outpatient mental health services.

Corney (1990) points to the difficulty of evaluating and a service when those providing it vary greatly in their training, therapeutic approach, and case mix. There are a variety of approaches and orientation; ‘counselling’ is not an easily understood term encompassing client-centred counselling, non-directive counselling, task-centred counselling, eclectic counselling, developmental counselling, psychodynamic counselling, etc. ‘Counselling’ is a term currently used to describe anything from skilled befriending to psychotherapy. The lack of a ‘standardised’ counsellor training, and the varied nature of counselling system, may have served to hinder the development of the talking therapy professions in general. Sibbald et al. (1993) in a study of 586 counsellors distributed in 484 practices reported that GPs were unaware of the counselling qualification by 1/5 of the counsellors working within the primary health care setting.

These initiatives have raised the question as to whether patients with non-psychotic disorders need to be cared for by existing mental health care services at all. Perhaps this group, not identified as the priority for existing secondary care psychiatric services, can, in any case, be more appropriately cared for by professionals, working entirely within primary care, and operating outside a mental illness model? Sibbald et al. (1993) addressing this issue suggest that the answer lies in the general practitioners becoming more discriminating in their referral
policies to practice based counsellors if the benefits of the service are to be maximised.

Information concerning which types of patient are best helped by which types of psychological intervention would do much to improve the choice of appropriate intervention whether that be within primary or secondary care services.

In addition to the confusion about the specific skills and levels of training attributed to the broad range of professional subsumed under the term "counsellor", there are presently no recognised NHS salary grades for counsellors and no formal structures by which GPs can easily employ counsellors. Counsellors and GPs tend to make their own arrangements with regard to hours of work and rates of pay. Consequently arrangements vary widely although the British Association for Counselling (BAC) has through a series of information sheets and guides, been trying to introduce standards (e.g., Rowland and Hurd, 1991). To date the majority of counsellors working in general practice have either initiated the arrangement themselves or been directly approached by a GP or group of GPs to provide the service.

The question often posed of whether psychological therapies actually work, would appear to be outdated in the face of many positive research findings (Jenkins, 1995). In general, research has tended to focus on this area i.e. the (cost) effectiveness of counselling and psychological therapies in primary care (e.g. Robson et al., 1984), and has not considered the implication of such a service on the links between secondary mental health services and primary care. It is perhaps time to move on to questions of the type that are of greater significance services within the to primary care setting. For example service organisation, accreditation of qualifications, standard setting, clinical audit and supervision. The links between primary care, counselling and secondary mental health services have, by and large,
been left to chance. Purchasers and providers have rarely taken a strategic view of the working relationship between these services. Services have not been planned in response to identified need, and the developments have not been managed ‘operationally’ in terms of an overall framework of mental health services. The result has been that duplications and gaps in services are frequently found (see, for example, Strathdee and Sutherby, undated).

The service development that is reported below is a attempt by the present author, supported by local service commissioners, providers and voluntary groups within Croydon, to address the strategic problems outlined above by bringing together ‘talking therapies’ in a service providing clinical input into both primary and secondary care settings in a co-ordinated manner. To understand the operation of this service development, it is necessary to understand the organisation of local mental health services.

3. The Organisation of Local Mental Health Services

3.1. The context of local services.

A major strategic review of local mental health services in Croydon, was concluded in late 1993 (Croydon Health Commissioning Agency 1994). Emphasised in the strategy document was the national policy implicit in the white paper Caring for People (1989), that mental health services should be based within the localities they serve, allowing users of these services to live within the community, as far as possible, as members of that community.
Historically, within the borough of Croydon, mental health services had been provided from a large Victorian style asylum built, in the early 1900s, to house a total of over one thousand patients. The Strategy for Mental Health Services Development (1994) was designed to serve as a blueprint for the move away from this institutional setting, into the local community, in a planned, and meaningful way, over a 3-5 year time period. The document concentrated on ‘strategic direction’ rather than operational detail, this level of interpretation being left to the management team within the mental health services provider unit.

The first major conceptual change in the organisation of local services, was a redrawing of existing clinical team boundaries, replacing the existing structure with three locality ‘community mental health teams’ (CMHTs) for adults aged eighteen (in special circumstances sixteen) to sixty-five years of age. These three teams serviced the northern, central and southern parts of the borough and, indeed, they are currently referred to by the name of the geographical area they serve i.e., North Locality CMHT, Central locality CMHT, and South Locality CMHT. The geographical changes, within mental health services reflected organisational changes within local Social Services.

At this time no account was taken of the proposed ‘locality organisation’ within primary care (GP services) as the organisational grouping of these services into locality purchasing groups, was at an early stage of discussion. During the latter part of 1994 and early 1995, this structure has been developed by general practitioners. The consequence, in terms of the purchasing power, and ability to influence the resources spent on local health services, by specifying local ‘need’ as perceived by the GPs in each locality purchasing organisation, has now become
significant to service providers. Unfortunately, the primary care ‘localities’ into which general practitioners have organised themselves, are not coterminous with those organised within local social services and mental health services. This problem has, in part, led to the local development, and operational incorporation of the concept of less well defined or ‘fuzzy’ boundaries. The most serious argument against rigid CMHT boundaries is when the strict application of what is an administrative convenience overrides the importance of an individual staff-patient relationship or contradicts the three essential principles, stated by Thornicroft et al. (1995) as necessary for the development of community care, - those of continuity, coordination and integration of care. This concept has been introduced to allow the CMHTs to provide a service for a patient depending on the general practice with which they are registered, rather than their actual home address that may well fall into the catchment area of a different CMHT. Consequently, although mental health services are organised on a geographic, community basis, there is a blurring around the edges to allow the incorporation of patients receiving services from a particular primary health care setting that falls into their locality.

Local service for those over sixty-five years of age and those under eighteen years, have developed along separate paths. Services for Children and Adolescents have been the focus of further study (1995) to determine the most appropriate way forward for these services. Mental health services for the over sixty-fives within the borough have been divided into two locality teams, north and south, on the basis of the boundaries used by local social services elderly care areas. As a consequence the catchment boundaries of the CMHTs for the elderly are not coterminous with those of the CMHTs providing services for those under sixty-five.
3.2. Operational issues.

The service blueprint, outlined in the strategy document, was translated into operational policy during the last quarter of 1993 and the first few months of 1994. In addition to the geographical changes, substantial role and organisational changes for the professionals providing services were proposed although it was recognised that these would not be implemented immediately in all areas. The central focus of the operational changes was the establishment of the Community Mental health Teams. Community Psychiatric Nurses (CPNs), who had previously functioned as a completely separate branch of the service, now became integral members of the newly formed CMHTs. Other full members of the CMHTs included occupational therapists, the day hospital nursing staff, secretarial and reception staff, and a CMHT manager. Other professionals were designated as ‘associate’ or ‘contracted’ members with the former term being applied to psychiatrists, and the latter to members of the psychological therapies service. This structure recognised the fact that a large proportion of the work of these two professional groups, lay outside the remit of the newly established CMHTs. This structural organisation can be illustrated by Figure A below.

A new role was specified for the CPNs within this operational structure. Apart from working as an integral part of the CMHT, CPNs were nominated as a ‘named nurse’ within a number of specified primary health care teams. Each general practice would have its own, named link nurse who would be in regular contact with the practice, and deal with all relevant clinical issues. This role was conceived of, by the service managers, as the ‘gate keeper’, or point of entry to the mental health services provided by the newly established CMHTs. The intention was that all referrals from the primary health care level would be channelled through the CPN
to the appropriate member of the team. The model adopted closely follows the *shifted outpatient* model refer to previously. In the case of the Psychological Therapies Service, and psychiatrists, it was recognised that referrals could be directed to these services without the need to involve other members of the CMHT - hence the status of these two groups of professionals as 'contracted' and 'associate' members.

Figure A illustrating the composition of the multidisciplinary CMHTs formed during 1994 and 1995 as a consequence of the strategic review of mental health services.

With the new shape of local services, in terms of new geographical catchment areas, and new operational procedures, 'service specifications' were introduced for each care area. The service specification for the CMHTs outlined the target population and means of access into
the service, the needs to be met, a description of the service, guidance on acceptable
approaches to care, performance targets, and quality standards (Smith 1994a).

The most significant change in respect of target populations, was the distinction between
category one and category two patients. Category one patients were targeted as those who
would normally receive help from the CMHTs. Patients within category one where defined by
their previous history of contact with mental health services, significant role disturbance, and a
need for social support (see Table B). Membership of this group was considered appropriate for
those with major mental illnesses for example, schizophrenia, major depression, psychotic
disorders in general, and those presenting as a suicidal risk. This distinction echoes that made
by Thornicroft et al. (1995) between first and second priority groups.

Membership of category two was seen as more appropriate to those experiencing the more
‘neurotic’ disorders, and/or, those sometimes labelled ‘the worried well’. Prior to the
reorganisation of services, and the adoption of the service specifications, a significant number of
the category two patients were referred directly to the then independent CPN service.
Therapeutic intervention would have been offered to patients from category two, by the CPNs
in the form of counselling, behaviour therapy, psychodynamic psychotherapy, or cognitive
therapy. The form of therapy on offer reflected the interests of the specific CPN to whom the
patient had been referred. In response to the volume of referrals seeking this form of help, many
of the CPNs had undertaken additional training in the branch of therapy with which
they most closely identified. Many were actively pursuing accreditation with an appropriate professional body e.g. English Nursing Board (ENB), British Association of Counsellors (BAC), British Psychological Society (BPS). However, many CPNs had not pursued further qualifications, leading to an anomalous service in which there was a highly discrepant skill base.

<table>
<thead>
<tr>
<th>CRITERIA</th>
<th></th>
</tr>
</thead>
</table>
| **1. HISTORY** | • has been hospitalised for a continuous period of six months or longer within the last ten years  
• has been admitted as an inpatient three or more times in the last two years  
• has spent more than six months cumulatively in hospital in the past three years  
• has required supportive or supervised living for three months  
• has required extensive treatment and community support for a period of three months or more in the last two years  
• is presenting for the first time with a psychotic/severe diagnosis |
| **2. ROLE DISTURBANCE** | • employment/education  
• family  
• social/recreational (e.g., socially isolated)  
• residential (e.g., at risk of becoming homeless)  
• judicial (e.g., at risk of becoming involved with the criminal justice system)  
• financial |
| **distress is of sufficient severity to cause significant upset in three of the listed areas of a person’s life** | |
| **3. SOCIAL SUPPORT** | If not seen by the CMHTs, an individual will deteriorate to the point of needing hospitalisation of be at risk of committing criminal behaviour and/or the person lacks an adequate support system to restore him/her to an acceptable level of functioning. |

Table B: the criteria for eligibility to receive help from the CMHT. An individual must meet each of the three sets of criteria shown above. (adapted from Smith 1994a).
Much of the research work in this area has pointed to the beneficial effects of appropriately trained counsellors, with sufficient experience (e.g. Jenkins, 1995). The same beneficial effects can not be guaranteed without these ingredients. Many issues relating to quality, standards, supervision and clinical audit had arisen as a consequence of this means of providing ‘psychological therapies’.

The therapy service being provided for category two (‘worried well’) patients resulted from the lack of any other significant ‘psychological therapy’ provision within local mental health services. The vision of services outlined in the strategy document effectively shifted the work load of the CPNs from the provision of psychological therapies to category two patients, to a concentration, as members of the newly formed CMHTs, on the needs of category one patients. Category two patients could gain access to the CMHTs if there were resources available: patients from this group would not receive the same priority as patients considered to belong to category one.

The reconfiguration of services, and the re-focusing of priorities, highlighted the role of the newly formed Psychological Therapies Service.

3.3 The Psychological Therapies Service (PTS).

Treatments for mental health problems can be seen as falling into two main categories: drugs and “talking therapies” (Strategy for Mental Health Services Development, 1994). The strategy document goes on to add that major advances have been made in drug therapies but that there is increasing evidence of the usefulness of talking therapies. Talking therapies include structured psychological therapies through to informal counselling approaches. "Talking
therapies” are generally well liked by service users and it is suggested, within the strategy
document, that future treatment approaches to mental health problems are likely to involve a
more balanced combination of drug and talking therapies. Bearing in mind the authorship of the
strategy document (local commissioners), this emphasis on the future liaison between medical
and psychological approaches to mental health care, takes on major significance for service
providers in terms of their local service provision.

During the latter half of 1993, in response to the service model proposed within the strategy
document, the views of local users, general practitioners (GPs), and the perceived need by local
service providers to introduce the new operational format of services, the Psychological
Therapies Service was established within the local Mental Health Unit. The mission of this new
service as stated in the original operational policy document (1993) is;

'......to enhance the mental health of local people through the application of appropriate psychological approaches. A range of high quality psychological services will be provided and developed in response to identified health care needs. The services will be:
responsive accessible equitable enterprising creative flexible'


Consultation with local stakeholders during preparation of the Mental Health Strategy Review
document, had indicated that the development of ‘Talking Therapies’ within the borough was
an immediate priority. Local unpublished reports and surveys (e.g., the General Practitioner
Survey conducted annually by the local Department of Public Health Medicine) had indicated
massive shortfalls between the level of need perceived and the resources available to met these
needs. The need for help with psychological distress makes a substantial demand on most mental health services. Making an accurate estimate of demand is difficult, but estimates have suggested that 20-50% of the population will experience a depressive disorder while 16-60% will suffer from anxiety states. Locally this translates to between 62,740-156,850 for depressive disorders and between 50,152-188,220 for anxiety states (Smith 1994b). As problems will range from severe and persisting conditions (category one) to less disabling psychological conditions (category two), not all of these problems will be appropriately referred to the PTS in the first instance, but a significant number will. Bearing in mind the change of focus with in the mental health service, the need to provide a quality service for category two patients, and the view that packages of mental health care in the future are likely to consist of a mixture of drug and talking therapies, a framework, within which co-operative service developments could occur was required.

At the time that the Psychological Therapies Service was established there was one Clinical Psychologist in post. Two Art Therapists and a locum Consultant Psychotherapist, who were considered to operate within the same theoretical framework and for whom no logical position within the new service configuration was presented, joined the embryonic therapy service. This bringing together of professionals makes sense conceptually. It was subsequently discovered that a working group on Psychological Therapies for Adults in the NHS, organised by the British Psychological Society and The Royal College of Psychiatrists were in the process of making recommendations compatible with this model of service. Previous levels of funding were "unfrozen" and an active recruitment drive was commenced. By the end of 1993, one grade A clinical psychologist, and two psychology assistants were in post. A further grade A clinical psychologist had been recruited.
4. The development of a Primary Care Counselling Service.

4.1 The birth of the service

In September 1993 the Head of the PTS (present author) was invited to attend the local LIZ steering group to discuss a variety of bids, six in total, for funding (both capital and revenue)

<table>
<thead>
<tr>
<th>ORGANISATION</th>
<th>PROPOSAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Croydon AASHYANA Project</td>
<td>Counselling for individuals and families with associated mental health problems</td>
</tr>
<tr>
<td>Croydon Community Health Council</td>
<td>Extended access to primary care for women</td>
</tr>
<tr>
<td>Croydon Community NHS Trust</td>
<td>Development of primary care mental health services within the primary health care team</td>
</tr>
<tr>
<td>Croydon Family Health Services Authority</td>
<td>Counselling services in general practice in the north of Croydon</td>
</tr>
<tr>
<td>Croydon young people's counselling centre</td>
<td>A bid to establish this service</td>
</tr>
<tr>
<td>Rape and sexual abuse support centre</td>
<td>Flexible counselling and support service for women with mental health problems resulting from child sexual abuse.</td>
</tr>
</tbody>
</table>

Table C. Outline of the six bids made to the local steering group for LIZ funding.
that had been received from local statutory and voluntary services to develop local, primary care focused counselling services. Bids had been submitted from the organisations listed in Table C. No submission had been made by the Mental Health Unit.

The LIZ (London Initiative Zone) steering group had been established to co-ordinate local bids for funding to the London Implementation Group (LIG). This group was charged with the task of distributing the health service funding freed by the closure of London Hospitals recommended by the Tomlinson Report (1992), to develop primary health care services within

Figure B: the boundaries of the LIZ zone in Croydon
the London Initiative Zone. The Liz covered an area approximately fifteen miles from the centre of London in which it could be demonstrated that local people had significantly use the resources provided by the hospitals within London scheduled for closure. The LIZ area covered part, but not all of the London Bough of Croydon as shown in Figure B. It was agreed by the local steering group that a bid for LIZ funding would be made bringing together the submitted bids plus an additional one from the local Mental Health Unit. Guidelines on the format that the bid should follow had been provided by the LIG and these included sections on population assessment, assessment of service development baseline (which would now be referred to as a need assessment), the development proposal, how the plan could be achieved and resource implementations. The present author was charged with the task of discussing, negotiating, writing and submitting a combined bid from the seven groups to the local steering group. This involved a series of meetings with representatives from the specified groups over a period of weeks. These meeting were continued for a period of months after submission of the final bid.

After considerable discussion, and revision, the eventual proposal submitted by the local LIZ steering group to the LIG group for consideration, was for £100,000 revenue to establish a Primary Care based Counselling Service (PCCS) under the management of the local mental health unit, specifically the Psychological Therapies Service. The detail of the bid asked for the establishment of three full time therapy posts and a half time secretary to provide support. The service was identified as a counselling service, as opposed to a psychological service, as a consequence of the process through which the bid was developed.
It was made clear throughout the negotiating process that bids addressing issues of quality, appropriateness of qualifications, supervision and audit would be favourably viewed. Purchasers had expressed concern at the multitude of 'counselling' services that had developed throughout the borough without any reference to quality issues and did not wish to see the development of an uncoordinated without external control. The issue of 'accreditation' as a means of promoting quality is increasingly being addressed by purchasers (Scrivens, 1995). It became apparent during the process of negotiation that local commissioners wished to develop a strategy for primary care counselling services and address many of the issues raised in the latter part of section 1.2 above, those of accreditation, standards, audit, the primary/secondary care interface with mental health services, co-ordination and management framework.

Despite the deadline for submission of bids (October 1993), confirmation of funding for successful projects was not received, by the purchasers, until 10. July 1994. As a consequence work on developing and implementing the service was unable to proceed until August 1994.

4.2 Implementing the new service.

4.2.1 The service model.

McLeod (1988), pointed out that working within the primary care setting presents many challenges to the therapist offering psychological therapies. The pace of work, organisation of the practice and variety of people involved are quite different from that found in more traditional secondary care services.
During 1992 and 1993 the present author worked within a primary care setting as a clinical psychologist/counsellor. As part of this attachment, various models of service were discussed with the general practitioners. The model developed jointly within this setting is represented in the flow chart shown in Figure D below. The significant features of the model can be summarised as follows:-

- identified problems are discussed with the counsellor by the GP prior to formal referral
- a decision is reached concerning the appropriateness of the referral
- referral to the counsellor is discussed with patient
- general information about the counselling service is given to the patient (Appendix A)
- patient decides to proceed with referral
- the patient is provided with a second information sheet giving practical details e.g., session length, how to make an appointment, how many sessions are available, etc. (Appendix B).
- appointment arranged
- feedback from counsellor to referrer as and when appropriate
- re-negotiation of therapy contract, if necessary, with patient, counsellor and referrer.

This model was developed to emphasise a shared approach to the care of referred patients and the benefits of learning through the discussion of specific cases, prior to referral and during therapy. The documentation used was specific to this practice and related to a study of the service undertaken by the senior partner and the present author.

The involvement of the patient at an early stage was considered important and provided an opportunity for the GP to evaluate the appropriateness of the referral and the patient's motivation to undertake therapy.
Figure D. Flow chart illustrating the model of service developed by the present author during an attachment to a primary health care team 1992-3.
Due to the demands of work within the primary health care setting, the number of therapy sessions was limited to six, with each session lasting 45 minutes.

When translating this model that had been developed, and proved successful with one set of GPs to the new primary care service, the present author made a number of alterations. Firstly, it seemed likely that eight, one hour, sessions would provide a more acceptable model to the new post holders who may not have the range of experience or training of the author. Secondly, it seemed likely that the interactive, consultative nature of the service would be more appropriately developed when everyone (therapists, GPs, patients, and secondary care mental health professionals) became more familiar with the concepts of Psychological Therapies and a Primary Care Counselling Service. In addition most service areas within local mental health services, had been subjected to considerable change and it seemed advisable to allow the counselling service to develop incrementally in a more stable environment in which strong links could be forged.

The remaining changes related to documentation. A standardised referral form (see appendix C) had recently been developed by the clinical psychologist within the PTS. It seemed appropriate to launch this new form with the development of a new service. From the author’s experience of working within primary care, the format in which the outcome of therapeutic intervention was reported back to the referrer was significant. In general GPs do not desire long reports preferring brief summaries. This aspect of the new service was to be discussed and negotiated with each practice.
4.2.2 Identification of primary care settings.

A list was obtained from local commissioners of all general practitioners within the LIZ boundary. A total of 44 GPs were identified grouped in 27 different practices. Of these 15 worked without a partner.

An initial letter was sent to all GP settings within this LIZ part of Croydon, a total of 27 letters, one per practice to the senior partner, in August 1995. This letter informed GPs that confirmation of funding had been received to develop a counselling service within primary care settings and that further communications would be forwarded in the next few months concerning the development of the service and asking interested GPs to contact the present author to express an interest in the scheme.

Due to uncertainty about recruitment, time scales, volume of work, and the response of local services, I felt it appropriate to start with the most interested GPs first and then extend the scheme based on initial feedback. Hence initial contact was by letter on the basis that the most interested would respond positively. It also seemed probable that once direct communication occurred with some of the targeted GPs 'word of mouth' would generate interest from the others.

The response to this initial letter was surprisingly poor despite additional notification of the scheme via the FHSA’s regular newsletter to general practitioners. A second letter was sent in October, informing GPs that those who had expressed an interest would be visited by the author in the next two months, and inviting, once again, any other interested GP to contact the
author. The FHSA also sent out additional information to all LIZ practices on the basis of the poor response. Eventually a total of eleven of the twenty seven practices were identified.

Visits were arranged with the doctors in each practice to commence after the recruitment process had taken place. This strategy allowed information to be presented about the start from which the service would be available and the professional background of the personnel.

4.2.3 Recruitment of personnel.

Between submission of bids in October 1993 and confirmation of funding in July 1994, various information had been requested by local commissioners. This information included job descriptions and recruitment adverts and information. Once funding was confirmed, adverts were placed in the Appointments Memorandum of the British Psychological Society and the local press. Interviews took place in September and October. The original proposal asked for funding for three full time posts and secretarial support. One of these posts was designated as the Co-ordinator of the new Primary Care Counselling Service. This post was designated as suitable for a Grade B Clinical Psychologist with a remit to ensure service quality via appropriate training (accreditation), audit and supervision of therapy staff. The remaining two full time posts were funded at Grade A Clinical Psychologist although it was recognised that the skills required for this new service may be found in professionals from a variety of backgrounds, e.g. nurses or social workers with an accredited training in behaviour therapy or counselling, or counsellors accredited by the BAC. In view of the difficulty recruiting qualified clinical psychologists, and the high profile of the service within the district, it was assumed that these posts would be filled by professionals other than clinical psychologists. However, applicants
were required to have sufficient knowledge and skills to work in the 'brief therapy' manner specified within the model of service outlined above.

The Grade B Co-ordinator of Primary Care Counselling Service and secretarial posts were successfully filled on the first round of interviews. The remaining two posts proved more difficult to fill at the advertised grade although a wide variety of applications from different professional groups were received. Applications were received from counsellors, nurses therapists, and counselling psychologists. Two rounds of interviews were held which resulted in the appointment of two counselling psychologists and one part time (0.4 wte.) counsellor who currently worked within a primary care setting. The selection of the counselling psychologists and counsellor, all without qualifications in a profession 'recognised' by the health service, presented administrative problems as outlined in the article on employing counselling psychologists by Collins and Murray (1995) not least of which was the determination of the appropriate salary scale. Advice was taken from the mental health units external human resources consultant and necessitated an evaluation of the responsibilities of the posts. In contrast to Collins and Murray (1995), the SMP (senior managers pay scale) was chosen in preference to the A & C (administration and clerical) scale on the advice of the external consultant. This choice has since raised a number concerns and is under review. Despite the administrative problems, three members of staff were appointed, two full time counselling psychologists, and one part-time counsellor.

All staff were in post at 1 January 1995.
4.2.4 Establishing the service

Following on from the information presented above the actual negotiation with GPs ended up being the easiest part of the process! During the arranged meetings the format outlined below was followed by the present author;

- An introduction outlining the recent reorganisation of mental health services and the process by which funding had become available to provide this service to their practice.
- What the service was offering. This included information on the service model, the staff that had been recruited, and the necessity to evaluate the service and how this would be undertaken.
- A discussion of what would be required from the practice. This included the regular availability of a quiet room, support from a member of the reception staff who would take responsibility for organising ‘the paper work’ and interacting with patients in the absence of the counsellor, and completion of referral and evaluation forms. Secretarial functions apart from these would be undertaken by the half time secretary funded by the LIZ project.
- Information was requested on the list size of each practice to determine the appropriate level of resource. Initially this was set as four hours counselling per week per list size of 6,000 plus.
- A potential problem was anticipated with single handed GPs who may not have the necessary resources available to support the service. It was suggested that this could be resolved by establishing a system of ‘referral rights’ to a service based in a neighbouring practice. This system already operated in respect of other services (e.g., physiotherapy).
- Detailed information was exchanged on suitable times for the practice to host the service, possible start dates, and the need for further discussions to occur between the therapy staff,
the Co-ordinator of the counselling service and practice staff before the commencement of the service.

The above process was taken over by the co-ordinator of the new service who took up post in January 1995. As predicted, 'word of mouth' resulted in further requests from general practitioners to receive the service. This process in continuing with two further requests for the service being received at the end of July 1995. Including these two requests, 23 practices (out of a possible 45) have been involved in the service.

The Primary Care Counselling Service become operational on 16. January 1995 with the commencement of the first session, provided by a counselling psychologist within a primary care setting. Data collection is ongoing and initial results will be reported to local commissioners by the end of 1995.

The aims and objectives specified in the introduction to this Clinical Audit were met in full.

5. Critical Review

The establishment of the Primary Care Counselling Service under the umbrella of the Psychological Therapies Service and local Mental Health Services was supported by local service users' groups, local voluntary sector agencies, local GPs and local service commissioners. Without this support the proposal would not have received funding from the
London Implementation Group. The identification of the Primary Care Counselling Service as a local priority grew out of a number of local factors which have been alluded to in the text above. For example,

- the increasing awareness by local 'stakeholders' of the mismatch between the supply of, and demand for psychological services. The proposed service provided a partial solution to the identified needs of a group of local people with a mental health problems.

- an increasing interest in non-drug treatments for mental health problems (Sibbald et al., 1993) supported by user groups and the local commissioners, albeit for different reasons (respectively choice vs. cost)

- the development of 'counselling services' within the voluntary sector, all of which reported a high demand for their services and a need for additional funding

- the reorganisation of local mental health services and the stated focus on group one (severely mentally ill) patients. This proposed strategy had raised concerns about the management of those patients defined as group two and therefore not automatically receiving a therapeutic input from mental health services (Smith 1994a, 1994b). It has been suggested (Rowland and Hurd, 1991) that as many as ½ of the people who approach their GP have a problem which relates to the stresses of daily life and who may, therefore, be defined as a group two patient.

- concerns about service organisation, accreditation, standards, clinical audit and supervision had been raised in respect of counsellors employed directly by GPs - a recognised growth area (e.g., Sibbald et al., 1993)
The proposal to develop a Primary Care Counselling service received significant local support as it brought these various strands together at a time when strong links (networks) had been made between the professional involved in delivering local services, and when 'strategic change' was heralded as the way forward for local mental health services (as evidenced by the Croydon Health Commissioning Agency's document 'Strategy for Mental Health Service Development 1993/4-1996/7'; 1994). Equally, for all of these reasons the proposed Primary Care Counselling Service had a high profile - it signified the way forward and was seen by interested parties as a 'ground breaker' for the substantial changes to come within mental health services emphasising, as this new service did, the move away from an institutional medical model of care to a more community based social/psychological care model. There was a strong commitment from the majority of local stakeholders to ensure that this service was funded.

Having reviewed the process by which the Primary Care Counselling Service was established, various steps taken, during the development of the service, could have been approached differently. For example;

• The initial proposal could have been limited to a small number of practices within the Borough known to support the attachment of a psychological service and/or the amount of money requested greater. At the time it was difficult to pursue either of these options due to the prevailing political climate. Every proposal was on a tight budget with a strong message that deviation from these parameters would result in the withdrawal of support for the proposal by the local LIG steering group. Bearing in mind the strength of local support for this service development, it may well have been worthwhile spending more time testing the
absoluteness of the parameters given in an attempt to win more funding and/or a smaller remit.

- The identification of practices within the LIZ area that would receive an input from the Primary Care Counselling Service did not follow a scientific method. The service was offered to those practices that responded to a notice informing them of the service’s availability and asking for their expression of interest in receiving it. This was seen as a pragmatic solution - a way of getting the service up and running quickly and maximising the chances of the success by focusing on those practices showing the greatest interest in, and motivation to pursue, the new service. In would have been better to base the choice of practices on a ‘needs assessment’, or possibly through a co-ordinated developmental process with the evolving CMHTs. This latter option would have proved challenging due to the difficulties experienced operationalising the new CMHTs. It would also have resulted in a considerable delay before the Primary Care Counselling Service became operational. Overall, it would certainly have been better if a response had been actively sought from all the potential practices in the planning stage rather than eliminating practices on the basis of their failure to respond to a mail drop. A ‘needs assessment’ could then have identified the practices that would benefit most from the new service.

- The amount of input into each identified practice was made on the basis of list size, that is the number of patients using the practice. No consideration was given to the incidence or prevalence of mental health problems within the practice. Within the Borough there are known to be wide discrepancies in the level of psychological distress between electoral wards (Croydon Health Commissioning Agency, 1994). An assessment of the need within each practice could have been made prior to the determination of the level of resource available to that practice.
When introducing this service there was a strong emphasis on responding to the needs, style and wishes of each practice. This was due to a recognition that each practice had its own culture and for the service to operate successfully this culture needed to be acknowledged. In reality, little difference was found amongst the various practices in terms of their expectations of the service, and indeed, the GPs were largely guided by my own experiences of working in primary care. The emphasis on face-to-face contact with GPs, and the expectation that there would be differences amongst the practices, discouraged me from producing too many written guidelines or operational policies. It would have been useful to have had these guidelines available, as a backup and frame of reference, from the first point of contact with each practice, rather than introduce them at a later meeting.

It is difficult to compare the Primary Care Counselling Service developed in Croydon with other services as no significant body of literature exists in this area. Thornicroft states that community mental health services are generally poorly developed (Thornicroft et al., 1995). Although many examples of psychiatrists, psychologists, CPNs (e.g. Kendrick et al., 1993) and counsellors (e.g. Jenkins, 1995) working within primary care settings have been reported, there is as yet little information about psychological services being provided, in a co-ordinated way, by professionals (clinical psychologists, counsellors and counselling psychologists) from the local mental health unit, whose sole function is to provide this type service. From this perspective, this service is helping to break new ground and it is only a matter of time before relevant literature is available.
6. Postscript.

6.1 Evaluating the new service.

In May 1994 a circular was received from the purchasers asking for bids to the South (West) Thames Primary Care Development Fund. In view of the anticipated confirmation of funding for the PCCS, and the stated criteria by which bids would be evaluated, a bid was submitted by the present author and a service manager, to undertake a study of the proposed new service. The aims of this study were to establish agreed referral criteria, to evaluate outcome, to study relevant changes in prescribing practices, and to develop simple outcome measures appropriate, to psychological therapies, for future use within primary care, and other, settings. Funding was obtained and would run from September 1994 to September 1995.

6.2 Future development of the service

Most recently a further bid to extend the Primary Care Counselling Service via Strategic Change Funding was submitted to local commissioners by the author and a management representative. The Strategic Change Fund has been established to facilitate the development initiatives within the primary health care setting. The bid was submitted at the end of May 1995 with the support of one of the major GP locality purchasing groups. Informal discussions with the lead GP in this purchasing group had revealed the purchasing priorities within this group to be firstly, increased physiotherapy and secondly, increased provision of psychological therapies within the primary care setting. It would appear that the conclusion of Thornicroft et al. (1995), that the second priority for community mental health services should be the 90% less severely ill, may not be shared by GPs.
A meeting was convened with interested GPs, local commissioners and the present author in August 1995 and a revenue sum of £20,000 has been made available to extend the PCCS to four practice settings within the south of the Borough. Much debate occurred concerning the level of need for the counselling/psychology service within the primary care setting and an implicit understanding was reached that the sum agreed was 'a start' and may be added to at a later date.

The process of establishing the PCCS in the LIZ area of the borough will be embarked upon again by the present author. It is hoped that the addition to the PCCS will be operational from October 1995.

The success of these bids, and the successful implementation of the service, reflects the purchasing priorities of local GPs, the perceived need of psychological services for patients, the views of local service users and the support for these services by local commissioners.
REFERENCES


FACT SHEET

CLINICAL PSYCHOLOGY

Clinical Psychologists are professional people with a great deal of knowledge about people, how they feel and behave, and the problems they may come across, in these areas, in their day to day lives.

The number of qualified Clinical Psychologists in the United Kingdom is small and the thought of seeing one may seem rather strange. However, the key phrase to describe their work is -

'PROBLEM SOLVING'.

A Clinical Psychologist uses his/her knowledge, and experience, to look at problems in a psychological way. By looking at problems in this manner, and by knowing how people find it easiest to bring about change, a psychologist tries to find one, or more, workable solutions for each person.

Seeking a solution to whatever the problem may be is a joint effort. A Clinical Psychologist may know a lot about people in general, but no one knows more about how you feel, and what you want to happen, in your circumstances, than you do.

When you come to see a Clinical Psychologist, you come to put your knowledge together with the psychologist's, to find a workable solution to your difficulties. It is then up to you to work to achieve that solution, or not, as you wish! To help you with this task, the psychologist may teach you various techniques that have been shown to be of help to other people with similar problems.

There are no secrets, mysteries, or magical cures, when you come to see a Clinical psychologist. You only talk about, and try to sort out those things that you wish to work on.

If you decide, following discussion with your doctor, that seeing a clinical psychologist may help you with your problems, please ask them to supply you with more information about what happens next.

(July '92)
Appendix B: Information given to patient after decision to see psychologist/counsellor.

WHAT NEXT?
Clinical Psychology Referral.

By now you will have decided that seeing a clinical psychologist may be of help with your present problems. Your doctor will have talked with the psychologist about your difficulties, and everyone is in general agreement that it would be worthwhile arranging an appointment.

The practice has obtained funding, for a limited period of time, to provide the services of a Clinical psychologist. We hope that this will allow you to obtain the help you are looking for quickly and without difficulty.

Your doctor will ask you to complete a form before your first session with the psychologist if he/she has not already done so. This form allows you to state your problem as you see it.

Following referral to the psychologist you will be offered up to SIX sessions with the psychologist. These sessions are likely to be offered over a period of weeks on either a Monday or Tuesday evening. Sessions may be offered to you on an individual basis, or as a member of a group of people with similar problems.

The length of each session may vary, but will not be longer than 45 minutes for an individual session, or 1½ hours for a group session.

Sessions will be held in a building adjoining the surgery. However, it would be helpful if you could inform the receptionists at the surgery that you have arrived for your first appointment. Subsequent appointments will be arranged between yourself and the psychologist.

After you have completed your series of sessions with the psychologist you will be asked to complete a further form. This is to help us evaluate the service and to obtain your views on the usefulness of the sessions.

We will inform you of the date and time of your first session as soon as possible.

(July '92)
Appendix C: Standardised referral form for the Psychological Therapies Service. (reproduced smaller than actual size).

CROYDON MENTAL HEALTH UNIT
REFERRAL TO PSYCHOLOGICAL THERAPIES SERVICE

This form will help to expedite your referral. The designated therapist responsible in future for this case will notify you when the patient is first seen, of any future progress and of their eventual discharge. Thank you for your referral.

Head of psychological therapies service.

| DATE OF REFERRAL | | |
|-------------------|-------------------|

1. Name and Address and Telephone No. of referring Doctor/Agency

2. Name and Address of Patient (please include home/work telephone numbers)

3. Current involvement of other agencies

| CPN | Psychiatrist | |
|-----|---------------|
| Social Services | |
| voluntary agency | Unsure |

Details of that intervention or previous intervention

4. Patient’s Age and Date of Birth

5. Gender

6. Marital Status

7. Is the patient literate in English?

Yes No Unsure

8. In what language can the patient converse

9. Patient’s ethnic origin

<table>
<thead>
<tr>
<th>White</th>
<th>Black Caribbean</th>
</tr>
</thead>
<tbody>
<tr>
<td>Black African</td>
<td>Indian</td>
</tr>
<tr>
<td>Pakistani</td>
<td>Bangladeshi</td>
</tr>
<tr>
<td>Chinese</td>
<td>Black Other</td>
</tr>
<tr>
<td>Asian Other</td>
<td>Not Given</td>
</tr>
</tbody>
</table>

10. Please state the reasons for which the patient is referred

/Continue overleaf
SECTION FOUR:

RESEARCH AUDIT
A Test of The Reformulated Learned Helplessness Model of Depression in Terms of Attribution Theory

This thesis is submitted in part fulfilment of the requirements for the Degree of Master of Science in Abnormal Psychology at the Queens University of Belfast.

Caron E. Gaw
(1979)
I think that perhaps this is the hardest part of writing this Thesis. It is extremely difficult to keep an account of everyone who assisted in the completion of the “finished product”. From those I leave out, I beg forgiveness. To everyone that offered assistance, I extend my heartfelt thanks. There are, however, some individuals whose contribution cannot go unremembered.

Firstly, I would like to thank Dr. Karen Trew for her invaluable help, her patience and her sound advice whilst supervising this thesis.

Secondly, I would like to thank Mr. D. O’Mahoney, Mr. J. Formby, Miss M. Olley, Professor Fenton, Dr. Potter, Dr. Skelly and Mr. Terry MaGill for their assistance in arranging for subjects and help in getting testing underway.

I would also like to express my thanks to Dr. Sykes, Dr. B. Greer, Dr. Casement, Mrs. P. McDowell and the secretaries in the Psychology Department at Windsor House (Belfast City Hospital) for their various contributions.

Last, but not least, I would like to thank Dr. M.E.P. Seligman and Dr. J. Teasdale for giving me permission to use the, as yet unpublished, questionnaire measuring attribution styles in the present study.

It goes without saying that I am also indebted to Mrs. P. Noble for her patience and skill in typing this Thesis.
ABSTRACT

The aim of the present study was to test and investigate the Abramson et al. (1978) reformulated learned helplessness model of depression in terms of attribution theory. A total of sixty-three hospitalised patients, forty psychiatric and twenty-three non-psychiatric, acted as subjects and completed a test booklet of questionnaires designed to measure the three dimensions of attribution (internality, stability and specificity as discussed by Abramson et al.), and level of depressive symptomatology (measured by Becks Depression Inventory: B.D.I.). Little support was found for a number of hypotheses derived from the reformulated learned helplessness model of depression. However, using the statistical technique of discriminant function analysis a significant discrimination (p<.001) was obtained among three broad diagnostic categories, normal, depressed psychiatric and nondepressed psychiatric hospitalised patients, on the basis of a number of measures of attribution styles. It was also found that normal and psychiatric patients in general, seem to consistently differ in their attributions for failure outcomes. These results were discussed in the context of Miller and Normans (1979) reformulation of the learned helplessness phenomena in terms of attribution theory, and in particular their emphasis on attributions of failure outcomes.

In conclusion, a number of questions regarding the relationship between cognitive processes, in particular attribution styles, in mental illness are raised which requires further experimental investigation.
CHAPTER 1.

INTRODUCTION.
1.1 BACKGROUND.

Over the past ten years or so there has been a rapid increase in the amount of research published on the phenomena of Learned Helplessness. This research developed from experiments by Overmier and Seligman (1967) who reported that dogs exposed to inescapable electric shocks, under a wide variety of conditions, later failed to learn an instrumental escape-avoidance response in a new situation. This proactive interference effect has been previously described by other investigators, notably those in the area of Pavlovian fear conditioning (e.g. Brown and Jacobs, 1949), and was attributed to either instrumental learning of skeletal-motor responses which later proved to be incompatible with the new response to be learned; or, to an adaptation to shock during pre-treatment and a subsequent lack of motivation to perform the appropriate escape or avoidance response.

Overmier and Seligman (1967) presented evidence that neither of these hypotheses were appropriate and suggested an alternative source of the interference in terms of learned helplessness. Helplessness results from receiving aversive stimuli in a situation in which all instrumental responses have no effect on the trauma. It was added that the interference effect of inescapable shock dissipated with time, leaving apparently normal subjects (in this case dogs) after about 48 hours.

Seligman and Maier (1967) concluded from a series of experiments that the learned helplessness phenomenon was actually caused by the uncontrollability of the original shocks. They further argued that it seemed sensible to introduce a third operation into learning theory since independence, or lack of contiguity (acquisition) or explicit noncontiguity (extinction) between events. In addition, this third operation (independence between events) was hypothesised to have effects upon behaviour different from those of
explicit pairing and explicit nonpairing, producing a subject who does not attempt to escape electric shock and who does not benefit from instrumental contingencies.

The term uncontrollability introduced by Seligman and Maier (1967), was operationally defined by Maier and Seligman (1976). Uncontrollability is obtained in a situation when any response will not change or affect subsequent reinforcement: specifically \( p(\text{RF}/\text{R}) = p(\text{RF}/\text{R}^*) \). Basically this means that the probability or likelihood of obtaining a reward after a given response or action is the same as the probability of obtaining a reward after no response. When all the organisms emitted responses conform to this rule, the subject cannot control the reinforcer and it is defined as being uncontrollable.

Since the original learned helplessness experiments with dogs, helplessness has been demonstrated in a number of species, including man, and a wide variety of situations.

One of the first demonstrations of the phenomenon in man was provided by Thornton and Jacobs (1971) who used a now typical helplessness inducing paradigm in which human subjects were given training trails of inescapable/unavoidable shock followed by test trails, in which escape/avoidance was possible. Statistical analysis supported the learned helplessness hypothesis in humans, but the authors concluded by stating that further investigation of the phenomena and, in particular, parameters such as generalisation, immunisation and alleviation, were required. Hiroto and Seligman (1975) tested the generality of the debilitation produced by uncontrollable events across tasks and

* Where \( \text{RF} \) = reinforcement; \( \text{R} \) = reward; \( \text{R}^* \) = no reward; \( p \) = probability.
motivational systems and concluded that insolubility of discrimination problems, and inescapability from an aversive tone, both produced learned helplessness in subsequent anagram solving tests. Cross-modal helplessness was also found in their study. Hiroto and Seligman further suggested that the learned helplessness seen in their subjects was an induced trait rather than a transitory state since there were debilitating effects on performance well beyond the conditions under which helplessness was first produced.

In all the learned helplessness experiments mentioned each subject has been physically capable of escape. The finding that subjects fail to escape after experience with uncontrollability has consequently been attributed to psychological processes. Maier and Seligman (1976) in a comprehensive review of the learned helplessness literature to date, summarised the known psychological deficits caused by learned helplessness under three separate headings: motivational, cognitive and emotional.

Motivational deficits after experience with uncontrollability are seen in the organisms retarded initiation of voluntary response. This is particularly noticeable in the subject’s failure to respond in the face of later aversive events. For example the dogs in the original learned helplessness experiments completely failed to initiate escape-behaviour in the presence of shock after experience with uncontrollable aversive stimuli.

The cognitive deficits have occasionally been referred to as anegative cognitive set. Exposure to uncontrollability seems to interfere with the organisms ability to perceive relationships between behaviour and outcome. For example if a dog that has been exposed to inescapable shock responds, on a subsequent task, in a manner that produces relief (e.g.
crossing a shuttle box) the animal frequently has difficulty learning that the response has been effective. This is clearly demonstrated when a helpless animal is forcibly carried across a shuttle box to obtain relief: it often takes many learning trials before the animal will spontaneously respond. Normal dogs reliably escape shock after one or two successful escapes.

An emotional component was first inferred from the fact that, in some circumstances, motivational effects dissipate with time. It has been found that rats given inescapable shocks show more stress or emotional effects (measured by stomach ulcers) than rats who can control shock (Maier and Seligman, 1976). Hokanson et al. (1971) in an analogous human study measured blood pressure changes at 30 second intervals and found that yoked subjects (i.e. those experiencing uncontrollability) showed consistently higher blood pressures that may reflect increased emotional arousal. Gatchel and Procter (1976) found that a group of human subjects, pre-treated with inescapable tones, demonstrated lower tonic skin conductance levels, smaller phasic skin conductance responses, and more spontaneous electrodermal activity relative to the group pre-treated with escapable tones. They added that these are symptoms that some studies have shown to be associated with clinical depression.

Analogies have been drawn between the emotional consequences of exposure to uncontrollability and the work on experimental neurosis (Maier and Seligman, 1976). The term experimental neurosis is not well defined and controllability has not been explicitly manipulated to produce the neurosis. In spite of this, the procedure for inducing experimental neurosis is frequently Pavlovian, and, by definition, the organism has no
control over the onset or offset of the stimuli presented. It is not clearly determined if these two phenomena are closely related, but uncontrollability is prominently present and emotional disruption is frequently a result.

As mentioned earlier it has been claimed that the effects of uncontrollability are usually not specific to the original learning situations and may have consequences for a wide range of behaviour and undermine response initiation generally (Maier and Seligman, 1976). This effect is thought to result, in part, from learning that responding is futile and therefore future responding will also be futile. This learning can be broken down into three steps:

Information about contingency → Cognitive representation of the contingency → Behaviour

(From Maier and Seligman, 1976)

The kind of contingency in which response and outcome are independent has been defined above i.e. \( p(RF/R) = p(RF/R) \). Seligman hypothesises that information of this sort is processed and transformed into a cognitive representation of the contingency. This representation may be referred to as an expectation, a belief, a perception, or as learning. An individual may be exposed to a contingency in which response and outcomes are, in fact, independent but not form this expectation. Or conversely, form this expectation when events are controllable. Once the expectation of uncontrollability has been established the individual’s behaviour changes to produce the effects associated with helplessness. Bandura (1977) has hypothesised that expectations of personal efficacy determine whether coping behaviour will be initiated, how much effort will be expended, and how long it will be sustained in the face of obstacles and aversive experiences. This assumption is central to the
hypothesised development of the helplessness behaviour. The incentive to initiate voluntary responses, states Bandura (1977), decreases in likelihood when a person or animal learns that relief is independent of responding. Thornton and Jacobs (1971) reported that college students demonstrating learned helplessness after exposure to inescapable shock felt that they had no control over shock and consequently felt responding was useless.

The learned helplessness hypothesis has been stated in cognitive language in that mere exposure to uncontrollability is insufficient to produce helpless behaviour. The individual must come to expect that outcomes are uncontrollable in order to exhibit helplessness.

A number of alternative explanations of the learned helplessness phenomenon, in S-R terms, have been reviewed by Levis (1976). An alternative S-R theory was also developed. The theories reviewed included the adaptation and incompatible motor response theories associated with Pavlovian fear conditioning. The third theory reviewed was that associated with Weiss et al. (1975) in which it was hypothesised that a deficiency in central noradrenergic activity is caused by exposure to inescapable shock and this deficiency prevents the learning and performance of the correct response in a subsequent task. While a number of interesting effects have been demonstrated by Weiss et al. (1975) the procedural differences between these experiments and those in the area of learned helplessness are very great. A number of conclusions drawn from experiments on the motor activation deficiency hypothesis have also been questioned. However Levis concludes that further investigations and clarification of definitions are required before any firm conclusions can be drawn regarding the power of these two different perspectives of behaviour.
Stimulated by Maier and Seligman’s statement that S-R analysis was unable to account for the data reviewed in their 1976 paper, Levis outlined an alternative two-process reinforcement theory of escape learning. In this theory he hypothesised that shock offset produces two related but conceptually different reinforcements, namely a reduction in painful stimuli, the effects of which are maximal following shock cessation: and secondly a reduction in the animals emotional state (fear) which is frequently manifested by increased gross bodily movement during shock onset, the reinforcing effect of which occurs gradually with the rate depending on the intensity of the shock used. During the inescapable shock procedure these two reinforcers will gradually summate and immobility will be shaped as the organisms response to shock onset. When transferred to an escape paradigm this reinforcement for immobility will produce a greater tendency for the animals to remain immobile in the presence of shock. This produces the learned helplessness effect. This model has failed in its stated purpose, that of stimulating research and increasing knowledge. It does, however, illustrate the fact that alternative theories to that of Seligman, do exist and are being developed. One of the greatest problems faced by these theories is that of explaining the range of phenomena encompassed by the learned helplessness concept (Seligman, 1975). Seligman also believes that cognitive theorising is more fruitful than that of the S-R school and, reflects more closely those processes that underlie human behaviour (Maier and Seligman, 1976).

Having outlined the development of the learned helplessness research the effects of uncontrollability, and the ability to demonstrate the effects in a wide variety of species, including man, the next section discusses the application of this theory to human depression.
1.2 LEARNED HELPLESSNESS AS A MODEL OF HUMAN DEPRESSION (1975).

Rippere (1977) states that Seligmans account of a decade of research on learned helplessness is an important landmark in the development of the psychology of depression, representing as it does the first full-scale treatment of the subject starting from an experimental, rather than a clinical, point of view.

Lubin et al. (1978) state that while there is an increasing number of empirical studies in the area of depression, there is a tendency for investigators to use a variety of measures whose construct or concurrent validity has not been determined. A further complicating factor in this area of research is the multidimensional nature of the disorder. The symptomatology of depression is multifaceted, and there are many symptoms that never seem to occur simultaneously (Heusmann, 1978). Depressives often feel blue or sad, but sadness need not be present to diagnose depression. Similarly with other symptoms. In fact, clinical phenomena, in general, are often vaguely delineated and poorly understood.

Seligman (1975) proposed that the laboratory phenomenon of learned helplessness modelled reactive depression in man. He states that approximately 75% of all depressions are reactions to some external events such as the death of a child. While reactive depressions are the primary focus of the learned helplessness model of depression, he adds, that endogenous depressions have much more in common psychologically with reactive depressions. An appropriate model may help to increase the precision of thinking about the disorder as well as providing deeper understanding.
The concept of learned helplessness need not cover the whole spectrum of depression, only those cases in which the individual is slow to initiate responses, believes himself to be powerless and hopeless, and sees his future as bleak. Seligman adds that if the learned helplessness model of depression proves adequate, the present concept of depression may have to be reshaped while other problems, not normally considered as depression, e.g. the disaster syndrome, may become included in the definition.

Miller et al. (1977) state that the similarities between learned helplessness and depression can be looked at in four areas: symptoms, cause, treatment and prevention.

1.2.1 SYMPTOMS.
Six symptoms of learned helplessness have been identified. Each parallels a symptom of depression.

(1) Lowered initiation of voluntary responses. The word depressed, as a behavioural description, means a depression or reduction in the rate of responding. Considering this, it is not surprising that a prominent symptom of depression is failure or slowness to initiate responses. Klein et al. (1976) and Miller and Seligman (1975) have ample demonstrated the striking similarity between the lowered response initiation of learned helplessness and that found in depression.

(2) The second symptom named is that of a negative cognitive set. This refers to the difficulty that subjects, exposed to a learned helplessness inducing procedure, appear to
have in learning that their responses control the outcome. Beck (Beck, 1967; Blaney, 1977) consider this negative cognitive set to be the primary characteristic of depression, and that other symptoms result from this belief. Miller and Seligman (1973) have demonstrated this negative cognitive set in depressed college students while Klein and Seligman (1976) demonstrated parallels between subjects exposed to inescapable noise and untreated depressed subjects firstly, on an escape task and, secondly, in their perceptions of response-reinforcement independence. Miller et al. (1977) state that these, and other studies clearly show parallels between the effects of learned helplessness and depression on the perception of reinforcement and on measures of cognitive functioning.

(3) The third symptom discussed by Seligman (1975) and Miller et al. (1977) is that of time course. Helplessness dissipates in time when induced by a single session of uncontrollable shock (see Overmier and Seligman, 1967); after multiple sessions, helplessness persists for prolonged periods of time. It is commonly thought that most depressions spontaneously remit, although whether they last days, weeks, months or years is a matter of dispute.

(4) Lack of aggression is the fourth symptom considered by Seligman (1975). Psychoanalysts have attributed this lowered aggression to introjected hostility and Freud and his followers have made it the basis of the psychoanalytic theory of depression (Pervin, 1975). This well-documented finding, i.e. that depressives lack aggression, is thought to correspond to the lack of aggression seen in subjects demonstrating the learned helplessness phenomenon. Aggression is not seen as causing depression, as in Freudian theory, but rather as another voluntary response system undermined by the belief of helplessness.
Seligman (1975) further cites the work of Harlow on depressed primates (where young monkeys have been separated from their mothers or placed in a dark pit) and the social and aggressive deficits that ensue, as support for the link between aggression, depression and learned helplessness.

(5) Depressives commonly show loss of appetite, and reduced interest in sex and interpersonal relations. Miller et al. (1977) state that these deficits are paralleled by similar symptoms in helpless animals. These symptoms of loss of appetite and libido are the fifth parallel between the symptoms of learned helplessness and depression considered to be present by Seligman (1975).

(6) The sixth and final parallel between these two syndromes is that of norepinephrine depletion and cholinergic activity. According to the catecholamine hypothesis of affective disorders (Mendels and Fraser, 1974; Miller et al., 1977) depression is associated with a deficiency of norepinephrine at receptor sites in the brain. There has also been some suggestion of an overactivation of cholinergic systems within the brain in depressives. These hypotheses are based on evidence from drug studies (see Klerman and Cole, 1965; Janowsky et al., 1972). These findings may correspond to the depletion of norepinephrine reported by Weiss et al. (1975) in rats exposed to a learned helplessness inducing procedure.

Before leaving this discussion of the similarities between the symptoms of learned helplessness and depression, it would seem appropriate to mention an additional area of similarity, that of subjective feelings and self evaluations. Bibring (see Libermann and
Ranskin, 1971) defines depression as the emotional expression of a state of helplessness, low self-esteem and powerlessness of the ego. Grinker et al. (1961) and Melges and Bowlby (1969) also characterise depressed patients in this way. Depressed individuals frequently say that they feel helpless, hopeless and powerless, in the sense of believing that they are unable to control or influence those aspects of their lives that are significant to them. As stated earlier Thornton and Jacobs (1971) reported similar feelings in college students demonstrating learned helplessness.

1.2.2 CAUSE.

While the aetiology of depression is even less clear than its symptoms, the cause of learned helplessness is reasonably well understood. The cause, perception of uncontrollability, has been outlined in Section 1.1 above. A number of recent theories regarding the aetiology of depression e.g. those of Bibring, Bowlby, Beck, agree on the importance of helplessness and hopelessness. Miller et al. (1977) state that the depressed patient has learned or believes that he cannot control those elements of his life that relieve suffering or bring him gratification. In short, he believes he is helpless. Miller and Seligman (1975) and Klein et al. (1976) reported experimental confirmation on this in the test task performance deficits of untreated depressed subjects and nondepressed subjects who had previously experienced uncontrollable stimuli.

Seligman (1975) believes that when a traumatic event occurs it causes a heightened state of emotionality. This state is similar to, and has been called, fear. Fear is thought to continue until the subject learns that he can or cannot control the trauma. If the subject can
control the event, fear is reduced and may disappear completely. On the other hand, if the subject believes that he cannot control the traumatic event, the fear state will decrease and be replaced by depression.

Lewinsohn (1974) hypothesises that the cause of depression is an individual's low rate of response-contingent positive reinforcement. Depression results from being reinforced for not emitting behaviour. This theory contrasts with that of Seligman. In terms of the learned helplessness theory of depression, as long as the organism has a way of controlling the environment, even if the individual can only increase the probability of being reinforced by doing nothing, this should not lead to depression. The subject is not experiencing uncontrollability. These two contrasting hypotheses have been tested by Price et al. (1978). Using hospitalised psychiatric and medical patients as subjects, they concluded that their results supported the learned helplessness model of depression in preference to the model proposed by Lewinsohn.

Blaney (1977) compared three theories that he feels have dominated recent empirically oriented literature on depression: Beck's cognitive view, Seligman's helplessness model and Lewinsohn's theory of a low rate of response-contingent reinforcement. Beck argues that the depressive is characterised by negative expectations and beliefs of personal adequacy. These beliefs form a triad of negative conceptions. The individual denigrates the past, doubts his ability to cope in the present, and is pessimistic about the future. In contrast to Seligman's view that the depressive believes response and outcome to be independent, Beck viewed depressives as assuming personal responsibility for outcomes, and in particular failure. The depressed affective state is seen as secondary to these negative
cognitions. Beck developed his theory from clinical observations of depressed patients and their commonly held beliefs relating to negative self-evaluations, self-blame, self-criticism and generally low opinion of themselves. This low level of self-esteem is found to lessen with clinical improvement (Abramson and Sackeim, 1977). Beck (1967) developed a self-report questionnaire based on his view of the nature of depression. This questionnaire has frequently been used in investigations of the learned helplessness phenomenon as a measure of a subject's level of depressive symptomatology. A copy of this questionnaire can be seen in Appendix 6. The two other theories (those of Lewinsohn and Seligman) have been discussed previously. Blaney (1977) concludes that there is considerable overlap among these three theoretical positions and there is ample evidence, from the literature, of the importance of three variables in depression; perception, control and rate of reinforcement. While no one of these theories explains all the phenomena of depression, Blaney does highlight one glaring omission in the learned helplessness theory of depression. It can be demonstrated experimentally that some, or all, depressive states have a self-blaming character similar to that described by Beck. No provision has been made in the learned helplessness model (of 1975) for the incorporation of this finding. The three elements suggested by the theories are not mutually exclusive. Each may well be sufficient to lead to depression or none may be necessary. The literature does not provide a firm basis for repudiating any one of these three theories in favour of another.

What then can be concluded about the aetiology of depression? A number of theories have been advanced to account for the development and maintenance of depression. A few of these, e.g. those of Beck and Lewinsohn, have been mentioned above. None of these theories account for all the phenomena found in depression. It can be said, however, that
Seligman's model makes more specific and testable predictions than most. Possibly as a result the theory lacks flexibility but it is arguable that greater knowledge will result from its testability.

1.2.3 TREATMENT.

As mentioned above helplessness dissipates with time. Forced exposure to the fact that responding produces reinforcement has also been noted to remove the effects of learned helplessness (Seligman, 1975). For example forcibly dragging dogs demonstrating helplessness from one side of the shuttle box to the other, thus producing relief, cured helplessness. Electroconvulsive shocks (E.C.T.), atropine and the antidepressant drug pargyline have also been reported successful in alleviating the deficits produced by experience with uncontrollability (see Miller et al., 1977).

It is well known that depression may spontaneously remit in clinical patients after an unspecified period of time. E.C.T. probably alleviates endogenous depression but its effects on reactive depression are unknown. The role of atropine in depression is also unknown.

There are a number of therapeutic interventions that have been found effective in the treatment of depression. According to the learned helplessness model, successful therapy should involve demonstrating to the patient that responding is effective in producing a desired outcome. Some of the therapies designed to alleviate depression are consonant with this theoretical position, but have developed from quite divergent sources. Taulbee and
Wright (1971), for example, have advocated forcing depressives to emit one of the most powerful responses' people have for controlling others, that of anger. Once this response is produced the individual is powerfully reinforced. Becks (1967) cognitive therapy involves removing an individual’s negative cognitive set through manipulating success and developing a more positive attitude. Lazarus (1968) view’s time projection therapy as allowing new or competing responses, which are more rewarding to the individual, to develop and thus alleviates depression. Lewinsohns therapy also involves participation in activity and other nondepressed behaviour as an effective control of therapy time. These reportedly effective methods of treatment are not, of course, tests or evidence for the learned helplessness model, rather they provide examples that seem to include exposure to response-produced success as part of the cure for depression. A more direct test of the applicability of the procedure for reversing helplessness to reversing depression was provided by Klein and Seligman (1976) and Kilpatrick-Tabak and Roth (1978). Klein and Seligman (1976) demonstrated that the behavioural deficits of both depression and learned helplessness were reversed after subjects were exposed to success experiences with solvable discrimination problems. Kilpatrick-Tabak and Roth (1978), however, failed to confirm the predictions of the learned helplessness model of depression although they did reverse the effects of uncontrollability by experience with solvable discrimination problems. They suggested that depressed and helpless subjects do, in fact, respond quite differently. They added, however, that there is clinical and experimental evidence that depressives do show positive changes in mood and behaviour following experience with success. It seems reasonable to conclude that the reversal of performance deficits in helpless and depressed subjects require further investigation and, if possible, isolation of the effective variables.
Miller et al. (1977) discussing the results of Klein and Seligman (1976) added that their procedure provided a useful method for testing the effectiveness of any therapy for depression in the laboratory. Depression, they state, can be brought into the laboratory in its naturally occurring state and in the form of learned helplessness, investigated and reversing therapies tested.

In conclusion a variety of techniques and theories suggest that therapy aimed at ameliorating depression should centre on the patient's sense of efficacy i.e. ability to control reinforcers. Depression may be directly antagonised when a patient learns that his responses are effective in alleviating aversive stimuli and producing gratification. There has not, however, been any definitive test of the theory in this area.

### 1.2.4 PREVENTION.

Learned helplessness can be prevented if a subject experiences control over outcomes before being exposed to a learned helplessness inducing procedure. Most people have, at one time or another been mildly and transiently depressed, possibly after loss of control over significant reinforcers such as the death of a loved one. The fact that some individuals become severely depressed after such experiences while others remain fairly resilient may be explained by the data on immunisation against helplessness. This difference in susceptibility to depression may result from past mastery of outcomes. Those individuals who are particularly resistant to depression may have lived lives filled with mastery and successful manipulation of reinforcers in their lives. Those susceptible to depression may have had lives relatively devoid of mastery. Seligman (1975) adds that too much success...
with controlling reinforcers, just like too little, might not allow the development and use of responses for coping with failure. Thus it seems that individuals can be immunised against depression by prior experience with controllability and by the development of a wide repertoire of coping responses that could be used when the usual responses prove ineffective.

1.2.5 SUMMARY.

Seligman (1975) states that the major symptoms of learned helplessness all have parallels in the symptoms of depression and suggests that reactive depression, as well as learned helplessness, stem from the belief that outcomes are uncontrollable. Similarities in symptoms, aetiology, cure and prevention between learned helplessness and depression have been outlined above. A number of areas still require investigation and elaboration. As well as the similarities outlined above there are a number of inadequacies in the learned helplessness model of depression (1975). These will be discussed in the next section.

1.3 INADEQUACIES OF THE LEARNED HELPLESSNESS MODEL OF DEPRESSION (1975).

There have been a number of studies published revealing gaps in the learned helplessness theory of depression (1975). For example the majority of investigations into the effects of uncontrollability have used subjects obtained from a population of college students rather than clinically depressed subjects. It has been assumed that the use of a clinical population
would enhance the performance discrepancies obtained with college students. While studies using depressed patients are now being reported, the generalizability and relevance of results to clinical populations remains to be demonstrated.

The question of the generalizability of experimental laboratory findings, whether obtained from humans or animals, to human behaviour outside the laboratory is raised by Rippere (1977). In particular Rippere feels that human helplessness subjects have to associate stimuli and arbitrary responses that bear no relation to the real world. Miller and Norman (1979) also point out that the degree of impairment found in human subjects after experience with uncontrollability, while being statistically significant, are relatively small. There do not appear to be reports of any behaviour as disabling as that found in research with infrahumans. This consistent finding raises questions concerning the relative significance of learned helplessness in humans. Miller and Norman (1979) add that the superior cognitive strategies available to humans lessens the effects of learned helplessness. Rippere (1977) states that laboratory experiments are also limited to the use of reinforcement arising from the immediate environmental consequences of behaviour. This seems to be a retrograde step as it has been acknowledged that there are important non-environmental mediators of complex human behaviour. Immediate environmental reinforcers may be sufficient for animal behaviour but they do not adequately account for that of human subjects.

In the previous section four areas of similarity between depression and learned helplessness were determined. Miller et al (1977) outlined a number of differences in these areas and these may suggest some fundamental differences between the two phenomena.
1.3.1 SYMPTOMS.

There are two symptoms found with uncontrollable shock that may, or may not correspond to symptoms of depression. Evidence is lacking. Firstly, a relationship between experience with uncontrollable shock and the development of stomach ulcers in rats, has been demonstrated by Weiss (1968). Miller et al (1977) state that they know of no study examining the relationship between depression and stomach ulcers. Secondly, a high level of anxiety, measured by subjective ratings, behavioural and physiological measures, has been found in subjects after experience with controllable shock. Subjects receiving controllable shock, in comparison, have a lower anxiety level. It has not been demonstrated conclusively that depressed people tend to be more anxious than non-depressed people.

A study by Krantz et al (1974) may provide some indirect evidence of a relationship between these two symptoms and depression. In this study, helplessness, stress level and the Coronary-Prone Behaviour Pattern were investigated. The Coronary Prone Behaviour Pattern (C.P.B.P.) reflects a style of life characterised by a strong sense of time urgency; hard driving competitiveness and a preoccupation with vocational and related deadlines. It seems reasonable to assume that this C.P.B.P. would be associated with high levels of anxiety and stress. The development of stomach ulcers in animals has also been associated with high stress and anxiety levels, (e.g. Weiss, 1977). Krantz et al (1974) cite evidence that suggests that sudden death due to coronary disease frequently occurs in men who have been depressed for anything from a week to several months before death. Using the stated parallels between helplessness and depression they found that measures of a C.P.B.P. were related to the ..differential susceptibility to the interference effect of uncontrollability
under the varying stress levels. While not providing a direct test of the relationship between the two symptoms of helplessness and depression, this study does suggest a relationship between stress and anxiety in coronary patients and helplessness and depression.

There are also a number of depressive symptoms that cannot be investigated in animal studies of helplessness; those of mood, feelings of self-blame and self-dislike, suicidal thoughts and crying to mention just a few. Since learned helplessness has been demonstrated in humans (e.g. Hiroto, 1974; Hiroto and Seligman, 1975; Klien et al., 1976), these states can now be investigated. Some of these findings will be referred to in a later section (Section 1.3.5). Miller et al. (1977) add that they have not found any evidence that disconfirms the correspondence of symptoms in learned helplessness and depression.

1.3.2 CAUSE.

The view that depression and helplessness are caused by learning that responses and reinforcement are independent runs into a number of problems. Can depression be caused by situations, other than extinction, in which reinforcements still occur but are not under the individuals control? Miller and Norman (1979) suggest that an expectancy of response-outcome independence and a non-desired outcome are both necessary for the development of learned helplessness. At present this is a matter for speculation.
Miller et al. (1977) do not wish to maintain, or give the impression, that helplessness is the only cause of reactive depression. They add that the absolute quality of life also alters mood. Holding the quality of life constant will tend to raise mood and controllable events will be less depressing or more cheering than uncontrollable ones while uncontrollable events will be more depressing or less cheering.

1.3.3 TREATMENT.

Many therapies have been developed and many claims have been made regarding their ability to alleviate depression. In section 1.2.3 only those which seemed compatible with helplessness were discussed. Despite the number of complimentary viewpoints, concrete evidence of the effectiveness of these treatments has yet to be published. Until this is forthcoming, it is impossible to attribute therapeutic successes to any particular variable, or to the reinstatement of a patients belief in self-efficacy.

1.3.4 PREVENTION.

Therapy is usually not focused solely on undoing the past. Hopefully, it should also aim to protect the patient against future depressions. The question of whether therapy for depression would be more successful, and prove a more adequate preventative measure, if it were aimed at providing the patient with a wide repertoire of coping responses for
situations where reinforcement seems uncontrollable, must at present remain unanswered. 
As in Section 1.3.3 above, further experimentation is required before any firm conclusion can be made.

1.3.5 FURTHER INADEQUACIES.

While most of the problems listed above relate to the difficulties in transferring a model derived from research with infrahumans to humans, the inadequacies that follow are related mainly to the adequacy of the model in accounting for the variety and complexity of human behaviour.

As previously stated the learned helplessness model of depression hypothesises that depression results when an individual perceives that responses and outcomes are independent - that he lacks control. This was thought to be equally true for both positive and negative events. Abrahamson et al. (1978) state that research evidence has (see Seligman 1975 and Maier and Seligman 1976 for reviews) been amassed which suggests that whereas motivational and cognitive deficits result from uncontrollability, affective change seems to result only from the expectation that bad outcomes will occur and not from their expected uncontrollability. Buchwald et al. (1978) reviewing a number of studies have taken this view a step further stating that while failure on one task interferes with performance on a second, there is little hard evidence that learned helplessness is, in fact, related to depression. This view is supported by Willis and Blaney (1978) who concluded
from their experimental results that the supposition that the perception of noncontingency plays a role in depression lacks support. McNitt and Thornton (1978) also argued against the view that a depressed individual misperceives response reinforcement contingencies and suggest that the depressed person overgeneralises from any experience of success or failure when forming expectations of future successes. The conclusion from these, and other, studies seem to be that the relationship between an expectation of uncontrollability and a depressed affect is not as clear-cut as first thought by the original proponents of the learned helplessness model of depression.

A second inadequacy of the learned helplessness model of depression has been mentioned in Section 1.2.2, that of lowered self-esteem as a symptom of depression. A number of investigators (e.g. Beck, 1967) regard low self-esteem as a hallmark symptom of depression. A major shortcoming of the 1975 model is that it does not explain the depressives low opinion of himself. The existence of a low self-esteem in some depressives has been amply demonstrated in experimental studies (Abramson and Sackeim, 1977). The 1975 model relating learned helplessness and depression does not appear to have any theoretical means of coping with this omission.

Generalisation of performance deficits beyond the specific experimental task and situation is a further unresolved issue in the learned helplessness literature (Miller and Norman; 1979). The 1975 model does not specify where and when a person who expects outcomes to be uncontrollable will show deficits or become depressed. No way of predicting the generality and chronicity of helplessness has been determined. Seligman (1975) argues that men and animals are born generalisers and that learned helplessness is no exception. He
believes that learned helplessness can be viewed as a generalised personality trait and consequently would be expected to influence behaviour in a wide range of situations. Unfortunately there is no conclusive evidence that the deficits of learned helplessness do generalise to any significant extent outside the original learning situation. In fact most studies investigating the effects of uncontrollability have used test phases with a similar task to that of the training phase (e.g. Hiroto, 1974; Hiroto and Seligman, 1975; Krantz et al., 1974). Some have demonstrated generalisation across types of task when the training and test situations have been similar (e.g. Gatchel and Proctor, 1976; Hiroto and Seligman, 1975; Miller and Seligman, 1975; Thornton and Jacobs, 1972). These studies have not investigated the degree of situational generality of the learned helplessness. Thus it seems that it is not certain that the effects of a learned helplessness inducing procedure would generalise outside the laboratory. The importance of situational similarity was demonstrated by Dweck and Reppuci (1973). Using children as subjects they found that they did generalise from the training phase but this generalisation was tied to the situational characteristics in which the learned helplessness was produced. Miller and Norman (1979) believe that there is evidence that learned helplessness generalises from one type of task to another, but there is no conclusive evidence regarding generalisation across situations. No study seems to have varied both situational and task dimensions. The failure to demonstrate cross-situational generalisation is a major flaw in the learned helplessness literature and without this evidence the significance of the learned helplessness phenomenon becomes questionable. If the learned helplessness model of depression is to maintain its credibility a detailed statement of how and when generalisation occurs, supported by research findings, is required.
In addition to the above omissions, Seligman (1975) has not explicitly included any individual difference variables in his formulation of the helplessness phenomenon. The study by Krantz et al (1974), mentioned previously,

An additional variable that has been found to alter the level of helplessness produced in experimental subjects was demonstrated by Roth and Kubal (1975). They found that greater helplessness was produced when the outcome of a particular task was important to the subject than when the outcome was unimportant. Perceived importance of the experimental task was a potent factor in the development of learned helplessness and can be manipulated by experimental instructions. The significance of these findings for the learned helplessness model of depression (1975) has not been determined as yet.

Instructions given to subjects in the experimental situation regarding response-outcome contingencies have been shown to affect the development of learned helplessness (e.g. Hiroto 1974) These results has not been discussed specifically by Seligman, but they are congruent with the focus of his theory. These instructions can be viewed as one way of manipulating expectations. Chance instructions, for example, induce an expectancy similar to that found after experience with inescapable aversive stimuli. Instructional set regarding the reinforcement contingencies appears to be a crucial variable in inducing learned helplessness. This variable has not been accounted for in the learned helplessness model of depression.
In addition to the subjects instructional set regarding the reinforcement contingencies of the experiment (e.g. chance or skill), the attributions made by a subject for successful or unsuccessful outcomes have been found to affect test performance. Klein et al. (1976) directly manipulated attributions by informing subjects about other subjects task performance. They found that the attribution instructions did not seem to affect nondepressed subjects but external instructions (i.e. that 90% of previous subjects had failed the problems) alleviated learned helplessness in depressed subjects. Miller and Norman (1979) concluded their review of the literature on manipulating subjects’ attributions by stating that attributions of noncontingent failure experiences are a potent factor in the development of learned helplessness. Attributions relating to personal competence are seen as resulting in increased deficits.

Research reviewed by Miller and Norman (1979) suggests that several variables (e.g. task instructions, task importance and attributions) appear to exert significant influences on the development and maintenance of learned helplessness. These variables appear to be interactive since studies have neither varied nor controlled for all these variables. These variables have been disregarded by Seligmans (1975) model of depression from the learned helplessness research. The preceding review clearly demonstrates that Seligmans theory of learned helplessness does not offer a full and viable explanation for the results of current research and does not adequately account for all the phenomena found in human depression. As a result of these inadequacies a reformulated model of learned helplessness has recently appeared (Abramson et al. 1978). This reformulation is discussed in the next section.

The reformulated learned helplessness model, in terms of attribution theory, first appeared in a paper in 1978 by Abramson, Seligman and Teasdale. This paper stated that while the early studies of human helplessness were aimed at reproducing the phenomena found in animals subjects, recent investigators had become increasingly concerned with the adequacy of the model in accounting for human behaviour. It was added that:

......investigators of human helplessness........have become increasingly disenchanted with the adequacy of theoretical constructs originating in animal helplessness for understanding helplessness in humans. And so have we.

(from Abramson et al. (1978) page 50)

Having thus rejected the previous learned helplessness model of human behaviour in no uncertain terms, Abramson et al. proceeded to present an attributional framework that they considered resolved several theoretical controversies about the effects of uncontrollability in humans. Attribution theory postulates that an individual's attribution of causality influences his or her expectations for probable outcomes of future performance (Miller and Norman, 1979). In developing the attributional framework for learned helplessness, Abramson et al. (1978) refined the attribution theory as stated by
investigators such as Weiner et al. (1972). In brief, Abramson et al. (1978) argue that when a person finds that he is helpless, he asks why he is helpless. The causal attribution that results determines the generality and chronicity of his helplessness deficits as well as his later self-esteem.

As mentioned in previous sections, a number of studies have manipulated the attributions of learned helplessness subjects. For example, Klein et al. (1976) found that attribution instructions, while not affecting nondepressed subjects, did affect the performance of depressives. Instructions causing the attribution of outcomes to luck, chance, fate or others, alleviated helplessness on anagram solutions.

Attribution theorists (e.g. Weiner et al., 1972) have determined two orthogonal dimensions of attribution, those of stable-unstable and internal-external. Stable factors are thought of as long-lived or recurrent, whereas unstable factors are short-lived or intermittent. Rotter (1966) states that when a reinforcement is perceived by an individual as following some action of his own, but not being entirely contingent upon this action, then it is perceived as the result of luck, chance, fate as under the control of powerful others, or as unpredictable. An event interpreted in this way by an individual defines a belief in external control. If the individual perceives that the event is contingent upon his own behaviour or personal characteristics e.g. skill, ability, effort, he is demonstrating a belief in internal control. When a bad outcome occurs, an individual can attribute it to (a) lack of ability (an internal-stable factor); (b) lack of effort (an internal-unstable factor); (c) the task being too difficult (an external-stable factor); or (d)
lack of luck (an external-unstable factor) (from Abramson et al., 1978). These attribution styles can be seen in Table 1 below.

<table>
<thead>
<tr>
<th>Internal</th>
<th>External</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stable</td>
<td>Lack of ability</td>
</tr>
<tr>
<td>Unstable</td>
<td>Lack of effort</td>
</tr>
</tbody>
</table>

Table 1 - the possible attributions for an unsuccessful outcome in terms of Attribution Theory.

Ample evidence for the existence of Internal and External expectancies of reinforcement control has been provided by Lefcourt (1966) and Rotter (1961, 1966).

The use of the stable-unstable attributional dimension provides a mechanism whereby the time course of helplessness and depression can be accommodated. As mentioned previously, helplessness has been found to dissipate with time. Interference from prior or later learning was invoked by Seligman (1975) as an explanation. In terms of the reformulated model chronic, or long-lived helplessness results from stable attributions, while transient, or short-lived helplessness, results from unstable attributions.
The internal-external attributional dimension, which Abramson et al. (1978) equate with personal and universal helplessness, allows the explanation of cases of helplessness, and depression, with and without low self-esteem. This dimension is neutral with regard to the cognitive and motivational deficits in helplessness.

Abramson et al. (1978) state that major determinant of attitudes towards the self is comparison with others. When an individual believes that he is personally helpless, that is, when he believes that significant others would be able to obtain a desired outcome (in the same situation) by use of a response in their repertoire, he will demonstrate a lower level of self-esteem than individuals who believe that desired outcomes are neither contingent on responses in their repertoires, nor contingent on acts in the repertoire of relevant others (universal helplessness). In brief, individuals that make more internal attributions will tend to have lower levels of self-esteem, than individuals that make more external attributions for failure outcomes. For example, a student who fails an exam that his peers pass will tend to have a lower self-esteem than a student who fails an exam that all of his peers failed as well (from Abramson et al., 1978, p55).

In addition to the two attributional dimensions stated above, Abramson et al. (1978) hypothesised the existence of a third dimension not found in the traditional Attribution Theory literature. This third dimension is orthogonal to those of stability and internality and was developed to explain the varying degrees of generalisation of helplessness from the original inducing situation to other unrelated instances. This third dimension varies between specific and global attributions. A global attribution implies that helplessness will occur across situations, whereas a specific attribution implies
helplessness only in the original situation. These three dimensions represent continua, not dichotomies: for the sake of simplicity these dimensions are discussed as if they represent dichotomies.

From these attributional dimensions a matrix of eight possible attributions can be obtained. This matrix is represented in Table 2.

<table>
<thead>
<tr>
<th></th>
<th>Internal</th>
<th>External</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Stable</td>
<td>Unstable</td>
</tr>
<tr>
<td><strong>Global</strong></td>
<td>Lack of</td>
<td>General</td>
</tr>
<tr>
<td></td>
<td>general</td>
<td>exhaustion</td>
</tr>
<tr>
<td></td>
<td>ability</td>
<td>(e.g. illness,</td>
</tr>
<tr>
<td></td>
<td></td>
<td>lack of sleep)</td>
</tr>
<tr>
<td><strong>Specific</strong></td>
<td>Lack of a</td>
<td>Lack of effort,</td>
</tr>
<tr>
<td></td>
<td>specific</td>
<td>or interest,</td>
</tr>
<tr>
<td></td>
<td>ability/skill</td>
<td>in this area.</td>
</tr>
</tbody>
</table>

Table 2 - Some examples of the eight possible attributions after experience with failure.

The severity of learned helplessness deficits are independent of chronicity and generality. Severity refers to how strong given deficits are at any one particular time. Abramson et al. (1978) believe that the severity of motivational and cognitive deficits is
related to the strength of a subject's expectation of noncontingency. Attributions predict the recurrence of helplessness, the generality and the self-esteem deficits, but the expectation of uncontrollability determines the occurrence of the helplessness deficits.

The attributional account of the chronicity and generality of helplessness explains why debriefing ensures that helplessness deficits are not carried outside the laboratory. By this means a global attribution can be altered to a specific one, and an internal one to a more external one.

A number of studies on human helplessness obtained findings that were difficult to explain in terms of the original helplessness model. For example, the findings of both Roth and Kubal (1975) that more helplessness was produced when the task outcome was important to the subject than when the outcome was unimportant. This result can be adequately explained in terms of the attributional dimensions hypothesised in the reformulated model, possibly by subjects in the important condition making more global, internal and stable attributions. In particular the helplessness studies that demonstrated improved or facilitated performance sometimes found in some subjects after experience with uncontrollability (e.g., Wortmen et al., 1976; Roth and Kubal, 1975) can be tentatively explained. Abramson et al. (1978) suggest that it seems reasonable to assume that compensatory attempts to reassert control might follow helplessness experiences after the individual leaves the helplessness inducing situation. This hypothesised compensatory rebound requires investigation, particularly into time course and situational factors. Facilitation effects may also occur when a subject cannot find a controlling response but has not yet concluded that he is helpless. Abramson et al.
(1978) conclude that overall, the helplessness studies that have assessed and manipulated attributions provided support for the reformulation. They add that future research will need to take that the three attributional dimensions are adequately differentiated as past studies have tended to confound them.

The reformulated learned helplessness model has direct implications for the learned helplessness model of depression. Abramson et al. (1978) state that the helplessness model of depression has been repeatedly shown to be inadequate in a number of areas. These have been discussed in Section 1.3 above. Abramson et al. believe that the majority of these shortcomings are directly remedied by the reformulation. The only remaining inadequacy not directly resolved is that of the necessary conditions for producing a depressed affect. As stated earlier the present resolution is that this affect results from the expectation that bad outcomes will occur rather than from uncontrollability per se.

The reformulated model of depression can now be explicitly stated. Depression is seen as consisting of four classes of deficits; motivational, cognitive, self-esteem and affective. When highly desired outcomes are believed improbable, or highly aversive outcomes believed probable and the individual expects that no response in his repertoire will change their likelihood, helplessness or depression results. Generality of depressive deficits are dependent on the globability of the attribution; the chronicity depend on the stability attribution; and whether self-esteem is lowered will depend on internality of the attribution. The strength or certainty of the expectation of
uncontrollability determines the intensity of the deficits, while affective and self-esteem deficits also depend on the importance of the outcome.

Individual differences probably exist in attribution styles, Blaney (1977), Rizley (1978), have stated that depressives attribute failures to internal factors and cited this as evidence against the learned helplessness model. There is obviously no contradiction between this finding and the reformulated model. Depressed individuals believing themselves personally helpless make internal attributions while those believing themselves universally helpless make external attributions. Do depressives have different attribution patterns from nondepressives? The available experimental evidence seems to suggest that depressed individuals make more internal-global-stable attributions for negative events, and more external-specific-unstable factors for success than nondepressed subjects (see Rizley, 1978; Kuiper, 1978; Feather and Simon, 1971). Research into attributional styles is required but it seems that those individuals who typically tend to attribute failure to global, stable and internal factors should be most prone to general, and chronic, helplessness depressions with a low self-esteem. This view is compatible with becks (1967) statement that the premorbid depressive individual makes logical errors in interpreting reality.

Abramson et al. (1978) state that the fact that women are 2 to 10 times more likely to be depressed than men, may be related to the different attribution styles repeatedly found in males and females see Deaux and Emswiller, 1974; Dweck and Reppucci, 1973; Pheterson et al. 1971), with girls attributing failure to lack of ability (global, stable). The
predominance of this pattern of attribution in the female, compared with the male, may predispose the female to depression following failure experiences with uncontrollability.

Therapeutic procedures suggested by the reformulated model include reducing the likelihood of aversive outcomes, making highly preferred outcomes less desirable, changing the expectations from uncontrollability to controllability when outcomes are attainable, and changing unrealistic attributions for failure towards external, unstable, specific factors and changing unrealistic attributions for success toward internal, stable, global factors. Harari and Hosey (1979) have produced experimental evidence suggesting that clients who attribute their problems to an internal locus of control are given a better prognosis by clinicians. This expectation of greater therapeutic success with internalizers may be explained in part by the findings of Bledsoe and Barber (1978). Using female subjects they found that internalisers were more likely to be controlled, emotionally stable, conscientious, trusting, shrewd and sociable, whereas externalisers tend to be more excitable and insecure.

Miller and Norman (1979) have, independently, developed an attributional learned helplessness model. Like Abramson et al. (1978) they advocate the attributional dimensions of locus of control (internal-external), stability and specifically but feel that further factors exist which modify the effects of learned helplessness. These include the subjective importance of the situation, relevant situational cues and individual differences. The necessity of these additional factors remains to be demonstrated.
Wortman and Dintzer (1978) like Miller and Norman (1979) also questioned whether the dimensions of attribution selected by Abramson et al. (1978) are the most significant ones in predicting the nature and magnitude of behaviour deficits. They feel that other significant attribution dimensions include mechanical versus philosophical and immediate versus prior causality. On a more basic level they question the relationship of attributions to behaviour and the fact that people make attributions at all. They cite a number of studies that appear to indicate that when attributions are elicited from subjects and measures of overt behaviour made, there is a puzzling discrepancy. This relationship seems to deserve more attention than it has so far received. Ledwidge (1978) also feels that the tendency to invoke and develop such cognitive explanations for behaviour are a step in the wrong direction. He believes that while behaviour therapy has been repeatedly validated, cognitive behaviour therapy has not. In addition he cites experimental evidence from which it becomes apparent that behaviour changes follow cognitive changes less often than cognitive changes follow behaviour changes. These findings seem rather disheartening for the therapeutic successfulness of the procedures suggested by the learned helplessness model of depression. The final judgement must be made by relevant future research.

Wortman and Dintzer, again like Miller and Norman, suggest that factors other than attributions and expectations for future control may influence reactions to uncontrollable outcomes. They name factors such as the cost of attempting to influence the outcome, and the degree of preparedness of the individual for the outcome, as influencing an individual’s reaction. These, again, require experimental validation.
In terms of the reformulated learned helplessness model, Wortman and Dintzer (1978) point out that, unless it is possible to specify the conditions under which a given attribution will be made, the model becomes circular and lacking in predictive power. Abramson et al. (1978) also recognised this shortcoming and stated that the reformulated hypotheses are necessarily post hoc as relevant measures of generality, stability and internality of attribution studies were not made. They add that the hypotheses can be tested by measuring the attributions and correlating them with the deficits, or by inducing the attributions and predicting the deficits.

Seligman (1978) addressed himself to those criticisms of the Learned Helplessness model of depression not anticipated by Abramson et al (1978). A number of these criticisms are aimed at the need to specify the type of depression that learned helplessness is posited to model. Seligman suggests that helplessness is a model of a yet-to-be-identified subclass of depressions, the defining feature of which is its causal mechanism: the expectation that highly desirable outcomes are of low probability or that highly aversive outcomes are of high probability and that their occurrence is independent of the individuals' actions. This seems rather post hoc and circular. Seligman, however, thinks not, as the defining characteristic (causal helplessness cognitions) can be independent of the identification of the symptoms of passivity, negative cognitive set, emotional deficits and lowered self-esteem.

The second criticism to which Seligman (1978) addressed himself between the Reformulated Learned Helplessness Model of depression and the early experimental
studies. Seligman states that Costello (1978) concluded that the early studies provided little or no support for the helplessness model of depression. Seligman's review of the studies cited by Costello concludes that his (Costello's) claim is far from substantiated and that the main findings in these experiments had been overlooked by him. Consequently, Costello's conclusions lack validity.

The final issue that Seligman discusses is the proposal by Costello (1978) and Depue and Munroe (1978) that helplessness research on mildly depressed populations is in fact analogue research. Seligman feels that this is a misnomer and that mild depression is a widespread and significant problem. He feels that helplessness research has increased our understanding of depression. Studies on the relevance of learned helplessness to clinical populations is only just beginning and the fruits of these labours are eagerly awaited.

It seems that the proponents of the learned helplessness model of depression have thrown down a challenge to clinicians. A testable model has been developed from experimental, rather than clinical psychology, which lacks the support, or refutation, of relevant clinical research. The present study hopes, in a small way, to start filling this gap.

1.5 THE PRESENT STUDY.

The basic aim of the present study is to investigate and test the reformulated learned helplessness model of depression in terms of attribution theory as stated by Abramson et al. (1978).
Learned Helplessness research has frequently been criticised (e.g., Rippere, 1977) for using college students, divided on the basis of their Beck Depressive Inventory scores into depressed and nondepressed groups, to investigate the effects of uncontrollability. Attempts are being made to remedy this situation and to investigate and replicate the phenomena in clinical populations (e.g., OLeary et al. 1978; Evans and Dinning, 1978).

To avoid the difficulties in generalising from such an artificial population and, in an attempt to demonstrate the validity of the learned helplessness formulated of clinical depression, subjects in the present study were obtained from hospitalised psychiatric patients. A number of non-psychiatric hospitalized patients were also tested to provide a normal comparison group. Hospitalised normals were utilised in an effort to control for the effects of institutionalisation (see Goffman (1961) for the characteristics and effects of institutionalisation, particularly for psychiatric patients). In terms of the reformulated learned helplessness model hospitalization, in effect, removes control from the individual and replaces it by the control of the institution (e.g., doctors, nurses, hospital rules). It seems reasonable to assume that hospitalized patients may tend to be more external in their attributions (i.e., attributing causes to forces outside themselves) than non-hospitalized individuals. The fact that some people become prone to depression once hospitalized, although in no immediate danger, may be a result of this lack of control.

In order to test the implicit assumption that depressives, rather than any other psychiatric group, are characterised by certain patterns of attributions, it was deemed necessary to test a selected psychiatric population without any reference to diagnosis, the only
exclusions being patients with known brain damage and those unable to complete the questionnaires due to inability to read and write, poor physical condition etc. Information regarding a patient's clinical diagnosis was collected after testing, bearing in mind the fact that learned helplessness researchers usually divide their student population into depressed and non-depressed groups on the basis of their B.D.I. (Beck Depression Inventory, Beck (1967); see Appendix 2) scores, it was felt that administering this questionnaire to the subjects in the present study would provide a more objective measure of the level of depressive symptomatology in line with past research. The B.D.I. scores also provide a measure of the depressive symptomatology in subjects other than those diagnosed as depressives.

As mentioned previously, Becks depressive Inventory is closely related to Becks cognitive theory of depression (see Section 1.2.2) which emphasises negative expectations and beliefs of personal adequacy. The low level of self-esteem frequently found in depressed patients forms a central concept in Becks theory. Until the reformulation of the learned helplessness model in 1978, low self-esteem could not be accounted for. The reformulated model hypothesises that depressed individuals with a low level of self-esteem tend to make more internal attributions. The B.D.I. lumps affective, behavioural, cognitive and somatic symptoms together to yield a single severity score (Seligman, 1978). In view of the theoretical basis of the B.D.I. it was felt that a measure of self-esteem could be obtained from this questionnaire by determining those items most closely related to self-esteem and adding each subject's ratings on to produce the measure.
Subjects attribution styles, on the three dimensions of stability, generality and locus of control (internal-external), can be investigated using an as yet unpublished questionnaire, developed by Seligman (1978) which addresses itself specifically to measuring the attribution dimensions specifically to measuring the dimensions specified in the reformulated model. As this questionnaire is still in the developmental stages, no information is available regarding its reliability and validity. Its use in the present study represents a departure from the usual format of learned helplessness experiments.

In an effort to validate at least part of this new questionnaire Rotters (1966) I-E (Internal-External locus of control) scale was administered to subjects. Rotters scale assesses the degree to which individuals perceive the events in their life as being a consequence of their own actions and thereby controllable (internal control) or as being unrelated to their own behaviours and therefore beyond personal control (external control). Rotters questionnaire is scored in the external direction. Thus the higher the score the greater the tendency to make external attributions. Since Seligmans measurement of locus of control is scored in the internal direction, that is the higher the score the greater the tendency to make internal attributions, if these two scales are measuring the same dimension a subjects scores should be negatively correlated. The relationship between a subjects score on Rotters I-E scale and on Seligmans locus of control measure will be investigated in an attempt to partially validate Seligmans questionnaire. In addition, self-esteem scores will be correlated with locus of control measures in an attempt to confirm the predicted self-esteem deficits in depressives making internal attributions (Abramson et al., 1978).
The reported experimental findings (Rizley, 1978; Kuiper, 1978) that depressed individuals make more internal-global-stable attributions for failure experiences (negative events) and more external-specific-unstable attributions for successes (positive events) than nondepressed subjects, will also be investigated in the present study. In this replication of previous experimental findings depressives were defined by their B.D.I. scores, those scoring above the population median being defined as depressed while those scoring at, or below, the median is defined as nondepressed (following the method of Evans and Dinning, 1978).

The last area covered in this study relates to the statement by Abramson et al (1978) that the reformulated model can be tested by measuring the attributions and correlating them with the deficits, or by inducing the attributions and producing the deficits. Using Rotters (1966) and Seligmans unpublished questionnaires, the attribution styles of the subjects used in this investigation have been quantified. The deficit measured is that of depressive symptomatology (B.D.I. score). It is hoped to demonstrate a relationship between the measured attributions and the measured deficit (level of depression) thus providing support for the reformulated learned helplessness model. The hypothesised existence of a relationship between attributions and depression was further developed and the conclusion reached that if such a relationship does exist then theoretically a subjects measured pattern of attributions an Seligmans and Rotters (1966) questionnaire should predict diagnostic category. In this case actual clinical diagnosis was used as the criterion rather than B.D.I. scores as in the previous hypothesised relationship. It was further predicted that adding a subjects B.D.I. score to the attribution measures, should increase the proficiency of the statistical model in correctly
predicting diagnostic category. If a valid relationship is demonstrated between these measures and that of diagnostic category it would raise a number of questions concerning the nature of depression and the importance of cognitive processes in this category of mental illness.

The next section consists of a formal statement of the experimental hypotheses and concludes the first chapter.

1.6 HYPOTHESES TO BE TESTED.

(1) Partial Validation: there is a negative correlation between scores on the locus of control items on Seligmans questionnaire and scores on Rotters Internal-External locus of control questionnaire.

(2) Self-esteem scores will be negatively correlated with attribution scores on Rotters I-E questionnaire and positively correlated with locus of control attribution items on Seligmans questionnaire.

(3) Subjects defined as depressed by their Beck Depressive Inventory score will make more (a) internal (b) global (c) stable attributions for failure than subjects defined as nondepressed subjects.
(4) Subjects defined as depressed by their Beck Depressive Inventory score will make more (a) external (b) specific (c) unstable attributions for success than nondepressed subjects.

(5) Scores on Rotters I-E questionnaire and Seligmans unpublished attribution questionnaire significantly predict a subject’s B.D.I. score.

(6) (a) A subject’s scores on the three measured attribution dimensions significantly discriminate between diagnostic categories.

(b) This discrimination is enhanced by the addition of B.D.I. scores to the discriminators.
CHAPTER 2.

METHOD.
2.1 DESIGN.

Two groups were utilised in this investigation. Group A consisted of male and female psychiatric patients resident within a psychiatric unit at the time of testing. Group B consisted of non-psychiatric male and female patients resident within a general hospital, and without a psychiatric history at the time of testing.

All subjects were selected on the basis of predefined criteria until a total of ninety Group A and forty Group B patients were identified. These subjects were then asked to complete a booklet of questionnaires.

2.2 SUBJECTS.

All subjects were tested between 28/3/79 and 24/5/79. Group A subjects (psychiatric) were selected from patients resident in Holywell Hospital (Wards 2 and 3, the Villa and Tobernorveen Units) and in Belfast City Hospital (Windsor House Unit). Group B subjects (non-psychiatric) were selected from patients resident in Whiteabbey Hospital, wards 3, 4 and 5 (gynaecological and cardiac patients).

Subjects were selected from all the above listed wards on the basis of the following criteria:

(1) A minimum age of 16 - no upper age limit was determined

(2) All brain damaged patients were excluded.
(3) Those judged as unable to complete the questionnaire by nursing staff due to (a) inability to read or write, or (b) inability to respond appropriately were excluded.

Group B subjects also had to fulfil a fourth criterion:

(4) Patients with a known psychiatric history were excluded.

Patients who satisfied these conditions were approached and asked to take part in the present study. Participation was voluntary.

A total of one hundred and thirty patients were asked to complete the questionnaires - ninety Group A and forty Group B.

2.3 TEST MATERIALS

2.3.1 Test Booklet: A 16 page test booklet, size 30 cms. X 21 cms. was made from the three self-report questionnaires and the title page described below. The order of the three self report questionnaires was randomized.

(i) Title page (see Appendix 1).

The purpose of this page was twofold - firstly to briefly outline the aims of the study for the subjects and, secondly to obtain a record of a subject’s name, age, occupation, occupation of spouse and length of time hospitalized.
(ii) Beck Depression Inventory - B.D.I. (see Appendix 2).

The B.D.I (Beck 1967) consists of twenty-six items for which the patient rates the severity of his or her symptoms on 0-3 dimensions. A measure of the subject's level of depressive symptomatology is then obtained by summing these ratings. The higher the score, the greater the amount of reported depressive symptomatology.

(iii) Rotter's Internal-External (I-E) attribution scale was devised by Rotter in 1966. It consists of twenty-nine forced-choice items, twenty-three of which are scored. This scale is scored in the external direction by summation of the number of weighted items selected by the subject. High scores indicate a greater endorsement of luck, chance, and other outside forces as the principle sources that determine reinforcement.

(iv) Seligman's unpublished Attribution Questionnaire (see Appendix 4). This questionnaire was developed by Seligman in 1978 to investigate the reformulated model of learned helplessness in terms of Attribution Theory. This questionnaire was used by permission of John Teasdale and Martin Seligman.

This questionnaire consists of twelve imaginary situations. Each subject is asked to vividly imagine the situations and list a major cause of the situation if it happened to them. For each situation the subject then answers, using a seven point rating scale, three questions about the cause of the situation (relating to the 3 dimensions of attribution hypothesised in the reformulated model of learned helplessness) and finally one question about the importance of the situation to them.
The twelve imaginary situations consist of six positive and six negative events.

Seven separate scores are obtained for each subject. These scores were given separate labels and obtained as described below -

(1) IPOS: obtained by summation of the subjects ratings (on the 6 positive events) on the question relating to the Internal-External attribution dimension. Low scores (below 24) indicate a higher endorsement of luck, fate, chance (External) factors, while high scores (above 24) indicate an attribution to Internal factors.

(2) INEG: obtained by summation of the subjects ratings (on the 6 negative events) on the question relating to the Internal-External attribution dimensions. Scores are interpreted as for IPOS.

(3) STABPOS: obtained by summation of the subjects ratings (on the 6 positive events) on the question relating to the Stable-Unstable attribution dimension. Low scores (below 24) suggest that the attributions tend to be unstable, while high scores (above 24) suggest that the attributions tend to be stable.

(4) STABNEG: obtained by summation of the subjects ratings (on the 6 negative events) on the question relating to the Stable-Unstable attribution dimension. Scores are interpreted as for STABPOS.

(5) GLOBPOS: obtained by summation of the subjects ratings (on the 6 positive events) on the question relating to the Global-Specific attribution dimension. Low scores (below 24)
suggest that the attributions tend to be specific to a particular situation while high scores (above 24) suggest that the attributions tend to be global and apply to other situations.

(6) GLOBNEG: obtained by summation of the subject's ratings (on the 6 negative events) on the question relating to the Global-Specific attribution dimension. Scores are interpreted as for GLOBPOS.

(7) IMPORT: obtained by summation of the subjects ratings (on all twelve events) on the question relating to the Importance of the situation to the subject. The higher the score, the greater the subjective importance of these events.

2.3.2 Personal Information Questionnaire (see Appendix 5)

This questionnaire was devised to collect relevant background information relating to the hospital admissions of psychiatric patients. It was originally intended that this information should be collected by nursing staff by a systematic examination of In-patient medical notes. This proved impracticable and the information relating to the number and length of psychiatric admissions, diagnosis and treatment were collected by the present investigator. The subject's age and occupation were also recorded and cross checked with that reported by the subject on the title page of the test booklet.
2.4 PROCEDURE.

A thesis proposal was circulated to the selected Hospital Authorities in December 1978 (see Appendix 8). This specified the purpose of the study and subject requirements. Testing commenced after approval of this proposal.

2.4.1 Administration of test booklet.

The test booklet was administered to subjects in groups. The number in each group varied between 2-11 depending on the number of patients in each ward capable of filling in the questionnaires at the time of testing.

Each subject that consented to take part in the investigation was provided with a pencil and copy of the test booklet. The purpose of the study was explained to each group by reading out the introduction on the title page of the test booklet. The following verbal instructions were also given:

“These questionnaires are all concerned with measuring attitudes and how people think about events. Since all people are different, and think differently from each other, there are no right or wrong answers. If you have any difficulty understanding a question, please ask and I will do my best to help. There is no time limit.”
A visual check was made of each test booklet during testing to ensure that the subjects were correctly completing the questionnaires. A similar check was made upon completion of the book for uncompleted items. The test booklets were collected from each subject when complete or when it became apparent that the subject was unable to complete the questionnaire. The usable data was then transferred to computer data sheets in preparation for computer processing.

2.4.2 Personal Information Questionnaire.

A personal information questionnaire was completed for each psychiatric patient that completed the test booklet correctly.

2.4.3 Self-Esteem ratings from the B.D.I.

To obtain a measure of self-esteem the twenty-six items of the B.D.I. were rated by a group of 10 professionals in the mental health field (psychiatrists, psychologists and social workers) given the following instructions -

“Look at the key word e.g. sadness, pessimism at the top of each cluster of answers and tell me those in which self-esteem would be a major factor in determining the level of the subject’s response. You may choose as many or as few of the items you like. There is no right or wrong answer.”
A copy of the B.D.I., obtained from Beck (1967), (see Appendix 6) was then shown to each of the raters, and a record kept of their responses (see Table 3). A subject’s score on the items, rated by more than 5 professionals, as having a level of self-esteem as a major factor determining the level of the subject’s response, were added together to create a new variable SELF. The higher the value of SELF, the lower the rated level of self-esteem.

<table>
<thead>
<tr>
<th>ITEM</th>
<th>No. of Individuals Rating this item</th>
<th>ITEM</th>
<th>No. of Individuals Rating this item</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>0</td>
<td>L</td>
<td>8*</td>
</tr>
<tr>
<td>B</td>
<td>5</td>
<td>M</td>
<td>7*</td>
</tr>
<tr>
<td>C</td>
<td>10*</td>
<td>N</td>
<td>7*</td>
</tr>
<tr>
<td>D</td>
<td>3</td>
<td>O</td>
<td>4</td>
</tr>
<tr>
<td>E</td>
<td>5</td>
<td>P</td>
<td>0</td>
</tr>
<tr>
<td>F</td>
<td>2</td>
<td>Q</td>
<td>2</td>
</tr>
<tr>
<td>G</td>
<td>10*</td>
<td>R</td>
<td>2</td>
</tr>
<tr>
<td>H</td>
<td>10*</td>
<td>S</td>
<td>1</td>
</tr>
<tr>
<td>I</td>
<td>4</td>
<td>T</td>
<td>2</td>
</tr>
<tr>
<td>J</td>
<td>1</td>
<td>U</td>
<td>5</td>
</tr>
<tr>
<td>K</td>
<td>0</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table 3. The number of professionals rating each item as having level of esteem as an important determinant. The scores obtained by each subject on the starred items were added to obtain the variable SELF. This variable was used as a measure of self-esteem.
2.4.4 Determination of social class using Occupation.

Using the General Register's Office's "Classification of Occupations" (1966) subjects were assigned to a social class. A sixth social class was created and used for those occupations which were not classified in the General Register's Office publication. These included patients who reported themselves as unemployed, students and retired individuals. The six classes can be broadly described as seen in Table 4.

The social class information was coded on computer data sheets for analysis.

<table>
<thead>
<tr>
<th>Social Class</th>
<th>Broad Category</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Professional occupations</td>
</tr>
<tr>
<td>2</td>
<td>Intermediate occupations</td>
</tr>
<tr>
<td>3</td>
<td>Skilled occupations</td>
</tr>
<tr>
<td>4</td>
<td>Partly Skilled occupations</td>
</tr>
<tr>
<td>5</td>
<td>Unskilled occupations</td>
</tr>
<tr>
<td>6</td>
<td>Unclassified class (retired etc.)</td>
</tr>
</tbody>
</table>

Table 4. The broad social class categories (adapted from the General Register's Office Classification of Occupations, 1966).

2.4.5 Determination of Diagnostic Category.

Using the diagnoses collected on the personal information questionnaire the categories shown in Table 5 were determined. Subjects were assigned to the appropriate category
and this information was also coded on computer data sheets to be used in statistical analysis.

<table>
<thead>
<tr>
<th>Categories</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Depressive</td>
</tr>
<tr>
<td>2</td>
<td>Anxiety</td>
</tr>
<tr>
<td>3</td>
<td>Manic Depressive</td>
</tr>
<tr>
<td>4</td>
<td>Personality Disorder</td>
</tr>
<tr>
<td>5</td>
<td>Behavioural e.g. anorexic</td>
</tr>
<tr>
<td>6</td>
<td>Psychotic</td>
</tr>
<tr>
<td>7</td>
<td>Alcoholic</td>
</tr>
<tr>
<td>9</td>
<td>Undiagnosed psychiatric</td>
</tr>
<tr>
<td>0</td>
<td>Non-psychiatric patients</td>
</tr>
</tbody>
</table>

Table 5. Diagnostic categories.

Information relating to marital status (single, married, widowed, divorced/separated); age; sex; and for Group A, information relating to number of hospital admissions and time spent in hospital (weeks), was transferred to the computer data sheets.
CHAPTER 3.

RESULTS.
3.1 POPULATION CHARACTERISTICS.

Of the one hundred and thirty patients approached completed questionnaires were obtained from forty psychiatric patients (Group A) and twenty-three non-psychiatric patients (Group B). Table 6 shows a breakdown of subjects responses into three categories, completed; unusable (defined as those in which one or more of the questionnaires were not completed); and refusals (those in which the patient did not wish to take part in the study).

<table>
<thead>
<tr>
<th>GROUP A</th>
<th>GROUP B</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number</td>
<td>%</td>
</tr>
<tr>
<td>Completed</td>
<td>40</td>
</tr>
<tr>
<td>Unusable</td>
<td>19</td>
</tr>
<tr>
<td>Refusals</td>
<td>31</td>
</tr>
<tr>
<td>Total</td>
<td>90</td>
</tr>
</tbody>
</table>

Table 6 - Breakdown of subjects into completed, unusable and refusal responses to the test booklet.

Table 6 shows that while the percentage of refusals in each group is similar, there is a much higher percentage of unusable responses (approximately twice as many) among the psychiatric patients (Group A) than among the non-psychiatric patients. The reason for this discrepancy is not immediately obvious. However, during testing it was apparent that Group A patients had greater difficulty answering the test questions and required much more assistance to understand the three different questionnaire formats. This difficulty was
reflected in the average length of time taken by the two groups to complete the questionnaires - whereas the psychiatric group took an average of three hours (none took less than 1½ hours), group B subjects took an average of an hour (the shortest time being ¾ hour, the longest 1¼).

Raw data was coded on computer data sheets as previously stated. Statistical analysis was obtained by use of the SPSS (statistical Package for the Social Sciences) integrated system of computer programs. This system is available at the Queen’s University of Belfast Computer Centre.

A descriptive analysis of the subject population in terms of sex, age, social class, marital status, diagnostic group, for all groups and number of admissions and total length of time hospitalised for psychiatric patients, can be seen in Appendix 7.

Table 7 describes statistically the questionnaire data obtained from the entire subject population in terms of mean, standard deviation, mode, minimum score, maximum score and median for each variable.

3.2 HYPOTHESIS NUMBER ONE.

“There is a negative correlation between scores on the locus of control items on Seligman’s questionnaire, and scores on Rotter’s Internal-External locus of control questionnaire”
This analysis was undertaken as a means of validating the locus of control section (variables IPOS and INEG) of Seligman’s unpublished questionnaire. Scores on the variables IPOS and INEG were correlated, using the Pearson Product-Moment correlation procedure, with scores on Rotter’s I-E scale. A negative correlation was predicted since Rotter’s scale measures in the external direction while Seligman’s scales measure in the internal direction. Table 8 shows the resultant correlation matrix for the whole population.

<table>
<thead>
<tr>
<th>Variable</th>
<th>Mean</th>
<th>S.D.</th>
<th>Mode</th>
<th>Min.</th>
<th>Max.</th>
<th>Median</th>
</tr>
</thead>
<tbody>
<tr>
<td>ROTTER</td>
<td>10.937</td>
<td>3.402</td>
<td>12</td>
<td>2</td>
<td>19</td>
<td>11.4</td>
</tr>
<tr>
<td>BECK</td>
<td>18.365</td>
<td>14.134</td>
<td>11</td>
<td>0</td>
<td>61</td>
<td>14.25</td>
</tr>
<tr>
<td>IPOS</td>
<td>27.873</td>
<td>6.453</td>
<td>30</td>
<td>15</td>
<td>41</td>
<td>28.2</td>
</tr>
<tr>
<td>INEG</td>
<td>27.254</td>
<td>6.263</td>
<td>21</td>
<td>15</td>
<td>42</td>
<td>27.375</td>
</tr>
<tr>
<td>STABPOS</td>
<td>28.379</td>
<td>6.351</td>
<td>30</td>
<td>15</td>
<td>42</td>
<td>28.625</td>
</tr>
<tr>
<td>STABNEG</td>
<td>27.079</td>
<td>6.457</td>
<td>36</td>
<td>12</td>
<td>42</td>
<td>26.583</td>
</tr>
<tr>
<td>GLOBNEG</td>
<td>24.714</td>
<td>6.793</td>
<td>21</td>
<td>6</td>
<td>42</td>
<td>25</td>
</tr>
<tr>
<td>IMPORT</td>
<td>61.206</td>
<td>13.035</td>
<td>51</td>
<td>30</td>
<td>84</td>
<td>61.75</td>
</tr>
<tr>
<td>SELF</td>
<td>5.349</td>
<td>4.667</td>
<td>0</td>
<td>0</td>
<td>16</td>
<td>4.2</td>
</tr>
</tbody>
</table>

Table 7 - Questionnaire data: descriptive statistics.

As would be expected, IPOS and INEG are significantly positively correlated indicating that individuals tend to make similar attributions for both positive and negative events. While the
correlations between the variables Rotter and IPOS, and Rotter and INEG are not significant, the correlations are in the predicted direction. It is interesting to note that the correlation between ROTTER and IPOS is much larger than that between ROTTER and INEG.

<table>
<thead>
<tr>
<th></th>
<th>IPOS</th>
<th>INEG</th>
</tr>
</thead>
<tbody>
<tr>
<td>ROTTER</td>
<td>-0.2406</td>
<td>-0.0091</td>
</tr>
<tr>
<td>IPOS</td>
<td>***</td>
<td>0.3425</td>
</tr>
</tbody>
</table>

Table 8 - Pearson-Product-Moment Correlation Matrix: whole population: ROTTER with IPOS and INEG. ***: significance at the 0.006 level.

The correlations between these three variables were further investigated by calculating the coefficients for the two subgroups - psychiatric and normal patients - separately.

<table>
<thead>
<tr>
<th></th>
<th>Group A - Psychiatric</th>
<th>Group B - Normals</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>IPOS</td>
<td>INEG</td>
</tr>
<tr>
<td>ROTTER</td>
<td>-0.2737</td>
<td>0.1294</td>
</tr>
<tr>
<td>IPOS</td>
<td>**</td>
<td>0.3846</td>
</tr>
</tbody>
</table>

Table 9 - Pearson-Product-Moment Correlation Matrix: subgroups: ROTTER with IPOS and INEG. **: significant at the 0.014 level.
It can be seen from Table 9 that the low correlation between ROTTER and INEG obtained in the whole population is produced by a discrepancy between the two subpopulations. While the predicted negative correlation is obtained between ROTTER and INEG in Group B (normal) there is a positive correlation between the two variables in Group A (psychiatric). The correlation between IPOS and INEG reaches significance in the psychiatric group but fails to do so in the normal group.

3.3 HYPOTHESIS NUMBER TWO.

"Self-esteem scores will be negatively correlated with attribution scores on Rotter’s I-E questionnaire and positively correlated with the locus of control attribution items on Seligman’s questionnaire”

The predicted relationships were investigated using the Pearson-Product-Moment correlation procedure. As with hypothesis one, three sets of correlations were obtained - one for the entire population, one for the psychiatric sub-group and the final one for the normal subgroup. These correlations can be seen in Table 10. The obtained correlations are in the opposite directions from those predicted. ROTTER scores are significantly positively correlated (p<.009) with SELF score indicating that increasingly externality is correlated levels of self-esteem (measured by increasing SELF). the same conclusion can be made from the negative correlations between SELF and IPOS and INEG.
As in hypothesis one there appears to be a different general pattern of correlations found in the normal and psychiatric subpopulations. While the correlations are in the same direction on each of the variable pairs, those that reach significance in the psychiatric population do not do so in the normal population and vice-versa.

### 3.4 Hypothesis Number Three.

"Subjects defined as depressed by their Beck depression Inventory score will make more (a) internal (b) global and (c) stable attributions for failure than subjects defined as nondepressed"
For the purpose of investigating this hypothesis, the whole subject population was divided into two groups, depressed and nondepressed, on the basis of their B.D.I. scores. Subjects scoring above the median of 14.25 were assigned to the depressed group, while those scoring below the population median were assigned to the nondepressed group (following the procedure used by Evans and Dinning, 1978).

T-Tests were used to test the experimental hypothesis, the null hypothesis being

"There is no significant difference between the scores of subjects defined as depressed and those defined as nondepressed on the variables INEG, GLOBNEG and STABNEG."

<table>
<thead>
<tr>
<th>VARIABLE</th>
<th>No. of cases</th>
<th>MEAN</th>
<th>S.D.</th>
<th>Standard Error</th>
<th>T obs</th>
<th>D.F.</th>
<th>2-Tailed Prob.</th>
</tr>
</thead>
<tbody>
<tr>
<td>INEG</td>
<td>(1) 32</td>
<td>26.6875</td>
<td>6.291</td>
<td>1.112</td>
<td>-0.73</td>
<td>61</td>
<td>0.470</td>
</tr>
<tr>
<td></td>
<td>(2) 31</td>
<td>27.8387</td>
<td>6.283</td>
<td>1.128</td>
<td>N.S.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>GLOBNEG</td>
<td>(1) 32</td>
<td>23.3125</td>
<td>6.640</td>
<td>1.174</td>
<td>-1.69</td>
<td>61</td>
<td>0.096</td>
</tr>
<tr>
<td></td>
<td>(2) 31</td>
<td>26.1613</td>
<td>6.748</td>
<td>1.212</td>
<td>N.S.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>STABNEG</td>
<td>(1) 32</td>
<td>26.3437</td>
<td>6.173</td>
<td>1.091</td>
<td>-0.92</td>
<td>61</td>
<td>0.362</td>
</tr>
<tr>
<td></td>
<td>(2) 31</td>
<td>27.8387</td>
<td>6.753</td>
<td>1.213</td>
<td>N.S.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

where (1) = nondepressed patients; (2) = depressed patients; as defined by B.D.I. score.


As can be seen from Table 11 no significant differences were found between depressed and nondepressed subjects on the named attributional dimensions and consequently the null
hypothesis is accepted. However, whilst the depressed and nondepressed populations are not significantly different, the groups do vary in the predicted direction with depressed individuals, as defined by their B.D.I. score (henceforth B.D.I. depressives), making more internal, global and stable attributions than B.D.I. nondepressed subjects (see mean scores Table 11). As with previous analyses the hypothesis was investigated in the two subpopulations, psychiatric and normal. Within

<table>
<thead>
<tr>
<th>VARIABLE</th>
<th>No. of cases</th>
<th>Mean</th>
<th>S.D.</th>
<th>Standard Error</th>
<th>T obs</th>
<th>D.F.</th>
<th>2-tailed Prob.</th>
</tr>
</thead>
<tbody>
<tr>
<td>NEG (1)</td>
<td>12</td>
<td>25.25</td>
<td>8.035</td>
<td>2.320</td>
<td>-1.37</td>
<td>38</td>
<td>0.179</td>
</tr>
<tr>
<td>(2)</td>
<td>28</td>
<td>28.4643</td>
<td>6.227</td>
<td>1.177</td>
<td>N.S.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>LOBNeg (1)</td>
<td>12</td>
<td>25.6667</td>
<td>7.463</td>
<td>2.154</td>
<td>-0.31</td>
<td>38</td>
<td>0.759</td>
</tr>
<tr>
<td>(2)</td>
<td>28</td>
<td>26.4286</td>
<td>7.010</td>
<td>1.325</td>
<td>N.S.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>TABNEG (1)</td>
<td>12</td>
<td>24.5</td>
<td>6.856</td>
<td>1.979</td>
<td>-1.62</td>
<td>38</td>
<td>0.113</td>
</tr>
<tr>
<td>(2)</td>
<td>28</td>
<td>28.250</td>
<td>6.648</td>
<td>1.256</td>
<td>N.S.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Where (1) = B.D.I. nondepressives; (2) = B.D.I. depressives


these two subpopulations the null hypothesis was also accepted as no significant differences were found between the two groups on the three attributional dimensions. While the mean scores obtained for the psychiatric subpopulation suggested the presence of a relationship in
the predicted direction, as with the whole population sample, the normal subpopulation did not provide support for experimental hypothesis number three (see Tables 12 and 13).

<table>
<thead>
<tr>
<th>VARIABLE</th>
<th>o. of cases</th>
<th>Mean</th>
<th>S.D.</th>
<th>Standard Error</th>
<th>T obs</th>
<th>D.F.</th>
<th>2-tailed Prob</th>
</tr>
</thead>
<tbody>
<tr>
<td>NEG</td>
<td>(1)</td>
<td>20</td>
<td>27.55</td>
<td>5.010</td>
<td>1.120</td>
<td>1.84</td>
<td>21</td>
</tr>
<tr>
<td></td>
<td>(2)</td>
<td>3</td>
<td>22.00</td>
<td>3.464</td>
<td>2.000</td>
<td></td>
<td>N.S.</td>
</tr>
<tr>
<td>LOBNEG</td>
<td>(1)</td>
<td>20</td>
<td>21.9</td>
<td>5.839</td>
<td>1.306</td>
<td>-0.51</td>
<td>21</td>
</tr>
<tr>
<td></td>
<td>(2)</td>
<td>3</td>
<td>23.667</td>
<td>3.055</td>
<td>1.764</td>
<td></td>
<td>N.S.</td>
</tr>
<tr>
<td>TABNEG</td>
<td>(1)</td>
<td>20</td>
<td>27.45</td>
<td>5.615</td>
<td>1.255</td>
<td>0.95</td>
<td>21</td>
</tr>
<tr>
<td></td>
<td>(2)</td>
<td>3</td>
<td>24.0</td>
<td>7.937</td>
<td>4.583</td>
<td></td>
<td>N.S.</td>
</tr>
</tbody>
</table>

Where (1) = B.D.I. nondepressives and (2) = B.D.I. depressives.


In conclusion, Statistical analysis of data do not support the experimental hypothesis but the B.D.I. depressed and nondepressed attribution scores do vary in the predicted direction for the whole population sample and psychiatric subpopulation.

3.5 HYPOTHESIS NUMBER FOUR.

"Subjects defined as depressed by their Beck Depression Inventory score will make more (a) external (b) specific (c) unstable attributions for success than nondepressed subjects".
Subjects were divided into depressed and nondepressed groups on the basis of their Beck Depression Inventory score in the same manner as that for hypothesis number three.

T-Tests were again used to test the experimental hypothesis, the null hypothesis being -

"There is no significant difference between the scores of subjects defined as depressed and those defined as nondepressed on the variables IPOS, GLOBPOS and STABPOS."

<table>
<thead>
<tr>
<th>VARIABLE</th>
<th>No. of cases</th>
<th>Mean</th>
<th>S.D.</th>
<th>Standard Error</th>
<th>T obs</th>
<th>D.F.</th>
<th>2-tailed Prob.</th>
</tr>
</thead>
<tbody>
<tr>
<td>IPOS</td>
<td>(1) 32</td>
<td>28.7812</td>
<td>5.265</td>
<td>0.931</td>
<td>1.14</td>
<td>61</td>
<td>0.260</td>
</tr>
<tr>
<td></td>
<td>(2) 31</td>
<td>26.9355</td>
<td>7.456</td>
<td>1.339</td>
<td>N.S.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>GLOBPOS</td>
<td>(1) 32</td>
<td>25.3125</td>
<td>6.761</td>
<td>1.195</td>
<td>-1.39</td>
<td>61</td>
<td>0.169</td>
</tr>
<tr>
<td></td>
<td>(2) 31</td>
<td>27.6774</td>
<td>6.735</td>
<td>1.210</td>
<td>N.S.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>STABPOS</td>
<td>(1) 32</td>
<td>28.6875</td>
<td>5.057</td>
<td>0.894</td>
<td>0.37</td>
<td>61</td>
<td>0.715</td>
</tr>
<tr>
<td></td>
<td>(2) 31</td>
<td>28.0968</td>
<td>7.534</td>
<td>1.353</td>
<td>N.S.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Where (1) = nondepressed patients; (2) = depressed patients; as defined by B.D.I. scores.

TABLE 14 - T-tests: between B.D.I. depressed and nondepressed subjects on IPOS, GLOBPOS, STABPOS: whole population.

As can be seen from Table 14 above no significant differences were found between the scores of depressed and nondepressed subjects on the variables IPOS, GLOBPOS and STABPOS. Consequently the null hypothesis is accepted. Two of the attribution dimensions, IPOS and STABPOS, do vary in the predicted direction indicating that B.D.I. depressives make more external and unstable attributions for success than B.D.I. nondepressives.
However, B.D.I. depressives seem to make more global attributions than B.D.I.
nondepressives (see Table 14). None of these differences reaches significance. An analysis of
the hypothesis was also obtained for the two subpopulations.

<table>
<thead>
<tr>
<th>VARIABLE</th>
<th>No. of cases</th>
<th>Mean</th>
<th>S.D.</th>
<th>Standard Error</th>
<th>T obs</th>
<th>D.F.</th>
<th>2-tailed Prob.</th>
</tr>
</thead>
<tbody>
<tr>
<td>IPOS</td>
<td>(1) 12</td>
<td>30.4167</td>
<td>6.612</td>
<td>1.909</td>
<td>1.37</td>
<td>38</td>
<td>0.178</td>
</tr>
<tr>
<td></td>
<td>(2) 28</td>
<td>26.9643</td>
<td>7.545</td>
<td>1.426</td>
<td></td>
<td></td>
<td>N.S.</td>
</tr>
<tr>
<td>GLOBPOS</td>
<td>(1) 12</td>
<td>27.6667</td>
<td>7.114</td>
<td>2.054</td>
<td>-0.06</td>
<td>38</td>
<td>0.949</td>
</tr>
<tr>
<td></td>
<td>(2) 28</td>
<td>27.8214</td>
<td>6.891</td>
<td>1.302</td>
<td></td>
<td></td>
<td>N.S.</td>
</tr>
<tr>
<td>STABPOS</td>
<td>(1) 12</td>
<td>29.9167</td>
<td>5.946</td>
<td>1.716</td>
<td>0.59</td>
<td>38</td>
<td>0.559</td>
</tr>
<tr>
<td></td>
<td>(2) 28</td>
<td>28.5</td>
<td>7.331</td>
<td>1.385</td>
<td></td>
<td></td>
<td>N.S.</td>
</tr>
</tbody>
</table>

Where (1) = B.D.I. nondepressives and (2) = B.D.I. depressives.

TABLE 15 - T-Tests: between B.D.I. depressed and nondepressed subjects on IPOS,
GLOBPOS, and STABPOS: psychiatric subpopulation.

<table>
<thead>
<tr>
<th>VARIABLE</th>
<th>No. of cases</th>
<th>Mean</th>
<th>S.D.</th>
<th>Standard Error</th>
<th>T obs</th>
<th>D.F.</th>
<th>2-tailed Prob.</th>
</tr>
</thead>
<tbody>
<tr>
<td>IPOS</td>
<td>(1) 20</td>
<td>27.8</td>
<td>4.150</td>
<td>0.928</td>
<td>0.39</td>
<td>21</td>
<td>0.699</td>
</tr>
<tr>
<td></td>
<td>(2) 3</td>
<td>26.6667</td>
<td>8.083</td>
<td>4.667</td>
<td></td>
<td></td>
<td>N.S.</td>
</tr>
<tr>
<td>GLOBPOS</td>
<td>(1) 20</td>
<td>23.9</td>
<td>6.299</td>
<td>1.408</td>
<td>-0.63</td>
<td>21</td>
<td>0.538</td>
</tr>
<tr>
<td></td>
<td>(2) 3</td>
<td>26.3333</td>
<td>6.028</td>
<td>3.480</td>
<td></td>
<td></td>
<td>N.S.</td>
</tr>
<tr>
<td>STABPOS</td>
<td>(1) 20</td>
<td>27.95</td>
<td>4.442</td>
<td>0.993</td>
<td>1.11</td>
<td>21</td>
<td>0.279</td>
</tr>
<tr>
<td></td>
<td>(2) 3</td>
<td>24.3333</td>
<td>10.116</td>
<td>5.840</td>
<td></td>
<td></td>
<td>N.S.</td>
</tr>
</tbody>
</table>

Where (1) = B.D.I. nondepressives and (2) = B.D.I. depressives.

TABLE 16 - T-Tests: between B.D.I. depressed and nondepressed subjects on IPOS,
GLOBPOS and STABPOS: normal subpopulation.
Statistical analysis of the data obtained from the two subpopulations (see Tables 15 and 16) also failed to find any significant differences between B.D.I. depressives and nondepressives on the attribution dimensions of internality, stability and specificity for successful outcomes. The previously found different pattern of attributions in the normal subpopulations when compared with the psychiatric subpopulation was not found in this analysis.

In conclusion, statistical analysis does not support the experimental hypothesis. B.D.I. depressed and nondepressed attribution scores on the variable IPOS and STABPOS, but not on the variable GLOBPOS, vary in the predicted direction for the whole population and for the two subpopulations.

3.6 HYPOTHESIS NUMBER FIVE.

"Scores on Rotter's I-E questionnaire and Seligman's unpublished attribution questionnaire significantly predict a subject's B.D.I. score."

Step-wise multiple regression techniques were used to analyse the data. Eight variables measuring different aspects of attribution style were used as predictors in the analysis. These variables were IPOS, INEG, GLOBPOS, GLOBNEG, STABPOS, STABNEG, ROTTER and IMPORT. As in previous statistical analyses, three multiple regression equations were obtained; the whole population, the psychiatric subpopulation and the normal subpopulation. The criterion was the variable BECK (B.D.I. score).
3.6.1 Determinants of Beck Depression Inventory Scores: whole population.

The major determinant of the criterion was the variable IPOS. The step-wise multiple regression of B.D.I. score on the independent variables accounted for a total of 21.22\% of the variance ($F(8/54) = 1.817, \text{N.S.}$) with 8.97\% being attributable to IPOS. None of the predictor variables, including IPOS, significantly predicted the criterion variable - BECK. Table 17 outlines the relationship between each of the eight predictor variables and the criterion variable. This result suggests that none of these eight attributional variables significantly predict level of depression in this subject population.

3.6.2 Determinants of Beck Depression Inventory Scores: psychiatric subpopulation.

A similar picture holds in the determinants of BECK in this subpopulation as for the whole population. The major determinant of the criterion was the variable IPOS. The step-wise multiple regression of B.D.I. score on the independent variables accounted for a total of 25.8\% of the variance ($F(8/31) = 1.35, \text{N.S.}$) with 16.71\% being attributable to IPOS (see Table 18 for a summary of results). None of the predictor variables, including IPOS, significantly predicted the criterion variable -BECK. It can be concluded from this result that none of the eight attributional variables significantly predict the level of depression in the psychiatric patients tested in this study.
<table>
<thead>
<tr>
<th>Variable</th>
<th>Simple R</th>
<th>Multiple R</th>
<th>Beta</th>
<th>Cumulative % variance accounted for</th>
<th>% variance accounted for</th>
<th>DF</th>
<th>F</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>IPOS</td>
<td>-0.29926</td>
<td>0.29926</td>
<td>-0.28423</td>
<td>8.95</td>
<td>8.95</td>
<td>1</td>
<td>2.506</td>
<td>N.S.</td>
</tr>
<tr>
<td>GLOBPOS</td>
<td>0.12522</td>
<td>0.36841</td>
<td>0.29910</td>
<td>13.57</td>
<td>4.62</td>
<td>1</td>
<td>3.034</td>
<td>N.S.</td>
</tr>
<tr>
<td>ROTTER</td>
<td>0.26343</td>
<td>0.44446</td>
<td>0.25737</td>
<td>19.755</td>
<td>6.185</td>
<td>1</td>
<td>3.626</td>
<td>N.S.</td>
</tr>
<tr>
<td>IMPORT</td>
<td>-0.16762</td>
<td>0.45611</td>
<td>-0.14547</td>
<td>20.803</td>
<td>1.048</td>
<td>1</td>
<td>0.780</td>
<td>N.S.</td>
</tr>
<tr>
<td>GLOBNEG</td>
<td>0.17900</td>
<td>0.45794</td>
<td>0.04844</td>
<td>20.971</td>
<td>0.168</td>
<td>1</td>
<td>0.100</td>
<td>N.S.</td>
</tr>
<tr>
<td>INEG</td>
<td>-0.04844</td>
<td>0.45908</td>
<td>0.05016</td>
<td>21.076</td>
<td>0.105</td>
<td>1</td>
<td>0.118</td>
<td>N.S.</td>
</tr>
<tr>
<td>STABNEG</td>
<td>0.03944</td>
<td>0.46001</td>
<td>-0.04621</td>
<td>21.161</td>
<td>0.0401</td>
<td>1</td>
<td>0.086</td>
<td>N.S.</td>
</tr>
<tr>
<td>STABPOS</td>
<td>-0.19783</td>
<td>0.46059</td>
<td>0.03521</td>
<td>21.215</td>
<td>0.0989</td>
<td>1</td>
<td>0.037</td>
<td>N.S.</td>
</tr>
</tbody>
</table>

8/31 1.8175 N.S.

TABLE 17 - Results of the Step-Wise Multiple Regression Analysis: whole population.

<table>
<thead>
<tr>
<th>Variable</th>
<th>Simple R</th>
<th>Multiple R</th>
<th>Beta</th>
<th>Cumulative % variance accounted for</th>
<th>% variance accounted for</th>
<th>DF</th>
<th>F</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>IPOS</td>
<td>-0.40877</td>
<td>0.40877</td>
<td>-0.40110</td>
<td>16.710</td>
<td>16.710</td>
<td>1</td>
<td>3.007</td>
<td>N.S.</td>
</tr>
<tr>
<td>STABNEG</td>
<td>0.11596</td>
<td>0.44502</td>
<td>0.12463</td>
<td>19.804</td>
<td>3.094</td>
<td>1</td>
<td>0.348</td>
<td>N.S.</td>
</tr>
<tr>
<td>GLOBPOS</td>
<td>-0.04488</td>
<td>0.46161</td>
<td>0.30704</td>
<td>21.308</td>
<td>1.504</td>
<td>1</td>
<td>1.571</td>
<td>N.S.</td>
</tr>
<tr>
<td>ROTTER</td>
<td>0.23299</td>
<td>0.47863</td>
<td>0.10216</td>
<td>22.908</td>
<td>1.6</td>
<td>1</td>
<td>0.253</td>
<td>N.S.</td>
</tr>
<tr>
<td>INEG</td>
<td>0.00117</td>
<td>0.48643</td>
<td>0.15372</td>
<td>23.661</td>
<td>0.753</td>
<td>1</td>
<td>0.576</td>
<td>N.S.</td>
</tr>
<tr>
<td>STABPOS</td>
<td>-0.29308</td>
<td>0.49787</td>
<td>-0.14396</td>
<td>24.788</td>
<td>1.127</td>
<td>1</td>
<td>0.295</td>
<td>N.S.</td>
</tr>
<tr>
<td>GLOBNEG</td>
<td>-0.00931</td>
<td>0.50467</td>
<td>-0.11113</td>
<td>25.469</td>
<td>0.681</td>
<td>1</td>
<td>0.321</td>
<td>N.S.</td>
</tr>
<tr>
<td>IMPORT</td>
<td>-0.28195</td>
<td>0.50837</td>
<td>-0.09433</td>
<td>25.844</td>
<td>0.375</td>
<td>1</td>
<td>0.157</td>
<td>N.S.</td>
</tr>
</tbody>
</table>

8/31 1.35044 N.S.

TABLE 18 - Results of the Step-wise Multiple regression Analysis: psychiatric subpopulation.
3.6.3 Determinants of Beck depression Inventory scores: normal subpopulation.

For the normal population the picture presented by the regression analysis is very different from that presented by the whole population and the psychiatric subpopulation. The major determinant of the criterion Beck was the variable INEG accounting for 24.527% of the variation in Beck Depression Inventory scores (variable BECK) (F(1/15) = 6.519, p < .01). Other variables of significant predictive ability are those of STABPOS, IPOS, and GLOBNEG accounting for 9.813%, 9.602% and 12.752% of the variation in BECK respectively (see Table 19). Tolerance level for inclusion as a predictor variable was not reached for the variable GLOBPOS and consequently computation of the regression analysis ceased. A total of 64.95% of the variance BECK was accounted for by the seven predictor variables.

<table>
<thead>
<tr>
<th>Variable</th>
<th>Simple R</th>
<th>Multiple R</th>
<th>Beta</th>
<th>% variance accounted for</th>
<th>% variance accounted for</th>
<th>DF</th>
<th>F</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>NEG</td>
<td>-0.49524</td>
<td>0.49524</td>
<td>-0.49414</td>
<td>24.527</td>
<td>24.527</td>
<td>1</td>
<td>6.519</td>
<td>&lt;.05</td>
</tr>
<tr>
<td>TABPOS</td>
<td>-0.32472</td>
<td>0.58601</td>
<td>-0.64075</td>
<td>34.34</td>
<td>9.813</td>
<td>1</td>
<td>7.576</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>POS</td>
<td>-0.10810</td>
<td>0.66289</td>
<td>0.67025</td>
<td>43.942</td>
<td>9.602</td>
<td>1</td>
<td>7.326</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>LOBNEG</td>
<td>0.25475</td>
<td>0.75295</td>
<td>0.46698</td>
<td>56.694</td>
<td>12.752</td>
<td>1</td>
<td>6.883</td>
<td>&lt;.05</td>
</tr>
<tr>
<td>MPORT</td>
<td>-0.22724</td>
<td>0.77500</td>
<td>-0.31387</td>
<td>60.062</td>
<td>3.368</td>
<td>1</td>
<td>2.978</td>
<td>N.S.</td>
</tr>
<tr>
<td>TABNEG</td>
<td>-0.25962</td>
<td>0.80513</td>
<td>-0.28955</td>
<td>64.824</td>
<td>4.792</td>
<td>1</td>
<td>1.978</td>
<td>N.S.</td>
</tr>
<tr>
<td>OTTER</td>
<td>0.08679</td>
<td>0.80590</td>
<td>0.04247</td>
<td>64.948</td>
<td>0.124</td>
<td>1</td>
<td>0.53</td>
<td>N.S.</td>
</tr>
</tbody>
</table>

Tolerance level insufficient for further computation: GLOBPOS was rejected 7/15 3.97046 <.001

TABLE 18 - Results of the Step-wise Multiple regression Analysis: normal subpopulation.
These results can be interpreted in the following manner: within the normal subgroups, a subject’s score on the variable BECK, which measures a subject’s level of depressive symptomatology, can be significantly predicted from the variables INEG, STABPOS, IPOS and GLOBNEG. Scores on the variables INEG, STABPOS and IPOS are negatively correlated with the variable BECK. This suggests that high levels of depressive symptomatology are predicted by low scores on INEG, indicating a tendency for external attributions for failure outcomes; STABPOS, indicating the tendency to have external attributions for failure outcomes; and IPOS, indicating a tendency for external attributions for success outcomes. The variable GLOBNEG is positively correlated with the criterion BECK suggesting that global attributions for failure are also significant predictors of level of depression.

3.6.4 Summary

Step-wise multiple regression was used to build a model by identifying the strongest predictor first and the adding the other variables in order of predictive strength.

For the entire population sample the multiple correlations ranged from R=0.29926 for two variables to R=0.46059 for eight variables and accounted for 21.215% of the variance. The eight attribution variables did not significantly predict the criterion variable (BECK) measuring level of depressive symptomatology.
For the psychiatric subpopulation sample the multiple correlations ranged from $R=0.40877$ for two variables to $R=0.50837$ for eight variables and accounted for 25.844% of the variance. Four variables INEG, STABPOS, IPOS and GLOBNEG were found to be significant predictors of the criterion variable BECK. This result again suggests some fundamental differences between psychiatric and non-psychiatric hospitalised patients.

3.7 HYPOTHESIS NUMBER SIX

(a) "A subject's scores on the three measured attributional dimensions significantly discriminate between diagnostic categories"

(b) "This discrimination is enhanced by the addition of B.D.I. scores to the discriminators."

Discriminant function analysis was used to investigate the two parts of hypothesis six. This statistical technique is a method used to find the weighted linear function of a set of variables that maximally discriminate between two populations. A composite score is calculated for each subject and plotted on a single axis. Minimal overlap between the distributions suggests the presence of separate categories.

For the purpose of this analysis the diagnostic shown in Table D Appendix A were regrouped as shown in Table 20. This regrouping determined three new groups, Group 1 = depressives including individuals categorized as manic depressives; Group 2 = all
other psychiatric group; Group 0 = non-psychiatric patients. As a result of this regrouping group one (depressives) contained 16 subjects, group two (other psychiatric) contained 24 subjects and group three (normals) contained 23 subjects.

<table>
<thead>
<tr>
<th>Diagnostic Category</th>
<th>Number of Patients</th>
<th>Recoded Category</th>
</tr>
</thead>
<tbody>
<tr>
<td>0. Non-psychiatric</td>
<td>23</td>
<td>0</td>
</tr>
<tr>
<td>1. Depressives</td>
<td>9</td>
<td>1</td>
</tr>
<tr>
<td>2. Anxiety</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>3. Manic Depressives</td>
<td>7</td>
<td>1</td>
</tr>
<tr>
<td>4. Personality disorder</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>5. Behavioural</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>6. Psychotic</td>
<td>11</td>
<td>2</td>
</tr>
<tr>
<td>7. Alcoholic</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>9. Undiagnosed Psychiatric</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>63</strong></td>
<td></td>
</tr>
</tbody>
</table>

TABLE 20 - regrouping of diagnostic categories.

Statistical analysis was divided into three stages, (1) discrimination between normal and depressed groups; (2) discrimination between depressed and other psychiatric groups; and (3) discrimination between all three groups. A step-wise discriminant analysis with the criterion of separation being to minimise Wilks' lambda, was used in all cases.
3.7.1 Discrimination between normal and depressed groups.

Analysis produced the standardized discriminant coefficients shown in Table 21. These indicate the relative contributions of the eight discriminating variables to the function. Thus the function, in this case primarily represents a combination of Rotter’s I-E locus of control scale and Seligman’s STABNEG dimension.

<table>
<thead>
<tr>
<th>Variable</th>
<th>Standardized Coefficient</th>
</tr>
</thead>
<tbody>
<tr>
<td>ROTTER</td>
<td>-1.04941</td>
</tr>
<tr>
<td>IPOS</td>
<td>0.35264</td>
</tr>
<tr>
<td>INEG</td>
<td>-0.80447</td>
</tr>
<tr>
<td>STABPOS</td>
<td>-0.20885</td>
</tr>
<tr>
<td>STABNEG</td>
<td>1.12253</td>
</tr>
<tr>
<td>GLOBPOS</td>
<td>-0.08354</td>
</tr>
<tr>
<td>GLOBNEG</td>
<td>-0.69905</td>
</tr>
<tr>
<td>IMPORT</td>
<td>0.51017</td>
</tr>
</tbody>
</table>

TABLE 21- Standardized discriminant function coefficients: normal and depressed groups.

Figure 1 illustrates graphically the group locations in the reduced space defined by the discriminant function. Evidence concerning group differences can be derived from the group centroids and a plot of the cases. The group centroids summarize the mean discriminant scores for each group on the determined functions. The group centroids are represented in Figure 1 by an asterisk.
FIGURE 1 - Group locations in the reduced space defined by the discriminant function: normal and depressive.
The significance of the discriminant function is tested by use of the chi-square where predicted group membership is compared with actual group membership. Table 22 presents the result of this analysis for the above discriminant function - 79.5% of known cases were correctly classified by the discriminant function. It can be concluded that the obtained discriminant function significantly discriminates (Chi-Square = 13.564, df (1), p<.001) between normal and depressed patients.

<table>
<thead>
<tr>
<th>Group</th>
<th>No. of cases</th>
<th>Group (0)</th>
<th>Group (1)</th>
</tr>
</thead>
<tbody>
<tr>
<td>(0) Normals</td>
<td>23</td>
<td>16</td>
<td>7</td>
</tr>
<tr>
<td></td>
<td></td>
<td>69.6%</td>
<td>30.4%</td>
</tr>
<tr>
<td>(1) Depressives</td>
<td>16</td>
<td>1</td>
<td>15</td>
</tr>
<tr>
<td></td>
<td></td>
<td>6.3%</td>
<td>93.8%</td>
</tr>
</tbody>
</table>

**Chi-Square = 13.564**  **Significance** **p< .001**

**TABLE 22 - Chi-square results: normals and depressives.**

A similar result was obtained after the addition of the variable BECK to the discrimination variables. Table 23 shows the standardized discriminant function coefficients while Table 24 shows the Chi-squared test of significance. Figure 2 illustrates graphically the group locations and centroids in the reduced space defined by the discriminant function including the variable BECK. The function in this case primarily represents depressive symptomatology as measured by the variable BECK. 87.2% of known cases were correctly classified. Thus it can be concluded that addition of the variable BECK (B.D.I. score) does improve the model’s discrimination between normals and depressives (chi-squared = 21.564, df (1), p< .001).
FIGURE 2 - Group locations in the reduced space defined by the discriminant function: normal and depressives with BECK.
<table>
<thead>
<tr>
<th>Variable</th>
<th>Standardized Coefficient</th>
</tr>
</thead>
<tbody>
<tr>
<td>ROTTER</td>
<td>-0.61436</td>
</tr>
<tr>
<td>BECK</td>
<td>-1.44420</td>
</tr>
<tr>
<td>IPOS</td>
<td>0.25837</td>
</tr>
<tr>
<td>INEG</td>
<td>-0.87653</td>
</tr>
<tr>
<td>STABPOS</td>
<td>-0.40336</td>
</tr>
<tr>
<td>STABNEG</td>
<td>0.57068</td>
</tr>
<tr>
<td>GLOBPOS</td>
<td>0.19528</td>
</tr>
<tr>
<td>GLOBNEG</td>
<td>-0.21547</td>
</tr>
<tr>
<td>IMPORT</td>
<td>-0.04443</td>
</tr>
</tbody>
</table>

**TABLE 23 - Standardized Discriminant Function Coefficients:**

normal and depressed groups: with BECK

<table>
<thead>
<tr>
<th>Group</th>
<th>No. of Cases</th>
<th>Group (0)</th>
<th>Group (1)</th>
</tr>
</thead>
<tbody>
<tr>
<td>(0) Normals</td>
<td>23</td>
<td>20</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td></td>
<td>87%</td>
<td>13%</td>
</tr>
<tr>
<td>(1) Depressives</td>
<td>16</td>
<td>2</td>
<td>14</td>
</tr>
<tr>
<td></td>
<td></td>
<td>12.5%</td>
<td>87.5%</td>
</tr>
</tbody>
</table>

**Chi-square = 21.564**

**Significance**  p<.001

**TABLE 24 - Chi-square results:**

normals and depressives with BECK.
3.7.2 Discrimination between depressed and other psychiatric groups.

The standardized discriminant function coefficient obtained from this analysis are shown in Table 25. The variable GLOBPOS failed to reach the criterion for entry into Table 25. The variable Globpos failed to reach the criterion for entry into the function. The function in this case seems to primarily represent Seligman’s attribution dimension INEG, with a number of other dimensions, notably STABNEG, IMPORT, IPOS and STABPOS also contributing to the function.

<table>
<thead>
<tr>
<th>Variable</th>
<th>Standardized Coefficients</th>
</tr>
</thead>
<tbody>
<tr>
<td>ROTTER</td>
<td>-0.11470</td>
</tr>
<tr>
<td>IPOS</td>
<td>-0.45551</td>
</tr>
<tr>
<td>INEG</td>
<td>0.94591</td>
</tr>
<tr>
<td>STABPOS</td>
<td>-0.44535</td>
</tr>
<tr>
<td>STABNEG</td>
<td>-0.68278</td>
</tr>
<tr>
<td>GLOBNEG</td>
<td>-0.08123</td>
</tr>
<tr>
<td>IMPORT</td>
<td>-0.51240</td>
</tr>
</tbody>
</table>

**TABLE 25 - Standardized Discriminant Function Coefficients:** depressed and other psychiatric groups.

Figure 3 illustrates graphically the group locations and centroids in the reduced space defined by the discriminant function. Table 26 shows the chi-square test of significance. 80% of the known cases were correctly classified by the function and it can be concluded that the obtained discriminant function significantly discriminates (chi-square 14.4, df(1), p< .001) between the two groups.
FIGURE 3 - Group locations in the reduced space defined by the discriminant function: depressed and other psychiatric groups.
TABLE 26 - Chi-square results; depressives and other psychiatric groups.

Addition of the variable Beck produced the standardized discriminant function coefficient shown in Table 27. The variable GLOBPOS failed to reach the criterion for entry into the function once again. The make up of this function is very similar to that shown in Table 25 which shows the standardized discriminant function coefficient produced by analysis of the same variables with the exception of BECK.

TABLE 27 - Standardized Discriminant Function Coefficients: depressed and other psychiatric groups: with BECK.
Figure 4 illustrates graphically the group locations and centroids in the reduced space defined by the discriminant function including the variable BECK. 80% of known cases were correctly classified by the function and thus it seems that the variable BECK did not add to the discrimination between diagnostic categories. Table 28 shows the predicted group membership and Chi-square test of significance (chi-square =14.4, df(1), p< .001). It can be seen that Table 28 is identical to Table 26.

<table>
<thead>
<tr>
<th>Group</th>
<th>No. of Cases</th>
<th>Group (1)</th>
<th>Group (2)</th>
</tr>
</thead>
<tbody>
<tr>
<td>(1) Depressives</td>
<td>16</td>
<td>13</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td></td>
<td>81.3%</td>
<td>18.8%</td>
</tr>
<tr>
<td>(2) Other Psychiatric</td>
<td>24</td>
<td>5</td>
<td>19</td>
</tr>
<tr>
<td>Groups</td>
<td></td>
<td>20.8%</td>
<td>79.2%</td>
</tr>
</tbody>
</table>

**Chi-square = 14.4**  
**Significance**  
**p< .001**

TABLE 28 - Chi-square results; depressives and other psychiatric groups: with BECK.

The function does, however, significantly discriminate between the two groups.

3.7.3. Discrimination between all three Diagnostic Groups.

Two discriminant functions were devised to distinguish between the three diagnostic groups. The standardized discriminant function coefficients obtained are shown in Table 29. The first function in table 29 primarily represents the dimension INEG with STABNEG and IMPORT also contributing to the function, while the second function is composed of Rotter’s I-E locus of control scale and Seligman’s STABNEG dimension. Figure % illustrates graphically the group locations and centroids in the reduced space defined by the two discriminant functions.
FIGURE 4 - Group locations in the reduced space defined by the discriminant function: depressed and other psychiatric groups with BECK.
Table 30 shows the chi-square test of significance. 63.5% of known cases were correctly classified and it can be concluded that the obtained discriminant functions significantly discriminate (chi-square = 25.786, df(4), p< .001) between the three groups.

<table>
<thead>
<tr>
<th>Variable</th>
<th>Standardized Coefficients</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1</td>
</tr>
<tr>
<td>ROTTER</td>
<td>-0.18451</td>
</tr>
<tr>
<td>IPOS</td>
<td>-0.36047</td>
</tr>
<tr>
<td>INEG</td>
<td>0.65262</td>
</tr>
<tr>
<td>STABPOS</td>
<td>-0.37507</td>
</tr>
<tr>
<td>STABNEG</td>
<td>-0.51649</td>
</tr>
<tr>
<td>GLOBPOS</td>
<td>-0.21337</td>
</tr>
<tr>
<td>GLOBNEG</td>
<td>-0.22424</td>
</tr>
<tr>
<td>IMPORT</td>
<td>-0.48129</td>
</tr>
</tbody>
</table>

TABLE 29 - Standardized discriminant function coefficients: all three diagnostic groups.

<table>
<thead>
<tr>
<th>Predicted Group Membership</th>
</tr>
</thead>
<tbody>
<tr>
<td>Group</td>
</tr>
<tr>
<td>-------</td>
</tr>
<tr>
<td>(0) Normals</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>(1) depressives</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>(2) Other Psychiatric</td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>

Chi-square = 25.786  
Significance p< .001

TABLE 30 - Chi-square results; all groups.
FIGURE 5 - Group locations in the reduced space defined by the discriminant function: three diagnostic groups.
Addition of the variable BECK improved the discrimination between the three diagnostic groups and produced two functions which correctly classified 69.8% of known cases.

<table>
<thead>
<tr>
<th>Variable</th>
<th>Standardized Coefficients</th>
</tr>
</thead>
<tbody>
<tr>
<td>ROTTER</td>
<td>-0.38639 -0.20638</td>
</tr>
<tr>
<td>BECK</td>
<td>-0.95623 -0.23844</td>
</tr>
<tr>
<td>IPOS</td>
<td>-0.16165 0.46866</td>
</tr>
<tr>
<td>INEG</td>
<td>0.09895 -0.76212</td>
</tr>
<tr>
<td>STABPOS</td>
<td>-0.44320 0.10091</td>
</tr>
<tr>
<td>STABNEG</td>
<td>0.14412 0.78162</td>
</tr>
<tr>
<td>GLOBPOS</td>
<td>-0.11335 0.02312</td>
</tr>
<tr>
<td>GLOBNEG</td>
<td>-0.33416 -0.00822</td>
</tr>
<tr>
<td>IMPORT</td>
<td>-0.21518 0.50589</td>
</tr>
</tbody>
</table>

TABLE 31 - Standardized discriminant function coefficients: all three diagnostic groups: with BECK.

<table>
<thead>
<tr>
<th>Group</th>
<th>No. of Cases</th>
<th>Group (0)</th>
<th>Group (1)</th>
<th>Group (2)</th>
</tr>
</thead>
<tbody>
<tr>
<td>(0) Normals</td>
<td>23</td>
<td>18 78.3%</td>
<td>3 13%</td>
<td>2 8.7%</td>
</tr>
<tr>
<td>(1) Depressives</td>
<td>16</td>
<td>2 12.5%</td>
<td>11 68.8%</td>
<td>3 18.8%</td>
</tr>
<tr>
<td>(2) Other Psychiatric</td>
<td>24</td>
<td>4 16.7%</td>
<td>5 20.8%</td>
<td>15 62.5%</td>
</tr>
</tbody>
</table>

Chi-square = 25.786  Significance p< .001

TABLE 32 - Chi-square results; all groups: with BECK.
FIGURE 6 - Group locations in the reduced space defined by the discriminant function: three diagnostic groups; with BECK.
Table 31 shows the standardized discriminant function coefficients while Table 32 shows the chi-square test of significance. Figure 6 illustrates graphically the group locations and centroids in the reduced space defined by the discriminant functions including the variable BECK.

Function number one primarily represents depressive symptomatology as measured by the variable BECK. Function number two is less clear cut and consists mainly of a combination of the dimensions INEG and STABPOS with the dimensions IMPORT and IPOS also contributing to the function. It can be concluded that the obtained discriminant functions significantly discriminate (chi-square 37.786, df(4), $p<.001$) between the three diagnostic groups and that the variable BECK adds to the discrimination power of the functions.

### 3.7.4 Summary.

Hypothesis number six, part (a), is supported by the statistical analysis and a subject’s scores on the three measured attribution dimensions do significantly discriminate between diagnostic categories. Addition of the variable BECK to the discriminating variables increased the predictive power of the discriminant function on only two of the discriminations, those between normals and depressives, and the three diagnostic categories. The discrimination between depressives and other psychiatric patients was not improved by the addition of the variable BECK to the discriminating variables. In this case 80% of known cases were correctly classified by the discriminant function using measures of attribution style.
CHAPTER 4.

DISCUSSION

and

CONCLUSIONS.
4.1 DISCUSSION OF RESULTS.

The first observation worthy of comment is the difference between normal and psychiatric patients in their ability to complete the test booklet. Table 6 shows that approximately twice as many psychiatric (21.1%) as non-psychiatric patients (10%) were unable to complete the test booklet. The average length of time taken to complete the questionnaire also differed between the two groups (psychiatric, 3 hours; non-psychiatric, 1 hour). It was apparent during testing that the psychiatric patients required more encouragement and help to complete the test booklet. Subjectively, they appeared to lack motivation and initiative and seemed unable to complete the booklet without constant encouragement and reassurance. In contrast, non-psychiatric patients required little encouragement or explanation and worked steadily through the questionnaires. This different response to the task may result from a number of factors such as the nature of the subject's condition, length of time hospitalised, or the different hospital conditions experienced by psychiatric and non-psychiatric patients.

In terms of the reformulated learned helplessness model these differences could be explained by the presence of different attributional styles in the two groups. It would seem that non-psychiatric patients have retained "control" of their actions and can attribute successful completion of the questionnaires to their own efforts (internalises). On the other hand, psychiatric patients seemed to "lack control" and did not seem to associate successful completion of the booklet with their own effort. They also lacked goal direction. It seems reasonable to assume that these patients had a more "external" orientation for events in their life attributing outcomes to others. This observed difference in the two groups ability to successfully undertake an assignment may well be a result of the long-term institutionalisation experienced by the majority of psychiatric patients in this study but not by the non-psychiatric patients (see Appendix 7 for data concerning length of time hospitalised).
No data available for non-psychiatric patients). The effects of institutionalisation have been documented by Goffman (1961). However, no direct measures of these effects were made in the present study and the observed differences must remain a matter of speculation.

4.1.1 Failure vs. Success Outcomes.

It has been hypothesized and demonstrated by a number of different investigators (e.g. Feathers and Simon 1971, Klein et al 1976) that individuals, and in particular depressed individuals, make different attributions for success and failure. Hypotheses three and four in the present study were concerned with investigating this finding. While not providing any direct support for these results, a number of interesting differences in attributions for failure outcomes, as measured by the variable INEG in particular, were found between the psychiatric and non-psychiatric (normal) subgroups. These differences will be discussed in this section in the context of the results from hypotheses number one, three and four.

Statistical analysis of questionnaire data did not reveal a significant relationship between Rotter’s I-E locus of control scale and the locus of control items of Seligman’s questionnaire (hypothesis 1). The obtained Pearson-product-moment correlation coefficients (see Table 8) did show a relationship in the predicted direction, albeit a small one. It may be that with a larger population sample a significant relationship would be found. However, the lack of a significant relationship between the two measures may not be a reflection of a lack of validity of this section of Seligman’s unpublished questionnaire. Reference to Appendix 3 (Rotter’s questionnaire) and Appendix 4 (Seligman’s questionnaire) will show that the two questionnaires, based on two different theoretical orientations, emphasize different types of
situations when measuring attribution style. Whereas Seligman phrases his situations in personal terms e.g. “You meet a friend who compliments you on your appearance” and then asks the subject to evaluate their attributions on a seven point scale, Rotter phrases his in impersonal terms e.g. “Children get into trouble because their parents punish them too much” and requires subjects to make a forced-choice between two items. This difference between personal, concrete events and impersonal, abstract choices may be equivalent to comparing personal values with political ideals and the two questionnaires may, in fact, be measuring different aspects of the same dimension. In addition to this difference, Seligman clearly divides his questionnaire into success and failure outcomes. No such clear distinction is made in Rotter’s questionnaire and, in fact, this scale seems to concentrate on undesired, negative, punishment or failure situations. It has frequently been reported that depressed individuals make different attributions for failure and success outcomes (see Abramson et al 1978, Rizley 1978 and Kuiper 1978). This distinction between attributions for success and failure outcomes is further highlighted in Table 9 reporting the Pearson-product-moment correlation coefficients, for the psychiatric and non-psychiatric subgroups, between the variables ROTTER, IPOS (attribution for positive events) and INEG (attribution for negative events). While the variables ROTTER and IPOS are related in a similar fashion in both subgroups, the variable INEG is positively related to ROTTER in the psychiatric group, and negatively correlated in the normal subgroup. In addition while IPOS and INEG are significantly correlated (p < .014) in the psychiatric group they are not significantly related in the normal subgroup. This seems to suggest that subjects in the two subpopulations react differently in their attributions for negative events but not in their attributions for positive events as measured by Seligman’s questionnaire. Rotter’s I-E locus of control scale, despite its concentration on undesired, negative, punishment and failure
situations seems to perform in a similar manner to IPOS in the two subpopulations and there seems to be consistent correlation of about -0.2 between the two variables in the whole population sample and the two subgroups.

Hypotheses number three and four are concerned with the investigation of different attributions for success and failure outcomes for depressed and nondepressed (defined by their B.D.I. scores, variable BECK) subjects. As with the Pearson-product-moment correlation analyses no significant differences were found between the groups. It was hypothesized (hypothesis number three) that B.D.I. depressives would make more internal, global and stable attributions for failure than B.D.I. nondepressives. While no significant differences were found for the whole population, the attribution scores did vary in the predicted direction. Once again a significant result may have been obtained with a larger population sample. The difference between the two subpopulations found on the variable INEG when investigating the relationship between ROTTER, IPOS and INEG was again found in the present investigation. The mean scores on the variable INEG and STABNEG in the psychiatric subpopulation suggest the presence of a relationship in the predicted direction, while the mean scores on these variables in the normal subpopulation suggest a relationship in the opposite direction i.e. B.D.I. depressives make less internal and less stable attributions for failure than B.D.I. nondepressives. In contrast it was hypothesized (hypothesis number 4) that B.D.I., depressives would make more external, specific and unstable attributions for success than B.D.I. nondepressives, and while no significant differences were found, the attribution scores did vary in the predicted direction on the variables IPOS and STABPOS, but not on the variable GLOBPOS for the whole population sample. The same relationships were found in the two subpopulations in contrast to the
previously found differences between the psychiatric and normal subpopulations. Thus it seems that normal and psychiatric patients tend to differ on the variables INEG and STABNEG, that is on the dimensions of internality and stability for failure outcomes. However, it should be pointed out that the results from the normal subpopulation are unreliable in this case as data from 20 subjects is compared with data obtained from 3 subjects defined as depressed (see Tables 13 and 16). The small number of depressives found in the normal subpopulation, compared with the relatively high number found in the psychiatric population is only to be expected. In order to make more definite conclusions, a higher number of B.D.I. depressives would have to be established within the normal subpopulation.

Miller and Norman (1979), independently of Abramson et al (1978), devised an attribution therapy model of the learned helplessness phenomena in which they emphasized the importance of both an expectancy of response-outcome independence and an expectancy of failure to obtain desired outcomes, in the development of learned helplessness. This emphasis on the importance of failure outcomes in the development of helplessness would seem compatible with the differences found between psychiatric and non-psychiatric patients in their attributions for failure outcomes. Miller and Norman have, in addition, hypothesized that an attributional dimension of subjective importance, that is, the relative value a person assigns to an event, should be added to the dimensions of internality, stability and specificity. They also believe that situations cues (e.g. instructions) and individual differences, mediate in the development of an individual’s attributions. A “chronology” of reactive depression is suggested by them on the basis of this model in which, due to some undefined combination of situational cues and repeated exposure to noncontingent and undesired outcomes, the
individual's attributions of these outcomes change from external, variable (unstable) and specific, to internal, stable and general (global) causes. In new situation, the individual expects noncontingency and failure, and when these occur, they are attributed to internal, stable and general causes whereas success is attributed to external variable and specific causes. The individual is then depressed and tends to disregard outcomes of success and contingency while overgeneralizing failure and noncontingent outcomes. This formulation by Miller and Norman (1979) mainly differs from that of Abramson et al in terms of the conditions necessary for producing helplessness and in the addition of a fourth attribution dimension of subjective importance. It is the addition of an expectancy of failure to obtain desired outcomes which makes this reformulation seem attractive in the light of the experimental findings discussed so far. However, this expectancy of failure has been related to helplessness as a model of depression whereas the present experimental results seem to suggest a different general pattern of attribution for failure outcomes in psychiatric patients compared to that found in non-psychiatric patients.

In conclusion, the finding that B.D.I. depressives in the psychiatric subpopulation differ from B.D.I. depressives in the normal subpopulation in their attributions for failure outcomes, while not differing in their attributions for success outcomes, taken with the results obtained from the Pearson-product-moment correlation analysis (between ROTTER, IPOS and INEG) suggests that there are some fundamental differences between psychiatric and normal patients on the variables INEG and STABNEG. The status of these two variables in a subject's attributions for failure outcomes requires further investigation and clarification and suggests, perhaps, that the attribution styles of psychiatric patients in general should be investigated and compared with those of normals. The model of learned helplessness in
terms of attribution theory developed by Miller and Norman (1979) also emphasises the importance of failure events and reinforces the need for further research in this area.

### 4.1.2 Self-Esteem and Attribution.

It was predicted, on the basis of Abramson at al’s (1978) reformulated model of learned helplessness, that low self-esteem would be significantly corrected with measures of internality. However, significant correlations, using the Pearson-product-moment correlation procedure, were obtained in the opposite direction from that predicted indicating that increasing externality is significantly correlated (p < .05) with low self-esteem (high SELF scores). As with all previously discussed statistical analyses in this study, there appears to be a different general pattern of correlations in the normal and psychiatric subgroups. In this case the correlations are in the same direction on each of the variable pairs, but those that reach significance in the psychiatric population do not do so in the normal population and vice-versa. Within the psychiatric subpopulation IPOS is significantly negatively correlated (p < 0.009) with SELF indicating that individuals with a low level of self-esteem (measured by increasing SELF) tend to make external attributions for successful outcomes. This result is confirmed by the significantly positive correlation (p < 0.05) between the variables ROTTER and SELF. These significant relationships were not found within the normal subpopulation. However, INEG was significantly negatively correlated (p < 0.014) with SELF indicating that normal patients with a low level of measured self-esteem tend to make external attributions for failure outcomes. This significant relationship does not exist within the psychiatric subpopulation. This result tends to suggest, once again, the presence of a different general pattern of attribution within the normal subgroup from that found in the psychiatric subgroup. This result also tends to suggest that the relationship
between a subject’s level of self-esteem and attributions for outcomes are more complex than hypothesized by Abramson et al (1978). For example hypothesis number four, based on the reformulated model states that B.D.I. depressives will make more external, specific and unstable attributions for success than B.D.I. nondepressives. This hypothesis was not supported but from the above significant correlation between IPOS and SELF (p < 0.009) it seems that individuals with a low level of self-esteem, within the psychiatric population, tend to make external attributions for successful outcomes. On the other hand, hypothesis number three, states that B.D.I. depressives will make more internal, global and stable attributions for failure than B.D.I. nondepressives. The significant correlation between INEG and SELF (p < 0.014) within the normal population suggests that non-psychiatric patients with a low level of self-esteem tend to make external attributions for failure outcomes. Thus it seems that there is a complex interrelationship between level of self-esteem, locus of control attributions for success and failure outcomes and membership of the two subpopulations (psychiatric and normal) within this study.

An obvious explanation for the failure to confirm experimental hypothesis number two is that the variable SELF is not an accurate measure of level of self-esteem. Perusal of Appendix 6 and Table 3 showing the items selected to form the variable SELF, suggest that the variable subjectively seems related to level of self-esteem. The level of agreement between the professionals selecting the B.D.I. items most closely reflecting a subject’s level of self-esteem would also tend to suggest that the variable SELF is a valid measure of self-esteem level. The fact that, within the whole population sample, the variable is significantly positively correlated with ROTTER (p < .017) two independent variables designed to measure locus of
control (scored in opposite directions), suggest that the variable is measuring something related in a consistent manner to externality.

Abramson and Sackeim (1977) believe that there is a conceptual paradox in the literature on depression between uncontrollability and self-blame. Lowered self-esteem is a function of high self-blame and low mood. They believe that attributing personal responsibility, measured by a high level of self-blame, for an outcome believed, or perceived, to be uncontrollable is prima facie illogical. Thus as Seligman’s theory of depression argues that a central etiological factor in depression is the belief in uncontrollability of outcomes, it seems that depressives should be less likely than non-depressives to assume personal responsibility for outcomes. Abramson and Sackeim (1977) argue that such a view is at odds with the idea that depressives evidence heightened tendencies to hold themselves responsible for negative outcomes and to engage in self-blame. They further add that a number of studies (e.g. Miller and Seligman (1973) have reported small but significant positive correlations between degree of externality and depression. An alternative statement of the paradox is that individuals assume personal responsibility for outcomes they view as externally controlled. Evidence for the existence of such a paradox is stronger in depressed populations than in normal populations.

The above mentioned paper by Abramson and Sackeim (1977) provides two possible explanations for the correlation between low self-esteem and externality. Firstly, the variable SELF derived from items on Beck’s Depression Inventory may simply be providing a measure of level of depressive symptomatology and thus the finding by Miller and Seligman (1973) that there is a significant positive correlation between degree of externality and level
of depression is being replicated. This is by far the simplest explanation of the experimental finding in the present study of a relationship between high SELF scores (low self-esteem) and increasing externality.

An additional explanation can also be derived from Abramson and Sackeim's statement of a paradox between externality and self-blame. It may be that the assumption by Abramson et al.'s reformulated learned helplessness model of depression that subjects demonstrating high self-blame, and consequently having a low self-esteem, would tend to make more internal attributions for outcomes, is simply wrong. The results of the present study, along with the evidence cited by Abramson and Sackeim, that subjects with a low level of self-esteem (high self-blame) tend to make more external attributions, while seeming less logical than the account provided by Abramson et al (1978), would consequently be a true reflection of depressed individual's attribution styles. If this is indeed the case, part at least of the reformulated learned helplessness model of depression would have to be restated to account for this paradox.

Evans and Dinning (1978) found that there was no relationship between a subject's score on Rotter's I-E locus of control questionnaire and level of depression defined by B.D.I. scores. They suggested that future research should employ more specific measures of control. The relationship between externality and the variable SELF was obtained in the present study using two independent measures of locus of control (ROTTER and IPOS) so it seems that the result was not simply a chance occurrence.
In conclusion the finding of a significant relationship between low level of self-esteem and increasing externality is hard to explain in terms of the reformulated learned helplessness model. This result requires replication and further investigation before any firm conclusions can be made. In particular, the use of a valid measure of self-esteem would add to the validity of any experimental finding.

4.1.3 The Relationship between Depression and Attribution Style.

It was hypothesized that a subject's B.D.I. score, that is level of depressive symptomatology, could be significantly predicted from that individual's attribution style as measured by Rotter's I-E scale and Seligman's attribution questionnaire. Step-wise multiple regression analysis was used to investigate this hypothesis and it was found that while attribution measures did not significantly predict a subject's B.D.I. score for the whole population, or for the psychiatric subpopulation, seven of the eight attribution measures used in the analysis (GLOBPOS was rejected) accounted for 64.95% of the variance of the variable BECK (B.D.I. score), with four of the variables (INEG, STABPOS, IPOS and GLOBNEG) being significant predictors of the criterion variable (BECK) within the normal subgroup. The variable INEG accounted for the largest percentage of this variance of the variable BECK (24.53%). This result emphasizes yet again the difference between the psychiatric and normal subgroups in terms of the measured attribution dimensions. Whereas the level of measured depressive symptomatology can be significantly predicted (p < .001) by the pattern of a subject's attributions within the normal subgroup, no such relationship exists within the psychiatric subgroup or the whole population sample. The lack of a significant relationship between level of depressive symptomatology and attribution style within the psychiatric
subpopulation is disappointing but is not necessarily damaging to the reformulated learned helplessness model of depression. Within the psychiatric subpopulation, psychiatric symptoms other than depression may be interacting with attribution styles and masking any pattern associated with depression. On the other hand, a high level of depressive symptomatology within the psychiatric population may not be related to depressions of the "reactive" kind and consequently it could be argued that they are technically outside the scope of the model. The failure to find a relationship may also be a reflection of the instrument used to measure the "deficit" i.e. the level of depressive symptomatology measured by B.D.I. score. The measure obtained is a qualitative and quantitative judgement by the patient and therefore is open to subjective biases and the effects of individual differences. These effects may be accentuated in a psychiatric population. On the other hand failure to produce a similar relationship in the psychiatric subpopulation to that found in the normal subpopulation, echoes again the criticism raised by Rippere (1977) that learned helplessness research is based largely on the results of experiments with an essentially "normal" population, that of college students. The question naturally arises, are the hypothesized processes transferable to a very different psychiatric population? This present result would suggest that while the attribution styles hypothesized by the reformulated model are related to the level of depressive symptomatology (as measured by the Beck Depression Inventory) in normals, they are not related in a psychiatric, or mixed population.

One further point which it seems appropriate to raise at this stage concerns the actual questionnaires used to test attribution styles (Rotter's I-E locus of control questionnaire and Seligman's unpublished questionnaire). These questionnaires were developed for use with a population of college students and consequently some of the situations described are outside
the frame of reference of many of the subjects in the present study. For example in Appendix 4 “you have given an important talk in front of a group and the audience reacts negatively”; or Appendix 3, question 5, regarding the grading of work by teachers. It was particularly noticeable that the psychiatric patients were unable to alter their frame of reference and “imagine” or even remember a situation. For example “You become very rich” (Appendix 4) was frequently responded to by a comment to the effect that they would not. When asked to try and imagine the situation the immediate response was that they could not as it was unlikely. This type of problem did not arise with the normal population. It seems that further investigation of the relationship between attribution styles and B.D.I. scores would be of interest using an attribution measure of more immediate relevance to the life style of long-term psychiatric patients.

Despite the above problems, there is a demonstrable relationship between B.D.I. score and the attribution measures in a normal population. Once again, as in the majority of statistical analyses in the present study, the variable INEG, that is a measure of the internal-external locus of control attribution for negative outcomes, stands out as being of greater predictive value than the other variables. The variable IPOS, that is a measure of the internal-external locus of control attribution for positive outcomes, does have this same predictive value. A number of investigators have reported differences between a depressives attributions for success and failure events (e.g. Feather and Simon 1971, Kuiper 1978, Klein et al 1976) but few have emphasized the importance of a subject’s attributions for failure events rather than success events as distinguishing between normals and psychiatric patients (see Miller and Norman (1979) for an emphasis of failure experiences). These differences require further
Hypothesis number six was concerned with distinguishing between three diagnostic categories, depressed, nondepressed psychiatric, and normals on the basis of the pattern of attribution within each group. Reference to Tables 30 and 32 shows that these three diagnostic groups can be significantly discriminated ($p < .001$) by discriminant functions derived from the eight variables measuring attribution style with or without the variable BECK added to the discriminating variables. With the variable BECK 68.8 percent of known cases were correctly classified as opposed to 63.5 percent by attribution style measures alone. The first function derived from attribution measures alone primarily represented the dimensions of INEG and STABNEG with IMPORT also contributing to the function. This function is similar to that obtained from a discriminant function between depressed and other psychiatric groups (see Table 25) and consequently it seems that this function is discriminating between these two groups. The appearance of the variable IMPORT as an important discriminator perhaps suggests that Miller and Norman’s (1979) inclusion of a fourth attribution dimension of subjective importance has some experimental support. The second function is composed of the variable ROTTER and Seligman’s STABNEG dimension. This function is similar to that shown in Table 21 which discriminates between depressives and normals. The dimension STABNEG appears as an important discriminating variable in both cases. This variable measures the stability of attributions for failure outcomes and it seems that the three diagnostic groups differ in terms of this attributional dimension. The addition of the variable BECK to the discriminator between normal and depressed groups but does not discriminate between depressives and
other psychiatric patients (see Tables 23 and 27). The second function is composed of the variables INEG and STABNEG the dimension which were previously shown (Tables 25 and 27) to significantly discriminate \( p < .001 \) between depressed and all other psychiatric groups. Thus it can be concluded that the three groups of normals, psychiatric depressed and psychiatric nondepressed can be significantly separated \( p < .001 \) by discriminant functions derived from measures of attribution style. The most important variables in this discrimination of the three groups appear to be INEG, STABNEG, IMPORT and ROTTER, that is the internality, stability and importance attributions mainly for negative events, and the variable ROTTER. As stated previously Rotter’s I-E locus of control questionnaire (see Appendix 3) concentrates mainly on undesired, negative, punishment or failure situations and consequently may be reflecting some of the same differences as the variable INEG. Bearing in mind the previously stated similarities between IPOS and ROTTER, it seems possible that the variable ROTTER overlaps the measurements of attribution style made by IPOS and INEG.

The broad conclusion seems to be that a subject’s attitudes to failure events is the important discriminating factor between the three groups and explains the rather confusing differences found in the results section between the normal and psychiatric subpopulations on the variable INEG.

The addition of a measure of depressive symptomatology, as measured by Beck’s Depression Inventory, only increased the number of known cases correctly classified from
63.5 to 69.8 percent of cases mainly by improving the discrimination between normals and the other two groups (see Tables 30 and 32)

The present study attempted to take the reformulated learned helplessness model (Abramson et al 1978) a step further and predict an individual's membership of a group of clinically depressed patients from measured attribution dimensions. The results of the present study suggest that not only is it possible to distinguish clinically depressed patients from normals on the basis of attribution score, it is possible to significantly discriminate (p < .001) clinically depressed patients, nondepressed psychiatric patients and normal patients on the basis of these scores. It seems that each group has its own recognizable pattern of attributions. This of course does not answer the question of what comes first, attribution style or group membership. In order to answer this question a series of measures of attribution styles over a prolonged period of time to determine whether attribution change follows or precedes movement from one group to another would be necessary.

Another interesting point is raised by the ability to significantly discriminate diagnostic groups on the basis of attribution style. In this study the depressive group was not homogenous. For a start Table 20 shows that the sixteen members of the depressed psychiatric group consisted of seven patients diagnosed as manic depressives and nine diagnosed simply as depressives. Of these nine, no distinction was made between reactive or endogenous depressives. These results would tend to suggest that all depressives have attribution styles which are similar enough for them to be recognized statistically as an independent group. Seligman has repeatedly stated, in the face of criticism, that the learned
helplessness model is primarily concerned with reactive depressions, the "disaster" syndrome, grief reactions and associated phenomena (see Seligman 1975, Abramson et al 1978). However, it seems from the evidence accumulated in the present study that while direct support from the attribution processes hypothesized by Abramson et al (1978) to account for depression following experience with uncontrollability e.g. that B.D.I. depressives will make more internal, global and stable attributions for failure, and external, specific and unstable attributions for success, was not obtained, there is evidence that clinical depressives of all types differ in terms of their attribution style from both normals and nondepressed psychiatric patients. In particular they appear to differ most in their pattern of attribution style from both normals and nondepressed psychiatric patients. In particular they appear to differ most in their pattern of attribution for negative outcomes (variables INEG and STABNEG). It is interesting to note that level of depression, as measured by Beck's Depression Inventory is not significantly related to attribution scores except in the normal subpopulation. This result probably arises from the high level of depressive symptomatology within the psychiatric subpopulation with twenty-eight out of forty scoring about the median for the whole population, and the above finding that clinically diagnosed depressives differ from clinically diagnosed non-depressives in terms of attribution styles.

In summary it seems that an individual's pattern of attributions for outcomes is associated with diagnostic category. The significance of this relationship has yet to be determined but suggests that an important area of mental illness, that of attribution styles, requires further investigation.
4.2 CONCLUSIONS

There has been a lack of emphasis, in the learned helplessness research with humans, on the cognitive aspects of the theory and there has been a tendency to equate the cognitive processes of infrahumans with those of humans. This is probably due to the origins of the learned helplessness phenomenon in animal research. An attempt has been made in the present study to investigate some of the cognitive processes of humans in relation to the reformulated theory of Abramson et al. (1978).

The format of this study represents a departure from the traditional method of investigating the learned helplessness in that no helplessness inducing procedures were employed. Rather the present study aimed at investigating the cognitive processes in existing populations and relating these to the attribution dimensions hypothesized by Abramson et al. (1978) in the reformulated learned helplessness model of depression.

Little evidence was found in the present study to support some of the predictions made by Abramson et al. (1978) (hypotheses numbers two, three and four). Attribution styles were measured using an unpublished questionnaire developed by Seligman as a basis for testing the reformulated model. This questionnaire remains to be validated and while not providing any direct support for the reformulated model some interesting results emerged indicating that the three diagnostic categories established in this study can be significantly discriminated (p < .001) by the dimensions measured by this questionnaire. If this result is replicated it raises a number of questions concerning the very nature of mental illness and the involvement of cognitive processes. It seems that different patterns of attribution are associated with diagnostic categories. The use of broad diagnostic categories in this study
leaves the specificity of this association undetermined. For example, do schizophrenics have a different attribution style from that of alcoholics or anxiety states? Are there, in fact, subtle differences between the attribution styles of manic depressives and individuals diagnosed as endogenous depressives?

The precise association between diagnostic category and attribution style also requires elucidation. Which comes first? The attribution style or the mental illness? Longitudinal research measuring changes in both attributional style and expression of psychiatric symptomatology is required to determine this relationship.

One finding that repeatedly appears in the difference between psychiatric and normal patients in their attributions for negative or failure outcomes. A number of different statistical techniques and different organizations of the data revealed this difference and suggests the result is robust. The precise significance of this finding also requires further investigation and suggests that the emphasis placed on an individual’s attributions for failure outcomes by Miller and Norman (1979) requires some close attention.

The area of research covered in this study is relatively new. Consequently there are a lot of factors e.g. sex, age, length of time institutionalized, social class etc., which may interact with the hypothesized dimensions of attribution. These have not been investigated as yet but is would be of interest to determine their importance with a view to obtaining a deeper understanding of attributional processes.
In conclusion the present study raises more questions than it answers concerning the relationship between cognitive processes, in particular attribution styles, and mental illness. These questions can only be answered by future research.
BIBLIOGRAPHY.


APPENDICES.
APPENDIX 1.

Test Booklet - Title Page.

The purpose of this study is to test the validity of the following questionnaires. I am interested in how the questionnaires work in groups rather than in your individual answers. You do not have to answer these questionnaires if you do not wish to do so. Feel free to refuse if you want. Any answers that you do make are completely confidential.

THANK YOU FOR YOUR CO-OPERATION.

NAME OR CODE ...........................................................
AGE ................................................................................
OCCUPATION ..................................................................
OCCUPATION OF SPOUSE ............................................

HOW LONG HAVE YOU BEEN IN HOSPITAL? (Weeks and days)
........................................

HOW LONG DO YOU EXPECT TO REMAIN IN HOSPITAL?
(Weeks and days)
........................................
APPENDIX 2.

Test Booklet - B.D.I.

In this questionnaire are a number of different groups of statements. I want you to pick out the ONE statement in each group which best describes the way you feel today, that is, right now. When you have decided, put the appropriate letter in the box on the right-hand side of the page.

If you are undecided between two statements, mark the one which best describes the way you feel right now.

Be sure to read all statements in each group before making your choice.

1. (a) I do not feel sad  
   (b) I feel blue or sad  
   (c) I am blue or sad all the time and I can’t snap out of it  
   (d) I am so sad or unhappy that it is quite painful  
   (e) I am so sad or unhappy that I can’t stand it

2. (a) I am not particularly pessimistic or discouraged about the future  
   (b) I feel discouraged about the future  
   (c) I feel that I have nothing to look forward to  
   (d) I feel I won’t ever get over my troubles  
   (e) I feel that the future is hopeless and that things cannot improve

3. (a) I do not feel like a failure  
   (b) I feel I have failed more than the average person  
   (c) I feel I have accomplished very little that is worthwhile or that means anything  
   (d) As I look back on my life all I can see is a lot of failures  
   (e) I feel I am a complete failure as a person (parent, husband, wife)

4. (a) I am not particularly dissatisfied  
   (b) I feel bored most of the time  
   (c) I don’t enjoy things the way I used to  
   (d) I don’t get satisfaction out of anything any more  
   (e) I am dissatisfied with everything
5. (a) I don’t feel particularly guilty
(b) I feel bad or unworthy a good part of the time
(c) I feel quite guilty
(d) I feel bad or unworthy practically all the time now
(e) I feel as though I am very bad or worthless

6. (a) I don’t feel I am being punished
(b) I have a feeling that something bad may happen to me
(c) I feel I am being punished or will be punished
(d) I feel I deserve to be punished
(e) I want to be punished

7. (a) I don’t feel disappointed in myself
(b) I am disappointed in myself
(c) I don’t like myself
(d) I am disgusted with myself
(e) I hate myself

8. (a) I don’t feel I am any worse than anyone else
(b) I am critical of myself for weakness or mistakes
(c) I blame myself for my faults
(d) I blame myself for everything bad that happens

9. (a) I don’t have any thoughts of harming myself
(b) I have thoughts of harming myself but I would not carry them out
(c) I feel I would be better off dead
(d) I feel my family would be better off if I were dead
(e) I have definite plans about committing suicide
(f) I would kill myself if I could

10. (a) I don’t cry any more than usual
(b) I cry more now than I used to
(c) I cry all the time now, I can’t stop it
(d) I used to be able to cry but now I can’t cry at all even though I want to

11. (a) I am no more irritated now than I ever am
(b) I get annoyed or irritated more easily than I used to
(c) I feel irritated all the time
(d) I don’t get irritated at all the things that used to irritate me
12. (a) I have not lost interest in other people  
(b) I am less interested in other people now than I used to be  
(c) I have lost most of my interest in other people and have little feeling for them  
(d) I have lost all my interest in other people and have little feeling for them

13. (a) I make decisions about as well as ever  
(b) I try to put off making decisions  
(c) I have great difficulty in making decisions  
(d) I can’t make decisions at all any more

14. (a) I don’t feel I look any worse than I used to  
(b) I am worried that I am looking old or unattractive  
(c) I feel that there are permanent changes in my appearance and they make me look unattractive  
(d) I feel that I am ugly or repulsive looking

15. (a) I can work about as well as before  
(b) It takes extra effort to get started at doing something  
(c) I don’t work as well as I used to  
(d) I have to push myself very hard to do anything  
(e) I can’t do any work at all

16. (a) I can sleep as well as usual  
(b) I wake up more tired in the morning than I used to  
(c) I wake up 1-2 hours earlier than usual and find it hard to get back to sleep  
(d) I wake up early every day and can’t get more than five hours sleep

17. (a) I don’t get any more tired than usual  
(b) I get tired more easily than I used to  
(c) I get tired from doing anything  
(d) I get too tired to do anything

18. (a) My appetite is no worse than usual  
(b) My appetite is not as good as it used to be  
(c) My appetite is much worse now  
(d) I have no appetite at all any more

244
19. (a) I haven’t lost much weight, if any, lately  
(b) I haven’t lost more than 5 pounds  
(c) I haven’t lost more than 10 pounds  
(d) I have lost more than 15 pounds

20. (a) I am no more concerned about my health than usual  
(b) I am concerned about aches and pains or upset stomach or constipation  
(c) I am so concerned with how I feel or what I feel that it’s hard to think of much else  
(d) I am completely absorbed in what I feel

21. (a) I have not noticed any recent change in my interest in sex  
(b) I am less interested in sex than I used to be  
(c) I am much less interested in sex now  
(d) I have lost interest in sex completely.
This is a questionnaire to find out the way in which certain important events in our society affect different people. Each question has two alternatives lettered 'a' and 'b'. Please select the one statement from each pair which you more strongly believe to be the case as far as you are concerned.

There is no right or wrong answer. Do not spend too much time on any one item.

In some instances you may discover that you believe both statements or neither one. In such cases select the one you more strongly believe to be the case as far as you are concerned. Try to respond to each item separately when making your choice: do not be influenced by previous answers.

PLEASE CIRCLE A or B WHEN YOU HAVE MADE YOUR CHOICE.

1. (a) Children get into trouble because their parents punish them too much
(b) The trouble with most children nowadays is that their parents are too easy with them

2. (a) Many of the unhappy things in people's lives are partly due to bad luck
(b) People's misfortunes result from the mistakes they make

3. (a) One of the major reasons why we have wars is because people don't take enough interest in politics
(b) There will always be wars, no matter how hard people try to prevent them

4. (a) In the long run people get the respect they deserve in this world
(b) Unfortunately, an individual's worth often passes unrecognised no matter how hard he tries

5. (a) The idea that teachers are unfair to students is nonsense
(b) Most students don't realise the extent to which their grades are influenced by accidental happenings.

6. (a) Without the right breaks one cannot be an effective leader.
(b) Capable people who fail to become leaders have not taken advantage of their opportunities

7. (a) No matter how hard you try some people just don't like you
(b) People who can't get others to like them don't understand how to get along with others.

8. (a) Heredity plays the major role in determining one's personality
(b) It is one's experiences in life which determine what they are like
9. (a) I have often found that what is going to happen will happen
(b) Trusting to fate has never turned out as well for me as making a decision to take a definite course of action
10. (a) In the case of the well prepared student there is rarely, if ever, such a thing as an unfair test
(b) Many times exam questions tend to be so unrelated to course work that studying is really useless
11. (a) Becoming a success is a matter of hard work, luck has little or nothing to do with it
(b) Getting a good job depends mainly on being in the right place at the right time
12. (a) The average citizen can have an influence in governmental decisions
(b) This world is run by the few people in power, and there is not much the little guy can do about it.
13. (a) When I make plans, I am almost certain that I can make them work
(b) It is not always wise to plan too far ahead because many things turn out to be a matter of good or bad fortune anyhow
14. (a) There are certain people who are just no good
(b) There is some good in everyone
15. (a) In my case getting what I want has little or nothing to do with luck
(b) Many times we might just as well decide what to do by flipping a coin
16. (a) Who gets to be the boss often depends on who was luck enough to be in the right place first
(b) Getting people to do the right thing depends upon ability, luck has little or nothing to do with it.
17. (a) As far as world affairs are concerned, most of us are the victims of forces we can neither understand, nor control
(b) By taking an active part in political and social affairs the people can control world events
18. (a) Most people don’t realise the extent to which their lives are controlled by accidental happenings
(b) There is really no such thing as luck
19. (a) One should always be willing to admit mistakes
(b) It is usually best to cover up one’s mistakes
20. (a) It hard to know whether or not a person really likes you
(b) How many friends you have depends upon how nice a person you are
21. (a) In the long run the bad things that happen to us are balanced by the good ones
(b) Most misfortunes are the result of lack of ability, ignorance, laziness or all three
22. (a) With enough effort we can wipe out political corruption
(b) It is difficult for people to have much control over the things politicians do in office

23. (a) Sometimes I can’t understand how teachers arrive at the grades they give
(b) There is a direct connection between how hard I study and the grades I get

24. (a) A good leader expects people to decide for themselves what they should do
(b) A good leader makes it clear to everybody what their jobs are

25. (a) Many times I feel that I have little influence over the things that happen to me
(b) It is impossible for me to believe that chance or luck plays an important role in my life

26. (a) People are lonely because they don’t try to be friendly
(b) There is not much use in trying too hard to please people, if they like you, they like you

27. (a) There is too much emphasis on athletics in high school
(b) Team sports are an excellent way to build character

28. (a) What happens to me is my own doing
(b) Sometimes I feel that I don’t have enough control over the direction my life is taking

29. (a) Most of the time I can’t understand why politicians behave the way they do
(b) In the long run the people are responsible for bad government on a national as well as on a local level
APPENDIX 4.
Test Booklet - Seligman’s Attribution Questionnaire

DIRECTIONS

Please try to vividly imagine yourself in the situations that follow. If such a situation happened to you, what would you feel would have caused it? While events may have many causes, we want you to pick only one - the major cause if this event happened to you. Please write this cause in the blank provided after each event. Next we want you to answer some questions about the cause and a final question about the situation. To summarise, we want you to:

1) Read each situation and vividly imagine it happening to you
2) Decide what you feel would be the major cause of this situation if it happened to you
3) Write one cause in the blank provided
4) Answer three questions about the cause
5) Answer one question about the situation
6) Go on to the next situation
YOU MEET A FRIEND WHO COMPLIMENTS YOU ON YOUR APPEARANCE
1) Write down the one major cause ____________________________

2) Is the cause of your friend’s compliment due to something about you or something about the other person or circumstances? (Circle one number)

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
</tr>
</thead>
<tbody>
<tr>
<td>Totally due to the other person or circumstances</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Totally due to me</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

3) In the future when you are with your friends, will this cause again be present? (Circle one number).

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
</tr>
</thead>
<tbody>
<tr>
<td>Will never again be present</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Will always be present</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

4) Is the cause something that just affects interacting with friends or does it also influence other areas of your life? (Circle one number)

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
</tr>
</thead>
<tbody>
<tr>
<td>Influences just this particular situation</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Influences all situations in my life</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

5) How important would this situation be if it happened to you? (Circle one number)

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not at all important</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Extremely important</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

YOU HAVE BEEN LOOKING FOR A JOB UNSUCCESSFULLY FOR SOME TIME
6) Write down the one major cause ____________________________

7) Is the cause of your unsuccessful job search due to something about you or something about other people or circumstances? (Circle one number)

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
</tr>
</thead>
<tbody>
<tr>
<td>Totally due to the other people or circumstances</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Totally due to me</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

8) In the future when looking for a job, will this cause again be present? (Circle one number).

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
</tr>
</thead>
<tbody>
<tr>
<td>Will never again be present</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Will always be present</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

9) Is the cause something that just influences looking for a job or does it also influence other areas of your life? (Circle one number)

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
</tr>
</thead>
<tbody>
<tr>
<td>Influences just this particular situation</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Influences all situations in my life</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

10) How important would this situation be if it happened to you? (Circle one number)

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not at all important</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Extremely important</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### YOU BECOME VERY RICH

11) Write down the one major cause ____________________________

12) Is the cause of your becoming rich due to something about you or something about other people or circumstances? (Circle one number)

<table>
<thead>
<tr>
<th>Totally due to the other people or circumstances</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
</tr>
</thead>
<tbody>
<tr>
<td>To me</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

13) In your financial future, will this cause again be present? (Circle one number).

<table>
<thead>
<tr>
<th>Will never again be present</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
</tr>
</thead>
<tbody>
<tr>
<td>Will always be present</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

14) Is the cause something that just affects money or does it also influence other areas of your life? (Circle one number)

<table>
<thead>
<tr>
<th>Influences just this particular situation</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
</tr>
</thead>
<tbody>
<tr>
<td>Influences all situations in my life</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

15) How important would this situation be if it happened to you? (Circle one number)

<table>
<thead>
<tr>
<th>Not at all important</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
</tr>
</thead>
<tbody>
<tr>
<td>Extremely important</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### A FRIEND COMES TO YOU WITH A PROBLEM AND YOU DON'T TRY TO HELP THEM.

16) Write down the one major cause ____________________________

17) Is the cause of your not helping your friend due to something about you or something about other people or circumstances? (Circle one number)

<table>
<thead>
<tr>
<th>Totally due to the other people or circumstances</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
</tr>
</thead>
<tbody>
<tr>
<td>To me</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

18) In the future when a friend comes to you with a problem, will this cause again be present? (Circle one number).

<table>
<thead>
<tr>
<th>Will never again be present</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
</tr>
</thead>
<tbody>
<tr>
<td>Will always be present</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

19) Is the cause something that just affects what happens when a friend comes to you with a problem, or does it also influence other areas of your life? (Circle one number)

<table>
<thead>
<tr>
<th>Influences just this particular situation</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
</tr>
</thead>
<tbody>
<tr>
<td>Influences all situations in my life</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

20) How important would this situation be if it happened to you? (Circle one number)

<table>
<thead>
<tr>
<th>Not at all important</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
</tr>
</thead>
<tbody>
<tr>
<td>Extremely important</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### YOU GIVE AN IMPORTANT TALK IN FRONT OF A GROUP AND THE AUDIENCE REACTS NEGATIVELY

21) Write down the one major cause: ________________________________

22) Is the cause of the audience reacting negatively due to something about you or something about other people or circumstances? (Circle one number)

<table>
<thead>
<tr>
<th>Totally due to the other people or circumstances</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
</tr>
</thead>
<tbody>
<tr>
<td>Totally due to me</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

23) In the future when giving talks, will this cause again be present? (Circle one number).

<table>
<thead>
<tr>
<th>Will never again be present</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
</tr>
</thead>
<tbody>
<tr>
<td>Will always be present</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

24) Is the cause something that just influences giving talks or does it also influence other areas of your life? (Circle one number)

<table>
<thead>
<tr>
<th>Influences just this particular situation</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
</tr>
</thead>
<tbody>
<tr>
<td>Influences all situations in my life</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

25) How important would this situation be if it happened to you? (Circle one number)

<table>
<thead>
<tr>
<th>Not at all important</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
</tr>
</thead>
<tbody>
<tr>
<td>Extremely important</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### YOU DO A PROJECT WHICH IS HIGHLY PRAISED

26) Write down the one major cause: ________________________________

27) Is the cause of being praised due to something about you or something about other people or circumstances? (Circle one number)

<table>
<thead>
<tr>
<th>Totally due to the other people or circumstances</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
</tr>
</thead>
<tbody>
<tr>
<td>Totally due to me</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

28) In the future when doing a project, will this cause again be present? (Circle one number).

<table>
<thead>
<tr>
<th>Will never again be present</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
</tr>
</thead>
<tbody>
<tr>
<td>Will always be present</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

29) Is the cause something that just affects doing projects, or does it also influence other areas of your life? (Circle one number)

<table>
<thead>
<tr>
<th>Influences just this particular situation</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
</tr>
</thead>
<tbody>
<tr>
<td>Influences all situations in my life</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

30) How important would this situation be if it happened to you? (Circle one number)

<table>
<thead>
<tr>
<th>Not at all important</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
</tr>
</thead>
<tbody>
<tr>
<td>Extremely important</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
YOU MEET A FRIEND WHO ACTS HOSTILELY TOWARDS YOU

31) Write down the one major cause ____________________________________________

32) Is the cause of your friend acting hostilely due to something about you or something about other people or circumstances? (Circle one number)

| Totally due to the other people or circumstances | 1 | 2 | 3 | 4 | 5 | 6 | 7 |

33) In the future when interacting with friends, will this cause again be present? (Circle one number).

| Will never again be present | 1 | 2 | 3 | 4 | 5 | 6 | 7 |

34) Is the cause something that just influences interacting with friends or does it also influence other areas of your life? (Circle one number)

| Influences just this particular situation | 1 | 2 | 3 | 4 | 5 | 6 | 7 |

35) How important would this situation be if it happened to you? (Circle one number)

| Not at all important | 1 | 2 | 3 | 4 | 5 | 6 | 7 | Extremely important |

YOU CAN'T GET ALL THE WORK DONE THAT OTHERS EXPECT OF YOU

36) Write down the one major cause ____________________________________________

37) Is the cause of your not getting the work done due to something about you or something about other people or circumstances? (Circle one number)

| Totally due to the other people or circumstances | 1 | 2 | 3 | 4 | 5 | 6 | 7 |

38) In the future when doing work that others expect, will this cause again be present? (Circle one number).

| Will never again be present | 1 | 2 | 3 | 4 | 5 | 6 | 7 |

39) Is the cause something that just affects doing work that others expect of you or does it also influence other areas of your life? (Circle one number)

| Influences just this particular situation | 1 | 2 | 3 | 4 | 5 | 6 | 7 |

40) How important would this situation be if it happened to you? (Circle one number)

| Not at all important | 1 | 2 | 3 | 4 | 5 | 6 | 7 | Extremely important |
YOUR SPOUSE (BOYFRIEND/GIRLFRIEND) HAS BEEN TREATING YOU MORE LOVINGLY

41) Write down the one major cause

42) Is the cause of spouse (boyfriend/girlfriend) treating you more lovingly due to something about you or something about other people or circumstances? (Circle one number)

<table>
<thead>
<tr>
<th>Totally due to the other people or circumstances</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
</tr>
</thead>
<tbody>
<tr>
<td>Totally due to me</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

43) In the future interactions with your spouse (boyfriend/girlfriend), will this cause again be present? (Circle one number).

<table>
<thead>
<tr>
<th>Will never again be present</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
</tr>
</thead>
<tbody>
<tr>
<td>Will always be present</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

44) Is the cause something that just affects how your spouse (boyfriend/girlfriend) treats you, or does it also influence other areas of your life? (Circle one number)

<table>
<thead>
<tr>
<th>Influences just this particular situation</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
</tr>
</thead>
<tbody>
<tr>
<td>Influences all situations in my life</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

45) How important would this situation be if it happened to you? (Circle one number)

<table>
<thead>
<tr>
<th>Not at all important</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
</tr>
</thead>
<tbody>
<tr>
<td>Extremely important</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

YOU APPLY FOR A POSITION THAT YOU WANT BADLY (e.g., IMPORTANT JOB, GRADUATE SCHOOL ADMISSION, etc.) AND YOU GET IT

46) Write down the one major cause

47) Is the cause of your getting the position due to something about you or something about other people or circumstances? (Circle one number)

<table>
<thead>
<tr>
<th>Totally due to the other people or circumstances</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
</tr>
</thead>
<tbody>
<tr>
<td>Totally due to me</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

48) In the future when applying for a position, will this cause again be present? (Circle one number).

<table>
<thead>
<tr>
<th>Will never again be present</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
</tr>
</thead>
<tbody>
<tr>
<td>Will always be present</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

49) Is the cause something that just influences applying for a position, or does it also influence other areas of your life? (Circle one number)

<table>
<thead>
<tr>
<th>Influences just this particular situation</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
</tr>
</thead>
<tbody>
<tr>
<td>Influences all situations in my life</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

50) How important would this situation be if it happened to you? (Circle one number)

<table>
<thead>
<tr>
<th>Not at all important</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
</tr>
</thead>
<tbody>
<tr>
<td>Extremely important</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
YOU GO OUT ON A DATE AND IT GOES BADLY

51) Write down the one major cause

52) Is the cause of the date going badly due to something about you or something about other people or circumstances? (Circle one number)

<table>
<thead>
<tr>
<th>Totally due to the other people or circumstances</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
</tr>
</thead>
<tbody>
<tr>
<td>Totally due to me</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

53) In the future when dating, will this cause again be present? (Circle one number).

<table>
<thead>
<tr>
<th>Will never again be present</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
</tr>
</thead>
<tbody>
<tr>
<td>Will always be present</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

54) Is the cause something that just influences dating or does it also influence other areas of your life? (Circle one number)

<table>
<thead>
<tr>
<th>Influences just this particular situation</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
</tr>
</thead>
<tbody>
<tr>
<td>Influences all situations in my life</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

55) How important would this situation be if it happened to you? (Circle one number)

<table>
<thead>
<tr>
<th>Not at all important</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
</tr>
</thead>
<tbody>
<tr>
<td>Extremely important</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

YOU GET A RAISE

56) Write down the one major cause

57) Is the cause of your getting a raise due to something about you or something about other people or circumstances? (Circle one number)

<table>
<thead>
<tr>
<th>Totally due to the other people or circumstances</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
</tr>
</thead>
<tbody>
<tr>
<td>Totally due to me</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

58) In the future on your job, will this cause again be present? (Circle one number).

<table>
<thead>
<tr>
<th>Will never again be present</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
</tr>
</thead>
<tbody>
<tr>
<td>Will always be present</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

59) Is the cause something that just affects getting a raise or does it also influence other areas of your life? (Circle one number)

<table>
<thead>
<tr>
<th>Influences just this particular situation</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
</tr>
</thead>
<tbody>
<tr>
<td>Influences all situations in my life</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

60) How important would this situation be if it happened to you? (Circle one number)

<table>
<thead>
<tr>
<th>Not at all important</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
</tr>
</thead>
<tbody>
<tr>
<td>Extremely important</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
APPENDIX 5.

Personal Information Questionnaire

PERSONAL INFORMATION QUESTIONNAIRE

NAME or CODE ____________________ MARRIED/SINGLE/DIVORCED/WIDOW(ER)

AGE _______________________

SEX ___________________________________

OCCUPATION ______ OCCUPATION OF SPOUSE ______

______________________________

PRESENT DIAGNOSIS

LENGTH OF TIME IN HOSPITAL (in weeks and days) __________________

LENGTH OF TIME TO DISCHARGE (in weeks and days). ______ (APPROX)

TREATMENT: please list where appropriate:-

(1) drug(s): type(s) ________________________________________________

(2) physical _______________________________________________________

(3) ECT (Number) _________________________________________________

(4) OTHER ______________________________________________________

FUTURE OUTCOME OF PRESENT CONDITION (please tick as appropriate)

(1) terminal _____________________________________________________

(2) cure _________________________________________________________

(3) readmission probable __________________________________________

(4) OTHER (please state) _________________________________________
### PAST MEDICAL HISTORY

Has patient been hospitalised for more than one week in the past?  

**YES/NO**

How many times?

Please list the occasions, diagnosis and treatment IF KNOWN

<table>
<thead>
<tr>
<th>DATES AND LENGTH OF ADMISSION</th>
<th>DIAGNOSIS</th>
<th>TREATMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Any other relevant information?

__________________________________________________________________________

__________________________________________________________________________
APPENDIX 6.


DEPRESSION INVENTORY

A  (SADNESS)
0  I do not feel sad
1  I feel blue or sad
2a I am blue or sad all the time and I can’t snap out of it
2b I am so sad or unhappy that it is quite painful
3  I am so sad or unhappy that I can’t stand it

B  (PESSIMISM)
0  I am not particularly pessimistic or discouraged about the future
1a I feel discouraged about the future
2a I feel I have nothing to look forward to
2b I feel I won’t ever get over my troubles
3  I feel that the future is hopeless and that things cannot improve

C  (SENSE OF FAILURE)
0  I do not feel like a failure
1  I feel I have failed more than the average person
2a I feel I have accomplished very little that is worthwhile or that means anything
2b As I look back on my life all I can see is a lot of failure
3  I feel I am a complete failure as a person (parent, husband, wife)

D  (DISSATISFACTION)
0  I am not particularly dissatisfied
1A I feel bored most of the time
1B I don’t enjoy things the way I used to
2  I don’t get satisfaction out of anything any more
3  I am dissatisfied with everything

E  (GUILT)
0  I don’t feel particularly guilty
1  I feel bad or unworthy a good part of the time
2a I feel quite guilty
2b I feel bad or unworthy practically all the time now
3  I feel as though I am very bad or worthless
<table>
<thead>
<tr>
<th></th>
<th>(EXPECTATION OF PUNISHMENT)</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>I don’t feel I am being punished</td>
</tr>
<tr>
<td>1</td>
<td>I have a feeling that something bad may happen to me</td>
</tr>
<tr>
<td>2</td>
<td>I feel I am being punished or will be punished</td>
</tr>
<tr>
<td>3a</td>
<td>I feel I deserve to be punished</td>
</tr>
<tr>
<td>3b</td>
<td>I want to be punished</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>G</th>
<th>(SELF-DISLIKE)</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>I don’t feel disappointed in myself</td>
</tr>
<tr>
<td>1a</td>
<td>I am disappointed in myself</td>
</tr>
<tr>
<td>1b</td>
<td>I don’t like myself</td>
</tr>
<tr>
<td>2</td>
<td>I am disgusted with myself</td>
</tr>
<tr>
<td>3</td>
<td>I hate myself</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>H</th>
<th>(SELF-ACCUSATIONS)</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>I don’t feel I am any worse than anybody else</td>
</tr>
<tr>
<td>2</td>
<td>I am critical of myself for my weaknesses or mistakes</td>
</tr>
<tr>
<td>2</td>
<td>I blame myself for my faults</td>
</tr>
<tr>
<td>3</td>
<td>I blame myself for everything bad that happens</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>I</th>
<th>(SUICIDAL IDEAS)</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>I don’t have any thoughts of harming myself</td>
</tr>
<tr>
<td>1</td>
<td>I have thoughts of harming myself but I would not carry them out</td>
</tr>
<tr>
<td>2a</td>
<td>I feel I would be better off dead</td>
</tr>
<tr>
<td>2b</td>
<td>I feel my family would be better off if I were dead</td>
</tr>
<tr>
<td>3a</td>
<td>I have definite plans about committing suicide</td>
</tr>
<tr>
<td>3b</td>
<td>I would kill myself if I could</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>J</th>
<th>(CRYING)</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>I don’t cry any more than usual</td>
</tr>
<tr>
<td>1</td>
<td>I cry more now than I used to</td>
</tr>
<tr>
<td>2</td>
<td>I cry all the time now. I can’t stop it</td>
</tr>
<tr>
<td>3</td>
<td>I used to be able to cry but now I can’t cry at all even though I want to</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>K</th>
<th>(IRRITABILITY)</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>I am no more irritated now than I ever am</td>
</tr>
<tr>
<td>1</td>
<td>I get annoyed or irritated more easily than I used to</td>
</tr>
<tr>
<td>2</td>
<td>I feel irritated all the time</td>
</tr>
<tr>
<td>3</td>
<td>I don’t get irritated at all the things that used to irritate me</td>
</tr>
<tr>
<td>L</td>
<td>(SOCIAL WITHDRAWAL)</td>
</tr>
<tr>
<td>---</td>
<td>---------------------</td>
</tr>
<tr>
<td>0</td>
<td>I have not lost interest in other people</td>
</tr>
<tr>
<td>1</td>
<td>I am less interested in other people now than I used to be</td>
</tr>
<tr>
<td>2</td>
<td>I have lost most of my interest in other people and have little feeling for them</td>
</tr>
<tr>
<td>3</td>
<td>I have lost all my interest in other people and have little feeling for them</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>M</th>
<th>(INDECISIVENESS)</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>I make decisions about as well as ever</td>
</tr>
<tr>
<td>1</td>
<td>I try to put off making decisions</td>
</tr>
<tr>
<td>2</td>
<td>I have great difficulty in making decisions</td>
</tr>
<tr>
<td>3</td>
<td>I can't make decisions at all any more</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>N</th>
<th>(BODY IMAGE CHANGE)</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>I don't feel I look any worse than I used to</td>
</tr>
<tr>
<td>1</td>
<td>I am worried that I am looking old or unattractive</td>
</tr>
<tr>
<td>2</td>
<td>I feel that there are permanent changes in my appearance and they make me look unattractive</td>
</tr>
<tr>
<td>3</td>
<td>I feel that I am ugly or repulsive looking</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>0</th>
<th>(WORK RETARDATION)</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>I can work about as well as before</td>
</tr>
<tr>
<td>1a</td>
<td>It takes extra effort to get started at doing something</td>
</tr>
<tr>
<td>1b</td>
<td>I don't work as well as I used to</td>
</tr>
<tr>
<td>2</td>
<td>I have to push myself very hard to do anything</td>
</tr>
<tr>
<td>3</td>
<td>I can't do any work at all</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>P</th>
<th>(INSOMNIA)</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>I can sleep as well as usual</td>
</tr>
<tr>
<td>1</td>
<td>I wake up more tired in the morning than I used to</td>
</tr>
<tr>
<td>2</td>
<td>I wake up 1-2 hours earlier than usual and find it hard to get back to sleep</td>
</tr>
<tr>
<td>3</td>
<td>I wake up early every day and can't get more than five hours sleep</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Q</th>
<th>(FATIGABILITY)</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>I don't get any more tired than usual</td>
</tr>
<tr>
<td>1</td>
<td>I get tired more easily than I used to</td>
</tr>
<tr>
<td>2</td>
<td>I get tired from doing anything</td>
</tr>
<tr>
<td>3</td>
<td>I get too tired to do anything</td>
</tr>
</tbody>
</table>
### ANOREXIA

R

<table>
<thead>
<tr>
<th>Score</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>My appetite is no worse than usual</td>
</tr>
<tr>
<td>1</td>
<td>My appetite is not as good as it used to be</td>
</tr>
<tr>
<td>2</td>
<td>My appetite is much worse now</td>
</tr>
<tr>
<td>3</td>
<td>I have no appetite at all any more</td>
</tr>
</tbody>
</table>

### WEIGHT LOSS

S

<table>
<thead>
<tr>
<th>Score</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>I haven’t lost much weight, if any, lately</td>
</tr>
<tr>
<td>1</td>
<td>I haven’t lost more than 5 pounds</td>
</tr>
<tr>
<td>2</td>
<td>I haven’t lost more than 10 pounds</td>
</tr>
<tr>
<td>3</td>
<td>I have lost more than 15 pounds</td>
</tr>
</tbody>
</table>

### SOMATIC PREOCCUPATION

T

<table>
<thead>
<tr>
<th>Score</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>I am no more concerned about my health than usual</td>
</tr>
<tr>
<td>1</td>
<td>I am concerned about aches and pains or upset stomach or constipation</td>
</tr>
<tr>
<td>2</td>
<td>I am so concerned with how I feel or what I feel that it’s hard to think of much else</td>
</tr>
<tr>
<td>3</td>
<td>I am completely absorbed in what I feel</td>
</tr>
</tbody>
</table>

### LOSS OF LIBIDO

U

<table>
<thead>
<tr>
<th>Score</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>I have not noticed any recent change in my interest in sex</td>
</tr>
<tr>
<td>1</td>
<td>I am less interested in sex than I used to be</td>
</tr>
<tr>
<td>2</td>
<td>I am much less interested in sex now</td>
</tr>
<tr>
<td>3</td>
<td>I have lost interest in sex completely.</td>
</tr>
</tbody>
</table>
APPENDIX 7.

DESCRIPTIVE STATISTICS.

Table A shows the breakdown of subjects by sex and group.

<table>
<thead>
<tr>
<th></th>
<th>GROUP A</th>
<th></th>
<th>GROUP B</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
<td>%</td>
<td>Number</td>
</tr>
<tr>
<td>Male</td>
<td>14</td>
<td>35%</td>
<td>11</td>
</tr>
<tr>
<td>Female</td>
<td>26</td>
<td>65%</td>
<td>12</td>
</tr>
<tr>
<td>Total</td>
<td>40</td>
<td>100%</td>
<td>23</td>
</tr>
</tbody>
</table>

TABLE A - breakdown of subjects by sex and group.

There is approximately the same number of males and females in Group B. However, there is roughly twice as many females as males in Group A. This reflects the tendency, found in psychiatric hospitals, and other long-term residential homes, for the number of females to exceed the number of males admitted at any one time. Subjects' ages ranged from sixteen to eighty years with a mean of 42.1 years and a mode of 28 years. The standard deviation was 17.08 years.

The frequency of the five social classes determined by use of the General Register's Office's Classification can be seen in Table B and Graph A.

Excluding unclassified cases the population adheres closely to a normal distribution with the most popular class being 3 (skilled occupations) (see Graph A).
### TABLE B - Breakdown of the Population by Social Class.

<table>
<thead>
<tr>
<th>Social Class</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>3</td>
<td>4.8%</td>
</tr>
<tr>
<td>2</td>
<td>11</td>
<td>17.5%</td>
</tr>
<tr>
<td>3</td>
<td>20</td>
<td>31.5%</td>
</tr>
<tr>
<td>4</td>
<td>7</td>
<td>11.1%</td>
</tr>
<tr>
<td>5</td>
<td>3</td>
<td>4.8%</td>
</tr>
<tr>
<td>Unclassified</td>
<td>19</td>
<td>30.2%</td>
</tr>
</tbody>
</table>

Table C details the marital status of the whole subject population and shows the proportionally higher number of single and married individuals. The divorced individuals all belonged to Group B.
A breakdown of the population by diagnosis is shown in Table D. A breakdown of the population by diagnosis is shown Table D.

<table>
<thead>
<tr>
<th>Marital Status</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Single</td>
<td>28</td>
<td>44.4%</td>
</tr>
<tr>
<td>Married</td>
<td>27</td>
<td>42.9%</td>
</tr>
<tr>
<td>Widowed</td>
<td>5</td>
<td>7.9%</td>
</tr>
<tr>
<td>Divorced/separated</td>
<td>3</td>
<td>4.8%</td>
</tr>
</tbody>
</table>

TABLE C - Marital Status of the Subject Population.

<table>
<thead>
<tr>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>0. Non-psychiatric</td>
<td>23</td>
</tr>
<tr>
<td>1. Depressives</td>
<td>9</td>
</tr>
<tr>
<td>2. Anxiety</td>
<td>3</td>
</tr>
<tr>
<td>3. Manic Depressive</td>
<td>7</td>
</tr>
<tr>
<td>4. Personality disorder</td>
<td>3</td>
</tr>
<tr>
<td>5. Behavioural</td>
<td>2</td>
</tr>
<tr>
<td>6. Psychiatric</td>
<td>11</td>
</tr>
<tr>
<td>7. Alcoholic</td>
<td>3</td>
</tr>
<tr>
<td>9. Undiagnosed</td>
<td>2</td>
</tr>
</tbody>
</table>

TABLE D - Breakdown of the population by Diagnosis.

A total of seven different psychiatric diagnoses were identified. The largest psychiatric subgroup was found to be psychotics (eleven) followed by depressives (nine).

The average number of admissions for the psychiatric population was 3.36, the standard deviation being 2.767 and the mode 1.0 (Table F). Data concerning number of admissions
and length of time hospitalised, was unobtainable for one psychiatric patient. Table E shows a breakdown of the population by number of admissions.

<table>
<thead>
<tr>
<th>Number of Admissions</th>
<th>No. of Cases</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>13</td>
<td>33.3</td>
</tr>
<tr>
<td>2</td>
<td>11</td>
<td>28.2</td>
</tr>
<tr>
<td>3</td>
<td>0</td>
<td>0.0</td>
</tr>
<tr>
<td>4</td>
<td>5</td>
<td>12.8</td>
</tr>
<tr>
<td>5</td>
<td>0</td>
<td>0.0</td>
</tr>
<tr>
<td>6</td>
<td>3</td>
<td>7.7</td>
</tr>
<tr>
<td>7</td>
<td>2</td>
<td>5.2</td>
</tr>
<tr>
<td>8</td>
<td>1</td>
<td>2.6</td>
</tr>
<tr>
<td>9</td>
<td>4</td>
<td>10.2</td>
</tr>
<tr>
<td></td>
<td>total =39</td>
<td></td>
</tr>
</tbody>
</table>

TABLE E - Number of Admissions of Group A Patients.

The amount of time hospitalised by each psychiatric patient was calculated in weeks. The shortest period hospitalised by any patient was three weeks and the longest 998 weeks (approx. 19.2 years). The mean period of hospitalisation was 195.4 weeks (3.76 years) while the mode was 8 weeks. The standard deviation was 266.6 weeks (5.13 years)

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>MEAN</td>
<td>= 3.359</td>
</tr>
<tr>
<td>STANDARD DEVIATION</td>
<td>= 2.767</td>
</tr>
<tr>
<td>MODE</td>
<td>= 1.0</td>
</tr>
<tr>
<td>MEDIAN</td>
<td>= 2.386</td>
</tr>
</tbody>
</table>

TABLE F - Number of Admissions: population descriptive statistics.
APPENDIX 8. Thesis Proposal

MSc. Thesis Proposal by Caron Gaw.

Part requirement for the MSc. Degree in Abnormal Psychology

AIM
To investigate the attribution styles of depressed psychiatric inpatients. Is their style different from non-depressed psychiatric inpatients and other long term hospital inpatients (non psychiatric)?

BACKGROUND
This study is based on the work of Seligman and the recent reformulation (1978) of his learned helplessness theory in terms of attribution styles. Basically he hypothesised 3 dimensions of attribution, viz.

(1) Internal vs. External
(2) Global vs. Specific
(3) Stable vs. Unstable

for any event. Depressives are hypothesised to have a different pattern of attribution for events than non-depressives. For example a depressive may attribute the cause of an event as:

(1) Internal, being due to his own ability.
(2) Global, applying over a wide range of situations.
(3) Stable, being present over a prolonged period of time.

This supposition is hypothetical and requires testing.

SUBJECTS
200 psychiatric inpatients - not selected to fit any particular group but excluding any unable to answer a number of questions.
100 non-psychiatric inpatients - excluding neurological patients with a range of long term/short term (one week).
METHOD
Three questionnaires are administered to the above subjects:

(1) An attribution questionnaire developed by Seligman et al.
(2) An internal/External attribution questionnaire developed by Rotter (1966).
(3) Beck’s Depression Inventory Questionnaire.

A fourth questionnaire has also to be filled in. This questionnaire contains information of relevance to the study e.g. age, sex, occupation, length of time in hospital etc. This questionnaire will best be filled in by staff having personal contact with the patient and will take no more than a few minutes.

The data obtained from these questionnaires is then analysed statistically to determine:

(1) If depressives have a different pattern of test scores.
(2) Does Seligman’s questionnaire measure the same Internal/External dimension as Rotter’s (1966) questionnaire? (validation).
(3) Does a high internal score imply a high loading on the low self esteem measures of the B.D.I.?
(4) Are there any factors extracted from the fourth questionnaire that are important in terms of attribution style, e.g. length of time institutionalised, profession, sex, age?

The time required by each subject to fill in the questionnaires should be less than one hour. Each subject will be approached and asked if he will fill in the questionnaires. The purpose of the study will be explained in terms of validation of Seligman’s questionnaire. Confidentiality will be maintained by the use of identifying symbols for each subject rather than names.

5.12.78.
Primary care referrals to local mental health services: Patient characteristics and the direction of referral.

by

Caron Elizabeth Gaw

Department of Clinical Psychology
University of Surrey
Guildford

September 1996
Abstract

The aims of the present study were firstly, to investigate the characteristics of patients, referred by GP’s to specialist mental health services and, secondly, to determine whether the direction of a patient referral to one of three mental health services (a primary care Counselling Service, a secondary care Clinical Psychology Service, and a secondary care Community Psychiatric Nursing Service) can be determined from the measured levels of these characteristics.

A total of fifty-five patients completed questionnaires measuring patient characteristics; the Inventory of Interpersonal Problems (IIP; Horowitz et al. 1988), the Coping Responses Inventory (CRI; Moos, 1990), the Significant Others Scale (SOS; Power et al 1988), the GHQ-12 (Goldberg and Williams, 1988), and a patient questionnaire designed by the present author. The referral direction chosen by GPs was investigated by comparison of the patient characteristics measured in each of three groups; the Primary Care Counselling Service (PCCS); the secondary care Clinical Psychology Service (CPS); and Community Psychiatric Nurses (CPN).

Patient characteristics are discussed in terms of the significant correlations found between the measured variables. Evidence is reported supporting previous research findings indicating a lack of coping skills, low levels of social support and the presence of interpersonal problems, in patients with a mental health problem (see Boardman, 1987; Lam and Power, 1991).
Comparison of each of the characteristics of patients referred to the three different groups of mental health professionals (PCCS, CPS and CPN), indicated a lack of a significant difference among the three groups. The results, while tentative, are discussed in the context of the organisation of local mental health services, service specifications and referral criteria.

A number of questions concerning patient characteristics measured in the present study are raised which require further investigation.
1. Introduction.

In recent years there has been an increasing emphasis on the evaluation of health care provision in terms of cost, patient benefit, and skill mix (viz. Øvretveit, 1994; Alexander, 1992; Kaasa, 1992). The organisation of mental health services is currently determined by local factors (e.g. Croydon Health Commissioning Agency, 1994), government initiatives (e.g. The Tomlinson Report, 1992), and the move from institutional to primary (community) care (Strathdee and Sutherby, undated). No consensus presently exists as to which service model provides the most efficient use of resources, delivering levels of care sufficient to meet the needs of the local population.

The majority of referrals to mental health services are made by GPs (Goldberg and Tantam, 1990). The identification of a mental health problem, and the subsequent decision to refer a patient on to a specialist mental health service, by general practitioners (GPs), has been studied from a number of different perspectives (e.g. Giel et al., 1990). The operation of any service is dependent on the people using that service as either referrers or patients. A number of characteristics have been identified, within both GPs and patients, which influence the process of referral to mental health services. As service providers, it is important to fully understand these factors.

The present study has two aims. Firstly, to examine, via the use of psychometric measures, characteristics of patients referred to one of three specialist mental health services; a Primary Care Counselling Service, a secondary care Clinical Psychology Service, and a secondary care Community Psychiatric Nursing (CPN) Service. The psychometric measures include
measures of psychological distress, levels of social support, interpersonal problems, and coping responses.

Secondly, to explore whether the direction of patient referral (that is, whether referral is to a primary care counsellor, a clinical psychologist, or community psychiatric nurse) can be determined from these factors. The local model of mental health services (see Croydon Health Commissioning Agency, 1994: Section 3: Clinical Audit, pages 72-117 of the present portfolio), clearly indicates that CPNs, as part of the newly formed Community Mental Health Teams (CMHTs), should be accepting referrals of patients with the highest level of psychological distress, lowest level of social support, greatest level of interpersonal problems, and low levels of coping skills. In contrast the Primary Care Counselling Service should be receiving referrals of patients with a lower level of psychological distress, less interpersonal problems, and higher levels of social support and coping skills. Theoretically, within the service model, referrals to the secondary care Clinical Psychology Service should overlap with the two other groups in terms of the measured patient characteristics.

1.1 The detection of mental health problems by general practitioners.

Survey data has repeatedly shown (Goldberg and Tantam, 1990) that not every individual with a mental health problem is known to a general practitioner; that not every mental health problem presented is identified; and that those problems that are identified are not always referred on to specialist mental health services.
Goldberg and Huxley (1980) proposed a model of ‘filters’ through which a patient must pass on the way to inpatient psychiatric care to explain these findings. The Goldberg/Huxley model identifies five levels of care, each level being separated by a ‘filter’ (see Table A). The filter is viewed as being selectively permeable allowing those with the most severe level of mental illness to pass on to the next level of care. The estimated number of cases at each level of care, is quoted on the basis of consistently reported findings from survey data. From Table A, it can be seen that while the majority of mental health patients are provided with treatment within the primary care setting (230 per 1000), many mental health disorders are not detected (approximately 128 per 1000) by the physician treating the patient.

The Goldberg/Huxley model is perhaps an oversimplification of the pathways to psychiatric care (Giel et al., 1990), due to the introduction, for example, of a self-referral pathway by which a patient can refer themselves directly to a mental health professional. The provision of such a service alters the operation of the filters as a ‘permeability’ is created outside the primary care setting and the control of the GP. Despite this type of change within the infrastructure of mental health services, it has been estimated (Goldberg and Tantam, 1990) that the model still accounts for the largest number (approximately two out of three), of all referrals to specialist mental health services.

Little can be done by service providers to modify the first filter (between the community and attendance at primary care services) as it is influenced by many interacting factors; the organisation of health care, peoples attitudes and the type of morbidity (type, and/or severity, of symptoms) experienced by the individual.
<table>
<thead>
<tr>
<th>LEVEL</th>
<th>FILTER</th>
<th>DESCRIPTION OF FILTER</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>(NB. numbers quoted are estimates)</td>
</tr>
<tr>
<td>1</td>
<td>COMMUNITY - total psychiatric morbidity in random samples</td>
<td>206-315 per 1000</td>
</tr>
<tr>
<td></td>
<td>FIRST FILTER</td>
<td>ILLNESS BEHAVIOUR the decision to consult</td>
</tr>
<tr>
<td>2</td>
<td>PRIMARY CARE - total psychiatric morbidity among attenders</td>
<td>230 per 1000</td>
</tr>
<tr>
<td></td>
<td>SECOND FILTER</td>
<td>ABILITY TO DETECT DISORDER GP recognition</td>
</tr>
<tr>
<td>3</td>
<td>PRIMARY CARE - identified morbidity</td>
<td>101.5 per 1000</td>
</tr>
<tr>
<td></td>
<td>THIRD FILTER</td>
<td>DECISION TO REFER</td>
</tr>
<tr>
<td>4</td>
<td>MENTAL ILLNESS SERVICES - total psychiatric morbidity</td>
<td>23.5 per 1000</td>
</tr>
<tr>
<td></td>
<td>FOURTH FILTER</td>
<td>FACTORS DETERMINING ADMISSION TO HOSPITAL</td>
</tr>
<tr>
<td>5</td>
<td>MENTAL ILLNESS SERVICES - admissions to hospital</td>
<td>5.71 per 1000</td>
</tr>
</tbody>
</table>

Table A. Showing Goldberg and Huxleys (1980) pathway to specialist mental health services indicating five levels of morbidity and four filters (adapted from Tyrer et al., 1993).

Both the second and the third filters operate at the primary care level. Much can be done to improve both the detection of mental health problems (the second filter), and the decision by the GP to refer the patient on to specialist mental health services (the third filter).
Strathdee et al. (1990) suggest that these filters become more permeable, or sensitive, allowing through more cases, when patients are seen by mental health professionals within the primary care setting. The presence of mental health professionals offering assessment and/or treatment (e.g. psychiatrists, CPNs, counsellors and psychologists), in the primary-care setting, may influence the amount of morbidity identified (filter two) and the consequent decision (filter three) to refer the patient on (Giel et al., 1990), by raising the GP’s awareness of patients’ ‘illness behaviour’ (Mechanic, 1962). This increased sensitivity to mental health problems, provides a strong argument for placing as much emphasis as possible on the treatment of mental health problems within the primary care setting.

1.2 Factors identified to operate at the primary care level to allow patients to pass through the filters.

1.2.1 The second filter; the detection of a mental health problem by the GP.

The operation of this second filter, the recognition of cases, has received much more attention from researchers than the first filter, that is the patient’s decision to consult (Giel et al., 1990). It would appear that the psychological reasons for the encounter between the GP and patient (besides severity, recency of onset and psychiatric co-morbidity), contribute to the GP’s case recognition (Ormel et al., 1990).

Corney et al. (1988) reporting on a study day for GPs on managing ‘difficult’ patients, identified a triad of factors that appeared to be involved in every case; characteristics within
the doctor, characteristics within the patient, and an interaction of the two. Characteristics in each of these three areas will be examined in the following sections.

i) Characteristics of the GP.

Great variations have been found to exist between individual general practitioners in their ability to detect psychiatric disorders (filter two). Attitudes held by the GP appears to be a crucial factor with interest, knowledge and skills, behaviour (such as the length of visits), a tendency to order diagnostic tests, and to refer to specialists, all being linked with the GP’s ability to detect mental health problems (Giel et al., 1990). Similarly, Goldberg and Gask (1992) reported that doctors with a high identification of mental health problems demonstrated a greater interest in, and concern for, individual patients, were more interested in psychiatry, more experienced in patient management, tended to be older and tended to ask more psychological questions. The interview style of the GP in terms of a tendency to ask social/psychological questions (Marks et al. 1979) and the personality of the GP, both appear to be of significance in the detection of mental health problems. Inspection of video taped doctor/patient interviews indicated that some GPs are unresponsive during the consultation to both verbal and non-verbal clues, given by the patient, to the presence of psychological distress. This lack of responsiveness may account for the increased detection of mental health problems in the primary care setting following the attachment of mental health workers (Tyrer et al. 1990) whom it can be assumed, would raise the GPs’ awareness of such distress.
Boardman (1987) in a study of Manchester and Lewisham GPs pointed to the existence of a 'positive patient' stereotype associated with the detection of a mental health problem. This stereotype consists of a:-

* middle aged house-wife with minimal education,
* separated from her husband,
* who may be looking after elderly relatives.

This positive stereotype would suggest the presence of a low level of social support, possible interpersonal difficulties, and, by inference, a lower level of coping responses. The 'negative patient' stereotype identified by Boardman (1987), which tended to suggest to GPs the absence of a mental health problem, consisted of a:-

* young,
* educated,
* bachelor or recently married man,
* in full time employment.

Boardman, (1987) suggests that although there is evidence for the positive and negative patient stereotypes described above, different GPs may have quite different perceptions of what actually constitutes a psychiatric case.
Attempts have been made to reduce the level of individual variation demonstrated by GPs in the detection of mental health problems by the use of standardised screening instruments. The most commonly used tool is the General health Questionnaire (GHQ) in one of its many variations. The GHQ (Goldberg and Williams 1988) was designed as a screening instrument for non-psychotic disorders and its validity in general practice populations has been well established (Boardman, 1987). Goldberg and Blackwell (1970) found the GHQ-60 to correlate well with a clinical assessment of mental illness.

ii) Characteristics of the patient.

In addition to the factors identified within GPs, patient characteristics have been found to influence the operation of the second and third filters (Giel et al., 1990). Boardman (1987) suggested that patient cues in general required more attention and investigation, most research attention having been directed towards factors within the GP. Obviously, the ‘illness behaviour’ of the patient, that is how the patient presents their problem, is crucial to the GPs’ management. Illness behaviour, at the simplest level, is reflected in the patient’s initial decision to visit the GP and the reason(s) subsequently given for their attendance during the consultation. Goldberg and Gask (1992) when examining video tapes of doctor/patient consultations, concluded that the patient’s behaviour during the consultation, often fails to give clues to the presence of a psychiatric disturbance despite high scores on screening tests (GHQ-60).
Mechanic (1962) introduced the concept of ‘illness behaviour’ to refer to the ways in which given symptoms may be differentially perceived, evaluated, and acted (or not acted) upon by different people. Some people make light of symptoms, others respond quickly to ‘twinges’ seeking whatever medical care is available. The ‘illness behaviour’ of the patient, in this way, determines whether diagnosis and treatment begin at all. Goldberg and Blackwell (1970) suggested that there were a number of possible reasons, in terms of social learning theory, why a patient may not report the presence of psychological distress or stressful life events. Firstly, doctors deal with physical illness and there is an expectation that, as a kind, friendly, and caring person, he/she will get to the bottom of the problem. Secondly, pain worsens at times of emotional stress and, when the symptoms seem worse so the patient goes to the doctor with a physical problem. Finally, it is socially more acceptable to be physically ill than to have a mental health problem. Minor affective illness and physical complaints are often found to accompany each other and there is usually a good prognosis with the psychological symptoms remitting within six months. Goldberg and Blackwell (1970) did not speculate on the level of insight possessed by the patient i.e. whether the patient was aware of the presence of a mental health problem at the time of the consultation. The work of Balint (Corney et al., 1988) would tend to suggest that, at least for a group of patients, the level of insight is low.

A number of additional patient factors have been identified which appear to increase the detection of psychiatric disorder. These factors include; having previously had a mental disorder, low levels of education and income (Giel et al., 1990) and a tendency to have recently attended their GP (Goldberg et al. 1976).
GP's often have knowledge of their patient's social network and personality. This knowledge has been gained over a number of years of contact with that individual and members of their household. These psychological and social factors within the patient have been shown to play an important role in determining the individual's reaction to adversity, and, by inference their 'illness behaviour'. The quality of the individual's social support has been extensively studied (e.g. Zimmermann-Tansella and Siciliani, 1990; Lam and Power, 1991). Whether social support acts as a 'buffer' (ameliorating factor) against, or whether the lack of it leads directly to, the occurrence of symptomatology, has not been determined. The relationship between social problems and the onset, and course, of psychological disorders, is known to be complicated by mediating interactions within the individual, for example, the social context, past and present experience and personality variables (Zimmermann-Tansella and Siciliani, 1990).

There are, however, several significant findings about the relationship between social problems, social support and emotional distress;

- firstly, social difficulties increase the likelihood of becoming a psychiatric patient independently of the severity of symptoms; this suggests that patients demonstrating social difficulties are more likely to be recognised by the GP when presenting with a mental health problem
- secondly, there are no gender differences in the number, or type, of social problems reported although men who are emotionally distressed tend to have more social difficulties than similarly distressed women;
• thirdly, the availability of a close confiding relationship (social support) appears to have a beneficial effect on mental health, either by exerting direct effects or by interaction effect with adversities;
• finally, social support appears to ‘buffer’ stressful life events.

Power et al. (1988) developed a new scale to measure social support, the Significant Others Scale (SOS). This scale measures different aspects of the social support that may be provided by a number of significant relationships within an individual's social network. A total of six measures is provided by the scale; actual and ideal levels of emotional and practical support and the discrepancy between ideal and actual levels. The scale has been shown (Power et al. 1988) to significantly distinguish between depressed and nondepressed respondents. The quality (emotional vs. practical) of available social support perceived by the individual, has been shown to be more important than simply the quantity, or number, of individuals in the network (Lam and Power, 1991) in a sample of depressed patients.

iii) Interaction between doctor and patient

Goldberg (1974) suggested that psychiatric screening within the primary health care setting may have many advantages in terms of creating a better understanding between the patient and doctor. Psychiatric and psychosocial factors can be potent determinants of the course of physical illness, and total patient care could be significantly enhanced by a better understanding of this relationship. The patient with a nonpsychotic mental health problem,
presenting with a physical complaint, might also be spared unnecessary physical investigations. An undertaking of this nature would, however, require the doctor to learn more about patterns of ‘illness behaviour’ presented by the patient, i.e. how different patients perceive, evaluate and act upon their symptoms.

The work of Balint (Corney et al. 1988) was directed towards helping doctors to look at their reactions and feelings in relation to the group of patients who regularly complained of a number of symptoms without verifiable physical pathology, i.e. those who may be masking an underlying mental health problem and/or failing to report life stresses. For this group, despite frequent consultations and referrals, no clinical progress appears to be made. In some cases not only does the patient fail to improve, but may seem to ignore advice or even obstruct attempts to bring about improvement. The patients apparent total lack of insight into the psychological cause, or component, of their symptoms, increases the doctors' frustration when dealing with this group (Corney et al., 1988) with an obvious effect on the ability of the doctor and patient to communicate effectively. The importance of effective communication was highlighted by Goldberg and Gask (1992). When looking at patient/doctor interaction, doctors who were good detectors of mental health problems, were found to facilitate communication with patients more during the consultation and ask more social questions. Better detection occurred in GPs demonstrating superior communication skills as defined by Goldberg and Gask (1992), which resulted in patients reporting more psychological symptoms.
1.2.2 The use of the GHQ to improve detection

The failure of the GP to detect the patient's level of psychological distress has been explained by Verhaak and Tuhuis (1992) as a difference in perceptual set. The GP has a perceptual set focused on assessing the reason for the patient's visit at this time, not the overall mental health status of the patient. There have been a number of attempts to improve the detection of mental health problems by the GP within the primary care setting. The GHQ (General health Questionnaire), a measure of psychological distress, has frequently been used in this context (Gureje and Obikoya, 1990).

Politi et al. (1994) in a study using GHQ-12 scores evaluated against psychiatrists' ratings, found that a cut off score of 8/9 (maximum possible score 36 when each item scored 0-3 on a Likert-type scale) gave the best balance between sensitivity and specificity. Analysis of the data identified two factors (general dysphoria and social dysfunction) which could discriminate between subjects with and without emotional disturbance in the nonpsychotic population of 18 year old males studied.

Feeding back distress scores obtained from the GHQ to physicians has been found to produce a marginal improvement in detection rates. Katon and Gonzales (1994) reported such improvements in detection for elderly people, African-Americans, and men, subgroups that have been shown in the US to have low rates of detection for physicians. Katon and Gonzales (1994) concluded that when GPs were given feedback on an individual's psychological distress score they would interview the patient, form a new differential diagnosis, and provide effective treatment. The use of a standardised measure thus functioned as a mechanism to prompt the delivery of appropriate care.
Mental distress is a common phenomenon among many patients attending a general practitioner. Marks et al. (1979) reported that patients identified by the GHQ as having a mental health problem, but not identified by the GP, are mainly consulting their doctor for physical symptoms, for which they typically receive symptomatic treatments. Many patients in apparent need of help for mental distress, do not put forward a demand for appropriate help, reporting instead a physical problem (McLeod, 1988). Those who express psychosocial problems, and request help, frequently do not appear to need it when standardised assessment measures are used (Verhaak and Tuhuis, 1992). A clear distinction can be made between the objectively measured needs of a patient and the patient’s demands for health services. The factors that determine which patients are referred to specialist mental health services are considered in the next section.

1.3 The third filter: the decision to refer the patient to a mental health professional.

The decision by the GP to refer the patient to specialist services represents the third, and the least permeable, filter. Many factors affect a patient’s likelihood of receiving some form of treatment including his/her confidence in managing his/her symptoms, attitude to doctors and psychiatrists, and the medical practitioner’s attitude at the time of interview (Neely, 1992). Corney (1992) in an evaluative study of counselling in general practice, referred to the importance of the patient’s motivation. Confidence in managing symptoms can be equated with a belief that help can be found to alleviate psychological symptoms. This belief in a successful outcome may influence the GP decision to refer a patient to specialists mental health services. Furthermore, the level of belief that a patient has in a successful outcome may determine the direction of the referral with CPNs receiving those with the lowest and
the counsellors those patients with the greatest belief in a successful outcome following
therapy.

Characteristics identified within the patient as playing a part in referral included; serious
psychiatric complaint or psychosis which were referred more often than neurotic problems;
gender, with men more likely to be referred than women; and age, with younger patients
being referred more often than the elderly (Verhaak 1993).

There are large differences in how often general practitioners refer patients to hospital
(Roland, 1988; Verhaak, 1993; Kincey and Creed, 1991) with some GPs referring many
patients, while others refer few. Verhaak, (1993) in a study of general practitioners in the
Netherlands reported that older GPs; those in urban areas; and those in single handed
practices made more referrals to psychiatric services.

Roland (1988) suggests that the differences in rates of referral to mental health services often
found, are also related to psychological characteristics of the doctors. These characteristics
include their tolerance of diagnostic uncertainty and their sense of autonomy. Giel et al.
(1990) reported findings from a study in the Netherlands in 1985-1987, suggesting that the
GP’s reasons for referring a patient included feelings of incompetence, a failure of the patient
to respond to treatment and a perceived risk of suicide. Verhaak (1993), added that it was
perhaps a feeling that all previous efforts had failed that determined onward referral, not the
type of problem. Giel et al., (1990) reported additional factors including the need for
inpatient care, the type of illness, pressure from relatives, requests by the patient to see a
specialist, serious impairment of patients working capacity, lack of emotional support for the
patient from members of the family, and the opinion of the GP that his patient may find it more acceptable to be told that he has nervous trouble by a specialist rather than their own doctor. The decision to refer has been shown to depend on many factors, not all of which are related to the symptoms expressed by the patient.

McLeod (1988) reported that GPs tended to select those who were young, relatively affluent and articulate for referral to mental health services and were less likely to select patients presenting physical or intermediate complaints such as headaches or sleeplessness. Verhaak and Tuhuis (1992) drew the conclusions that many patients with a probable mental illness (according to objective need measured by GHQ-30) present only physical symptoms. Referrals to mental health services in general are made almost exclusively on the basis of psychological symptoms and not on the basis of individuals with a somatic complaint. Screening tests, such as the GHQ, can be used to provide an objective picture of the patient's, need irrespective of articulated demands, at that point in time, and improve the process of detection and referral.

Roland (1988) added that there are, in any case, methodological problems associated with measuring referral rates and making statements about the significance of these. For example, there are no standards that determine what referral rates should actually be for a given condition, and whether they should be related to how many patients are seen by a GP or by the amount of contact per individual patient.

In an effort to clarify the process through which a decision to refer a patient on to specialist mental health services are made, Goldberg (1992) proposed a classification system for the
types of emotional distress observed in primary care. Psychological disorders are very heterogeneous and the presence or absence of a symptom is insufficient to determine onward referral. The specific problem may be minor or major. The system proposed by Goldberg (1992) is based on the patient’s need for intervention, rather than symptoms, and is perhaps of more relevance to the emotional disorders seen by GPs than a psychiatric classification system. The model also reflects the dimensional nature of mental health problems; individuals within the same category, e.g. depressed, can experience a range of symptoms from mild to severe.

Goldberg (1992) model divided the mental health problems into three groups:-

- the largest group consists of those whose emotional distress needs recognition and discussion;
- the next group needs social intervention in addition to recognition and discussion;
- those in the final group benefit from the recognition of a mental disorder needing medical or psychological treatment.
- a fourth group, consisting of patients who do not wish to discuss their distress and are not likely to benefit from an intrusion into their privacy, is also proposed.

The first, and largest group, consists of two important groups of patients; firstly, those with mixed symptoms of anxiety/depression insufficiently severe to attract a formal diagnosis, and secondly, those with a somatic presentation of a psychological problem who are not sufficiently depressed, or distressed, to attract a psychiatric label.
The second group consists of patients, well known to their doctors, with long standing symptoms of both anxiety and depression, who typically complain of fatigue, irritability and a lack of concentration.

The third group consists of those who would benefit from medical treatment. These problems either do not remit spontaneously or the active treatment speeds remission. These disorders include schizophrenia, mania, severe depressions, phobias, obsessive compulsive disorders, anxiety states, and sexual disorders. The most important intervention with this group of patients is considered to be the appropriate onward referral to mental health services.

Goldberg (1992) suggests that the GP can manage patients within groups one and two by recognition, reinterpretation, listening and ‘social’ (services) referral as appropriate. Only those within group three were thought to require onward referral to specialist services. It is arguable that the psychological needs of patients within groups one and two could be appropriately met by doctors working in a psychological, as opposed to medical, manner within the primary care setting. This is especially so in view of the time constraints placed upon the average GP during a patient consultation and the emphasis placed on interacting (communicating) with the patient in Goldberg’s (1992) model.

Significant life events have been shown to affect an individual’s physical, social, and emotional functioning although such effects may not be long term (Billings and Moos, 1981). An individual’s attempt to cope with stressful life events can be viewed as a complex set of processes, both cognitive and behavioural. These processes are directed towards moderating
the impact of significant events on the individual's physical, social, and emotional functioning. Variation in the appraisal of, and response to, specific life events by different individuals, has supported the concept of moderating factors, or coping responses, within the individual.

The Coping Responses Inventory (CRI) was developed by Moos (1990) to evaluate personal coping strategies. The inventory allows coping to be broken down into eight subscales and allows examination of an individual's strengths and weaknesses. It has been proposed (Milne, 1992) that this instrument can be used as an aid to decision-making about which clients need to be seen by mental health professionals and, to then to allocate them, according to needs, to the most relevant professional. It can be speculated that those with the highest level of coping skills will need less intense and skilled therapeutic input to mobilise their strategies, while the opposite would hold true for those with lower coping responses (see Billings and Moos (1981), for a consideration of the role of coping skills and social support).

In summary, the process that conditions the act of establishing medical contact, being correctly identified as having a psychiatric problem and subsequently receiving appropriate treatment, is related to a large extent to socio-demographic factors (Vázquez-Barquero, 1990) rather than symptom level. Once the decision has been made by the GP to refer the patient on to specialist services, a further problem arises as there is no consensus as to which mental health professional is best suited to manage which type of problem (France 1995). Psychological disorders are very heterogeneous (Goldberg, 1974), with each individual
presenting different levels of symptoms in different combinations. Balestrieri et al. (1988) in a meta-analytic study, compared the treatment approaches of different mental health professionals. Counselling, behaviour therapy, and general psychiatry all proved similar in their overall effect although a few specific differences were identified; counselling seemed to be most helpful on social functioning, while behaviour therapy appeared to exert its greatest impact on reducing contact with psychiatric services. Similar results were found by Burns et al., (1991) when reporting a follow up study of an earlier study by Paykel et al. (1982) on the effectiveness of community care by a CPN vs. outpatient care. No differences were found in the long term although initial reports had favoured the community based CPN service. Consequently, no help is offered in this decision process by validated and reliable findings indicating the preference for one therapy, or professional over another when the GP makes a decision about whom to refer to.

The following section will describe the factors that have been found to be of significance in the choice of referral direction by the GP.

1. 4 Factors influencing direction of referral

Great variations exist between GPs in their views of psychological problems, their interest, knowledge and skills in dealing with people who have mental health difficulties, and their use of mental health services (Eastman and McPherson, 1982; Griffith and Cormack, 1993). This affects whether a patient is referred at all to specialist services, but also influences onward referral to particular mental health professionals. Where GPs decide to refer is of major
significance to service providers; the demand, and consequently the resources available, for local services result from where the GP decides to refer the patient (Broome and Kat, 1981).

Chadd and Svanberg (1994) looked at GP’s perception of different mental health professions. Consultant psychiatrists and CPNs are generally viewed positively by GPs. Clinical psychologists were seen as combining the same qualities of professionalism, training, and ‘sound science’ attributed to consultant psychiatrists and CPNs, but were seen as significantly less accessible than the other two professions. Chadd and Svanberg (1994) speculated that what GPs seemed to value highly when referring a patient is the speed of the mental health worker’s response. Results of this study suggest that the GP must make some judgement concerning ‘speed’ of response before referring a patient to a specific discipline. Factors listed above as contributing to the GP’s decision to refer may also contribute to the choice of referral direction. For example, the GP’s choice of referral direction may be determined by service he wishes to access e.g. inpatient services may be best accessed by referral to a psychiatrist or CPN; a non-medical approach by referral to a psychologist or counsellor. Indeed the attitudes of the patient may influence a decision about whether or not referral takes place. The patients strong preference for a medical or non-medical approach may determine the direction of the referral. Such views and preferences may interact with the views and knowledge of GPs (Kincey and Creed, 1991).

A recent survey of GP referral patterns (Burton and Ramsden, 1994) showed that GPs differ widely in where they referred patients for psychological problems. In contrast there was relative agreement on where to refer patients with problems deemed as psychotic, the direction being to psychiatry or Community Psychiatric Nursing (CPN). Examination of
local GP referral patterns by Kincey and Creed (1991) and Creed et al. (1990) concluded that:-

- firstly, GPs vary considerably between themselves in their rates of referral to the specialist mental health services (psychology and psychiatry) but are consistent over time within themselves;
- secondly, there is no significant correlation between the rates of referral by GPs to psychologists or psychiatrists;
- and finally the highest rates of referral to clinical psychology are by GPs producing high quality letters while the highest rate of referral to psychiatrists are by GPs producing low quality letters.

The Consumers' Association (1991) considered how services provided by clinical psychologists, in the primary care setting, could be most appropriately used by attempting to specify appropriate referral categories. Problems were seen as falling into five main categories as indicated in Table B. Cursory inspection provides evidence of the inherent problem of such classifications. For example, 'anxiety and stress' problems can range from mild and transient, requiring only recognition and re-interpretation by the GP in Goldberg’s (1992) model; to those presenting with severe and enduring symptoms requiring psychiatric intervention. Within the Consumers’ Association (1991) model, no referral category is specified for depression. This omission may be considered unusual in view of the cognitive approaches found to be helpful to people classified as depressed (Burton and Ramsden 1994). However, (reactive) 'depression' may be viewed as a consequence of, and therefore secondary to, any one of the problems specified within the other categories.
Clinical Psychologists are not the only professionals to offer therapy to those with psychological problems; counsellors, social workers, psychiatrists and CPN's all offer psychological therapies to patients. Other staff, in both the statutory and voluntary sectors, may also deal with a limited range of psychological problems e.g. hospice staff, Relate, social services. In many parts of the health service, specifically within Community Mental health Teams (CMHT's) terms such as role blurring, skill mix, and skill audit are increasingly being used (Alexander 1992). It is becoming increasingly difficult to distinguish between professions due to the spread, and development, of psychological techniques. Accurate identification of which problems should be referred to which service will be necessary if referrals are to be directed appropriately (Kincey and Creed, 1991).

<table>
<thead>
<tr>
<th>Anxiety and stress</th>
<th>Generalised anxiety, panic attacks, phobias, obsessional ideas, psychosomatic or stress related illness e.g. migraine, asthma.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Habit disorders</td>
<td>E.g. smoking, eating disorders, problem drinking, drug addiction.</td>
</tr>
<tr>
<td>Educational or occupational difficulties</td>
<td>Study problems, lack of confidence and social skills, transition points in life, e.g. leaving school, change job, retirement.</td>
</tr>
<tr>
<td>Interpersonal relationships</td>
<td>Marital discord, psychosexual difficulties, antisocial and/or aggressive behaviour.</td>
</tr>
<tr>
<td>Adjustment to illness and other life events</td>
<td>E.g. chronic disability, childbirth, accident, physical terminal illness, bereavement.</td>
</tr>
</tbody>
</table>

Table B: five categories of problem seen as appropriate for referral to Clinical psychology (adapted from Consumers’ Association, 1991)
The process by which this identification occurs may be enlightened by examination of characteristics within the patients referred to different mental health professionals.

A recent study Burton and Ramsden (1994) reinforced the complicated nature of the factors involved in the choice of referral direction for nonpsychotic mental health problems. The authors understandably concluded from their comprehensive study that factors other than diagnostic category entered the referral decision. Risk factors appeared to head the list with waiting times coming a close second. There was some suggestion that the direction of referral also related to local knowledge and known specialisms within service areas. Rates of referral to clinical psychology and to psychiatry are influenced by local availability of services (Kincey and Creed, 1991). For example, in the Burton and Ramsden (1994) study, most anger management referrals were directed towards the psychology service, possibly due to the provision of a treatment group within this service. The authors added a word of caution as the referral patterns reported reflected the situation at one point in time. The pattern of GP referrals in a matter of months may look completely different due to service changes and developments.

Verhaak (1993), in a study in the Netherlands also found that referrals for the most prevalent diagnoses (neurotic conditions and relationship problems) seemed to be more or less randomly distributed over the various possible referral destinations. Referral preferences appeared to be most strongly related to the amount of regular contact between the general practitioners and the mental health specialists and a positive evaluation by the GP of the institution represented.
Little attention appears to have been paid by researchers to the role of interpersonal problems manifested by the patient and the decision by the GP to refer and the direction of that referral. This is perhaps surprising as one of the prime aims of psychotherapy is the reduction of interpersonal relationship difficulties (Parry, 1992).

In conclusion, the decision by the GP to refer to specialist mental health services is likely to reflect a set of complex interactions. Referral is complicated by a number of factors including social phenomena such as doctor/patient relationship, support offered by the community, attitudes and characteristics of the patient, and the characteristics and interest of the GP. These factors exert an influence beyond the actual referral as a shared perception of the existing problems, and the issues to be tackled by the patient, and others involved in their care, significantly facilitate compliance (Morlino et al, 1995).

1.5 The present study

Despite the attention paid to the operation of the second and third filters and the identification of patient and GP characteristics associated with detection and the decision to refer, little attention has been given to the measurement, and identification of patient characteristics using standardised measures. Strathdee et al. (1990) reported the first comparison study of psychiatric patients attending hospital and primary care out-patient settings, using standardised assessment schedules. Both groups were reported to have similar degrees of physical and social dysfunction and comparable levels of psychiatric morbidity.
The aim of the present study is to investigate characteristics, within the patient, which may be associated with the decision made by the GP to refer this person to specialist mental health services. Firstly, by exploring the presence of 'the positive patient stereotype' proposed by Boardman (1987). This stereotype was associated with the detection by a GP of a mental health problem and suggested the presence of a low level of social support, possible interpersonal difficulties, and by inference, inadequate or inappropriate coping responses. These patient characteristics will be measured by

- SOS: Significant others Scale (Power et al. 1988), measuring social support
- IIP: The Inventory of Interpersonal Problems (Horowitz et al. 1988), measuring interpersonal problems
- CRI: The Coping Responses Inventory (Billings and Moos, 1981), measuring coping skills
- GHQ-12; The General Health Questionnaire, 12 items (Goldberg and Williams, 1988)
- By asking the patient two direct questions - how long they have had this problem and, secondly, how distressing they find their problem in everyday life.

The patient's perception of their psychological problem will also be examined by the use of a forced choice categorisation of their problem. For this purpose the

- problem type, as specified by the categories listed by the Consumers' Association (1991)
will be included in the study. A patient’s scores on these variables will be examined in terms of their relationship to the standardised measures used in this study (GHQ-12, SOS, IIP, CRI).

The second aim of the present study extends beyond the comparison undertaken by Strathdee et al. (1990) seeking to examine and explore whether patient characteristics determine the specialist mental health service to which patients are referred by GPs. Patient characteristics will be examined in relation to the direction of referral to one of three specialist mental health services. The three specialist mental health services examined in the present study are:

- PCCS: A newly established Primary Care Counselling Service
- CPS: A secondary care Clinical Psychology Service
- CPN: A Community Psychiatric Nursing Service

The measures of psychological distress outlined above are of particular interest in this respect as the context of local mental health services (as outlined by the local strategy for mental health, Croydon Health Commissioning Agency, 1994) suggests that the CPN service should receive referrals of the most distressed patients with the longest problem duration; the counselling service those with the least distress and shortest problem duration; with the psychology service occupying an intermediate position. The utilisation of counselling service in the past may also provide an indication of the severity of the patient’s problem. The
patient’s belief in the likelihood of a reduction in their symptoms following therapy will also be explored as a characteristic determining referral.

The problem category selected by the patient will be examined in the context of the three different groups to determine whether the direction of referral by the GP is influenced by the problem type.

An additional patient questionnaire will be designed for the purpose of the present research to gather the self reported information from patients outlined above. This questionnaire will include questions about-

- problem type, as specified by the categories listed by the Consumers’ Association (1991)
- the level of problem severity and duration
- predicted outcome of therapeutic intervention
- use of other mental health related services

Descriptive demographic information concerning age, gender and ethnic group will be collected from the mental health professional to which the patient has been referred.

The organisation of local services is of significance to the present study as referral criteria have been established for various service areas. The following section will outline these structural issues.
1.6 The local context.

In 1993 a major strategic review of local mental services was undertaken by the services, commissioners (Croydon Mental Health Commissioning Agency, 1994). This review recommended a number of major alterations to the configuration of local services. The most significant of these, for the purpose of this study, was a change in the role of local CPNs.

Prior to the review CPNs provided a therapy service, based on counselling, psychotherapy, cognitive therapy etc. depending on the preference of the individual CPN involved. The review stipulated that the main therapeutic input of CPNs in future would be with the most severely mentally ill, and not those frequently labelled as the 'worried well' or 'neurotic'. Consequently referrals made to the CPN service should demonstrate high levels of distress, interpersonal difficulties and low levels of coping skills and social support. Kincey and Creed (1991) recognised the importance of an implicit or explicit set of criteria governing the reception and management of referrals from GPs. The criteria may influence referral rates quite markedly (Wooff and Goldberg, 1988) as may the GPs actual understanding and perception of these. There is some evidence, for contact with local GPs that these referral criteria are not consistently used or understood.

The Primary Care Counselling Service, established, in part, as a consequence of the Strategic Review of Mental Health Services, has been developed to respond to the needs of those with less severe mental health problems, and lower levels of distress, within the primary health care setting. Consequently patients referred to this service, as a matter of local policy,
should exhibit lower levels of distress, less interpersonal difficulties, and higher levels of coping skills and social support than patients referred to the CPN service.

Referrals from GP’s to the secondary care Clinical Psychology service should take an intermediate position.

1.7 Aims and hypotheses.

The broad aim of the present study is to examine the characteristics of patients who have passed through the third filter and been referred on to specialist mental health services. This broad aim can be divided into two discrete aspects.

Firstly, to examine, via the use of psychometric measures, the characteristics of a group of patients referred to one of three specialist mental health services (a Primary Care Counselling Service, a secondary care Clinical Psychology Service, and a secondary care Community Psychiatric Nursing (CPN) Service) and the relationships between these characteristics. The psychometric measures include measures of psychological distress, levels of social support, interpersonal problems, and coping responses. The measured patient characteristics will be reviewed in terms of (a) support for the positive patient stereotype suggested by Boardman (1987) with low levels of social support being significantly related to the presence of interpersonal difficulties and inadequate, or use of inappropriate, coping skills and (b) the level of insight patients have into their mental health problem in terms of the patient’s self reported level of psychological distress and that measured by the GHQ-12.
Secondly, to determine whether the direction of the GP's referral to one of three specialist services (that is, the Primary Care Counselling Service, Secondary Care Clinical Psychology Service and Community Psychiatric Nursing Service) can be identified on the basis of any of the measured patient characteristics. The local model of mental health services (see Croydon Health Commissioning Agency, 1994: Section 3: Clinical Audit, pages 72-117 of the present portfolio), clearly indicates that CPNs, should be accepting referrals of patients with the highest level of psychological distress, lowest level of social support, greatest level of interpersonal problems, and low levels of coping skills. In contrast the Primary Care Counselling Service should be receiving referrals of patients with a lower level of psychological distress, less interpersonal problems, and higher levels of social support and coping skills. Referrals to the secondary care Clinical Psychology Service should overlap with the two other groups in terms of the measured patient characteristics.

From the above aims, a number of experimental hypotheses have been derived.

1) There will be significant relationships between a patient's obtained scores on the GHQ-12, IIP, CRI, and SOS. Scores on these measures will also be significantly related to the patient's self reported characteristics of problem severity, duration, and predicted outcome.

2) There will be a significant difference between patients referred to the PCCS, CPS and CPN specialist mental health services in terms of the patient's self reported characteristics (problem severity, duration, and predicted outcome and scores obtained from the GHQ-12,
IIP, CRI, and SOS), with those referred to the CPNs obtaining the highest test scores on the GHQ-12, problem severity and problem duration measures and the lowest score on the predicted outcome measure, the PCCS referral obtaining the lowest scores on the first three variables and the highest on the last, with the CPS obtaining intermediate scores.
2. METHODOLOGY

2.1 Research design

Self-report questionnaires were administered to patients referred, by general practitioners, to specialist mental health services. A between groups design was used with three separate groups being identified. The three groups were distinguished by the identifiers and definitions shown in Table C.

<table>
<thead>
<tr>
<th>GROUP</th>
<th>IDENTIFIER</th>
<th>DEFINITION</th>
</tr>
</thead>
<tbody>
<tr>
<td>group 1</td>
<td>PCCS</td>
<td>Referrals to the primary care counselling services.</td>
</tr>
<tr>
<td>group 2</td>
<td>CPS</td>
<td>Referrals to the secondary care clinical psychology service</td>
</tr>
<tr>
<td>group 3</td>
<td>CPN</td>
<td>Referrals to the community psychiatric nurses</td>
</tr>
</tbody>
</table>

Table C. Showing the three patient groups identified by service area

2.2 Subjects

Patients referred by GPs and offered assessment appointments by one of the three identified mental health service areas, were requested to complete the questionnaires. Each patient offered an initial assessment appointment after the 1st June 1995 was asked to complete the questionnaires. Participation in the study was voluntary.
A total of 70 patients were approached and asked to complete the questionnaires, 22 in the Primary Care Counselling Service, 27 in the Secondary Care Clinical Psychology Service and 21 in the Community Psychiatric Nursing Service.

Data was collected between 1st. June 1995 and 20th. September 1995.

A total of 10 patients asked to complete the questionnaires failed to do so. The main reason given by therapists for patients failing to complete the questionnaires was the patient not keeping their initial appointment. Other reasons given for not completing the questionnaires included loosing the questionnaires, 'forgetting', and not wishing to waste their time. Table D shows the number of patients in each group failing or refusing to complete the questionnaires.

<table>
<thead>
<tr>
<th>GROUP</th>
<th>NUMBER OF CASES</th>
<th>REASONS GIVEN</th>
</tr>
</thead>
<tbody>
<tr>
<td>group1 PCCS</td>
<td>2</td>
<td>one lost the questionnaires</td>
</tr>
<tr>
<td></td>
<td></td>
<td>one 'forgot'</td>
</tr>
<tr>
<td>group2 CPS</td>
<td>7</td>
<td>6 - did not keep their appointments</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1 - no reason given by therapist</td>
</tr>
<tr>
<td>group3 CPN</td>
<td>1</td>
<td>did not wish to waste their time</td>
</tr>
<tr>
<td></td>
<td></td>
<td>completing 'silly forms' - patient failed appointment</td>
</tr>
</tbody>
</table>

Table D. Showing number of patient in each group failing/refusing to complete the questionnaires.
Positive patient responses were reported by five of the therapists (four CPN and one CPS) taking part in the study. These responses included spontaneous discussion by the patient of the questionnaires, further inquiry about the study, and requests to have the questionnaire results fed back.

Five sets of questionnaires from the CPN group had to be omitted due to an error in administration. This meant that a total of 20 questionnaires were returned by therapists within the PCCS and CPS and a total of 15 completed questionnaires were returned by CPN therapists within the time scale of the study. Consequently, a total of 55 sets of questionnaires were used in this study giving an overall percentage response rate of 78.57%.

<table>
<thead>
<tr>
<th></th>
<th>PCCS</th>
<th>CPS</th>
<th>CPN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of patients asked to complete the questionnaires</td>
<td>22</td>
<td>27</td>
<td>21</td>
</tr>
<tr>
<td>Number of patients refusing or failing to complete the questionnaires</td>
<td>2</td>
<td>7</td>
<td>1</td>
</tr>
<tr>
<td>Number of completed questionnaires received</td>
<td>20</td>
<td>20</td>
<td>15</td>
</tr>
<tr>
<td>Percentage response rate per group</td>
<td>90.9%</td>
<td>70.07%</td>
<td>71.43%</td>
</tr>
</tbody>
</table>

Table E. Showing the number of patients in each group asked to complete the questionnaires, the number who refused or failed to do so, the completed questionnaires returned, and the percentage response rate for each group.
2.2.1 Gender

36.4% of the total sample were male giving a male to female ratio of 4:7 (see Table F). This pattern was not maintained within the subgroups with the male:female ratio in the CPN group approaching 1:3.

<table>
<thead>
<tr>
<th>Gender</th>
<th>TOTAL</th>
<th>PCCS</th>
<th>CPS</th>
<th>CPN</th>
</tr>
</thead>
<tbody>
<tr>
<td>MALE</td>
<td>20</td>
<td>7</td>
<td>9</td>
<td>4</td>
</tr>
<tr>
<td>(36.4%)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>FEMALE</td>
<td>35</td>
<td>13</td>
<td>11</td>
<td>11</td>
</tr>
<tr>
<td>(63.6%)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>TOTAL</td>
<td>55</td>
<td>20</td>
<td>20</td>
<td>15</td>
</tr>
</tbody>
</table>

Table F. Showing a breakdown, by gender of the patient groups.

2.2.2 Age

The average age of the population sample is 38.36 years (s.e. of the mean =1.697). Ages ranged from 15-72 years of age.

<table>
<thead>
<tr>
<th>STATISTIC</th>
<th>TOTAL</th>
<th>PCCS</th>
<th>CPS</th>
<th>CPN</th>
</tr>
</thead>
<tbody>
<tr>
<td>mean</td>
<td>38.36</td>
<td>37.45</td>
<td>40.55</td>
<td>36.67</td>
</tr>
<tr>
<td>standard deviation</td>
<td>12.58</td>
<td>14.07</td>
<td>13.25</td>
<td>9.69</td>
</tr>
<tr>
<td>range</td>
<td>from 15 to 72</td>
<td>from 15 to 72</td>
<td>from 23 to 71</td>
<td>from 22 to 58</td>
</tr>
<tr>
<td>number of cases</td>
<td>55</td>
<td>20</td>
<td>20</td>
<td>15</td>
</tr>
</tbody>
</table>

Table G. Showing the age distribution of the population sample.
A one-way between groups analysis of variance indicated that there was no significant difference between the groups in age distribution \( (F=0.4816, \ p=0.6205). \)

### 2.2.3 Ethnic Origin

The majority of the population sample (92.73%) were classified as white (see Table H).

<table>
<thead>
<tr>
<th>ETHNIC GROUP</th>
<th>PCCS</th>
<th>CPS</th>
<th>CPN</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>WHITE</td>
<td>17</td>
<td>19</td>
<td>15</td>
<td>51</td>
</tr>
<tr>
<td>(92.72%)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>BLACK AFRICAN</td>
<td>1</td>
<td></td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>(1.82%)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ASIAN OTHER</td>
<td>1</td>
<td>1</td>
<td></td>
<td>2</td>
</tr>
<tr>
<td>(3.64%)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>INDIAN</td>
<td>1</td>
<td></td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>(1.82%)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td>20</td>
<td>20</td>
<td>15</td>
<td>55</td>
</tr>
</tbody>
</table>

Table H. Showing ethnic origin of population sample in each of the three groups.

### 2.3 Measures.

A total of five questionnaires were distributed to each patient, the GHQ-12, IIP, SOS, CRI, and a Patient Questionnaire designed by the present author. A further questionnaire, Therapist Questionnaire, was completed for each subject by their respective therapist to provide the descriptive data outlined above.
2.3.1 The GHQ-12: The General Health Questionnaire.

There are several versions of the General Health Questionnaire (Goldberg, 1972) each of which is known by the number of items used e.g. GHQ-60, GHQ-30. The GHQ-12 is the shortest version available. Half the items relate to health with the remainder indicating illness.

All versions of the GHQ can be used to obtain a measure of psychological distress. The GHQ-12 has been used to assess changes in psychological distress and there is evidence (Goldberg and Williams 1988) that scores on the instrument rise and fall as the level of distress changes.

The present study used the Likert method of scoring the questionnaire assigning scores of 0-1-2-3 to the columns yielding a total score in the range 0-36. Increasing scores on the GHQ-12 indicate increased mental health problems (increased psychological distress). Goldberg and Williams (1988) in a User’s Guide to the General Health Questionnaire report the test-retest reliability of the GHQ-12 as 0.73 with Cronbach’s alpha equalling 0.85. The variance-weighted mean validity coefficient from validity studies was quoted as 89% sensitivity and 80% specificity.

2.3.2 The IIP: Inventory of Interpersonal Problems.

There are 127 items and six sub-scales in the Inventory of Interpersonal Problems (IIP). (Horowitz et al, 1980). Of the 127 items the first 78 involve how hard it is to do things while the last 49 focus on things that are done too much. Each item is rated on a five
point scale from 0 - 4. The higher the obtained score, the greater the problem. The self-administered form of the IIP was used in the present study. It takes approximately 15 minutes to complete.

The total IIP score is the sum of all the responses to the 127 items. A mean score is calculated by dividing the total score by 127. The six sub-scales, obtained by summing the appropriate items and calculating a mean, are assertive (21 items), sociable (18 items), submissive (10 items), intimate (12 items), responsible (12 items), and controlling (10 items). High scores indicate difficulties. Templates are available to assist with scoring of subject responses. Forty-four items do not contribute to the sub-scales but describe problems frequently raised in therapy. For the purpose of the present study, only scores on the six subscales will be included in the analysis.

Horowitz (1988) reported the test-retest reliability of the six subscales, reporting that the values of alpha ranged from 0.82 to 0.94 and the test-retest correlation (across a ten week period) ranged from 0.80 to 0.90. The overall mean self-ratings test-retest correlation coefficient was 0.98.

2.3.3 The SOS: Significant Others Scale.

This measure was developed by Power, Champion and Avis (1988) and is used to elicit information on the perceived form and function of social support for a range of significant
relationships within an individual’s life. The short form questionnaire of this scale, which takes about 5-10 minutes to complete, was used in the present study. Higher scores indicate a higher level of social support. Scores can be produced for actual social support; ideal social support; the discrepancy between actual and ideal support in relation to the two general functions of support (emotional and practical). Scoring of the SOS was achieved via computer analysis, the programme having been obtained directly from the main author of the test.

For the purpose of the present study six subscales were calculated: actual emotional support (AEM), ideal emotional support (IEM), the discrepancy between the two (DEM), actual practical support (APR), ideal practical support (IPR), and the discrepancy between the two (DPR) will be examined. AEM, IEM, APR, and IPR scores range from 1-7. Discrepancy scores are calculated by comparing the “ideal” with the “actual” scores. Negative discrepancies (when actual support scores are higher than ideal) are recorded as zero.

Power et al (1988) reported that the test-retest reliability ranged from 0.73 to 0.83.

2.3.4 The CRI: Coping Responses Inventory

The Coping Responses Inventory (Moos 1990) is a 48-item questionnaire which yields eight sub-scales based on two dimensions one of which relates to coping responses (Approach-Avoiding) and the other to coping strategies (cognitive-behavioural). The eight sub-scales, each consisting of five items, are logical analysis (LA), positive appraisal
(PA), seeking support (SS), problem solving (PS), cognitive avoidance (CA), acceptance (A), alternative rewards (AR) and emotional discharge (ED).

Each coping response item is rated on a four point scale from 0 to 3 yielding sub-scale scores that range from 0 - 18. Scoring templates are available. Higher scores indicate a greater use of the measured coping strategy. The raw scores can be converted to standard scores by the use of a conversion table, to yield an individual’s coping profile which may be used clinically. For the purpose of the present study, raw scores were utilised.

It is reported within the test portfolio (Milne, 1992) that the reliability of the CRI was tested over a one year period and a satisfactory correlation was found. The CRI correlates highly (coefficients of 0.56 to 0.83 ) with earlier coping questionnaires emanating from previous research of Moos (op.cit.)

2.3.5 Patient questionnaire.

A questionnaire was developed by the present author (see Appendix A) to collect information from the patient in five areas.

Firstly, the patient was asked to indicate into which broad group they felt their problem fell. Subjects were able to indicate more than one group. This item was included in the questionnaire to explore the patient’s perception of their mental health problem (see the work of Goldberg and Blackwell, 1970; Corney et al. 1988).
Information was requested concerning the patients’ perception of the length of time the problem had been present and the level of distress experienced in every day life. This latter item was included to determine whether the patient’s perception of the problem, and hence their verbal reports to the GP, were positively related to a standardised psychometric tool, the GHQ-12. The former item (duration) was included as an adjunct to the patient’s perception of their level of distress. Local service specifications (Croydon Health Commissioning Agency, 1994: Smith, 1994a, 1994b) would suggest that those experiencing the greatest level of distress for the longest time should be referred either to the secondary care Clinical Psychology or Community Psychiatric Nursing services.

Thirdly, the patient was asked to estimate how much improvement they expected to experience following intervention by the mental health professional. The patient’s motivation to engage in therapy has been mentioned as an important factor in the evaluation of therapy (counselling) services (Corney, 1992). The belief that a successful outcome can be achieved through appropriate help may influence the GP’s direction of referral. Those with the lowest belief should be referred, on the basis of service criteria to the CPN, while those with the greatest to the counselling service. This belief may be reflecting the patients available coping responses and strategies in that a belief that help is available can be categorised as an Approach Coping Response and a Behavioural Coping Response (Milne 1992).
Finally, information was requested concerning previous counselling interventions as a population descriptive.

No reliability or validity evaluation was undertaken of the assessment measure.

2.3.6 Therapist questionnaire

This questionnaire was developed by the present author (see Appendix B) to gather demographic data about each patient i.e. age, sex, ethnic origin. The form also checked that the referrer was indeed a GP, involvement with other agencies, the identity of the therapist, date of completion, and a section for any other information.

No reliability or validity evaluation was undertaken of the assessment measure.

2.4 Method

2.4.1 Procedure

All members of the Primary Care Counselling Service (PCCS), and all secondary care Clinical Psychologists, approached all patients offered a first appointment after the 1. June 1995, who had been referred by a general practitioner (GP), and asked them to complete the patient questionnaires.

The managers of the three Community Mental Health Teams (Adult Services) were approached, informed of the study, and asked whether all CPN’s within their respective
services could participate in the study. All managers agreed, and undertook to introduce
the procedure to their respective CPN’s at their regular team meetings. A copy of each
of the questionnaires was supplied to the CMHT managers.

Information concerning the questionnaires, their administration, and scoring procedures
were made available to all therapists taking part in the study. Identified therapists were
requested to approach each new patient offered an appointment, referred by a general
practitioner to their care area, and ask them to complete five questionnaires, prior to their
first appointment.

Patients were asked in an explanatory letter (see Appendix C) accompanying the
questionnaires, to return the completed questionnaires at the time of their first
appointment. Questionnaires were distributed to patients with the notification of their
appointment time. Subjects were advised that completion of the questionnaires was
voluntary.

Upon receipt of completed patient questionnaires, therapists completed the brief
Therapists Questionnaire described above.

Completed questionnaires (patient and therapist questionnaire), were passed to the
present author for scoring and collation of data.

Those therapists wishing to directly use the information provided by the questionnaires
during their therapeutic intervention with the patient were encouraged to do so. Following
scoring, a summary sheet of the data obtained (see Appendix D) was returned to the appropriate therapist. All therapists were encouraged to discuss the obtained questionnaire scores with the author to assist with the correct interpretation of data.

2.4.2. Data analysis

To investigate relationships between the measured patient characteristics of the total sample (55), Pearson correlations were calculated between the variables producing a 24 by 24 correlation matrix.

To examine and investigate the differences between patients in the three groups, Kruskal-Wallis one-way anovas were undertaken for each variable.

All statistical procedures were calculated using the computer programme SPSS for Windows.
3. RESULTS

In the following section the abbreviations listed below with be frequently used to refer to the measured variables.

**KEY**

<table>
<thead>
<tr>
<th>SOS : Significant Others Scale</th>
<th>CRI: Coping Responses Inventory</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>SUBSCALES OF THE SOS</strong></td>
<td><strong>SUBSCALES OF THE CRI</strong></td>
</tr>
<tr>
<td>A: acceptance</td>
<td>AEM: actual emotional support</td>
</tr>
<tr>
<td>CA: cognitive avoidance</td>
<td>APR: actual practical support</td>
</tr>
<tr>
<td>AR: alternative rewards</td>
<td>IEM: ideal emotional support</td>
</tr>
<tr>
<td>ED: emotional discharge</td>
<td>IPR: ideal practical support</td>
</tr>
<tr>
<td>LA: logical analysis</td>
<td>DEM: discrepancy emotional support</td>
</tr>
<tr>
<td>PA: positive reappraisal</td>
<td>DPR: discrepancy practical support</td>
</tr>
<tr>
<td>PS: problem solving</td>
<td></td>
</tr>
<tr>
<td>SS: seeking support</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>IIP : Inventory of Interpersonal Problems</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>SUBSCALES OF THE IIP</strong></td>
</tr>
<tr>
<td>ASS: assertive</td>
</tr>
<tr>
<td>CON: controlling</td>
</tr>
<tr>
<td>INT: intimate</td>
</tr>
<tr>
<td>RES: responsible</td>
</tr>
<tr>
<td>SOC: sociable</td>
</tr>
<tr>
<td>SUB: submissive</td>
</tr>
</tbody>
</table>

**GHQ**: General Health Questionnaire (specifically GHQ-12 that is the twelve question version).

**DUR**: Duration of the problem as measured by question B on the Patient questionnaire.

**DIS**: Distress as measured by question C on the Patient questionnaire.

**PRE**: Prediction of improvement following therapy as measured by question D on the Patient Questionnaire.
3.1 Problem Type reported by patient

The most frequently selected category, chosen by 78.2% of patients, was anxiety and stress. Approximately 44% (24) of patients indicated that their problem fell into more than one category. Of this percentage, the majority, 83.3% (20 cases) indicated two problem categories, one patient picked three categories, one four, with the remaining (2 cases) indicating 5 categories.

A total of four patients indicated that they felt their problem fell within the ‘other’ problem category. Of these, two patients also selected the anxiety/stress category. Only one patient indicated that they considered their problem to be ‘other’ and specified depression in the free response space. As mentioned in section 1.4 (page 261) in the context of this study only less severe, or reactive depressions, are likely to be referred directly by GPs to the three chosen groups of therapists (Counsellors, Clinical Psychologists, and Community Psychiatric Nurses). A lowered mood can be viewed as a consequence of problems within the five categories (see Table I) outlined by the Consumers’ Association (1991). It would appear that patients are able to attribute emotional distress, including a lowering of mood (depression), to discrete problem areas such as ‘interpersonal relationships’ or ‘adjustment to life events’.

3.2 Number of patients that have previously received counselling for their problem

Table J indicates the number of patients who have received counselling for their problem for which they have been referred previously. Five patients indicated that they had received help
from a private counsellor (2 PCCS; 2 CPS); five from mental health services (3 CPS; 2 CPN); five from the voluntary sector (4 CPS; one CPN). Four indicated that they had received counselling help from another source (2 PCCS; 2 CPS).

<table>
<thead>
<tr>
<th>PROBLEM TYPE</th>
<th>PCCS</th>
<th>CPS</th>
<th>CPN</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sample size=55</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>anxiety and stress</td>
<td>14</td>
<td>15</td>
<td>14</td>
<td>43</td>
</tr>
<tr>
<td>habit disorders</td>
<td>0</td>
<td>2</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>educational or occupational difficulties</td>
<td>5</td>
<td>5</td>
<td>1</td>
<td>11</td>
</tr>
<tr>
<td>interpersonal relationships</td>
<td>5</td>
<td>9</td>
<td>6</td>
<td>20</td>
</tr>
<tr>
<td>adjustment to physical illness and other life events</td>
<td>1</td>
<td>4</td>
<td>2</td>
<td>7</td>
</tr>
<tr>
<td>other</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>4</td>
</tr>
</tbody>
</table>

Table I. Showing category of problem reported by patients in each of the three groups

<table>
<thead>
<tr>
<th>received counselling previously?</th>
<th>TOTAL</th>
<th>PCCS</th>
<th>CPS</th>
<th>CPN</th>
</tr>
</thead>
<tbody>
<tr>
<td>NO</td>
<td>36</td>
<td>16</td>
<td>8</td>
<td>12</td>
</tr>
<tr>
<td></td>
<td>(65.5%)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>YES</td>
<td>19</td>
<td>4</td>
<td>12</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>(34.5%)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>TOTAL</td>
<td>55</td>
<td>20</td>
<td>20</td>
<td>15</td>
</tr>
</tbody>
</table>

Table J. Showing the number of patients that had received counselling for their problem previously.
3.3 Hypothesis one:

There will be significant relationships between a patient's obtained scores on the GHQ-12, IIP, CRI, and SOS. Scores on these measures will also be significantly related to the patient's self reported characteristics of problem severity, duration, and predicted outcome.

Tables K show the relationships between the variables measured for each patient as determined by Pearson's product-moment correlation. A significant correlation was indicated by a 'p' value of less than 0.05.

Inspection of the data presented in Tables K indicates that a number of significant correlations were found. These are described in the following section.

3.3.1 Subscale correlations between the measured variables

(a) All six sub scales of the Significant Others Scale (SOS) correlated positively with each other.

(b) All six subscales of the Inventory of Interpersonal Problems (IIP) correlated positively with each other with the exception of ASS with SUB (Assertive and Submissive) and RES with SUB (Responsible and Submissive). There was no relationship between these latter pairs of variables.
Table K. The relationship between variables as determined by Pearson’s product-moment correlation. The correlation coefficient between each variable is indicated in the appropriate box. The statistical significance of this correlation coefficient is indicated by the presence of one or more stars within that box. Table K is continued on next page.

| Variable names: |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|-----------------|-----------------|-----------------|-----------------|-----------------|-----------------|-----------------|-----------------|-----------------|-----------------|-----------------|-----------------|-----------------|-----------------|-----------------|-----------------|-----------------|-----------------|-----------------|-----------------|-----------------|
| AEM             | 1.00             | 0.83             | 0.41             | 0.31             | -0.58            | -0.47            | -0.28            | -0.33            | -0.19            | -0.34            | -0.35            | -0.42            | -0.28            | -0.22            | -0.20            | -0.02            | -0.18            | -0.20            | -0.02            | -0.01            | 0.19             | -0.32            | 0.04             | -0.08            |            |
| APR             | 1.00             | 0.34             | 0.45             | -0.48            | ***              | ***              | -0.29            | -0.17            | -0.03            | -0.15            | -0.15            | -0.32            | -0.27            | 0.05             | -0.20            | -0.16            | -0.00            | 0.05             | -0.21            | 0.22             | 0.16             | 0.12             |        |
| IEM             | 1.00             | 0.83             | 0.38             | 0.33             | ***              | **              | -0.24            | -0.06            | 0.03             | -0.02            | -0.08            | -0.07            | 0.02             | -0.10            | -0.12            | -0.15            | -0.00            | 0.10             | -0.12            | 0.08             | -0.10            | -0.08            | -0.22            | |        |
| IPR             | 1.00             | 0.29             | 0.35             | -0.18            | 0.03             | 0.09             | 0.06             | 0.06             | 0.04             | 0.04             | -0.07            | -0.22            | -0.12            | -0.07            | 0.09             | 0.12             | -0.07            | 0.10             | 0.01             | 0.01             | -0.03            | |        |
| DEM             | 1.00             | 0.81             | 0.09             | 0.24             | 0.25             | 0.21             | 0.25             | 0.25             | 0.21             | 0.18             | 0.14             | 0.03             | 0.24             | 0.36             | 0.31             | 0.21             | 0.02             | -0.01            | 0.18             | -0.08            | -0.15            | |        |
| DPR             | 1.00             | 0.14             | 0.15             | 0.20             | 0.05             | 0.16             | 0.23             | 0.16             | 0.17             | 0.17             | 0.02             | 0.26             | 0.33             | 0.24             | -0.03            | -0.03            | 0.16             | -0.18            | -0.18            | -0.21            | |        |
| GHQ             | 1.00             | 0.34             | 0.06             | 0.17             | 0.17             | 0.36             | 0.17             | 0.24             | 0.14             | 0.39             | -0.25            | -0.12            | -0.34            | -0.43            | -0.13            | 0.55             | -0.20            | -0.05            | |        |
| ASS             | 1.00             | 0.30             | 0.50             | 0.63             | **              | 0.70             | 0.21             | 0.05             | 0.10             | -0.16            | -0.09            | 0.03             | -0.22            | -0.17            | -0.22            | 0.38             | -0.01            | 0.22             | |        |
| CON             | 1.00             | 0.41             | 0.52             | 0.54             | 0.11             | 0.03             | 0.03             | 0.16             | 0.07             | 0.18             | 0.11             | 0.12             | 0.12             | 0.07             | 0.02             | |        |
| INT             | 1.00             | 0.40             | 0.65             | 0.71             | 0.04             | 0.21             | 0.16             | 0.16             | -0.21            | -0.14            | -0.11            | 0.39             | -0.18            | -0.12            | |        |
| RES             | 1.00             | 0.60             | 0.22             | -0.01            | -0.15            | -0.15            | -0.08            | -0.08            | 0.01             | -0.20            | -0.07            | -0.06            | 0.33             | -0.31            | -0.11            | -0.23            | |        |
| SOC             | 1.00             | 0.62             | 0.08             | 0.18             | -0.23            | 0.16             | 0.03             | 0.19             | -0.09            | -0.21            | 0.49             | -0.07            | 0.11             | |        |
Table K continued. The relationship between variables as determined by Pearson’s product-moment correlation. The correlation coefficient between each variable is indicated in the appropriate box. The statistical significance of this correlation coefficient is indicated by the presence of one or more stars within that box. Continued from previous page.

|      | AEM | APR | IEM | IPR | DEM | DPR | GHQ | ASS | CON | INT | RES | SOC | SUB | A   | CA   | AR   | ED   | LA   | PA   | PS   | SS   | DIS  | DUR  | PRE  |
|------|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|
| SUB  |     |     |     |     |     |     |     |     |     |     |     |     |     | 1.00| 0.08 | 0.24 | -0.32|   *  |     |     |     |     |     |     |
| A    |     | 1.00| 0.63| 0.11| 0.44| 0.36| 0.20| 0.10| -0.08| 0.20| 0.03| -0.32|     |     |     |     |     |     |     |     |     |     |     |
| CA   |     | 1.00| -0.07| 0.43|   **| 0.29| 0.27| 0.04| -0.19| 0.23| -0.06| -0.34|     |     |     |     |     |     |     |     |     |     |     |
| AR   |     | 1.00| 0.03 | 0.30 | 0.34 | 0.43 | 0.27 | -0.44| 0.21 | 0.09 |     |     |     |     |     |     |     |     |     |     |     |
| ED   |     | 1.00| 0.32 | 0.13 | 0.09 | 0.11 | 0.37 | 0.05 | -0.24|     |     |     |     |     |     |     |     |     |     |     |     |
| LA   |     |     |     |     |     |     |     |     |     |     |     |     |     |     | 1.00| 0.61 | 0.67 | 0.25 | 0.03 | 0.01 | 0.20 |     |     |     |
| PA   |     |     | 1.00| 0.60 | 0.31 | -0.07| -0.06| -0.23|     |     |     |     |     |     |     |     |     |     |     |     |     |     |
| SS   |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     | 1.00| 0.45 |     |     |     |     |
| DIS  |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     | 1.00| 0.16 |     |
| DUR  |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     | 1.00|
| PRE  |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |

**Variable names:**

**SOS**

- AEM: actual emotional support
- APR: actual practical support
- IEM: ideal emotional support
- IPR: ideal practical support
- DEM: discrepancy emotional support
- DPR: discrepancy practical support
- GHQ: GHQ-12
- ASS: assertive
- CON: controlling
- INT: intimate
- RES: responsible
- SOC: sociable
- SUB: submissive

**IIP**

- A: acceptance
- CA: cognitive avoidance
- AR: alternative rewards
- ED: emotional discharge
- LA: logical analysis
- SOC: sociable
- SUB: submissive

**CRI**

- PS: problem solving

* = p<0.05
** = p<0.01
*** = p<0.001
(c) Fifteen (15) out of the twenty-eight (28) possible correlations between the eight subscales of the Coping Responses Inventory obtained significance. All significant correlations were in the positive direction.

(d) Scores on AEM (actual emotional support) a subscale of the CRI (Coping Responses Inventory) correlated negatively with five of the six subscales of the IIP (Inventory of Interpersonal Problems) namely, ASS (assertive), INT (intimate), RES (responsible), SOC (sociable), SUB (submissive), and with DIS (distress; as measured by the patient questionnaire). This indicates that low scores on the AEM are significantly related to high scores on the other variables.

(e) Scores on DIS, the patient’s self reported level of distress via the patient questionnaire, correlated negatively with one subscales of the SOS (Significant Others Scale) namely AEM (actual emotional support) and one subscale of the CRI (Coping responses Inventory) namely AR (alternative rewards). This suggests that high scores on DIS are related to low scores on AEM and AR.

(f) Scores on DIS, the patient’s self reported level of distress via the patient questionnaire, correlate positively with scores on the GHQ-12, five of the six subscales of the IIP namely ASS (assertive), INT (intimate), RES (responsible), SOC (sociable), SUB (submissive), and one subscale of the CRI namely ED (emotional discharge). This suggests that high scores on DIS are related to high scores on the other variables.
(g) Scores on the GHQ-12 correlated positively with three subscales on the IIP namely ASS (assertive), RES (responsible), and SOC (sociable), and with the variable DIS (distress). This indicates that high scores on the GHQ-12 are related to high scores on the other variables.

(h) Scores on the GHQ-12 correlate negatively with the APR (actual practical support) subscale of the SOS (Significant Others Scale), and three subscales of the CRI namely AR (alternative rewards), PA (positive reappraisal), and SS (seeking support). This suggests that high scores on the GHQ-12 will be associated with low scores on the other variables.

(i) Scores on SUB (submissive), a subscale of the IIP, correlated positively with the variable ED (emotional discharge) a subscale of the CRI, and DIS (distress). This suggests that high scores on Sub are related to high scores on the other two variables.

(j) Scores on SUB (submissive), a subscale of the IIP, correlated negatively with PRE (scores on the patients prediction of improvement following therapy from the patient questionnaire) and AEM (actual emotional support), a subscale of the SOS. This indicates that high scores on SUB are related to low scores on PRE and AEM.

(k) Scores on PRE, the prediction of improvement after therapy made by the patient on the patient questionnaire, correlated negatively with SUB (submissive) a subscale of the IIP, and two subscales of the CRI namely A (acceptance), and CA (cognitive avoidance). This suggests that high scores on PRE are related to low scores on the other variables.
(l) Positive correlations were also found between LA (logical analysis; CRI) and DEM (discrepancy emotional support; SOS) and LA and DPR (discrepancy practical support; SOS). This suggests that high scores on LA are related to high scores on the two other variables.

(m) A negative correlation was found between SOC (sociable; IIP) and APR (actual practical support; SOS). This indicates that high scores on SOC are related to low scores on APR.

3.3.2 Conclusion from the Pearson product-moment analysis of data.

It can be concluded that, in respect of the significant correlations indicated above, the Null Hypothesis can not be rejected. Significant relationships have been found to exist amongst some of the variables measured by the GHQ-12, subscales of the IIP, CRI, and SOS, and the self-reported, patient characteristics. The meaning of the significant correlation in terms of Boardman’s (1987) positive patient stereotype, interpersonal problem, and the patient’s perception of their mental health problem will be discussed in Section 4.

3.4 Hypothesis Two:

There will be a significant difference between patients referred to the PCCS, CPS and CPN specialist mental health services in terms of the patient’s self reported characteristics (problem severity, duration, and predicted outcome and scores obtained from the GHQ-12, IIP, CRI, and SOS), with those
referred to the CPNs obtaining the highest test scores on the GHQ-12, problem severity and problem duration measures and the lowest score on the predicted outcome measure, the PCCS referral obtaining the lowest scores on the first three variables and the highest on the last, with the CPS obtaining intermediate scores.

It was hypothesised that there would be a difference between patients referred to the PCCS, CPS and CPN specialist mental health services in terms of the patient's self reported characteristics (problem severity, duration, and predicted outcome and scores obtained from the GHQ-12, IIP, CRI, and SOS).

Bearing in mind the number of cases (55) and the large number of variables reported, nonparametric statistics were used. Kruskal-Wallis one-way anovas were calculated for each variable. Group means, standard deviations, and the Chi-square values are shown in Table L.

All Chi-square values failed to reach significance at the p< 0.05. The variable SUB (IIP; Submissive) was the only variable of those measured to approach significance (p=0.0543).

Inspection of Table L indicates that the standard deviations calculated for the variable AR (CRI: Alternative Rewards) are larger than the obtained means. Reference to the data base, and the distribution of scores on this variable, suggests the presence of a 'floor effect'.
<table>
<thead>
<tr>
<th>VARIABLE</th>
<th>PCCS</th>
<th>CPS</th>
<th>CPN</th>
<th>ALL GROUPS</th>
<th>Chi-square</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>mean</td>
<td>s.d.</td>
<td>mean</td>
<td>s.d.</td>
<td>mean</td>
</tr>
<tr>
<td>AEM</td>
<td>4.29</td>
<td>1.21</td>
<td>3.56</td>
<td>1.12</td>
<td>3.84</td>
</tr>
<tr>
<td>APR</td>
<td>4.23</td>
<td>1.30</td>
<td>3.58</td>
<td>1.45</td>
<td>3.93</td>
</tr>
<tr>
<td>IEM</td>
<td>5.69</td>
<td>1.07</td>
<td>5.63</td>
<td>1.07</td>
<td>5.79</td>
</tr>
<tr>
<td>IPR</td>
<td>5.32</td>
<td>0.95</td>
<td>5.33</td>
<td>1.21</td>
<td>5.36</td>
</tr>
<tr>
<td>DEM</td>
<td>1.62</td>
<td>1.25</td>
<td>2.15</td>
<td>1.04</td>
<td>1.89</td>
</tr>
<tr>
<td>DPR</td>
<td>1.25</td>
<td>1.18</td>
<td>1.81</td>
<td>1.01</td>
<td>1.54</td>
</tr>
<tr>
<td>GHQ</td>
<td>21.58</td>
<td>8.61</td>
<td>25.45</td>
<td>8.80</td>
<td>22.30</td>
</tr>
<tr>
<td>ASS</td>
<td>1.90</td>
<td>0.83</td>
<td>2.21</td>
<td>0.73</td>
<td>2.35</td>
</tr>
<tr>
<td>CON</td>
<td>0.78</td>
<td>0.31</td>
<td>1.28</td>
<td>0.52</td>
<td>0.88</td>
</tr>
<tr>
<td>INT</td>
<td>0.81</td>
<td>0.51</td>
<td>1.49</td>
<td>0.86</td>
<td>1.38</td>
</tr>
<tr>
<td>RES</td>
<td>1.83</td>
<td>0.70</td>
<td>2.20</td>
<td>0.70</td>
<td>2.15</td>
</tr>
<tr>
<td>SOC</td>
<td>1.74</td>
<td>0.88</td>
<td>2.77</td>
<td>0.90</td>
<td>2.61</td>
</tr>
<tr>
<td>SUB</td>
<td>0.99</td>
<td>0.56</td>
<td>2.08</td>
<td>1.05</td>
<td>1.29</td>
</tr>
<tr>
<td>A</td>
<td>10.67</td>
<td>4.41</td>
<td>11.09</td>
<td>3.39</td>
<td>9.90</td>
</tr>
<tr>
<td>CA</td>
<td>9.08</td>
<td>3.94</td>
<td>11.18</td>
<td>3.92</td>
<td>11.00</td>
</tr>
<tr>
<td>AR</td>
<td>4.08</td>
<td>4.31</td>
<td>2.18</td>
<td>2.48</td>
<td>4.50</td>
</tr>
<tr>
<td>ED</td>
<td>7.58</td>
<td>3.96</td>
<td>8.64</td>
<td>3.17</td>
<td>6.80</td>
</tr>
<tr>
<td>LA</td>
<td>11.25</td>
<td>4.27</td>
<td>8.55</td>
<td>3.96</td>
<td>7.70</td>
</tr>
<tr>
<td>PA</td>
<td>7.50</td>
<td>4.48</td>
<td>5.64</td>
<td>5.07</td>
<td>7.50</td>
</tr>
<tr>
<td>PS</td>
<td>9.50</td>
<td>3.92</td>
<td>6.27</td>
<td>3.58</td>
<td>7.20</td>
</tr>
<tr>
<td>SS</td>
<td>9.25</td>
<td>4.03</td>
<td>7.55</td>
<td>2.98</td>
<td>7.10</td>
</tr>
<tr>
<td>DIS</td>
<td>4.58</td>
<td>2.35</td>
<td>6.73</td>
<td>1.90</td>
<td>6.70</td>
</tr>
<tr>
<td>DUR</td>
<td>3.83</td>
<td>0.39</td>
<td>3.82</td>
<td>0.40</td>
<td>3.50</td>
</tr>
<tr>
<td>PRE</td>
<td>6.58</td>
<td>1.83</td>
<td>5.27</td>
<td>2.76</td>
<td>7.60</td>
</tr>
</tbody>
</table>

Table L showing the mean and standard deviations of all variables. All Chi-square values failed to reach significance at the p<0.05 level.
A large proportion of respondents (40 patients) scored at the lower end of the subscale (0-5). A minority (6 patients) scored at the upper end of the range (10-14, maximum score 18). This result suggests that this type of coping response is rarely used by the present population.

3.4.1 Conclusions from the Kruskal-Wallis one-way anovas

There are no significant differences amongst the three groups on all the variables measured. Consequently the null hypothesis is supported.
4. Discussion

The aims of the present study were twofold. Firstly, to investigate and examine the characteristics of patients, referred by GP's, to specialist mental health services, and secondly, to explore the relationship between patient characteristics and the direction of referral. To achieve this aim a number of questionnaires were used to measure patient characteristics; the Inventory of Interpersonal Problems (IIP; Horowitz et al. 1988), the Coping Responses Inventory (CRI; Moos, 1990), the Significant Others Scale (SOS; Power et al. 1988), the GHQ-12 (Goldberg and Williams, 1988), and a Patient Questionnaire developed specifically for the present study. The direction of referral chosen by GPs was investigated by comparison of the measured patient characteristics for patients referred to one of the three groups, Primary Care Counselling Service (PCCS; secondary care Clinical Psychology Service (CPS); and Community Psychiatric Nurses (CPN). Demographic data indicated that there is a male:female ratio of 4:7, the average age of the sample is 38.34 years (range 15-72); the majority of patient are white (92.72%); and 34.5% had received some form of counselling prior to their present referral.

The majority of patients reported their problem type as anxiety and stress (78.2%). Unexpectedly, 44% of patients indicated that their problem fell into more than one category suggesting that patients tend to see their problems on more than one dimension. Four patients (7.3%) indicated that their problem belonged in the ‘other’ category. Only one of these patients indicated that their problem type was ‘general depression’ the others listing problems that appropriately belonged within one of the other categories viz. personal relationship, loss of right kidney and unemployment. The use of multiple categories to
represent the type of problem experienced suggests that any referral decisions made on the basis of how the patient defines their problem may be limited in its application and offer little to GPs. This finding is also of interest in relation to the often quoted lack of insight into mental health problems displayed by patients within primary care settings. The lack of insight may be related to the multidimensional way in which patients see mental health problems.

The finding that patients in general did not report 'depression' as a problem (apart from one) may be an artefact of questionnaire design and the categories specified by the Consumers' Association (1991). It may also be a reflection of the findings reported by Burton and Ramsden (1994) that patients with certain categories of mental health problems tend to be referred directly to psychiatrists. It is also possible that patients reporting depressed symptomatology and deemed to have an endogenous depression, will be appropriately treated via medication, and may be managed by their GP or referred for to a psychiatrist for 'drug therapy' and are consequently not represented in the present sample. Patients suffering a 'reactive depression' to an environmental or personal stressor, appear to be able to identify a 'source' of their symptoms in terms of the categories stated by the Consumer's Association (1991).

The selection of multiple categories by 44% of patients to describe their problem is of interest. Table I indicates that the twenty patients in the PCCS group marked 26 categories, the twenty patients in CPS marked 37, while the fifteen patients in the CPN group marked
26. This gives a patient:problem category ratio of 1:1.3 for the PCCS; 1:1.85 for the CPS; and 1:1.73 for the CPN group. From this it would appear that the patient referred to the CPS and CPN groups tend to perceive their problems as more complex than patients referred to the PCCS.

4.1 Patient Characteristics measured by the SOS, IIP, CRI:

Significant positive correlations were found among all six subscales of the SOS suggesting that there is a significant relationship between actual and ideal level of emotional and practical support in this population. The SOS has been shown to significantly distinguish between depressed and nondepressed respondents (Power et al., 1988). Depressed cases (identified by GHQ-28 scores) were reported to show much higher actual/ideal discrepancy scores than controls. Unrealistically high levels of ideal support (IEM and IPR) have also been reported to correlate with levels of depression, but not in older adults (Lam and Power, 1991). This lack of a relationship in older adults was suggested to result from more a realistic expectation of the level of support available from close relationships. Inspection of the population mean subscale scores suggests that higher ideal support scores have been reported by this group. This result is of interest as only one patient in the present sample mentioned 'depression' as a problem. This may well have resulted from the choice of problem categories provided to patients as previously discussed. However, there is an absence of significant relationships between scores on the subscales of the SOS (specifically those reported to be related to measured levels of depression i.e. IEM, IPR, DEM, DPR) and the two scales (GHQ-12 and DIS) measuring an individuals reported level of
psychological distress. The only subscale related to level of distress in the present study is that of actual emotional support (AEM with DIS). This result will be discussed further in section 4.2.

Significant positive correlations were found between all subscales of the IIP with the exception of the variables ASS and SUB, and RES and SUB. This result suggests that interpersonal problems reported in one area, tend to be related to interpersonal problems in the other measured areas except for ASS/SUB and RES/SUB.

The scores on the CRI present a more complicated picture with scores on many of the subscales being unrelated to scores on the others. An individual’s attempt to cope with stressful life events can be viewed as a complex set of processes, both cognitive and behavioural. Moderating factors, or coping responses, within the individual, have been assumed to account for variations in the appraisal of, and response to, specific life events. Coping strategies, and responses, moderate the effect of stressful events on the individual’s physical, social, and emotional functioning (Billings and Moos, 1981). It is not the level of stress per se that determines the development of psychological distress, rather how the individual copes with the stressors.

The eight subscales of the CRI can be divided into two dimensions as demonstrated in Table M.
The double ended arrows show the variables found to significantly correlate with each other. No coherent pattern is discernible in this schematic representation. There is, however, a lack of any significant relationship between those variables classed as behavioural coping strategies and those classed as avoiding coping strategies (bottom left to top right) - an approach-avoidance contrast. In the present sample it would appear that there is a core number of significantly related coping responses and certain combinations of coping strategies and responses that are not significantly related.

The scores from the CRI subscales can be converted to standard scores (Moos, 1990) to obtain an individual’s coping profile. Inspection of the mean scores for the present sample, and conversion to standard scores, indicates that the coping profile of this patient population
falls below the average population score on LA, PA, PS, SS, and AR (see Table N). Emotional discharge (ED), Acceptance (A), and cognitive avoidance (CA) skills appear to be used more.

<table>
<thead>
<tr>
<th>Variable</th>
<th>LA</th>
<th>PA</th>
<th>PS</th>
<th>SS</th>
<th>ED</th>
<th>A</th>
<th>AR</th>
<th>CA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean</td>
<td>9.27</td>
<td>6.89</td>
<td>7.73</td>
<td>8.03</td>
<td>7.70</td>
<td>10.58</td>
<td>3.58</td>
<td>10.36</td>
</tr>
<tr>
<td>Standard score</td>
<td>44</td>
<td>42</td>
<td>43</td>
<td>47</td>
<td>62</td>
<td>58</td>
<td>45</td>
<td>58</td>
</tr>
</tbody>
</table>

Table N. Showing standard scores for each of the CRI subscales. A standard score of 50 represents average.

It has been proposed (Milne, 1992) that the CRI can be used as an aid to decision-making about which clients need to be seen by mental health professionals by examination of their coping profile. No guidelines concerning the operation of this process have been found following extensive literature searches by the present author. It would appear that the present patient sample is demonstrating a coping profile in which certain variables are significantly related and the majority of coping responses are not used sufficiently. The interaction of the identified coping response pattern with stressful life events is unclear although the pattern found suggests that individuals in this patient group generally use coping strategies less effectively to moderate the effect of life stresses. It seems that within this group of patients the most likely coping skills used in stressful situations are emotional
discharge, cognitive avoidance of the problem and an acceptance of the situation. Further research and a comparison of this group with subjects without a mental health problem, may shed further light on the significance, if any, of this pattern.

4.2 Patient characteristics and relationships between the SOS, IIP and CRI.

Very few significant correlations were found amongst the various subscales of the SOS, IIP, and CRI. AEM (Actual Emotional Support; SOS) significantly correlated with ASS (assertive), INT (intimate), RES (responsible), SOC (sociable), and SUB (submissive) five of the six subscales on the IIP. Five further significant correlations were obtained. These were between LA (Logical Analysis; CRI) and DEM (Discrepancy Emotional Support; SOS); LA and DPR (Discrepancy Practical Support; SOS); SUB (Submissive; IIP) and AR (Alternative Rewards; CRI); SOC and APR (Actual Practical support; SOS) and SUB and ED (Emotional Discharge; CRI). These clusters of significant correlations will be discussed in the following sections.

4.2.1 The relationship between AEM with the five subscales of the Inventory of Interpersonal Problems (IIP) specifically ASS, INT, RES, SOC, and SUB

AEM correlated negatively with five of the six subscales of the IIP (ASS, INT, RES, SOC, and SUB). These tests are scored in opposite directions with high scores on AEM indicating high levels of emotional support while high scores on the subscales of the IIP are indicative of a problem within the measured area of interpersonal functioning. Consequently, the obtained negative correlation suggests that patients reporting a low level of actual emotional
support are likely to experience interpersonal problems of the type measured by the assertive, intimate, responsible, sociable and submissive subscales of the IIP. This finding tends to confirm the presence of the positive patient stereotype found by Boardman (1987) in terms of low level of (actual) social support and interpersonal problems.

4.2.2 The relationship between LA and two subscales of the Significant Others Scale (SOS), specifically, DEM and DPR

LA (logical analysis), a coping response measured by the CRI, correlated positively with DEM and DPR, the discrepancy scores between actual and ideal emotional (DEM), and actual and ideal practical (DPR), support as measured by the SOS (Significant Others Scale). The meaning of this relationship is unclear but suggests that there is a relationship between a style of coping (logical analysis) and the individuals perception of the difference in their level of actual support and ideal support.

4.2.3 The relationship between SUB (a subscale of the IIP) and AR (a subscale of the CRI).

SUB and AR are negatively correlated. High scores on the variable submissive are indicative of an interpersonal problem in this area. This subscale measures how hard an individual finds it to be dominant in a relationship and whether the individual demonstrates ‘too much’ of the dimension, in this case submission, in relationships. AR (alternative rewards) is a
behavioural, avoidance, coping strategy. High scores on this variable indicate a high level of usage of this specific coping skill. Thus it would appear that patients with an interpersonal problem of the type 'submissive' tend to demonstrate a poor coping strategy of the type measured by the variable alternative rewards. However, inspection of the means and standard deviations of this variable (see Table L) shows that the standard deviations of the three separate groups approximates to the level of the group mean, and in the case of CPS group, the standard deviation exceeds the mean. This suggests that there may be a 'floor effect' with many of the patients in the present study rarely displaying this coping strategy. Reference to Table N which shows the standard scores for each of the coping styles below average levels of this coping skill.

### 4.2.4 The relationship between SUB (a subscale of the IIP) and ED (a subscale of the CRI)

SUB and ED are positively correlated indicating that patients experiencing an interpersonal personal problem on the submissive subscale of the IIP (SUB) also score highly on the emotional discharge subscale (ED) of the CRI. ED is identified as a behavioural, avoidance coping response in Table M. This finding suggests that patients in the present sample experiencing problems in authority relationships respond emotionally. Authority relationships may include those of a parent to a child, employer to employee, doctor to patient, landlord to tenant, statutory authorities (e.g. police) to member of the public and so on.
4.2.5 The relationship between SOC (a subscale of the IIP) and APR (a subscale of the SOS).

SOC and APR are negatively correlated suggesting that high scores on the variable SOC (sociable) are significantly related to low scores on actual practical support. It would appear that patients who have an interpersonal problem socialising with others report low levels of actual practical support. Common sense would tend to support the presence of this measured relationship.

This finding is of interest in the context of the suggested “buffering effect of social support to stressful life events” (for a discussion see section 1.2.1(ii) Characteristics of the Patient) and the relationship can be elaborated to read:-

\[
\begin{align*}
&\text{Individual with difficulties forming social relationships} \\
&\downarrow \\
&\text{Low levels of practical social support} \\
&\downarrow \\
&\text{Vulnerability to stressful life events.}
\end{align*}
\]

Not only is this model of interest in terms of appropriate therapeutic intervention with, social skills training becoming and integral part of a therapy package, it may point to factors within the doctor-patient relationship which provide cues to the possibility of a mental health problem, and the decision to make referral to mental health services.
4.3 The relationship between measures of psychological distress (GHQ-12 and Distress) and other patient characteristics.

The GHQ-12 is a reliable and valid measure of psychological distress frequently used in research studies (see Mathers et al. 1993). A single item measure of self-reported ‘distress’ was included in the patient questionnaire, in the form of a nine point rating scale from ‘distressing at infrequent intervals’ to ‘significantly distressing during most of every day’ (see Appendix A). While DIS and GHQ-12 scores are significantly positively correlated (see Table K), indicating that high levels of distress measured by the GHQ-12 are related to high levels of distress measured by DIS, the two variables have different profiles when considered in terms of their relationship with the other variables measured in the present study.

The positive correlation between these two variables is of interest as DIS asks a simple, global question, of how distressing the patient finds their problem in everyday life. The positive correlation with GHQ-12 scores suggests that GPs can make a valid judgement of a patient’s level of distress on the basis of the response to this single item. An item of this nature may prove of value in the detection of problems and the decision to refer a patient on to specialist services. The nature of this variable is worth further investigation to determine whether the same positive correlation with valid and reliable measures of psychological distress remains if the single question is asked of the patient verbally in a direct face-to-face manner by the GP, or another member of the primary health care team.

The different profiles of the GHQ-12 and DIS can be examined in relation to the differing patterns of significant correlations found with other variables. For example significant positive correlations were obtained between patient scores on the GHQ-12 and ASS, RES,
and SOC (subscales of the IIP), while negative correlations were obtained with APR (a subscale of the SOS), and three subscales on the CRI; AR, PA (Positive Reappraisal), and PS (Problem Solving). On the other hand significant positive correlations were obtained between DIS, and five subscales of the IIP namely ASS, INT, RES, SOC, SUB and one subscale of the CRI namely ED (emotional discharge), while negative correlations were obtained between DIS and AEM (Significant Others Scale) and AR (Coping Responses Inventory).

The similarities and difference between the GHQ-12 and DIS will be explored in the following sections.

4.3.1 Similarities between the GHQ-12 and DIS profiles

Both the GHQ-12 and DIS are positively correlated with ASS, RES and SOC and negatively correlated with AR. These significant relationships indicate that a high level of distress is significantly related to high scores on the assertive, responsible and sociable subscales of the IIP. High scores on the IIP are indicative of difficulties in interpersonal relationships. The obtained positive correlations suggest that patients reporting a high level of psychological distress are unassertive, have difficulty taking responsibility for their own actions in a relationship, but may take responsibility for those of their partner, and have problems making friends and joining in socially. These three variables (ASS, RES, SOC) are all negatively correlated with AEM once again confirming the reported relationship (see Boardman, 1987; Neeleman and Power, 1994) between perceived level of emotional support (social support), psychological distress, and problems with close relationships. The quality of the individual’s
social support, as provided by their social network, has been shown to play a part in the individual's reaction to stressful life events (Zimmermann-Tansella and Siciliani, 1990; Lam and Power, 1991). Whether social support acts as a buffer, or whether the lack of it leads directly to the occurrence of symptomotology, has not been determined. There are several significant findings about the relationship between social problems, social support and emotional distress. Social difficulties increase the likelihood of an individual becoming a psychiatric patient independently of the severity of symptoms (Zimmermann-Tansella and Siciliani, 1990). The availability of a close confiding relationship appears to have a beneficial effect on mental health, either by exerting direct effects or by interaction effect with adversities (Lam and Power, 1991). It is reasonable to assume that the presence of interpersonal difficulties, as measured by the IIP, would mitigate against the presence of close, supportive relationships, and hence reduce the 'buffering' effect on the level of emotional distress experienced by the individual.

4.3.2. Differences between the profiles of the GHQ-12 scores and the variable DIS

The profile of significant correlations between the measures variables and the GHQ-12 and DIS differ in terms of the GHQ-12 correlating negatively with APR, PA, and PS while DIS is positively correlated with INT, SUB and ED and negatively with AEM. DIS is correlated positively with all the subscales of the IIP with the exception of CON. This indicates that high scores on DIS tend to be associated with high scores on five subscales of the IIP. The GHQ-12 is only positively correlated with three of these subscales namely ASS, RES and SOC.
The GHQ-12 is correlated negatively with APR (Significant Others Scale), PA and PS (Coping Responses Inventory). Thus higher levels of psychological distress are significantly correlated with low levels of actual practical support, and low levels of coping skills of positive reappraisal and problem solving (both ‘approach coping responses’ see Table M).

It would appear that the level of psychological distress measured by DIS reflects a broad range of interpersonal difficulties, while the GHQ-12 accesses coping skills and levels of social support. Inspection of the individual items forming the GHQ-12 questionnaire, indicates that reference is made to coping (item 8) with possible reference to levels of social support (items 3 and 6). Obviously a twelve item questionnaire is able to cover a richness and breadth of information denied to a single item. However the significant positive correlation found between the two variables (GHQ-12 and DIS) with the present population suggests that the single item question is worth further investigation to determine it’s reliability and validity.

4.4 The relationships between DUR, PRE and all other reported variables.

No relationships were found between DUR and the other variables suggesting that levels of social support, interpersonal problems, coping responses and level of psychological distress, are unrelated to the length of time that the problem has been present. This would tend to lend support to the suggestion made earlier (Section 4.2.5) that aspects of personality, assumed to be fairly stable across time, are associated with the level of psychological distress experienced rather than the duration of the present problem.
PRE, which asked the patient to predict how much their level of distress would improve following their final session with the therapist, was negatively correlated with SUB (Significant Others Scale), and two subscales of the CRI namely A (acceptance), and CA (cognitive avoidance). The submissive (SUB) subscale on the IIP relates to how hard the individual finds it to accept another’s authority, or become irritated or annoyed, in a relationship. Low scores on this scale suggest the absence of a problem and these tend to be correlated with high PRE scores. This relationship suggests that patients who predict a favourable outcome following therapy tend to accept the authority of others. A relationship of this sort is reminiscent of a patient’s ‘illness behaviour’ (described in Section 1.2.1) and Goldberg and Blackwell’s (1970) suggestion that there is a belief that ‘the doctor will get to the bottom of the problem’ and make it better.

A and CA relate to coping skills of acceptance and cognitive avoidance as measured by the Coping Responses Inventory. The negative correlation found with the variable PRE, suggests that low levels of these coping skills are related to high scores on PRE, that is a prediction that their level of distress will improve. Both A and CA are cognitive coping strategies/avoidance coping responses (see Table M) suggesting that patients predicting a successful outcome following therapy (that is a reduction in their level of distress) tend to cognitively ‘accept’ the situation and use ‘cognitive avoidance’ strategies. Such patients may have little insight into their problem as one of their major coping strategies used is that of cognitive avoidance.
4.5 Summary: Characteristics of the group of patients referred to all three specialist mental health services by local GPs.

It has been reported that the detection of patients with a mental health problem, and the subsequent decision to refer the patient on to specialist services is related to characteristics within the patient, the GP and the interaction of the patient and GP (e.g. Corney et al. 1988). In the present study patient characteristics were investigated using a number of psychometric measures. While the conclusions are tentative various trends can be identified.

Firstly, patients tend to cope ineffectively. There is a suggestion that a ‘coping responses profile’ common to patients referred to the Primary Care Counselling Service (PCCS), secondary care Clinical Psychology Service (CPS), and the Community Psychiatric Nurses (CPN) exists. The exclusiveness of this profile to patients referred to specialist mental health services cannot be judged within the present study as no measures were obtained from an appropriate control group.

Secondly, patients appear to demonstrate a range of interpersonal problems (as measured by the Inventory of Interpersonal Problems) and these are statistically related to low levels of social support (as measured by the Significant Others Scale). This is perhaps a commonsense finding as those experiencing relationship problems would be more likely to report the lack of supportive relationships. The significance of this finding to the GP’s detection of the patient’s mental health problem and the decision to refer the patient on to specialist mental health services requires further investigation.
Thirdly, patients reporting a high level of psychological distress tend to experience interpersonal difficulties as measured by ASS, RES and SOC. While only tentative conclusions can be drawn from the present study, this relationship is worthy of further investigation.

Relationships between PRE and SUB, A, and CA suggest that patients who predict that their level of distress will improve following therapeutic intervention tend to accept the authority of others in interpersonal relationships and use cognitive coping strategies/avoidance coping responses (see Table M). However, whether the variable PRE is a valid and reliable measure could be questioned.

AEM correlated negatively with five of the six subscales of the IIP (ASS, INT, RES, SOC, and SUB). This finding tends to confirm the presence of the positive patient stereotype reported by Boardman (1987) consisting of low level of social of (actual) social support and interpersonal problems within this group of patients. Further investigation of the role played by this positive stereotype in the GP’s decision to refer a patient to mental health services is required.

Finally, patients do not tend to see their problems in terms of a single category, but do make valid judgements of their level of distress via a single, direct question. Although there is a significant correlation between the GHQ-12 and the variable DIS, the validity and reliability of DIS can be questioned.
4.5.1 Conclusion: Characteristics of the group of patients referred to all three specialist mental health services by local GPs.

The relationships found between and among patient characteristics in this study relate to relationships reported elsewhere (e.g. Boardman, 1987; Billings and Moos, 1981). Further study is required to investigate the validity and generalizability of these findings and to determine how these characteristics are linked to the decision of the GP to refer that patient on for further help.

4.6 Referral direction

Milne, (1992) suggests that patients could be allocated, according to needs, to the most relevant professional on the basis of their coping profile as measured by the CRI. No further information/data has been found by the present author on this proposition despite extensive literature searches. The relationship between patient characteristics and referral direction was examined in the present study using variables obtained from the Coping Responses Inventory (CRI), Inventory of Interpersonal problems (IIP), Significant Other Scale (SOS), General health Questionnaire - twelve question version (GHQ-12) and patient questionnaire (yielding variables DIS, DUR, PRE). Three professional groups were identified a primary care counselling service (PCCS), a secondary care Clinical psychology Service (CPS), and a secondary care Community psychiatric Nursing Service (CPN). It was hypothesised that patient referred to one of the three groups would differ in terms of the measured patient characteristics. Local policies and referral criteria suggest that each of the three groups should receive, and accept different types of patient referrals from GPs. The CPNs group have been associated with referrals of the most severely mentally ill, while the PCCS has been established to respond to the needs of the ‘worried well’. The CPS service should
demonstrate an intermediate role accepting referrals of both the severely mentally ill and the ‘worried well’. Consequently it was hypothesised that patients referred to the primary care counselling service should demonstrate the lowest level of distress, and interpersonal problems and the highest levels of coping skills and social support. Their problems should also be of more recent origin, and the prediction of a successful outcome to therapy the highest.

No significant differences were found between the three groups on any of the measured variables using nonparametric Kruskal-Wallis one-way Anovas (see Table L). This result suggests that there is no difference, on any of the measured variables, amongst patients referred to the three service areas.

In view of the small number of subjects and the large number of variables measured, only very tentative conclusions concerning the direction of referral can be made on the basis of the results reported here.

Local factors (e.g. waiting times, professional relationships), have been shown to affect the pattern of referral. No attempt has been made within the present study to investigate factors such as GP’s familiarity with services, attitudes, beliefs, or interest in mental health problems that may have contributed to the present findings. If the proposed model of local mental health services is to develop in the fashion outlined within the Strategy for Mental Health Service Development (Croydon Commissioning Agency, 1994), the similarity between the
referrals made by GPs to the Primary Care Counselling Service, CPNs, and Clinical Psychologists, requires monitoring and further investigation.

CPNs operate as the link between GPs and the CMHTs. The CMHTs (CPNs) and the Psychological Therapies Service (which includes the PCCS) accept referrals on the basis of referral criteria clearly stated within Service Specifications (Smith, 1994a, 1994b). A complimentary set of referral criteria is presently being developed for the PCCS. The results of the present study tend to suggest that there is very little difference between referrals made by GPs to these professional groups despite the extensive differences in the service criteria, the training and experience levels of the professionals involved and the mode of operation of each service area.

The local Mental Health Strategy Document, published by local service commissioners, makes clear statements about providing community based mental health services (via the CMHTs) for the most severely mentally ill. The results of the present study, albeit very tentative, suggest that this aspect of the model adopted within the strategy, does not appear to have been translated into operational practice by local service providers. This failure suggests that the manner in which professionals within local provider services identify, and respond to, the needs of the local population is based on unspecified factors and an unclear service model. It would appear that services are not appropriately targeting those patients whose 'need' can most appropriately be met by their service area and hence the service, as a whole, is operating in a fashion wasteful of resources.
As referrers to the services, GPs have a choice of referral direction. The relationship between these choices, the service model outlined by the local mental health strategy, and the operation of established service specifications, require further investigation.

4.6.1 Conclusions: Referral direction

No differences in the measured patient characteristics were found amongst the three groups. While this result is tentative, in view of the stated local service model, further investigation of this lack of difference is required.

4.7 Methodological limitations

The sample size in the present study is limited, and the number of variables measured large. An increase in the size of the sample and the numbers in each group, would increase the power of the statistical analysis and the conclusions reached. At best the results of the present study can only be used as pointers to areas worthy of further investigation. In the present study, mental health professionals in each of the three groups were asked to request the patient to complete the questionnaires prior to their first appointment. Although detailed instructions were provided to the relevant staff, and a number of cross checks included (for example the therapist questionnaire), there is no certainty that these instructions were followed in all cases. In future research of this nature it would seem advisable to request the patient to complete the questionnaires in the presence of a researcher.
The services examined in the present study were a Primary Care Counselling Service, a secondary care Clinical Psychology Service and a Community Psychiatric Nursing Service. Referrals from GP's directly to Psychiatrists were not included in the study. While many of these referrals fall into 'group 1' (that is those with severe mental illnesses such as schizophrenia) a number of 'group 2' patients are referred directly to psychiatry. It would have been interesting to include group 2 patients referred from primary care in this direction within the study to determine the similarity (or not) of the data from this group of patients.

Data was not gathered from patients attending their GP identified as not having a mental health problem now, or in the past. Data from this group would have allowed comparison on all the variables measured and substantially strengthened the conclusions that could be drawn concerning patient characteristics within the group referred to mental health services.

Two questionnaires were developed for the present study. The therapist questionnaire was developed to collect demographic information (for example age and ethnic group), to cross check information provided elsewhere by the patient (for example use of other service) and to determine that the patient had indeed been referred to the therapist by a GP. The second questionnaire, the patient questionnaire, seeks to measure patient characteristics. Whether this set of questions generated reliable or valid data was not evaluated.

The data collected in the present study was provided by the patients referred to local mental health services. No information was collected about the referring GPs or indeed about the relationship between the GP and the patient, and factors shown to influence the onward referral of a patient to specialist mental health services to (see section 1.2.1). The
information collected within the present study thus provides some insight into one aspect of this complex jigsaw.

Cohen and Lazarus (1980) discussing coping with the stresses of physical illness state

'...we are in an early stage in the study of the powerful forces that contribute to health and well-being or to illness and distress'

(Cohen and Lazarus (1980), page 254)

This still holds true in the field of mental health and mental illness. The central questions referred to by Cohen and Lazarus (1980) are how do we measure coping and how does coping work to facilitate, or impair, an adaptive outcome? Since 1980 the Coping Responses Inventory (Moos, 1990) has become available providing a measure of 'coping'. Lazarus and Folkman (1984) outlined a comprehensive theory of stress taking into account cognitive and interactive factors. The cognitive appraisal of a stressor or stressful experience is followed by an appraisal process. Stress is the result of the individual’s appraisal of the environment as taxing or exceeding their resources, and endangering their well-being. This model proposes a link between stress, coping and consequent strain. The measures chosen in the present study focus on the two latter stages of this process. There is, however a lack of a comprehensive theoretical model linking patient characteristics (for example coping skills, interpersonal problems, social support) and the GP's decision to refer on to mental health services.
4.8 Suggestions for future research

The manner in which patients reported the category into which their problem fell, suggests that patients do not see their problems in terms of a single problem area. Forty-four percent of the present sample indicated two or more categories. It was not a stated aim of the present study to relate the category(s) in which a patient placed their psychological problem to characteristics measured by the psychometric tools used. Investigation of this relationship would be of interest and could shed some light on the complicated way in which a patient perceives, and hence reports, their mental health problem to their GP. It would be useful to determine whether the category chosen by the patient is reliably reflected in the scores obtained on the questionnaires. For example, is the patient’s selection of the category ‘interpersonal relationships’ reflected in their scores on the various subtests of the IIP (Inventory of Interpersonal Problems), and if so, in what fashion? Does this inform the choice of referral direction to a counsellor, clinical psychologist or community psychiatric nurse? Furthermore do relationships between these measures inform the appropriate treatment intervention for that patient? Similarly is there a relationship between selection of the problem category ‘anxiety and stress’ and scores on the CRI (Coping Responses Inventory) and the SOS (Significant Others Scale). The presence of reliable significant relationships between problem category, questionnaire scores, and treatment of choice could help inform referral decisions by the use, at the primary health care level, of a simple check list. Obviously, such speculation is extremely tentative and a substantial amount of empirical data investigating these relationships would be required before these relationships could be added to an acceptable theoretical model of the process of identification, referral and treatment of a mental health problem.
The importance of service evaluation has increased in recent years (Wilde and Svanberg, 1990). Few valid measures of ‘outcome’ exist for mental health services (Jenkins, 1990). In the present study a highly significant correlation (see Table K) was found between the level of distress reported by a the GHQ-12 and the patient in response to the question

‘How distressing do you find your problem in everyday life?’
(item C: patient questionnaire)

The small sample size limits the conclusions that can be drawn. However, in the absence of outcome measures, that are reliable, valid, simple to use and efficient in terms of resources, the use of the above question pre and post therapy, as a service outcome measure, invites further investigation of this specific question’s relationship to existing valid and reliable measures such as the GHQ-12.

The existence of a patient coping response profile was suggested by the examination of patient characteristic. It has been suggested that coping responses act as a ‘buffer’ moderating the impact of stressful life events (Billings and Moos, 1981). The results of the present study tentatively suggests that, not only do patients referred by GPs to specialist mental health services have cope less effectively, their skills appear to be arranged in a specific fashion. Milne (1992) suggested that a patient’s coping responses profile could be used to inform the direction of referral. To date there does not appear to be any detailed information in this area and the results of the present study can only suggest an area worthy of further examination. A more detailed inspection of patient coping profiles than that provided in the present study is warranted. Linking this to the direction of referral may shed some light on the factors influencing the referral of a patient from a primary care setting.
Of significance is the lack of difference found in patient characteristics among the three referral groups (PCCS, CPS and CPN). Local policies, referral criteria and service specifications (see Croydon Health Commissioning Agency, 1994; Smith, 1994a;) indicate that there should be a marked difference between these three groups with the PCCS seeing the group commonly labelled 'the worried well' (see Neely, 1992), and the CPNs receiving referrals of those with the most severe and enduring mental health problems (see Smith 1994a). Referrals from GPs to CPS are less definite as the service accepts referrals of both groups ('worried well' and the more severely ill) and should consequently overlap the characteristics of patients referred to PCCS and CPN. This lack of difference requires further investigation as the operation of local mental health services has been based on these distinctions. In particular, the apparent similarity between the CPN and PCCS services warrant closer examination.

Overall it would appear that the present study has raised many questions about, and aspects of, patient characteristics worthy of further investigation. There is presently a lack of theoretically based research in the area of patient characteristics and referral to mental health services. There is a need for further research in this area driven by theory.
References.


Appendices
Dear

We are hoping to find out if this service is of any use to people like yourself. It would be very helpful if you could take a few minutes to complete the questions below and give the form to...............................when you have your first appointment.

A. In which broad group do you think your problem belongs?

☐ Anxiety and stress  generalised anxiety, panic attacks, phobias, obsessional ideas, psychosomatic or stress related illness e.g. migraine, asthma.

☐ Habit disorders  e.g. smoking, eating disorders, problem drinking, drug addiction.

☐ Educational or occupational difficulties  study problems, lack of confidence and social skills, transition points in life, e.g. leaving school, change job, retirement.

☐ Interpersonal relationships  marital discord, psychosexual difficulties, antisocial and/or aggressive behaviour.

☐ Adjustment to physical illness and other life events  e.g. chronic disability, childbirth, accident, terminal illness, bereavement.

☐ Other (please state) ............................................................................... 

B. How long have you had this problem?

☐ 0-3 months  ☐ 3-6 months  ☐ 6-12 months  ☐ more than one year

C. How distressing do you find your problem in your everyday life

distressing at infrequent intervals

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
</tr>
</thead>
</table>
| significantly distressing during most of every day

D. How much improvement in your level of distress do you think you will feel immediately after your final therapy session?

☐ 0-10%  ☐ 10-20%  ☐ 20-30%  ☐ 30-40%  ☐ 40-50%  ☐ 50-60%  ☐ 60-70%  ☐ 70-80%  ☐ 80-90%  ☐ 90-100%

E. Have you had counselling for this problem before?  yes ☐ no ☐

If 'yes' with whom?

☐ private counsellor  ☐ voluntary sector worker

☐ mental health service worker  ☐ other

THANK YOU FOR YOUR HELP
Appendix B: Therapist Questionnaire.

**THERAPIST QUESTIONNAIRE**

Please fill in the following information and return with completed patient questionnaires for scoring. THANK YOU.

<table>
<thead>
<tr>
<th>Patient’s Age</th>
<th>Date of birth</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**GENDER**

- Male
- Female

**PATIENT REFERRED BY:**

- GP [ ]
- Psychiatrist [ ]
- Other [ ]

**INVolVEMENT WITh OTHER AG ENCIES**

- CPN [ ]
- Psychiatrist [ ]
- Social Service [ ]
- Voluntary Sector [ ]
- Other [ ]
- Unsure [ ]

**Patient’s Ethnic Origin**

- White [ ]
- Black African [ ]
- Pakistani [ ]
- Chinese [ ]
- Asian other [ ]
- Black Caribbean [ ]
- Indian [ ]
- Bangladeshi [ ]
- Black other [ ]
- Not given [ ]

**Date of completion.**

[ ]

**Any other information.**

[ ]
Appendix C: Explanatory letter sent to patients with the GHQ-12, IIP, SOS, CRI and patient questionnaire.

Dear

We are due to meet for the first time on

We are currently looking at ways in which our services can be improved and would be grateful if you could spend some time (about one hour) completing the attached questionnaires. The information provided will be used to help us to improve our service to yourself and others. The questionnaires are self-explanatory with instructions printed at the beginning of each one. Once completed, please bring your questionnaires with you to your first appointment.

If you do not wish to complete these questionnaires, it would be helpful if you could return your blank questionnaires to us.

If you have any problems with the questionnaires, or would like to ask some more questions, please do not hesitate to contact me on extension .

Thank you, in anticipation, for your help.

Yours sincerely
Dear
Thank you for helping with this project. We have scored the questionnaires provided recently by you and ........................................................and are pleased to report back to you the obtained scores below. As mentioned previously this information is available to you for your clinical use with this patient’s difficulties. Should you have any difficulty interpreting the information, or wish to discuss the results further, please contact me, or one of my colleagues directly.
No records will be kept by us identifying individual patients and consequently we will shortly return the questionnaires to you for filing, or disposal as judged appropriate.

<table>
<thead>
<tr>
<th>VARIABLE</th>
<th>SCORE</th>
</tr>
</thead>
<tbody>
<tr>
<td>GHQ-12</td>
<td></td>
</tr>
<tr>
<td>total IIP score</td>
<td></td>
</tr>
<tr>
<td>IIP-assertive</td>
<td></td>
</tr>
<tr>
<td>IIP-sociable</td>
<td></td>
</tr>
<tr>
<td>IIP-submissive</td>
<td></td>
</tr>
<tr>
<td>IIP-intimate</td>
<td></td>
</tr>
<tr>
<td>IIP-responsible</td>
<td></td>
</tr>
<tr>
<td>IIP-controlling</td>
<td></td>
</tr>
<tr>
<td>SOS actual emotional support</td>
<td></td>
</tr>
<tr>
<td>SOS ideal emotional support</td>
<td></td>
</tr>
<tr>
<td>discrepancy actual/ideal emotional</td>
<td></td>
</tr>
<tr>
<td>SOS actual practical support</td>
<td></td>
</tr>
<tr>
<td>SOS ideal practical support</td>
<td></td>
</tr>
<tr>
<td>discrepancy actual/ideal support</td>
<td></td>
</tr>
<tr>
<td>CRI-logical analysis</td>
<td></td>
</tr>
<tr>
<td>CRI-positive appraisal</td>
<td></td>
</tr>
<tr>
<td>CRI-seeking support</td>
<td></td>
</tr>
<tr>
<td>CRI-problem solving</td>
<td></td>
</tr>
<tr>
<td>CRI-cognitive avoidance</td>
<td></td>
</tr>
<tr>
<td>CRI-acceptance</td>
<td></td>
</tr>
<tr>
<td>CRI-alternative rewards</td>
<td></td>
</tr>
<tr>
<td>CRI-emotional discharge</td>
<td></td>
</tr>
</tbody>
</table>

Please refer to the information previously provided concerning the tests, their meaning, and how to interpret the results.

Once again, thank you for your help.

Yours sincerely,

Caron Gaw
Clinical Psychologist.