An investigation into the effects shame has on the recovery style of those individuals with a diagnosis of psychosis

by

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Submitted for the degree of Doctor of Psychology (Clinical Psychology)

Volume 1

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Thanks go to my family, they have been more understanding than I would have hoped for. I hope I have made them proud after these three years. Finally, to one last person, she has stood by me, helped me and supported me more than I can express.
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Overview

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**Critically discuss the evidence base that people with borderline personality disorder can be treated effectively by general adult mental health services.**

*What implications might this have for the provision of services?*

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**RESEARCH DOSSIER**

Overview
INTRODUCTION – VOLUME ONE

Overview

This portfolio is made up of two volumes. The volumes contain a collection of my work completed during my training on the PsychD Clinical Psychology training course at the University of Surrey. The work presented in the portfolio demonstrates the different clients, different client groups, presenting problems and psychological approaches I have experienced. Within each section the chronological order of the work that I have undertaken is kept. I have done this so I can convey a sense of development and progression in my skills and competencies, both academically and clinically.

Volume One is made up of my academic dossier, clinical dossier and research dossier. The academic dossier contains four essays which represent the four core placements and client groups. The clinical dossier is made up of summaries of each placement, four core placements and two specialist, and summaries of five case reports, four from my core placements and one from a specialist placement. The research dossier is made of the Service Related Research Project from Year One and the Major Research Project from Year Three.

Volume Two gives my extended clinical dossier. The volume is made up of the full case reports from each of my four core placements and one case report from a specialist placement. The volume also contains documents from each of my
placements, which include, placement contracts, evaluation forms, summaries of clinical activity, logbooks of clinical experience and samples of correspondences.

As Volume Two contains confidential clinical material it is held in the Clinical Psychology Department at the University of Surrey.
Overview

Essays from the four core client groups are contained in the academic dossier. The core client groups are as follows:

1. Adult mental health
2. People with learning disabilities
3. Children, adolescents and families
4. Older people

These essays critically evaluate certain psychological theories, models and interventions relevant to the different core client groups and how these approaches are relevant across the lifespan and applicable within psychological clinical practice. Each essay was written whilst I was on the corresponding core placement.
Critically discuss the evidence base that people with borderline personality disorder can be treated effectively by general adult mental health services. What implications might this have for the provision of services?

January 2003

Year 1
Adult Mental Health Essay

Introduction

In 2001, Bender and her colleagues commented that, 'the nature, severity, and varying phenomenology of the borderline personality disorder diagnosis continue to pose significant challenges to treating clinicians' (Bender et al., 2001; p.300). This comment typifies recent thinking in treating those people with a diagnosis of borderline personality disorder (BPD). It is also a good place to start this essay as it highlights the difficulty in defining BPD and the problems that are faced in treating individuals with this disorder.

Outline of the essay

In order to critically discuss the evidence base that people with BPD can be effectively treated by general adult mental health services (GAMHS), this essay will be structured in the following way; first, the concepts will be defined, this will include the current popular definition of BPD and what is understood by the term GAMHS. Secondly, the evidence base of effective treatments of BPD will be discussed and critically evaluated, as well as the relevant issues concerning treatment. Thirdly, any effective services that have been identified will be examined in terms of where and how these services are provided and whether this provision can be undertaken by GAMHS; thus answering the question whether GAMHS can provide the necessary treatment that has shown efficacy in treating people with BPD. Finally, given the discussion generated by the first three points, the provision of services for people with BPD will be
investigated. This will be examined in terms of resources, staffing, knowledge base and skills.

**Current Definitions of BPD**

One of the first times BPD came into formal nosological being was in the third revision of the Diagnostic and Statistical Manual of Mental Disorders (DSM-III), written by the American Psychiatric Association (APA, 1980). The term borderline personality was in use before then, but was more of a psychoanalytic concept (Mohan, 2002). With the advent of DSM-III, borderline personality became a more descriptive term with its own symptoms and behaviours.

Along with the DSM-III came the multi-axial classification, where an individual can be diagnosed on a number of domains or axes. Axis I being where mental illness is diagnosed, such as mood disorder, schizophrenia and anxiety states. Axis II where personality disorders (PD) are diagnosed, these being seen as characterological pathologies. In this way an individual can have more than one diagnosis.

In the current revision of the DSM (DSM-IV; APA, 1994) BPD is one of 10 PDs and falls within the cluster of disorders that are labelled dramatic, emotional or erratic. The main features that contribute to the diagnosis of a PD are, inner experiences and behaviour that deviate from an individual’s cultural expectations. This pattern is inflexible across a range of personal and social situations and also leads to clinically significant distress or impairment in social, occupational and other important areas of functioning. The pattern is thought to be stable and of long duration (APA, 1994).
To receive a specific diagnosis of BPD the individual must have a pervasive pattern of instability of personal relationships, self image and affect, and also demonstrate marked impulsivity. In terms of criteria, five out of the nine variables must be met to receive a diagnosis, these include: suicidal behaviour, chronic feelings of emptiness and efforts to avoid real or imagined abandonment (APA, 1994).

One factor analytic study of the DSM criteria of BPD revealed three factors underlying the disorder (Sanislow et al., 2000). These were disturbed relatedness (characterised by unstable relationships, identity disturbance and chronic emptiness); behavioural dysregulation (seen in impulsivity and suicidal/self mutilative behaviour); and affective dysregulation (shown in affective instability, inappropriate anger and efforts to avoid abandonment).

BPD has been found to have a general population prevalence of 2% and is predominantly diagnosed in females, seen in about 75% of cases (APA, 1994). There is also high degree of comorbidity with other psychiatric conditions (Mohan, 2002) and other personality disorders (Haw et al., 2001).

The tenth revision of the International Classification of Mental and Behavioural Disorders (ICD-10) compiled by the World Health Organisation (WHO, 1993) is similar to the DSM-IV criteria, but subsumes the borderline type under the broader diagnosis of the emotionally unstable personality disorder. The ICD-10 is only briefly mentioned here as all of the studies quoted in this essay use the DSM criteria.
Though it is beyond the scope of this essay, the DSM system is not without its criticisms, only a couple are briefly mentioned here. As the definition of a PD is culturally based, the diagnosis then operates on the deviant assumption. Critics therefore believe the DSM is the medical profession’s moral judgement discriminating against those who break social rules (Pilgrim & Hewitt, 2001). Additionally, in order to fulfil the diagnosis of a BPD, individuals have to meet five out of the nine criteria. In this way the diagnosis for different people can be achieved with barely overlapping symptomatology. With such heterogeneity of one diagnosis the reliability of the concept can be readily compromised (Higgitt & Fonagy, 1992). There is also debate as to whether PDs are a form of mental illness (Kendall, 2002).

**Definition of general adult mental health services**

In trying to define what GAMHS are it seems prudent to initially define what these services are not, namely specialist services. In this country the Department of Health (DoH, 2002a) defines specialist services as those services caring for people with serious and complex mental health needs. These services are sometimes seen as tertiary referral services. The DoH (2002a) lists ten specialist areas, the most relevant of these to this essay and the issues of BPD are; Specialist Psychological Therapies (in-patient and specialised out-patient), and Complex and/or Treatment Resistant Disorders.

For the purposes of this essay, a working definition of GAMHS will be outlined here. These services include primary care services, such as GP surgeries, and secondary care services, such as Community Mental Health Teams. It also includes in-patient
and out-patient settings which can be hospital or community based. It also includes the resources, staffing, knowledge base, skills and experience found within these kinds of services.

The appropriateness of treating BPD whether it be within GAMHS or specialist services will be examined after assessing whether there are any treatments that are effective for BPD.

**Treatment of BPD**

Using the formal criteria to diagnose BPD, it has been mentioned that this condition can present itself in a number of ways and by its nature is a pervasive, long-standing condition. Given such an amorphous presentation and pervasive condition this would inevitably make treatment planning and treatment process a fraught task. Even then, the question remains of whether a personality, albeit pathological, can be changed.

Before this essay looks at those treatments that specifically target BPD, it is worth commenting on how people with BPD use mental health services.

**Treatment use and therapy issues**

Studies have shown that people with BPD are heavy users of mental health services. Bender *et al.* (2001) found that people with BPD received significantly more psychosocial treatment, such as individual psychotherapy, group psychotherapy, out-patient treatment and in-patient treatment, than people with major affective disorders or other PDs. Interestingly, people with BPD were more likely to have used more
different types of medication than people with a depressive disorder. Zanarini et al. (2001) found similar outcomes when they compared people with BPD to other PD controls. Skodol et al. (1983) again found the same results when they compared treatment histories of people with BPD to those with neurotic/other PDs and people with schizophrenia. They found in their sample half of the people with BPD had been hospitalised and at a younger age than those people with schizophrenia. These authors concluded that people BPD are more disturbed than their other samples. Indeed, Hull et al. (1996) found that the co-existence of anorexia, psychotic symptoms and suicidal behaviour was more likely to increase hospitalisation for people with BPD.

Attrition rates from therapy are also high. Gunderson et al. (1989) found that 60% of their hospitalised patients with BPD dropped out of psychotherapy. Chiesa et al. (2000) found that people with BPD were more likely to drop out of a 12-month in-patient psychotherapy hospital than those with other PDs.

In her qualitative study of mental health case managers, Nehls (2000) found some of the inherent difficulties in caring for those with BPD. Problems arise around the relationship between the care manager and person with BPD. This is perhaps unsurprising as disrupted interpersonal relatedness are part of the borderline diagnosis (Sanislow et al., 2000). Case managers feel threatened when their professional boundaries are pushed and uncomfortable when symptoms of BPD become more acute, such as acts of self-harm.

Oldham et al. (2001) also warn that splitting within mental health teams can also occur. Part of the process of affective dysregulation is that people with BPD can
sometimes see people or situations as either all good or all bad. So if the person with BPD treats one member of the team in an idealised fashion and another in a devalued way, then this can cause internal professional divergences.

Higgitt and Fonagy (1992), utilising psychodynamic concepts, warn of dangers the psychotherapist could face in seeing an individual with BPD in therapy. The individual with BPD, through projective identification, can relocate persecutory feelings within the therapist, and so the therapist becomes the bad object and treated as such. Through the mechanisms of counter transference negative feelings can then be attributed back to the individual with BPD, thus leading to a downward spiral in the therapeutic relationship, disrupting all contacts.

For the therapist to witness the affective and behavioural dysregulation of BPD, such as anger, parasuicidal acts or impulsivity, this can be challenging, especially whilst they are trying to foster a therapeutic relationship and offer containment. Therefore the therapeutic process can be difficult to negotiate for both the therapist and the individual with BPD. A skilled therapist would need to understand what is happening in the relationship and the underlying processes, else they may encounter the difficulties that Nehls (2000) has described, which could be counter-productive. To help with this, regular and competent supervision would appear essential.

BPD has been found to have an effect on the treatment of comorbid diagnoses. Ball et al. (2000), in treating depression, found that people with BPD, as well as other PDs, comorbidly diagnosed with depression had lower rates of recovery, than those with just a diagnosis of depression. Shea et al. (1990) also had similar findings.
These findings highlight the difficulties services have when attempting to meet the needs of people with BPD. With over use, erratic use and disruptive use of services, combined with the issues of severity of presentation and comorbidity, has led some to believe that BPD is an untreatable condition (as discussed in Adshead, 2001) or that treatment success is of limited value (Waldinger & Gunderson, 1984). People with BPD were seen to be so badly damaged (Stevenson & Meares, 1992) and so chaotic that they would be difficult to engage in exploratory psychotherapeutic work (Cookson et al., 2001). In such a situation, frustration can be felt by services in their inability to do anything useful, thus leading to negative attributions of people with BPD (Norton & Hinshelwood, 1996). Bender et al. (2001) have commented that services are inadequate in treating BPD given its severity and persistence, and they also question the appropriateness of existing treatments.

All these issues are relevant to GAMHS, but also lead to a rather bleak picture as to the availability and efficacy of treatments of BPD; effective treatments would, for example, be expected to lower service use. However, this bleak picture is beginning to change. Only recently have there been some emerging studies that show positive outcomes in the treatment of BPD.

Recently, guidelines have been published that detail appropriate treatment strategies for BPD (Oldham et al., 2001). However, some feel this is a little premature (McGlashan, 2002) as only limited evidence is available. These positive findings are still in the early stages of development as only a handful of studies have been
reported, and even these have a number of methodological limitations. These limitations will now be discussed.

**Problems with the research on the treatment of BPD**

As Bateman and Fonagy (2000) note, few of the studies reach the requirements that contribute to an evidence based clinical discipline. There is a paucity of randomised controlled treatment (RCT) trials. Whilst some of these studies do exist (for example, Bateman & Fonagy, 1999), others compare one treated group pre- and post-therapy (such as, Stevenson & Meares, 1992) or compare to treatment as usual (TAU) or a standard care group (for example, Evans et al., 1999). With these studies ethics must be considered, treatment cannot be withheld from individuals, hence the use of particular control groups (Dolan et al., 1997).

There is also no set method that defines treatment effectiveness. Some studies use standardised assessment scales (Chiesa & Fonagy, 2000) whereas others use criteria such as whether participants still fulfil the DSM diagnosis (Stevenson & Meares, 1992). This lack of agreement makes comparisons between studies difficult.

Perry et al. (1999) have found that some investigations combine all PDs into one group (for example, Chiesa et al., 1996). This added to the issue of comorbidity between PDs and Axis I diagnoses and can have a consequence of obscuring or exaggerating treatment effects (Bateman & Fonagy, 2000), especially when examining for effects on a specific disorder. As BPD itself has a heterogeneous
presentation, some studies have tended to focus on specific symptoms, for example, parasuicide (Linehan et al., 1991).

As with any treatment trial attrition is always a problem, this is made more acute when considering BPD. It has already been discussed that high rates of attrition occur from standard care. Combine this with the problems of maintaining a treatment trial then a number of participants can drop out. Even without attrition rates, participant rates can be rather small (for example, Cookson et al., 2001).

However, even with these difficulties positive findings have emerged, which will be discussed now. These are divided up into their treatment orientations.

**Psychoanalytic psychodynamic therapy**

Bateman and Fonagy (1999) investigated the effectiveness of psychoanalytically informed partial hospitalisation (day hospital) in the treatment of BPD. Two groups were randomly allocated, one to partial hospitalisation, the other to standard care, which acted as the control group. The treatment group received individual psychoanalytic therapy, expressive therapy, and had a community meeting once a week; group analytic therapy three times a week; had meetings with their care coordinator and had a medication review once a month. This kind of psychoanalytic therapy views BPD as a disorder of attachment, separation intolerance and the inability to think about others’ state of mind and about oneself in relation to others.
The control group received regular psychiatric review, in-patient admission where appropriate, out-patient and community follow up and no psychotherapy. The investigation lasted 18 months. The outcome measures used were; number of acts of self-harm, subjective symptom experience, measures of depression, anxiety and social adjustment, length and number of in-patient episodes, and need for medication.

Participants in the treatment group demonstrated significant reductions in all outcome measures when compared to the control group. In a follow-up study to their original investigation, Bateman and Fonagy (2001) found that these improvements for the treatment group were maintained over 18 months. Indeed, they even found that more clinical gains were made over this period, thus showing the effectiveness of this type of treatment for people with BPD.

Stevenson and Meares (1992) employed the psychology of the self in their investigation of the treatment of people with BPD. This is based on the theory that BPD stems from a disruption in the development of the self. Therapy is seen to be maturational, giving space for the individual to integrate their own personal reality. In their study people with BPD were given twice weekly out-patient psychotherapy.

Outcome measures included frequency of drug use, number of visits to mental health professionals, number of episodes of violence and self-harm, time away from work, number of hospital admissions, length of time as an in-patient and subjective measures. The study used a repeated measures design, participants were tested pre- and post-treatment, and where appropriate, measures were taken in the year prior to therapy and then the year following therapy. Psychotherapy lasted 12 months.
Over the treatment year statistically significant improvements were made on all measures, gains which were maintained in the year following therapy. In an additional study, Meares et al. (1999) compared this treatment group to a waiting list control group, receiving TAU; 30% of the treatment group no longer fulfilled the DSM criteria for BPD, there was no change in the TAU group.

_Therapeutic communities_

The idea behind treatment within a therapeutic community follows on from psychoanalytic psychodynamic concepts. These types of community offer integrated psychosocial treatments within a social milieu of personal responsibility (Dolan et al., 1997; Hafner & Holme, 1996), fostering understanding of maladaptive patterns of behaviour (Chiesa et al., 1996).

One of the major problems with the studies of therapeutic communities is that all PDs are combined, thus obscuring the presence of treatment effects between disorders. However, people with BPD usually make up the majority of the sample in these studies (Hafner & Holme, 1996) which merits discussion of their findings.

Dolan et al. (1997) compared people admitted to a therapeutic community with those that were not, on a subjective measure of borderline symptoms. This measure was taken at referral and again at either one year post-treatment or one year post-referral. Those in the admitted group demonstrated a significantly greater reduction in borderline symptoms than those not admitted.
Chiesa et al. (1996) compared a pre-treatment group with a post-treatment therapeutic community sample one year after treatment cessation. The post-treatment group showed a significant decrease in their use of medical and psychiatric services, relied less on psychotropic medication, and were more likely to be employed.

Borderline participants made up 71% of the sample used in the Hafner and Holme (1996) study, which used a repeated measures design. With an average stay of 64 days within a therapeutic community the level of self reported psychiatric symptoms fell significantly from admission to discharge and significantly again at a three month follow-up. Hospital admission rates also fell in the year following discharge.

Chiesa and Fonagy (2000) compared two types of treatment model of a therapeutic community. The first being a one-stage treatment model, an 11 to 16 month in-patient stay with no follow-up, and the second a two-stage model, 6 month in-patient stay with 12 to 18 months of community follow-up. Whilst both models showed improvement in levels of functioning and social adjustment, the participants in the two-stage model made more significant improvements. This finding was found to be especially relevant for people with BPD.

_Cognitive behaviour therapy_

Whilst the theory behind the treatment of BPD with cognitive behaviour therapy (CBT) had been set out and proposed (Beck, 1998), there has been few studies investigating its usefulness (Linehan, 2000). There is, however, one form of CBT,
though it incorporates other types of therapy (Scheel, 2000), which has been labelled Dialectical Behaviour Therapy (DBT).

To outline DBT, it is a therapy that utilises cognitive and behavioural strategies. It views BPD as a disorder arising from emotional dysregulation combined with an invalidating environment (Scheel, 2000). The dialectic stems from accepting the person as they are whilst also encouraging a process of change (Swales et al., 2000). DBT uses four modes of treatment; weekly group skills training, weekly individual therapy, telephone contact with the therapist when needed, and weekly group supervision sessions for therapists. DBT was initially used to help treat parasuicide in people with BPD (Linehan, 2000).

In the first randomised control study Linehan et al. (1991) compared two groups of people with BPD. The first was treated with DBT and the second underwent TAU. Treatment lasted for one year. Those participants who received DBT had significantly fewer parasuicidal acts and less medically severe parasuicides. They also spent less time as in-patients. No differences were found between the groups on measures of depression, hopelessness and suicidal ideation. On further examination of the data, Linehan et al. (1994) found that the DBT group achieved significantly better scores on measures of anger, social adjustment and levels of functioning.

In a follow-up study conducted one year later, Linehan et al. (1993) found that the benefits for the DBT group generally held. Improvements were found in levels of functioning and employment performance, though in the last 6 months of follow-up numbers of parasuicidal acts between the groups evened out.
In an independent study of DBT, Koons et al. (2001) compared two groups of people with BPD; one receiving DBT, the other, TAU. Treatment lasted 6 months. Compared to the TAU the DBT group showed significant decline in suicidal ideation, depression, hopelessness and anger expression. From pre- to post-treatment the DBT group demonstrated significant reductions in the number of parasuicidal acts and number of hospitalisations.

Evans et al. (1999) also found evidence for the effectiveness of DBT (compared to TAU) in treating those people who repeatedly self-harm by reducing the number of parasuicidal acts. Low et al. (2001) also found similar results.

**Cognitive analytic therapy**

Cognitive analytic therapy (CAT) has been proposed as a treatment for BPD (Ryle, 1997). CAT views BPD as a partial dissociation of the personality into self states that are characterised by mood. Therapy involves the identification of these states and the switching between them to the goal of integrating them. Only one study has been carried out assessing the effectiveness of CAT (Ryle & Golynkina, 2000) which found that after 26 sessions of CAT approximately half their participants no longer fulfilled the criteria of a diagnosable BPD. Other studies using case studies have shown fairly limited success (Beard et al., 1990; Ryle & Beard, 1993).
Psychopharmacology

There have been two recent reviews outlining the effective use of medication in treating BPD (Grossman, 2002; Soloff, 2000). Summarising these reviews it appears that no medication is effective across the symptom domains of BPD. Anti-depressants can be used to treat depressive type symptoms or co-morbid Axis I diagnoses. Low dose neuroleptics can be used to treat transient psychotic or acute states, though this should only be in the short term. Both Grossman (2002) and Soloff (2000) conclude that medication should only be seen as adjunct to ongoing psychotherapeutic work.

Summary

Though these studies are not without their flaws, it is clear however, that BPD can be effectively treated, especially in the case of psychoanalytic psychodynamic therapy and DBT. In reviewing the evidence, Bateman and Fonagy (2000) point out the evidence does not indicate the superiority of one type of therapy over another, nor whether in-patient or out-patient is a preferred method of treatment. Future studies should compare treatment models or, as a starting point, replicate these positive findings.

Treatments of BPD and the application to general adult mental health services

As the effective treatments of BPD have been reviewed, this essay now discusses if these treatments can be given in a general adult mental health setting. In order to do
By their nature therapeutic communities are specialist services and so are not compatible with the GAMHS model. However, psychopharmacology can be more readily provided by GAMHS, as long as medication options are known. As medications should be adjunctive, they in themselves do not act as wholly effective treatment.

Psychoanalytic psychodynamic therapy, DBT and CAT all require specialist knowledge. They require lengthy training, specific skills and adherence to a theoretical model (Bateman & Fonagy, 2000). These therapies also require a lot of therapist time and investment, both for seeing clients and the supervision that is involved, a service GAMHS may not be able to provide due to the pressure of reducing waiting lists and maintaining caseload numbers.

As it stands GAMHS do not have the type of knowledge and skills these effective therapies require. Workers can be trained in these techniques, for example DBT is manualised, however, this must be weighed up against the costs of doing so. GAMHS may not have the spare time that staff can give, or the monetary funds that can be given over to the training and undertaking of these types of therapies. The costs of treating one specific disorder has to be seen in relation to treating other disorders.

There may also be the possibility that staff and managers may not want to invest their time and money into the treatment of people with BPD. As already discussed, there is
still a prevailing view that BPD is untreatable and even with treatment, people with BPD still pose significant challenges. If frustration with this ensues then this can engender an unwillingness to engage with this client group (Nehls, 2000; Norton & Hinshelwood, 1996). Splitting in the team can also become disruptive. To help overcome this supervision can be provided, but this would require specialist skills.

GAMHS can provide some form of effective treatment for people with BPD. Adjunctive medication would be the first of these. These services could also respond to the short term, immediate needs of people with BPD. For example, if an individual with people with BPD was experiencing a transient dissociative episode, or self-harming, GAMHS can respond quickly by either offering support or an in-patient stay. However, this can only be seen as an interim measure helping people with BPD through a series of crises and not treating the underlying pathology (Norton & Hinshelwood, 1996). As Bateman and Fonagy (2000) note, change in therapy for people with BPD occurs over a longer period of time. So unless people with BPD receive these longer term effective therapies they will continue to put pressure on GAMHS through their untreated needs.

Training for mental health workers could be provided so that they can recognise people with BPD and refer them on to the appropriate treatment. Through education and support, professionals can be helped to understand the impacts of working with people with BPD (Adshead, 2001), which can help ameliorate some of the negative feelings GAMHS have towards this client group.
As Adshead (2001) notes, specialist services for people with PD can offer interventions that GAMHS cannot. Indeed, given the nature of BPD and the way the DoH (2002a) define specialist services, in providing specialist psychological therapies and caring for complex disorders, the government appears to currently perceive the effective treatment of BPD taking place within specialist services. However, the government does recognise that CMHTs do have a role to play in the ongoing treatment of people with BPD (DoH, 2002b).

**Provision of services**

The above discussion appears, on the whole, to point to the effective treatment of people with BPD taking place within specialist services, though GAMHS can play an important role. This does have one caveat in that this conclusion is based upon current knowledge, which is still in the early stages of development and can change. The implications of this will now be discussed.

With this conclusion, it can cause a perception in the divergence of services. However, as Bateman and Fonagy (2000) point out, competent treatment of BPD is found in well integrated services that are available to the individual. Therefore, there needs to be good communication and joint working between GAMHS and specialist services.

The current climate of the National Health Service (NHS) is moving towards cost effectiveness of efficacious treatments. In light of this there have been financial costing studies examining the therapies detailed above.
In a cost analysis follow up of their initial studies, Stevenson and Meares (1999) compared the cost of treating their sample one year before therapy to one year after therapy. Factoring in the cost of therapy they found the average cost saving per patient one year after therapy was $8431 (Australian). A later study (Hall et al., 2001) found that the largest savings were made in those people who were high users of hospital services.

In a cost analysis of a therapeutic community, Dolan et al., (1996) found that in the year prior to treatment service cost for their sample was £13966 compared to £1308 in the year following therapy. Though the cost of the specialist admission was £25641, the authors predicted the saving would be recouped within two years, presuming the effects of therapy were maintained.

In a comparison of a therapeutic community with two day hospitals in the treatment of PD, Chiesa et al. (2002) found no differences in the improvement of symptoms, but that the day hospitals were significantly cheaper in providing services than the therapeutic community.

Linehan (2000) found that DBT was cost effective in her initial treatment group. She found that GAMHS costs reduced by 58% following treatment.

These studies, whilst showing that therapies are expensive, also demonstrate they are cost effective. Savings are made in reducing the use of GAMHS by people with BPD after they have been successfully treated.
Drawing the work together on treatment and cost effectiveness in terms of service provision for people with BPD: there are currently few therapists trained in DBT, there are not many therapists available to the NHS to carry out longer term psychoanalytic work, and there are few therapeutic communities in this country. It would therefore seem prudent to make extra funding available to set up or expand these services, as they are cost effective, or at least make these services and therapies more available to GAMHS, thus taking the pressure off of GAMHS and effectively treating people with BPD.

**Conclusion**

At this current time the effective treatment of people with BPD is a rare commodity. As work in this area is continuing, some of the skills and knowledge found should start to filter down to GAMHS. However, given the complex needs and presentation of people with BPD, specialist services are in the best position, in terms of staff, knowledge, skills and costing to currently provide the most effective care and should receive the appropriate funding. Unfortunately, these services are not readily available so the GAMHS are left struggling to care for this group of people with complex needs.
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Critically assess current assessment and treatment initiatives for people with learning disabilities who show offending behaviour.

August 2003

Year 1
People with Learning Disabilities Essay

Introduction

Over the past decade there has been an increase in the volume of research investigating issues of offending behaviour shown by people with learning disabilities (LD) (Lindsay, 2002b). Prior to this, there was a steady, though limited, output of literature (Simpson & Hogg, 2001a). This essay aims to examine this growing area of research paying particular attention to assessment and treatment initiatives. Other issues will also be considered. These are relevant to the essay as they are matters currently being discussed and resolved in this developing literature which impact assessment and treatment efforts. Their connections with the main aims of this essay will be drawn out.

Definitions and terminology

This essay will use the British Psychological Society’s (BPS; 2000) definition of people with LD. The BPS states that those considered to have a learning disability should ideally fulfil three criteria. Firstly, there should be a significant impairment in intellectual functioning. This is, on the whole, determined by having an Intelligence Quotient (IQ) score below 70, as measured by the Wechsler Adult Intelligence Scale-3rd Edition (WAIS-III; Wechsler, 1999) or its predecessor. Secondly, there should be a significant impairment in social/adaptive functioning. Finally, the age of onset must be prior to adulthood.
The literature often uses terms such as mental retardation, mental handicap and intellectual disability. These are synonymous with learning disability, which will be the preferred term throughout.

Outlining such definitions now helps to assess the quality of the research projects for people with LD. In the studies that will be reviewed, inclusion criteria of people with LD can tend to become vague and flexible, and hence problematic. Often individuals with an IQ above 70 are included, and that is when IQ is used. Additionally, there is hardly any mention of social/adaptive functioning.

The term offending behaviour will be used to refer to those alleged behaviours that are considered to unlawful, regardless of whether the individual enacting them is prosecuted or not. The term offender will only be used to refer to those individuals who have been prosecuted for their behaviour, otherwise it will be alleged offender.

**Historical Perspective**

In the early twentieth century there was a widespread belief that people with LD, then labelled as the feeble-minded or mentally deficient, and people with mental health problems were more likely to engage in criminal behaviours (Murphy & Mason, 1999). With the support of the eugenics movement feeble-mindedness became synonymous with criminality (Holland et al., 2002). So widespread and influential was this belief that Acts of Parliament, such as the Mental Deficiency Act of 1913, were passed which paved the way for the segregation of people with LD from the rest
of society (Holland, 1998). This led to the expansion of institutions that housed people with LD (Holland et al., 2002).

These discriminatory beliefs were challenged during the 1950s and 1960s (Turk, 1989) but the segregation continued. Not until the full advent of deinstitutionalisation, particularly in the 1970s and 1980s, did beliefs and practices start to change (Caine et al., 1998). This was fuelled by the ideas of normalisation, scandals within the institutions, and the civil rights movement of people with LD (Mason & Murphy, 2002a). Combined with government policy, the physical segregation of people with LD from the rest of the community started to dissolve.

With more community presence the long-standing assumption that people with LD have the propensity to commit crime could be more closely examined. This has helped to increase the amount of published material in the area of offending and LD as Lindsay (2002a) has noted. As more people with LD were in the community there was the possibility, as with all members of society, of engaging in criminal behaviour. Whether people with LD are more or less likely to do this will be addressed below.

If people with LD do commit crimes the government has taken the initiative (for example, Department of Health & Home Office, 1994) to recommend that they are diverted away from prison and towards multi-agency social care. As a consequence, there has become the need to devise effective assessment and treatment strategies for offending behaviour, giving more impetus for research to be carried out.
Prevalence

One of the benefits in calculating the numbers of people with LD who engage in offending behaviour is in service provision. Specialist services can be set up that assess and treat, once the size and characteristics of the target population have been established. However, there is confusion in the literature that makes finding the size of this population a difficult task to complete. This area of research seems to be plagued by inconsistency and methodological problems. The assumption that people with LD are likely to commit more than their fair share of crime seems to overshadow this work.

It is beyond the scope of this essay to present a full review of prevalence studies. However, relevant issues and reviews will be discussed.

Methodological Issues

When researchers have approached the question of the prevalence of alleged offenders or offenders with a LD McBrien (2003) has noted two themes of inquiry; those which ask how many alleged offenders or offenders have LD, and, those that ask which people with LD engage in offending behaviour. Regardless of how the question is asked Lindsay (2002a) comments that all the research encounters three methodological issues that need to be resolved; firstly, the inclusion criteria of the sample under study, which includes the level of IQ and type of offending behaviour. Secondly, where the sample is drawn from and thirdly, the method by which the level of learning disability is determined. Simpson and Hogg (2001a) add that research has to deal with different criminal justice systems (CJS) and different LD services in
different areas. How each study copes with these issues can either help or undermine the findings.

**Prevalence studies**

There have been three recent reviews examining the prevalence of people with LD in the offender population (Holland *et al.*, 2002; McBrien, 2003; Simpson & Hogg, 2001a). They show that rates vary from 0 to 21%. These authors comment that the rates vary so much due to the issues in methodology not being resolved adequately. LD was determined by a number of measures, such as; self report tools, which can over-estimate prevalence of LD (Winter *et al.*, 1997); specially designed measures (for example, Mason & Mason, 2002b) and use of the WAIS. There is sparse mention of social and adaptive functioning.

Simpson and Hogg (2001a) notice a complicating factor that could affect prevalence figures. They say that a lot of behaviours that are technically criminal are going unreported. For example, services for people with LD have a high tolerance for would be offending behaviour, as staff are unsure what constitutes an offence or find reasons to excuse it (Holland *et al.*, 2002; Lyall *et al.*, 1995). Additionally, the police can also overlook infringements of the law (Swanson & Garwick, 1990). In the Lyall *et al.* (1995) series of studies, these researchers found that those people in residential LD placements who were interviewed by police for alleged offences, none went to court. Furthermore, they found that people with a LD who appeared in court, none received a prison sentence and were diverted to the health service. This demonstrates that people with LD are dropping out of the CJS which would inevitably have an effect on prevalence rates.
Murphy and Mason (1999) note that it is possible that people with LD are not as successful at evading police detection than their non-LD counterparts. They could also be more visible and vulnerable to arrest (Thompson & Brown, 1997). Again, this would have an effect on prevalence rates.

In summary, there are factors that indicate that people with LD can be more likely to come into contact with the police, as well as factors which could make them less likely. Combined with the methodological problems in the research this has led to confusion in this area.

McBrien (2003) has concluded that the answers to the prevalence question remain elusive. Other authors (Lindsay, 2002b; Simpson & Hogg, 2001a) conclude that there is no convincing evidence that the prevalence of offending among people with LD is higher than that found in the general population and that this group of people are not over-represented in the CJS.

At the end of her review and study, MacEachron (1979) concludes that social and legal factors are more relevant to the problem of offending behaviour rather than intelligence. Fraser (2002) notes that it appears that it is people who are intellectually disadvantaged rather than people with LD who are over-represented in the criminal justice system. Turk (1989) comments that there are a number of factors that predispose individuals to criminal behaviour. Knowing such factors can help inform risk assessment initiatives. Furthermore, these factors should be considered when treatment strategies are being devised.
Two final points need to be made to conclude this section. The first comes from Mason and Murphy (2002a). These authors note that it is becoming apparent that few people with LD are being sent to prison, as shown in the Lyall et al. (1995) study. This appears to be following the recommendations made by the Home Office (Circular 66/90, 1990), and Department of Health & Home Office (1994). This is where individuals identified as having a LD should be diverted away from the CJS and towards appropriate health or multi-agency care. This builds upon legislation of the Mental Health Act (Department of Health, 1983) which identifies routes how offenders with mental subnormality (which roughly equates to people with significant or mild LD) can be transferred to health services. Judging by these government publications it is hoped that these people are diverted before court proceedings.

Barron et al. (2002) note that the offending behaviour of people with LD present ethical problems for the CJS. In English law a crime in not only defined by a behaviour or its consequence (Clare & Murphy, 1998). Human agency is one of the other factors that is also required (Jahoda, 2002). A guilty state of mind (mens rea) is needed, such as the intention to do something (Clare & Murphy, 1998). In regards to this issue of criminal responsibility the recommendations are that those identified with a LD are diverted towards healthcare and community based intervention. This then places the ethical dilemma upon the service providers, where assessment and treatment is required for those who may or may not recognise that they have done wrong.
The second point is made by Fraser (2002) who remarks that there appears to be a lowering of public tolerance to offending behaviour, particularly sex offending. As a response there are proposed moves towards more public protection. With proposals for broader mental health legislation this could lead to a re-expansion of the institutional models of care (Holland et al., 2002). This makes the mandate for effective assessment and treatment more pressing, demonstrating that people with LD can be managed under the current service provision set-up.

**Characteristics and type of crime**

As with prevalence studies, determining the characteristics and types of crime people with LD engage in can help assessment and treatment initiatives, helping the direction of where service provision should be aimed. However, as with the prevalence studies, there are no clear cut findings.

A whole number of factors have been identified that may make people with LD more vulnerable to offending (Murphy & Mason, 1999). However, as there are so many, any conclusions are unworkable. Simpson and Hogg (2001b), in their summary of this research conclude that it is not possible to make any firm statements about the characteristic profile of a typical offender with LD. Nonetheless, a history of behaviour problems, homelessness and low socio-economic status may be associated with a propensity to offend.

In regards to types of crime, there were early indications that suggested people with LD were more likely to commit sexual offences (Day, 1994) and arson (Lund, 1990).
However, these studies have been criticised by their use of bias samples from which their study population is drawn (Lindsay & MacLeod, 2001). Simpson and Hogg (2001a) conclude that people with LD are under-represented in more serious offences, such as murder and armed robbery. They also note that offending is rare if an individual's IQ is below 50. This suggests that treatment should be designed for those with mild LD.

One clear finding is that the majority of offending behaviour is committed by men with LD (Kearns & O'Connor, 1988). There may also be an effect of age, as people with LD commit crimes at an older age than their non-disabled counterparts (Hodgins, 1992). Again, this would affect assessment and treatment initiatives.

Assessment of people with LD who show offending behaviour

There is only a limited amount of literature regarding the assessment of people with LD who show offending behaviour. This essay will identify four areas of research in relation to assessment initiatives. These are, the assessment of people with LD entering the CJS; the assessment of vulnerability within the CJS; forensic and clinical risk assessment; assessment for treatment. Assessment to stand trial can also be considered, but this area will not be discussed as diversion options are available. This kind of assessment can also generally fall under the following.

Assessment entering the CJS

This area is concerned with the identification of people entering the CJS who have LD. On the whole, this was examined above in the prevalence section. One of the
issues raised was that how could the identification of people with LD be made more robust, so that this group can be diverted out of the CJS. This is instead of using screening questions such as asking the individual if they attended a special needs school, which can be unreliable (Lyall et al., 1995), or using the WAIS, which only Clinical Psychologists can use.

Mason and Murphy (2002a, b) have recently reported the creation and use of a screening tool to assess for LD. The tool uses a vocabulary and clock drawing test and shows good concurrent validity with the WAIS. It correctly classified 87% of participants with or without a LD. However, in this study the researchers used a comparable WAIS cut off score of 75 to classify LD, which is above usual classification for LD. Additionally, the successful classification rate of 87% may be too low, indicating that some people will be missed and hence their needs not met.

Hayes (2002) reports the development of the Hayes Ability Screening Index (HASI). It is designed as a screening tool that can identify individuals for further diagnostic assessment. The HASI employs tests that assess both intellectual and adaptive functioning. On examination it was found it could correctly identify 73% of participants in regard to intellectual functioning. Though not perfect in identification, the HASI does offer a rounded assessment.

The creation of these kinds of assessment and screening tools is a step forward in identifying LD. However, these are in the early stages of development and need further evaluation and refinement. It should also be inherent in such tools that they are quick and easy to use, conducive to those administering them. Police stations, courts
and probation services are busy systems and any unwieldy tools are unlikely to be adopted.

**Vulnerability within the CJS**

Gudjonsson and his colleagues (for example, Clare & Gudjonsson, 1993, 1995) have highlighted the vulnerability of people with LD within the CJS. From their research study interviews they have found that people with LD, compared to non-LD sample, were more susceptible to leading questions, confabulated more and were more acquiescent. This suggests that people with LD are more likely to make erroneous testimony during police interrogation. It is thought that this is likely to be due to the naivety of people with LD in recognising the seriousness of the situation and lack of understanding as to the consequences of their actions (Clare & Gudjonsson, 1995).

Beail (2002b) has criticised this work on the use of memory. He claims that these studies only examine a unimodal input into semantic memory. Beail contests that police interviews rarely focus just on semantic memory but also use autobiographical memory with multimodal input. With this type of memory and input people with LD demonstrate higher levels of accuracy, less acquiescence and more resistance to suggestion, indicating that people with LD may not be as vulnerable as originally believed.

**Forensic and clinical risk assessment**

Clinical risk assessment is becoming a common feature of work within the LD field (Taylor & Halstead, 2001). Risk assessment can be defined as assessing the probability or likelihood that an individual will engage in an adverse or hazardous
event that will be a danger to others (Heyman et al., 2002; Timms & Goreczny, 2002). It is a dual concept encompassing the likelihood and impact of an event (Taylor & Halstead, 2001).

In mainstream psychiatry Borum (1996) observes that risk assessment comprises of two areas: actuarial and clinical methods. Actuarial methods utilise statistical relationships between known variables and the risk behaviour that is being assessed. Clinical methods take an individualistic approach, using an idiographic framework to assess risk. Within these methods two types of risk factors should be considered (Taylor & Halstead, 2001): static and dynamic. Static factors relate to the historical variables of the person undergoing assessment. Dynamic factors assess those factors that can change, such as an individual’s mental state. Risk assessment is a progressing field, with a number of models and tools, though prediction of future re-offending is still limited (Turner, 2000).

Taylor and Halstead (2001) comment that there is a gulf between researchers and clinicians in this area. Clinicians complain that available tools rely too much on actuarial variables and prefer to use clinical methods instead. However, as clinical judgement has been shown to be consistently faulty (Borum, 1996), there are calls to move away from this and towards an increased use of actuarial methods in decision-making (Johnston, 2002).

Johnston (2002), in her review of risk assessment of offenders with LD, notes that theoretical models and tools from the non-LD offender population have been borrowed and adapted. She adds that these tools have not been validated for people
with LD and that there is no research to suggest that non-LD risk assessment can be applied to the LD population. As yet there is also no evidence to suggest that existing assessments for people with LD is useful for predicting re-offending and devising risk management plans. There remains little in the way of models and tools specifically designed for people with LD (ibid.). There are only suggestions that are based on the characteristics discussed above.

Turner (2000) recognises that risk can never be eliminated. It is dynamic and can change over time. Mainstream forensic assessment now understands this and has now moved towards risk management. Applied to the assessment of people with LD this becomes a positive feature and falls in line with normalisation principles of risk taking (Johnston, 2002). Normalisation theory emphasises the individual’s rights to autonomy and risk taking which is essential in discouraging dependency, passivity and incompetence (Turner, 2000).

Johnston (2002) states that local risk assessments are being used. Turner (2000) conducted his own study into the use of risk assessment of people with LD. He found that 42% of the services that responded to his survey operated a risk assessment in relation to offending. However, most of these assessments were conducted within an overall general assessment of need and as a responsive action, rather than a proactive one.

Heyman et al. (2002) report their own risk management system established within a hospital system. The authors use the metaphor of a risk escalator where clients can move up and down depending on their behaviour and therapeutic progress. Whilst
showing that a comprehensive risk management system is being used, it is not possible to assess its overall effectiveness. The authors describe the process of the tool within the hospital environment, but do not provide any outcome measures for those that have been discharged.

Assessment for treatment

Clare (1993) maintains that the aim of assessment is to clarify factors that contribute to the aetiology and maintenance of an individual’s offending so that a formulation can be drawn up, a formulation that suggests treatment and management options.

Clare and Murphy (1998) suggest their own assessment guidelines. They recommend that information should be gathered regarding the individual’s background, current situation and offending behaviour. Clare (1993) provides her own assessment guidelines with sex offenders with LD, which is based within a cognitive behavioural framework. She recommends that sexual interests, socio-sexual behaviour, and attitudes and thinking should be assessed.

Whilst these tools are useful for the clinician as they provide full information and suggest possible areas for intervention there are, however, some problems. As with the risk assessments, there is no evidence to suggest that the information gathered is productive to therapeutic interventions, or to outcomes.

In both areas of risk assessment and assessment for treatment more research and validated tools are needed. Any assessment tool used not only needs to be validated on
the LD population, but also needs to be understood by people with LD (Lindsay & MacLeod, 2001) and cope with any expression of denial (Clare & Murphy, 1998).

Treatment

Though there has been an increase in the literature regarding people with LD and offending behaviour, there still remains little in the way of treatment studies. The studies that do exist show methodological flaws. These will be discussed as well as the major areas of treatment that have been recently developed.

One of the major flaws in this area is that there are no randomised controlled treatment trials. This weakens the evidence base. However, providing a treatment service or not providing that service remains an ethical concern, especially for offenders with LD (Brown & Thompson, 1997).

Within the area, the best outcome measure for treatment is recidivism. This would include a lengthy amount of time for follow-up, of at least four years (Beail, 2002a), as re-offending increases as time goes on (Lindsay et al., 2002). Recidivism rates for untreated offenders with LD range from 41% to 68% (Lindsay & MacLeod, 2001).

Cognitive behavioural intervention

Lindsay and colleagues have taken a cognitive approach in the treatment of male sex offenders with LD. They have treated offenders against children (Lindsay, Neilson et al., 1998), adolescent sex offenders (Lindsay et al., 1999), exhibitionism (Lindsay, Marshall et al., 1998) and also stalking (Lindsay, Olley et al., 1998). The aim of
therapy is for offenders to take responsibility for their offence, work with denial, and understand the harm done to the victim and review patterns of offending behaviour.

On the whole, promising outcomes are reported. Good responses to treatment were found as attitudes changed. Only a minority of offenders re-offended in the follow-up periods of at least three years. Another positive note is that these studies work within a defined framework of offending, one that offers explanations of behaviour as well as treatment. Lindsay and Smith (1998) also found that the longer the participant was in treatment, the better the outcome.

As a criticism of these studies, none employ a control group so comparisons cannot be made between treatment and no treatment. Additionally, some participants had IQs over 70, which could mean that these individuals have characteristics that may bias results away from the relevancy to the LD population. These studies also employ small sample sizes, indeed the Lindsay, Olley et al. (1998) study is a case study of two men. Similarly, Mageth-Nezu et al. (1998) offer two case studies of sex offenders treated within a cognitive framework. This questions the generalisability to the LD sex offender population at large.

A cognitive behavioural approach has also been used in the treatment of anger and aggression in offenders with LD (Taylor, 2002), an example of this work is shown by Taylor et al. (2002). These authors found that, compared to a waiting list group, men treated for aggressive behaviour showed significant reductions in intensity of self-reported anger. However, as with other studies, there was no follow-up data beyond treatment. It is difficult to conclude whether this kind of intervention impacts upon re-
offending. There is also a paucity of anger assessment tools validated for those people with LD (Taylor, 2002).

**Psychodynamic psychotherapy**

Beail (2001) reports the findings of a study in which 13 male offenders were treated with psychodynamic psychotherapy. 11 of the men had not re-offended in the four years following the cessation of treatment. There was a control group which was made up of those who refused treatment. All five members of this group re-offended within four years. However, this group is a poor control, as refusers may have introduced uncontrolled differences between the groups. Beail’s treatment group was also a small and mixed sample, made up of different offence types, so it is unclear what treatment aspects was beneficial for which offenders. There was also no mention of IQ.

**Group intervention**

Rose *et al.* (2002) report a pilot study for a group of men who showed sexual offending behaviour. The group was based around the cognitive behavioural model with elements of sexual education. Of the five participants none re-offended over the follow-up period of one year. There was no control group.

Friedman *et al.* (1999) provide a commentary on a group based upon a behavioural approach. There were only four members in the group, with at least one participant having an IQ over 70. There was a significant improvement in prosocial behaviour over the treatment period, though no follow-up data was provided.
Gubb-Blubaugh et al. (1994) report a peer management behavioural group. This operated within a community based residential setting, running alongside the usual therapeutic programme. All participants were male offenders with IQs below 70. Over the ten month study period notable improvements in maladaptive behaviour was observed.

**In-patient treatment**

There are two studies that report treatment for offenders within an in-patient setting (Day, 1988; Halstead et al., 2001). Whilst the latter study reports good outcomes, further comment will not be made as around half the participants in both studies had an IQ over 70.

**Pharmacological intervention**

Pharmacological treatments have been suggested for male sex offenders with LD (Cooper, 1995). However, there have been no controlled treatment trials and only case studies are reported (Myers, 1991).

**Care staff training**

Taylor et al. (2003) present a study which aimed to increase knowledge and improve attitudes of care staff working with learning disabled sex offenders. The study utilised workshops. It was found that self-reported knowledge and attitudes were improved. This is a useful study showing the needs of care staff. It demonstrates how interventions may improve the therapeutic environment and working practices, as well as help in overcoming prejudices of care staff (Thompson & Brown, 1997).
Summary

Most of the treatment initiatives described are concerned with sex offenders. It is unclear why this is the case, possibly it could be in the suggestion that people with LD are more likely to commit sexual offences. It could also be due to the current increased public awareness of sexual offending and the push towards public protection, more research into other areas of offending needs to be undertaken.

This work has also focused on the mild end of the LD range, even going into the borderline range. It is recognised that in reviewing the studies it might have been harsh to criticise those who included participants with an IQ over 70. Given that IQ measurement has confidence limits and that intellectual functioning is a continuous variable, it is conceivably fair that individuals with IQ a little above 70 should be included. However, as social and adaptive functioning is rarely reported, IQ is the only variable by which to critique this research.

All the studies discussed do show methodological flaws. This situation needs to be improved if work in this area is going to progress.

Further considerations

Women with LD who show offending behaviour

All the treatment studies reported above used men as their participants. Whilst there is evidence that women with LD do offend (Maden et al., 1994), they have largely been ignored by the research literature, possibly because they are a small minority group. Allen et al. (2001) report one study in which they treated five women, who had been
involved in the CJS, for aggression. As outcomes, they found that self-reported levels of anger decreased over the treatment period and follow-up. Only one participant re-offended. Again, this study encounters the same problems in methodology seen above. Two of the women had IQs over 70, there was a small sample size and no comparison group.

*Cultural issues*

There are no reports of any treatment or assessment initiatives that specifically examine issues of ethnicity or culture.

*Dual diagnosis*

One of the problems is this area is that a diagnosis of LD tends to overshadow other potential diagnoses. Whilst there are studies that show high rates of dual diagnosis for offenders with LD (for example, Day, 1988), there are no treatment or assessment studies that address this (O'Brien, 2002). Indeed, there is little indication how and in what way comorbid disorders influence treatment outcome (Barron et al., 2002).

The three areas mentioned here all show the need for more research and development.

*Conclusion*

It is clear from the research on assessment and treatment initiatives that there is a dearth of good quality literature covering all areas of offending. Even identifying the appropriate population in and out of the CJS has been problematic. Nevertheless, there are some reasonable studies that point the way to effective assessment and treatment.
options. However, these alone do not provide a quality evidence base that stands up to rigorous scientific scrutiny.

It is possible that this state of the literature is due to the work still being in the early stages of development, whilst also trying to overcome the belief that LD is intimately linked with criminality. Now as it appears that attention is being focused on this area, improved quality of work will emerge, work that builds on the findings that people with LD can potentially be assessed and treated for offending behaviour.
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Child, Adolescents and Families Essay

It is more clinically effective to work through parents and carers than to undertake individual therapeutic work with the child. Critically discuss this proposition.

December 2003

Year 2
Child, Adolescents and Families Essay

Introduction

In their review article Kendall and Morris (1991) asked who is the client in child therapy? They recognised that when a child is referred to mental health services he or she can be seen individually for therapeutic work. However, parents or significant others can also be seen as part of this work, or parents can be seen alone with minimal therapist contact with the child. Who is seen would appear in part to depend on the treatment plan. This plan would naturally be informed by the answers to the long-standing question of what treatment delivered under what circumstances is most effective for which particular problem delivered (Kazdin et al., 1990).

Though this is a generic question it has implications for this essay. This essay will discuss, in relation to childhood disorders, who is it best to work with therapeutically: the parents and carers or the individual child? The essay title proposes that it is more effective to work through the parents. To discuss this proposition this essay will draw upon the research evidence that is available. However, as will be seen, the literature, on the whole, does not directly answer this question. Nonetheless, clues are given which will guide the discussion.

Before this discussion begins, some issues need to be examined: family-based interventions, the limitations of child therapy research and the scope of the review.
Family-based interventions

This essay will need to consider family-based interventions. Though not strictly required by the essay title, it is regarded as necessary for two reasons. First, in child mental health services it is rare to work with the child by themselves; parental or carer involvement is fairly common practice. This can range from minimal contact, such as bringing the child to the clinical session, to being active participants in the session. Secondly, the available research literature again nearly always involves the parents, so to review this literature means to also review the family interventions. There is a prevailing view that children are seen within the context of their environment, which includes parents, regardless of the disorder (Weisz et al., 1998).

The kinds of family intervention that will be discussed in this essay can be considered as family therapy (Carr, 2000), as they involve family members in therapeutic work. However, some authors prefer a more strict definition, where family therapeutic work focuses on changing family interactions seeking to improve the functioning of the family as a whole and/or its subsystems, such as individual members (Cottrell & Boston, 2002). Types of family therapy will be considered in this essay, but in a limited way. This is mainly as a result of a paucity in the literature of well designed research studies investigating their efficacy (Racusin & Kaslow, 1994).

Based on the studies, family interventions that will be discussed will be defined as those that work with parents and carers, though the child may be involved, it is not direct individual work with the child.
Limitations of research

A number of authors (Kazdin et al., 1990; Kendall & Morris, 1991; Lonigan et al., 1998; Weisz et al., 1998) have commented on limitations in the child therapy research. Firstly, there is a gap between research and clinical practice. Kazdin et al. (1990) note that whilst there are many forms of therapy being used with children only a small fraction have been empirically tested.

Secondly, the quality of the research has been criticised. The suitability of control groups has been questioned. Kendall and Morris (1990) report that a wait list control group may not suitable. Instead they recommend the use of placebo conditions to control for therapist contact and attention. Small sample sizes and limited length of follow-ups have also been criticised.

Thirdly, the representative nature of the research has been doubted. Samples used have often come from non-clinical, sub-clinical and non-referred populations (Lonigan et al., 1998), which questions how findings can be generalised to clinical populations. Weisz et al. (1998) also point out that issues of ethnicity, class and culture remain relatively unaddressed by the literature. Of the 223 studies Kazdin et al. (1990) reviewed 80% did not identify the ethnic mix of their sample.

The final point is related to the first and involves clinically meaningful outcome data. Kazdin (1997) defines this as the practical value in the positive changes to the child’s lives and the people they interact with. This is different from psychometric measures which only show statistically significant changes after a sample group has undergone an intervention and may lack real world meaning.
These limitations reduce some of the efficacy of the research that will be discussed. In spite of this, reliable research has been carried out providing good evidence that childhood disorders can be treated (Lonigan et al., 1998).

**Scope of the review**

This essay will focus on more recent advances in child therapy. In light of the limitations, only the well designed and more scientifically rigorous studies will be considered. Given the current popularity and amenability to investigation that cognitive-behavioural therapy (CBT) possesses, it will be the dominant type of intervention discussed in the essay. Other types of therapy will be discussed, such as family based therapy and interventions, as well as other types of individual therapy.

This essay will also use the term child to refer to all individuals under the age of 18 years; this inevitably includes adolescents. While attempts will be made to omit studies that use adolescents as their participants, as the essay title poses the question about children, discussion of these are unavoidable, as they provide relevant discussion points. Additionally, some investigations often employ broad age ranges in their sample, for example, in their study, Nauta et al. (2003) used a sample that ranged in age from 7 to 18 years.

Discussion will now turn to the evidence base investigating who best to intervene with when treating childhood disorders. It will not be feasible to consider all disorders, so this essay will focus on the three most prevalent disorders found in a clinical sample.
of the UK child population (Ford et al., 2003): anxiety, depressive and behavioural disorders.

**Behavioural disorders**

This essay will use Kazdin’s (1995, 1997) definition of behavioural disorders; this term is used synonymously with conduct disorders. It refers to a pattern of antisocial behaviour that significantly impairs everyday functioning, beyond the range of ‘normal’ functioning, and is regarded as unmanageable by carers.

*Parent management training*

There is a wealth of evidence that demonstrates the efficacy of intervening through parents to treat child behavioural problems. This mainly comes in the form of parent management training (PMT), which is regarded as the treatment of choice for this problem (Remschmidt, 2003).

The underlying theory guiding PMT is that problems are inadvertently developed and maintained by maladaptive parent-child interactions (Kazdin, 1997). Treatment is conducted with parents, training them to effectively manage disruptive behaviour, with little therapeutic contact being made with the child (Webster-Stratton & Herbert, 1994). Parents are effectively trained to be their own therapists. PMT is designed mainly for pre-adolescent children.

The evidence base for PMT comes from a number of studies, such as Webster-Stratton (1985) and Sonuga-Barke et al. (2001). PMT has been shown to be superior to
parenting groups (Taylor et al., 1998) and been found to be useful when delivered as a brief psycho-educational programme (Bradley et al., 2003). Long-term maintenance of PMT gains have also been found, for example, Webster-Stratton (1990), who followed-up treated families after three years. Kazdin (1997) notes that PMT treatment effects have shown improvements in child behavioural measures, parental and teacher reports of problem behaviours, and direct observation of the child’s behaviour. Additionally, PMT can bring problematic behaviour to within non-clinical normative levels (Kazdin, 1995).

Comparison studies

Kazdin et al. (1992) compared PMT to problem-solving skills training (PSST). The theory underlying PSST is that behavioural disordered children show distortions and deficiencies in particular cognitive processes, so that when they interact with the environment certain events trigger behavioural problems. It is the way in which these events are processed and perceived that lead to problems (Kazdin, 1997). PSST is a child-focused treatment teaching problem solving and interpersonal management skills, utilising techniques of practice, modelling, role playing, and token reinforcement (Kazdin et al., 1992). In the study, children aged between 7 and 13 years were randomly allocated to one of three conditions: PMT only, PSST only, or PMT and PSST combined.

The findings from this study were that all three conditions led to significant improvements in overall child dysfunction, prosocial competence, and aggressive, antisocial and delinquent behaviour; this was evident at home and school. Improvements were maintained at one-year follow-up. The combined PMT and PSST
condition demonstrated more marked changes in aggression, antisocial and delinquent behaviour, and parental stress and depression. This condition also returned more children to normative levels of behaviour. When the PMT and PSST conditions were compared, few differences emerged. Self-report measures of aggression and delinquency favoured PSST, whilst some child improvements were lost in the PMT condition at the one-year follow-up.

One criticism of this study is that it did not have a control group. However, a study conducted by Connolly et al. (2001) comparing two conditions of a video-based PMT programme did have a wait list control group. The two PMT conditions were, parent training only, and parent training with clinically appropriate treatment for the child. Entry in the conditions was uncontrolled and decided by the length of waiting lists and clinical presentation.

The researchers found that after intervention both treatment groups significantly improved when compared to the control group in terms of the child’s aggressive and delinquent behaviour, as well as parental mental health. These improvements were generally maintained at follow-up, though there was a 53% attrition rate of the sample. Unfortunately, these researchers did not statistically compare the treatment groups. However, by examining the data, the combined PMT and child-focused group achieved higher levels of significance than the PMT only group. This indicates, as with the Kazdin et al. (1992) study, that combining parent and child interventions an increase in clinically effective results can be found.
A study carried out by Szapocznik et al. (1989) links into the next section as 30% of the sample comprised of anxiety disordered children. The rest of the sample were diagnosed with behavioural problems. All of the sample were Hispanic boys aged between 6 and 12 years. The boys were randomly assigned to one of three conditions: structural family therapy (SFT), individual psychodynamic child therapy (IPCT) and a recreational control condition. The researchers stated that for IPCT symptom amelioration comes through individually treating the child’s internal world. For SFT, treatment focused on family interactions and it was thought to be more suited to Hispanic families given their cultural values and interpersonal style preferences.

The researchers found that the treatment conditions were more effective in retaining children and their families in therapy. They were also found to be equivalent in improving emotional and behavioural problems. The only advantage SFT had was at the one-year follow-up where it was found to be more effective in maintaining family integrity. As SFT affected child psychodynamic ratings and IPCT affected family functioning this raises the issue of non-specific treatment effects.

Summary

It is clear that treating behavioural disordered children through their parents is effective, supporting the proposition of this essay title. However, there is data that shows that working with children individually can be effective as well. Furthermore, when parent and child programmes are combined they produce a synergistic effect that out perform parent only and child only conditions.
Anxiety disorders

Child-focused research

Kendall (1994) studied a child-focused CBT intervention for treating children diagnosed with an anxiety disorder. He utilised theory from the adult literature regarding how anxiety disorders are created and maintained. It has been found that cognitive processes relating to fear, threat, evaluations from others, and self monitoring are distorted (Wells, 1997). Kendall (1994) kept the principles of adult treatment, but adapted them to make them more user-friendly for children. The treatment consisted of recognising anxious feelings and physiological reactions, clarifying cognitive distortions, developing coping strategies, and evaluating performance giving self-reinforcement where necessary.

All children included in Kendall's study were aged between 9 and 13 years and were randomly assigned to either the treatment group or the wait list control. The children were diagnosed with over-anxious disorder, separation anxiety and avoidant disorder; there was also a good sample mix of sex and ethnic origin. After treatment, children in the intervention group significantly improved on child self-report, parental report and direct observational measures. Additionally, 64% of children no longer met the diagnostic criteria for an anxiety disorder compared to 5% of the control group. Treatment gains were maintained at one-year follow-up, though the control group did enter therapy after 8 week wait and were unavailable for this follow-up, which makes comparisons between the groups less robust.
Kendall and Southam-Gerow (1996) followed up the children who had completed the above intervention. The follow-up spanned between two and five years and averaged 3.35 years. It was found that gains made immediately post-treatment were maintained over this period. Time to follow-up assessment was not significantly related to maintenance of gains.

In a replication study, Kendall et al. (1997) found very similar results to the original study. Children in the treatment group improved on all measures, with half of the group no longer fulfilling an anxiety disorder diagnosis. Other authors (for example, Léger et al., 2003) have also found similar results.

CBT for anxiety disorders has also been taken into a group format. Flannery-Schroeder and Kendall (2000) randomly allocated 8 to 14 year old children to one of three groups: individual CBT, group CBT and wait list control. The group CBT was based on the individual CBT programme but adapted for a group setting. Both treatment groups held significant improvements over the control group after the intervention. The only significant difference between the treatment groups was on a child self-report measure of anxious distress, which favoured individual CBT.

Inclusion of parents

Whilst the above studies show that children can be treated individually for anxiety disorders, with minimal contact with parents, other studies have investigated the effects when parents are involved in treatment. Reason for parental involvement will be discussed in a later section.
Manassis et al. (2002) randomly allocated 8 to 12 year old children to either a group or individual CBT condition. Both conditions had parental involvement, where parents were trained how to manage their child’s anxiety. Results were similar to Flannery-Schroeder and Kendall (2000), demonstrating that effective CBT treatment can be administered in either an individual or group format. Silverman et al. (1999) compared a group CBT intervention, including parental management sessions, with a wait list condition. The group intervention produced and maintained, over one year, significant improvements, with 64% of children no longer meeting diagnostic criteria, compared to 13% of the control condition. From these studies it is not possible to tease out if parental involvement had any added beneficial effects; others studies can be used to answer this.

Barrett et al. (1996) randomly allocated 7 to 14 year old children to one of three conditions: CBT, CBT plus family management, and wait list. CBT was administered individually to the children. Family management involved training the parents in three ways, firstly, how to reinforce courageous behaviour and not anxious behaviour; secondly, how to manage their own anxiety and thirdly, to learn communication and problem-solving skills. The rationale behind including parents was that an ‘expert team’ could be created to tackle the difficulties.

At the end of the intervention both treatment groups made significant improvements in comparison to the control condition. However, the CBT plus family group tended to out perform CBT only group on self-report and clinician rated measures. At post-treatment, 57% of the CBT group no longer fulfilled diagnostic criteria compared to 84% of the CBT plus family condition. At 12-month follow-up this increased to 70%
and 96% respectively, again showing differences but also suggesting gains can also be made beyond treatment. Barrett (1998) replicated this study, with the only difference being a group format instead of individual work. The CBT group plus family management was found to have marginal added benefits over the group CBT only condition.

Though these studies demonstrate the added benefits of including parents in the treatment there are other studies which do not show this benefit. Children in a study by Nauta et al. (2003) were randomly assigned to one of three groups: individual CBT, individual CBT with parent training and a wait list control. This study followed the same procedures as Barrett et al. (1996). Whilst Nauta et al. (2003) found both treatment groups led to improvements compared to the control condition, no significant differences emerged between the treatment conditions. It is not clear why this study differs from Barrett et al. (1996). The most obvious difference is that the earlier study was conducted in Australia and the later one in the Netherlands. Other possible reasons for differences can be identified in the last section.

Öst et al. (2001) in treating 7 to 17 year old children with specific phobias with CBT, found no added benefit of including parents in treatment, though this was a brief one session treatment. Similarly, Spence et al. (2000) used CBT to treat social phobia in 7 to 14 year olds. Though the treatment was effective, the inclusion of parents was not associated with any significant additional improvements.

Though useful information, these studies do not address the essay question directly. One study that does was carried out by Mendlowitz et al. (1999). These researchers
randomly assigned 7 to 12 year old anxious children to one of three groups: child only, parent only, parent and child. CBT was given to the children and parental management of anxiety was given to parents. Significant improvements from pre- to post-therapy were found in all groups, shown in measures of anxiety, depression and coping skills. However, the parent and child condition had significantly better effects on children’s coping skills when compared to the other two conditions.

Heyne et al. (2002) randomly allocated 7 to 14 year old school refusing children to either a CBT child therapy condition, parent/teacher training condition, or a combination of both. After treatment, statistically and clinically significant changes were found. However, contrary to expectations that the combined condition would produce better outcomes, no differences were found between the groups.

Summary

In regard to childhood anxiety disorders there is good evidence to show that children can be treated effectively when they are the focus of the intervention. There is emerging evidence that when parents are involved in treatment synergistic effects can produce better outcomes. However, more research is needed as this is not universally found. When child-focused interventions are compared to parent-focused interventions, outcomes are equal. Again, more research is needed as few studies address this.
Depressive disorders

Discussion on treating childhood depressive disorders will mirror the anxiety disorders section in examining who may be more effective to work with.

Child-focused interventions

Like anxiety disorders, the most often reported treatment for child depression in recent years is CBT (TADS team, 2003). The underlying theory is again taken from the adult literature and adapted for children, where distorted and negative thoughts and beliefs, as well as cognitive biases, lead to and maintain depression (Verduyn, 2000). There is now a growing evidence base of well designed treatment trials that show the efficacy of individually treating children with depression (Harrington, Whittaker et al., 1998), some examples will be described. Treatment typically involves addressing behavioural symptoms and cognitive distortions, as well as problem-solving areas of difficulty, such as school or home life (Verduyn, 2000).

Wood et al. (1996) randomly allocated children and adolescents, aged between 9 and 17 years, to either an individual CBT condition or a control condition that involved relaxation training. At post-treatment the CBT condition had significantly improved on measures of depression, 54% of this group no longer fulfilled the diagnosis of a depressive disorder, compared to 21% of the control condition. At six-month follow-up the differences between the two conditions had reduced, which was ascribed to a high relapse rate in the treatment condition combined with the continued recovery of those in the control group.
Friedberg et al. (2003) treated 8 to 11 year old children presenting with depressive and anxious symptoms. At the end of the group CBT treatment the children reported fewer symptoms. Parents also reported satisfaction with the intervention. Limitations of this study were that the sample size was small and that a control group was not included.

Comparison studies

Lewisohn et al. (1990) randomly assigned depressed adolescents, aged 14 to 18 years, to one of three experimental conditions: adolescent only, adolescent and parent, and wait list control. The adolescents were treated with a group coping with depression course. Parents were provided with an overview of the adolescent programme as well as being presented with coping skills workshops that address family conflicts; the adolescents were also presented with this. After treatment both intervention groups significantly improved on depression measures compared to the control group. In the adolescent only condition 57%, and 52% of the adolescent and parent condition, no longer fulfilled the diagnosis of depression, compared with 95% of the control condition. Though only half of the entire sample was available at a two-year follow-up, treatment gains were maintained. Though there was a trend for improved outcome favouring the adolescent and parent condition, differences did not reach statistical significance.

A study conducted by Diamond et al. (2002) compared treatment using attachment-based family therapy (ABFT) to a wait list control condition. Adolescents aged between 13 and 17 years were randomly allocated to either condition. ABFT, as a treatment, aims to improve family relationships by repairing attachments between parents and the adolescent, then building competency and allowing autonomy for the
adolescent to make connections outside the secure family base. Post-treatment, adolescents in the ABFT condition showed a significant reduction in depressive and anxiety symptoms, and family conflict; 81% of this group no longer met diagnostic criteria for depression compared to 41% of the control group.

Harrington, Kerfoot, et al. (1998) randomly assigned children under 16-years, who had deliberately poisoned themselves, to either a routine care condition or a routine care plus brief intervention condition. This intervention was a home based family intervention, which consisted of developing problem-solving and communication skills. After the treatment, no differences were found between the conditions on measures of suicidal ideation, hopelessness and family functioning. However, parents in the intervention condition were more satisfied with the treatment and more compliance with this treatment was found.

Asarnow et al. (2002) found that group CBT combined with family education of depression and coping skills reduced depressive symptoms and negative automatic thoughts in 8 to 10 year olds. Group CBT combined with family therapy has also been found to be effective in treating depressed adolescents who abuse substances (Curry et al., 2003).

Summary
There is good evidence to suggest that children can be individually treated for a depressive disorder. However, the majority of the studies use adolescents as their sample (Harrington, Wittaker, et al., 1998), unlike the anxiety disorder studies. The bias here is probably a reflection that depression is more likely to occur in
adolescence, where anxiety is more evenly spread across childhood (Ford et al., 2003). Though not directly addressing the essay title, it appears that by including parents in treatment additional benefits can be made to its efficacy.

Further considerations

Before the conclusion of this essay one final section will be included. This will discuss additional considerations and issues when working with children and their parents. These factors have been found to have some impact on treatment efficacy and can help flesh out the essay title as well as inform clinical practice.

Behavioural problems revisited

Webster-Stratton (1985) and Webster-Stratton and Hammond (1990) have identified some predictors that impede PMT success. Socio-economic disadvantage, encompassing single parent family, low income, and low education, strongly predict poorer response to treatment. Lack of social support, parental depression, marital conflict and negative life events also predict poorer response. Webster-Stratton (1985) also noted that benefits from PMT may not be apparent immediately after the intervention, a number of months may need to pass before positive changes are observed.

These predictors should be considered in clinical practice and efforts made to ameliorate their impact. This may mean that treatment and treatment options may need to go beyond PMT in order to effectively treat the behavioural disorder. Clinician patience is also needed, as improvement may not happen straight away.
Anxiety disorders revisited

It has been found that anxious children often have anxious parents (Turner et al., 1987). In one study over half the children with an anxiety disorder had a mother presenting with an anxiety disorder (Last et al., 1987). Whilst a heritability component to anxiety transmission has been found (Thapar & McGuffin, 1995), child rearing practices and environmental experiences have also been implicated (Dadds & Barrett, 2001; Rapee, 1997). Higher parental anxiety has also been associated with the child’s poorer response to anxiety treatment (Cobham et al., 1998). These findings have important repercussions for clinical practice as parents may be unskilled in anxiety management and hence have difficulties helping their child cope with anxiety (Hirshfeld-Becker & Biederman, 2002). Parents may require treatment for their own difficulties, which may explain why some of the studies discussed above involved parents, providing them with training, not only for their child, but also for themselves. Studies rarely use parental anxiety measures as an outcome and therefore it is difficult to ascertain the full effects of the intervention within the family system.

Child factors have also been found to mediate treatment success. The most significant of these is depressive symptoms. When these form part of the child’s presentation they can lead to a poorer response to anxiety treatment (Berman et al., 2000). The comorbidity of anxiety and depression is often reported in childhood (Ford et al., 2003), so the clinician may need to treat these disorders simultaneously. However, Kendall (1994) found no mediation of depressive symptoms in treatment efficacy of anxiety, so comorbidity may not be an issue.
Dadds and Barrett (2001) also draw attention to the possibility that a child may be unwilling or unmotivated to participate in therapy. This can be found for any disorder, not just anxiety. The child may not see their behaviour as a problem and may be brought to the clinical setting by their parents. Engaging the child for active participation in treatment is of critical importance; if this is unsuccessful then other methods of treatment will need consideration.

Family dysfunction has also been related to less favourable treatment outcome (Crawford & Manassis, 2001). This suggests that some kind of family intervention may be required, but also raises the point that parents may not want to engage therapeutically, especially if they locate difficulties within the child.

*Depressive disorder revisited*

A number of issues discussed above are relevant here, such as the genetic and social transmission of depressive symptoms (Nilzon & Palmerus, 1997), these issues will not be examined again.

One positive finding reported in this area by Clarke *et al.* (1992) was that parental involvement was associated with a more favourable treatment outcome. This was for adolescents who were treated in a group format for depression.

*Child's developmental level*

To engage in any individual therapeutic work a child will need to have the necessary verbal skills as well as some ability to reflect and report upon their own internal state
(Verduyn, 2000). Some children, particularly younger children, may not be able to do this, so some interventions will not be appropriate for them.

Durlak et al. (1991) performed a meta-analysis on the effectiveness of CBT when treating emotional disorders. These researchers found that overall, CBT was effective, though there were differences between age groups. CBT was found to be more successful in treating older children, aged 11 to 13 years, than younger children, aged 5 to 10 years. This difference was ascribed to the child's cognitive-development level. Older children in the formal operation stage of development were more likely to benefit from CBT than younger children. Clinicians therefore need to take the child's cognitive development into account when deciding on the therapeutic intervention.

Summary

There are a number of child, parental and environmental factors that need to be considered when working with either the child or the parent, any of which can impact upon treatment success.

Conclusion

In order to answer the title this essay has considered, firstly, different childhood disorders and, secondly, ages of the children when discussing the best approach to intervention. It is clear that both factors can influence how the question is answered.

When responding to the proposition that it is more effective to work with parents than with the child this assertion holds in the case of behavioural disorders. Though
working with the child can also be of some benefit. In the case of anxiety and depressive disorders working with the child individually is an effective treatment. However, working with parents and family has also shown treatment success. Contact with the parents is never ruled out even when the child is seen individually.

What this essay has attempted to show is that working with parents and children at the same time, regardless of the disorder or age, produce positive effects, often over and above just child-focused or parent-focused interventions. This essay has also attempted to consider additional factors which impact upon treatment success that need to be addressed in clinical practice. Again, this adds further weight in taking a joint approach. In conclusion, though the essay title is not false as evidence demonstrates this, though the converse also possesses good evidence. Moreover, there is research that suggests intervening with parents and children in combination is also effective.
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Outline some of the major life transitions, and their impacts, faced in older age? What contribution can psychological theory and practice make in understanding and managing such transitions?

August 2004

Year 2
Introduction

In starting this essay I will briefly discuss the widely held negative beliefs of older age, as it acts as a prelude to the rest of the essay and sets up a number of relevant themes. A number of authors, for example, Ruth and Coleman (1996), have noted the negative perceptions of older age, where this time of life is characterised by a number of losses, deficits and imminent decline. This pessimistic view is created and recreated through our society (Dittmann-Kohli, 1990). So pervasive are these beliefs that Tornstam (1992) has commented that this negativity found its way into some of the early psychological literature on older age, such as Disengagement Theory (LaBauve & Robinson, 1999). Davenhill et al. (2003) also warn these prejudices can also enter clinical practice, as clinicians may struggle with the want to repair in the face of perceived deterioration.

Naturally, as a reaction to these cultural stereotypes and myths, authors were eager to point out the positive aspects of ageing (Ruth & Coleman, 1996). However, Coleman and O’Hanlon (2004) caution that this positive position can also be extreme, and suggested that a balance is needed. It appears that among the research community there is agreement that whilst ageing is a complex process (Stevealink et al., 1998), and does involve loss, decline and stress, it also offers gains, opportunities for growth and older people can cope with the vicissitudes of later life (Myers & Harper, 2004; 1

1 I have taken the choice to use the first person throughout this essay.
Ruth & Coleman, 1996). As the current literature recognises and adopts this position I will too.

It should also be acknowledged that there is diversity in the ageing process (Neugarten, 1979). There is the tendency to presume homogeneity in the older population (Fisher, 1993). I take the belief that this is not the case, every individual ages differently. Additionally, Heller (1993) points out age does not eradicate gender, ethnicity or socio-economic status, so some attributes of a person retain consistency. Thus adding a sense of continuity in the ageing process.

Outline of the essay

As I have now set up the themes, albeit briefly, that of balance, positive and negative aspects of older age, and continuity and diversity in the ageing process, I will now outline the essay. I plan to review some transitions that are faced in older age and begin a discussion as to their impact. Then I will move on to a psychological theory and practice that can help understand and manage such transitions. I will only discuss one theory, as space is limited, which unfortunately will also truncate other discussions.

Definitions

It would be useful to define older age and transitions. As I have noted above ageing is a variable and individual process, so to delineate when it begins would be both difficult and perhaps inappropriate. However, I do need a boundary that allows me to identify research that I can include in this essay. At the risk of creating an older group distinction and falling into cultural norms, I will use 65 years as the advent of older
age, though I will use this flexibly. Additionally, it has long been recognised that as people are living longer, as they enter older age they have a good chance of living another 20 years (LaBauve & Robinson, 1999). This makes the concept of older age at 65 seem somewhat redundant, and has lead researchers to divided the older population into the grouping of younger-old and the older-old (Coleman & O’Hanlon, 2004).

Transitions can be seen as changes that happen overtime. The psychological and sociological literature see transitions as the relinquishment of familiar roles and the assumption of new ones (Foner & Kertzer, 1978; Hareven, 1994). Transitions can be seen as happening around discrete life events as they allow adaptation to occur. The older person should not be seen as a passive recipient of the transition, but as an active agent living through and coping with it, utilising resources they have at their disposal, which have evolved over a lifetime (Myers & Harper, 2004; Steverlink et al., 1998).

Transitions

Notes on transitions

The older person can encounter a number of transitions, just as any individual can irrespective of their age. However, Folkman et al. (1987) characterise older age transitions as ones of loss, such as the loss of health, employment and loved ones. I feel this may fall into the negative stereotypical aspects of ageing. Whilst I see the death of a loved one as a loss, the loss of employment can be seen as the gaining of an opportunity to try new activities. Whilst there are deleterious effects of ageing on health, this does not guarantee an overwhelming imminent decline (Briggs, 1993).
Positive transitions also occur such as the move into grandparenthood, which could happen before older age, and great-grandparenthood (Jerrome, 1993).

Ruth and Coleman (1996) report that older people experience relatively fewer life events and transitions then their younger counterparts. When these transitions occur they are not condensed into shorter time periods. Younger people usually face transitions of leaving home, setting up careers, and establishing their own family life. These are major transitions and can occur in a relatively short period of time, something not readily found in older age (Coleman & O’Hanlon, 2004). This again disputes the belief that older age is a cumulative series of negative events.

I will now turn to specific transitions and attempt to discuss their impact, only two key transitions will be discussed. Palmore et al. (1985) identified five major transitions in older age. These were, retirement, retirement of a spouse, medical problems, widowhood and the empty-nest syndrome.

**Retirement**

Retirement in older age can be seen as a life event rather than a transition, as it can be a discrete occurrence and a normative event, which is usually predictable (Floyd et al., 1992). This can be true to all transitions noted above, but researchers (for example, Rosenkoetter & Garris, 2001) have preferred to investigate retirement as a transition, so that it can be planned for and undertaken gradually (Lo & Brown, 1999). This also has clinical utility where the transition into retirement can be prepared for and support networks put in place (LaBauve & Robinson, 1999). Retirement is also essentially a
socially defined construct (Phillipson, 1993) and can, for some, mark the transition into older age (Floyd et al., 1992).

The impact of retirement is difficult to discern. To reiterate the theme of diversity, it can affect those experiencing it in a number of possible ways. To judge whether the transition into retirement is a positive or negative experience is a complex picture and may rely on a number of interacting factors.

On the negative side, retirement has been associated as having a harmful effect on health and can cause rapid physical deterioration (as reported by Phillipson, 1993). It can lead to depression, a decrease in life satisfaction, interpersonal difficulties and more symptoms of psychological distress (Floyd et al., 1992). It may be regarded as a stressful period as it can result in a loss of role, lead to a reduction in income, status and social relationships, as well as increase unstructured time (Lo & Brown, 1999).

On the positive side, workers may feel that retirement has come at the right time, so that they are ready to move on (Tornstam, 1992). Energy can also be re-channelled into new interests and activities (Lo & Brown, 1999). Dorfman and Moffett (1987) found that good health of older people increased their satisfaction as they moved into retirement. Knesek (1992) reported that those who retired early did not differ in retirement satisfaction than those who retired later. Reitzes et al. (1996) compared two groups of older people, those who retired at the normative age and those who chose to continue working. The researchers found that subjective well-being did not differ between the two groups. Over a two year follow-up, they found that retirement increased this group’s self esteem and reduced any signs of depression. Reitzes et al.
also found that those individuals who had more work-related identities and more personal investment to work did not experience an identity crisis in retirement and that their self esteem did not decline.

Floyd et al. (1992) found that those individuals who took voluntary retirement were more positively adjusted and satisfied, as they pursued new interests and goals, than those who took involuntary retirement, as they held negative attitudes about leaving their job. Additionally, those individuals from a higher socio-economic status were more satisfied with retirement than those from a lower status, however lower socio-economic status individuals enjoyed retirement more as it reduced their stress levels.

Given the current older person cohort, cultural expectations were for women not to enter the workplace. This may suggest that there could be some differences in the way women react to retirement, in terms of their work role investment. Rosenkoetter and Garris (2001) observe that gender differences have only been found in some studies. For example, Floyd et al. (1992) found that woman found it slightly more difficult to adjust to retirement and tended to utilise more social support to help adjustment.

LaBauve and Robinson (1999) observe that women may have lower life satisfaction in retirement, but this may be more do to with economic reasons related to why they entered into work in the first place, as retirement can place financial strain on an older individual or couple. Similarly, Gibson and Burns (1991) found that older people from a black ethnic minority had more adjustment problems, which were due to financial and health concerns. These problems could be due to older discriminatory cohort attitudes in regard to education and opportunity.
Retirement is also likely to have an affect upon the marital relationship, as roles need to be reorganised for the retired person and their partner (Walsh, 1988). Again, researchers have found positive and negative impacts. Couples have more time together to allow beneficial reinvestment into their relationship (as well as other family relationships; Motenko & Greenberg, 1995). Barnes and Parry (2004) found that in households where traditional gendered roles predominated, men found retirement less comfortable than women. Changing and renegotiating roles can also create friction, but this should be seen within the context of the whole relationship and the way previous transitions were negotiated (Thompson, 1992).

Tornstam (1992) claims that the trauma of retirement is a cultural myth, not endorsed by well designed research. This may be an over optimistic position, but it does appear, according to the research, that a positive adjustment to retirement can be dependent on finances, health, gender, culture, social networks and planning. Rosenkoetter and Garris (2001) assert that planning and preparation seem to be the best predictors to positively adjust to retirement.

As transition adjusting to retirement is an ongoing process and may go through different stages (Atchley, 1988), all the positive and negative impacts noted above can undergo change. For example, the Floyd et al. (1992) study only offers a snapshot of post-retirement experiences. Older people can adapt and evolve, and so as Rosenkoetter and Garris (2001) note, retirement involves the search for a new identity, new meaning and the search for personal values. This is an important point and will be returned to in the second part of the essay in how theory can help understand transitions.
Death of a partner

This transition will not be discussed in such detail as the retirement transition. This will be the last transition discussed before the next section of the essay.

Older people can, if they want, avoid retirement, no-one can avoid death. In a relationship, the death of a partner or spouse is ever-present, increasingly so as ageing progresses. With gender differences in longevity, women are more likely to experience widowhood (Coleman & O'Hanlon, 2004). There is evidence that suggests that those who experience the death of a spouse are more likely to die themselves, in comparison to a non-bereaved control group (for example, Bowling, 1987). Loosing a spouse also increases the chances of developing depression (Myers & Harper, 2004), lowering psychological well-being (Fry, 2001) and lowering life satisfaction (Chipperfield & Havens, 2001). All of these effects were found to be worse for men.

Relationships can usually act as protective buffers against the stresses of everyday living so the loss of a spouse can naturally be painful and traumatic (Coleman & O'Hanlon, 2004). There are factors which can influence well-being following the death of a spouse. Those found include, the quality of the relationship, where less dependency was associated with less anxiety (Carr et al., 2000); the younger age of the deceased and a poorer marital relationship was associated with higher levels of reported grief (Gamino et al., 1998), though a closer relationship was associated with more yearning (Carr et al., 2000). Interestingly, Carr et al. (2001) compared two groups of older people, those who experienced a sudden spousal loss and those who anticipated the death. The authors found no differences in depression, anger, shock or
grief between the groups, questioning the belief that more grief is associated with sudden death, bereavement appears to occur in equal measures. A fairly unique study conducted by Fry (2001) found that existential factors such as religiosity, spirituality and the search for personal meaning can help psychological well being in the older adult after a spousal loss. Finally, Coleman and O’Hanlon (2004) contend that time can lessen the distress and sense of loss associated with a bereavement.

Concluding notes on transitions

Transitions can be regarded as stressful times for the individual and those close to them (Carter & McGoldrick, 1988) or they can be seen as a chance for new opportunities (Folkman et al., 1987). This may depend on the older person’s appraisal of the transition and the coping resources, be it cognitive, emotional, social, that they can utilise (Lazarus & DeLongis, 1983). It has been found that older people cope with transitions the same way they have coped with changes throughout their lives, thus retaining continuity (Atchley, 1989). Older age, as a transition itself, does not negate the experience that an individual can draw upon in order to cope. However, some adaptation may be needed as life circumstances, through transitions, change. As noted before, at these times older people search for meaning and balance.

To conclude this section, Robins et al. (2002) conducted a study examining global self-esteem across the life span. They found that after 70 years of age self-esteem dropped dramatically. The authors speculated that the trauma of losses experienced in older age could contribute to the loss in self-esteem, thus fitting in with the cultural stereotypes of ageing. However, Robins et al. take a different line and invoke Erikson’s theorising (Erikson et al., 1986) and claim that it is not a drop in self-worth
per se but older persons’ acceptance of their limitations and faults, combined with the diminished need for self promotion which can artificially inflate self-esteem in younger people.

A psychological theory

In this section I will discuss a theory, with implications for practice, that can help understand and manage transitions in older age. Due to limitations I will only discuss one model, which will be Erikson’s epigenetic life cycle model of human development. However, discussion will not be exclusive to this theory as Erikson has stimulated other areas of work, which will be mentioned.

The life cycle

Erikson’s model first appeared in the 1950s (Erikson, 1950) and grew from the psychodynamic tradition. It is now an often quoted theory in the older person literature (Coleman & O’Hanlon, 2004). Its popularity may be due to the theory taking a whole life cycle approach (Kettell, 2001), affirming the continued growth of the person throughout their life, and seeming to capture some essence of clinical and personal meaning. Subsequent theorists have used Erikson’s theory as a basis for their own work, for example Levinson et al. (1978).

Erikson called his life cycle model epigenetic, an old term borrowed from embryology that relates to the stepwise growth of the foetus (Liptzin, 1985). For Erikson the epigenetic principle is used to create the idea that at critical periods in a person’s life there are opportunities that allow the ego to grow in adaptive strength. Erikson uses
the term crisis to describe these turning points, crisis meaning challenges or turning points. It is important to note that the model is psychosocial in origin, so the person is placed firmly within their environment and culture, which determines when the growth can happen and allows it to happen, as the individual’s capacity to relate to the society ever increases. It is in the interface between the individual and society that gives rise to the crises. Inner and outer conditions must be met before new development can occur or is necessary to occur (Coleman, 1993).

Erikson formulated that there are eight stages to his model, each characterised by new developmental crisis. In a crisis, the ego has to deal with a conflict between syntonic and dystonic forces. The developmental task is in how the individual resolves or balances these forces; a positive way leads to growth, a negative way can lead to stagnation and confusion (Schwatz, 2001).

The eight developmental stages are seen as hierarchical, where each stage is built upon the development of the previous one. Stages do not replace one another, as threads of resolution from earlier stages are seen in the later stages. As this creates a wholeness and continuity, it implies that earlier stages can be revisited and a balance searched for again. Whilst Erikson asserts these stages are universal, he recognises that each individual can proceed through the stages at differing momentums.

The Erikson stage that is relevant to the essay is the eighth and last stage of older age, the fruition of the previous seven stages. In this stage the individual is confronted by the syntonic ego integrity and dystonic despair and disgust. Despair is characterised by bitterness, misanthropy and contempt. Erikson asserts that the syntonic position
must be dominant, but balanced with a pervasive sense of despair. This then creates the final adaptive strength of wisdom, which, through integrity, is defined as a ‘detached concern with life itself. It maintains and learns to convey the integrity of experience, in spite of the declines of bodily and mental functions’ (Erikson et al., 1986, pp.37-38) and is ‘truly involved disinvolve’ment’ (ibid., p.51). Wisdom is the acceptance and integration of the only lived life, that some things cannot be changed, and that life has been experienced as a coherent whole. It is also the recognition that an individual is just one person in a family and in a society. Furthermore, wisdom is the acceptance of death and that society will continue after death, and moving towards a more existential and transcendent identity.

**Critique of the life cycle theory**

One of the major problems with Erikson’s theory is in its imprecision (Schwartz, 2001). Erikson offered no clear time limits of the stages, their starting points and completion (Coleman & O’Hanlon, 2004). Conceivably, an individual may never progress onto the eighth stage, being stuck in earlier stages.

The terminology Erikson uses tends to be inexact, which makes operational definitions difficult to extract (Schwartz, 2001). Erikson seemed to be almost deliberately vague in his writing (Kettell, 2001). This probably explains why, given the age of the theory, fairly little research has been carried out into it (Kogan 1990), the focus being more on case studies (Rosel, 1988). However, some investigations have been conducted, which will be discussed now.
Ryff and Heincke (1983) operationalised the key dimensions of integrity and of generativity. Generativity is the seventh stage and task of middle adulthood, where the adaptive function is to care for the next generation, rather than being lost in self-absorption. The authors compared three cohort groups: young adulthood, middle-aged adults and older people. The findings were as Erikson would have predicted, that older people endorsed more integrity related dimensions than the other two groups and the middle-aged cohort endorsed more generative dimensions. This demonstrates a qualitative shift of adjustment concerns in different age groups. Ryff and Heincke also found that older people were less defensive, accepting the good and negative features about their lives, supporting the claims of Robins et al. (2002) noted above.

Hannah et al. (1996) examined the achievement of ego integrity. They found that integrity was linked to most other stages of Erikson’s model. The strongest link was with generativity, where the quality of resolution at this stage led to the achievements made in integrity. Thus showing support for the model.

Vaillant and Milofsky (1980) examined the earlier stages of Erikson’s theory up to the generative stage, for American men. They found support for the theory in that stages of the life cycle had to be completed sequentially, and failure to master a stage would lead to failures at later stages. They also found that the age by which a stage is mastered varies enormously and that the interaction of the individual and their social world propels their growth. Vaillant and Milofsky also found that adult development is not greatly influenced by education or privilege.
Ochse and Plug (1986) examined Erikson’s theory in South Africa, comparing gender and ethnic grouping. Unfortunately, these researchers did not include the eighth stage in their study, though they did find general support for Erikson’s idea that stages are inter-related. They also found stage achievement differed across gender and race. White women reached the crisis of identity, the fifth stage, earlier than white men. Black men resolved this stage later then the other groups. Black women’s psychosocial development was found to be impeded. Finally, psychosocial well-being, in terms of syntonic balance, was related to psychological well-being in white participants. This study does present some support for Erikson’s theory, but does question its universal applicability.

Given that Erikson’s theory is psychosocial, and sets out to embed an individual within their society (Schwartz, 2001), it is an irony that the theory is very culturally bound. Vaillant and Milosky (1980) claim the theory is best suited to those cultures that value individualism, which makes it Western society based. The theory, being from the 1950s, has cultural norms and values of the 1950s (Coleman & O’Hanlon, 2004), thus questioning its relevance to other cultures and cultural evolutions.

In terms of gender, both Ryff and Heincke (1983), and Hannah et al. (1996) found no gender differences in their studies. However, Domino and Hannah (1989) did find gender differences in resolutions in some of Erikson’s stages, and Rennemark and Hagberg (1997b) found gender differences in generativity. Vaillant and Milofsky (1980) note that the theory can be applied to women as long as they are given the same social privileges as men.
Erikson has been criticised for paying insufficient attention to the negative aspects of development, examining the more destructive qualities of human nature (Coleman & O’Hanlon, 2004). Additionally, the theory can be seen as an idealistic way of perceiving older age (Coleman, 1993).

Coleman and O’Hanlon (2004) note that the strengths of the model lay in its whole life approach and creativity that has inspired later generations of researchers, such as the work on ego identity, within psychology and sociology (Schwartz, 2001). The theory also recognises the inevitability of death, something which gerontological research hitherto has almost ignored (Coleman, 1993).

Erikson’s theory has remained essentially the same since its inception in the 1950s. Erikson did contemplate adding a ninth stage to his model, given increasing longevity, thinking about the idea of immortality, but he chose not to (Erikson et al., 1986). Tomstam (1996) has taken this step and introduced the concept of gerotranscendence, where the older-old adult leaves a materialistic, pragmatic view of the self and society and takes on a more cosmic and transcendent view.

**Transitions and Erikson’s theory**

In this section I will attempt to discuss how Erikson’s life cycle theory and practices derived from it can help understand and manage transitions in older age. The strengths of the theory are in understanding the transitions of older age and even the transition into older age itself. Erikson’s theory points to factors that need to be considered in the adjustment to ageing (Coleman, 1993).
Understanding

The developmental task for the older person as set out by Erikson can be seen as a transition itself, as the individual tries to achieve a balance between ego integrity and despair and disgust. The transitions described above, retirement, the loss of a spouse, as well as others, can be seen as giving rise to or being part of the developmental task in the growth towards wisdom. Erikson’s theory understands the processes and consequential impacts of these transitions.

Retirement is a socially prescribed event and being a psychosocial theory recognition of the impact is built into it. As noted previously, Rosenkoetter and Garris (2001) reported that in retirement individuals can search for meaning and personal values. This echoes the task of older age as meaning of life is sought and acceptance of what has happened. Therefore retirement can precipitate the developmental task in search of wisdom, but also be a part of it.

As with retirement, the loss of a spouse can start the process of searching for meaning (Fry, 2001). Existential factors can also help this process, something which is seen in the task of the eighth stage, the development of an existential identity.

It was also discussed above that through continuity theory (Atchley, 1989) older people cope with transitions, be it functional or dysfunctional, the same way they have coped with changes throughout their life. Erikson understands this as continuity is inherent to the theory as earlier stages and their resolutions affect the balance of later stages, be it syntonic or dystonic.
Other research has also shown the applicability of Erikson’s theory as the ongoing transition into older age is made. Both Thompson (1992), in a qualitative study, and Rennemark and Hagberg (1997a) found that older people try to achieve a sense of coherence in their lives as they recall past experience. This ties in with Erikson’s theory as integrity and continuity is worked for. Freund and Smith (1999) studied how older people defined themselves. They found that the self-definitions were inward looking, regarding personal characteristics and life review, and outward focused, being part of a family and social participation. Again, the themes of personal meaning and continuity is present, but Erikson’s phrase of involved disinvolvment also applies here, as the older people in the study are part of the society but also take a step back in their own life review.

Black and Rubinstein (2004) conducted an interesting qualitative study on the themes of suffering in later life. They found that they could only define suffering in terms of culture and the self, similarly to Erikson’s theory. They found that for their participants’ suffering had an existential quality that was rooted in being human, there was a bounded yet boundless quality to their pain. Suffering challenges identity, its integrity and content, and participants existed in a state between social, psychological and experiential dimensions. All the words I have used here are taken straight from Black and Rubinstein’s article and I am struck by how much they mirror Erikson’s writings on the task of integrity and wisdom.
Managing

Being a developmental theory, Erikson’s life cycle model is better at describing rather than enacting. As discussed above, the theory is effective in understanding older age transitions, but Erikson offers little in the way of clinical use and practice of the theory in managing such transitions. Again, given the theory’s long history it’s surprising how little clinical intervention or clinical case studies have been based on it (Liptzin, 1985). The theory has not readily transferred into practice, which is a shame as it makes this part of the essay somewhat asymmetrical. However, by knowing what tasks need to be achieved, this can help therapeutic work.

As transitions can be seen as part of the eighth developmental stage how an older person copes with these comes from the resolutions of earlier stages. So transitions can expose the more dystonic resolutions from earlier life. The benefit of Erikson’s model is that earlier stages can be revisited and worked through again (Kettell, 2001). This suggests that if older age transitions are causing clinically relevant disruption than management can come through examining earlier transitions and trying to find a more balanced way of coping.

One of the practical assets derived from Erikson’s theory in managing the transitions into older age is life review and reminiscence (Butler, 1963). When the theory first emerged, life review was judge as unnecessary (Kettell, 1985), but as Erikson recommended the benefits in reviewing one’s one and only life and integrating it into a coherent whole, the view shifted. Life review in practice has shown clinical benefits as it can identify strengths which can be utilised and consolidated upon (Coleman, 1993). This can help maintain a sense of coherence in the management of any ongoing
transitions. Though Coleman and O'Hanlon (2004) warn that caution is needed in reviewing certain types of memory and the method by which this is done as it could potentially be damaging and may lead to a sense of despair.

Concluding remarks and reflections

Transitions happen in older age, as they do at any age. Research shows that the impact of these transitions can be positive and negative, but older people do cope in a society that generally views being old pessimistically. Erikson's life cycle theory is useful in its aims, in that development should be viewed over the lifespan. I hope I have shown its usefulness in older age, in regard to understanding and managing transitions. As the theory itself is in its sixth decade, I wonder if researchers will view it with integrity or despair.

As Erikson used case studies in his work I would have like to give examples from my own clinical work in the second part of the essay, but space, like life, is limited so I was unable to do this.
References


Overview

The clinical dossier is made up of the clinical experience gained whilst on each of the training placements. A summary of each of the four core placements is given, these are: adult mental health, people with learning disabilities, child, adolescents and families, and older people. Summaries are also given for the two specialist placements, which are: neuropsychology and primary care.

The dossier is also made up of brief summaries of the case reports written at the end of five of the placements. Case report summaries are given for each of the four core placements, as well as a summary for the specialist neuropsychology placement. The full case reports, placement contracts, evaluation forms and log books of clinical experience are contained in Volume Two of this portfolio. Volume Two contains confidential information and is held at the Psychology Department at the University of Surrey.

The summaries are presented in the same order that the placements were completed. All client names and identifying information have been changed in order to preserve anonymity.
Placement details

Dates: October 2002 to March 2003

Supervisors: MATERIAL REDACTED AT REQUEST OF UNIVERSITY

Region: Surrey Oaklands NHS Trust (East Molesey and Horley, Surrey)

Summary of placement experience

This was a split placement that provided me with experience of working within two Community Mental Health Teams (CMHT). I worked mainly within a cognitive behavioural framework for a range of adult mental health difficulties, but did have the opportunity to work with one client using a psychoanalytically informed approach. Clinical work included assessment interviews, assessment for psychological interventions and shorter-term psychological interventions. I was able to see clients on an individual basis; I also co-devised, co-designed and co-facilitated a therapeutic group focusing on the enhancement of cognitive skills. I worked with clients who all lived in the community. Client ages ranged from 19 years to 63 years, were a mixture of male and female, and were mostly from White-British background.

Clinical skills and experience

Presenting problems of clients I worked with included: depression, panic attacks, obsessive-compulsive disorder, identity issues, post traumatic stress disorder, low self-esteem, mild eating disorder, social anxiety, and adult attention deficit hyperactivity disorder. The group I co-facilitated was specifically designed for those individuals with either low mood, low self-esteem or an anxiety disorder, such as panic attacks or
generalised anxiety. Assessment tools I used on placement were: Beck Depression Inventory (BDI), Beck Anxiety Inventory (BAI), Hospital Anxiety and Depression Scale (HADS), General Health Questionnaire (GHQ-28), and the Maudsley Obsessive Compulsive Inventory (MOCI). The vast majority of my work was conducted within the community team base.

Meetings, seminars, visits and research
I was able to observe my supervisors on a number of occasions carrying out their ongoing client work. When I was able I visited both teams’ multidisciplinary team meetings, where client status was reviewed and discussed. I had the opportunity to meet up with various team members, namely team co-ordinators, social workers, community psychiatric nurses and support workers to discuss their roles and working practices. I also attended the monthly regional clinical psychologists meeting and special interest group for adult mental health problems. I gave a presentation on obsessive-compulsive disorder to this special interest group. I attended a bi-monthly CBT peer supervision group with my supervisor. I visited the local in-patient unit and attended a ward review there. I also visited a local voluntary organisation set up to provide support for those individuals with long-term enduring mental illness, which were mainly psychotic disorders.

My service related research project (SRRP) was carried out whilst I was on the placement, which was entitled, ‘An investigation into the current practices of a Community Mental Health Team in providing early intervention services for individuals with a first-episode of psychosis’. I was given the opportunity to feedback my findings to the team at a specialist team meeting.
Cognitive behavioural therapy with a 22-year-old woman presenting with
symptoms of an obsessive-compulsive disorder

Some details have been changed to preserve anonymity of the client

Referral

Ms Baxter was referred by her G.P. as she was experiencing symptoms of an
obsessive-compulsive disorder (OCD).

Presenting problem

Ms Baxter was experiencing intrusive thoughts regarding contamination. These
thoughts were triggered when she ate food, particularly when out of her home, when
she came into contact with other people, or when she came into contact with objects
that she perceived as dirty. To avoid these thoughts she did not eat or drink out of her
own home. To help neutralise these thoughts she would complete an extensive
cleaning ritual. She recognised the intrusive thoughts as unrealistic, but felt compelled
to act upon them, which caused her further distress. She had been prescribed anti-
depressant medication.

Assessment

I initially saw Ms Baxter over three assessment sessions. Information was gathered
from these sessions and also from her case notes. She was given a thought diary to
record her thoughts and behaviour, something she continued to record throughout the intervention.

**Formulation**

Ms Baxter’s formulation was guided by Wells’ (1997) model of OCD. The model is based within the cognitive behavioural tradition and is useful in identifying the variables that maintain obsessive thoughts and compulsions. The model posits that certain situations or events trigger off intrusive thoughts. An example of a situation for Ms Baxter was playing with her dog, triggering off the thought of ‘I am dirty’. This then activates meta-beliefs, that for Ms Baxter being dirty was dangerous for her. Appraisal of the intrusion then occurs; this involved the unstoppability of the thoughts and that she could act on the thoughts to stop the contamination. This appraisal then leads to the beliefs about the rituals or behaviours, where she believed that if she cleaned herself she would no longer be dirty and that avoiding situations in the first place would cut down the chances of contamination. This then leads to the actual behaviour of cleaning and avoiding, but also she sought reassurance from her partner and attempted to suppress the intrusive thoughts in the first place. Additionally, the intrusive thought creates anxiety that the behavioural response then relieves. However, the behavioural response and reduction in anxiety feed into the intrusion and faulty cognitive processing and create a cognitive behaviour loop, a loop that’s prevents disconfirmation of the intrusive thought.

**Intervention**

I saw Ms Baxter for 12 sessions of cognitive behavioural therapy (CBT). CBT has been shown to be effective in intervening with OCD (for example, Abramowitz,
The plan, agreed with Ms Baxter, was to reduce the impact of the intrusive thoughts and reduce the frequency of the compulsive acts. A number of techniques were used. She was introduced to the CBT model, as the formulation was constructed and shared with her. Normalisation occurred as Ms Baxter was shown how often intrusive thoughts happen in the everyday population. Anxiety management was also practiced. Exposure and response prevention was undertaken, which allowed reappraisal of the thought. Wells' concept of detached mindfulness was also used. Finally, a relapse prevention plan was written.

Outcome
As Ms Baxter continued to use a thought diary, a reduction was noted in the number of behaviours enacted as well as a reduction in the distress the intrusive thought caused. She was also given the Maudsley Obsessive-Compulsive Inventory (MOCI; Hodgson and Rachman, 1977), she scored 4 which is a very mild score of OCD.

Critique
The main critique of my work stems from omissions. I neglected to give Ms Baxter any baseline measures before we started the intervention. It would have also been valuable for her to complete a ritual diary. Tape recording of our sessions would have also been useful. Follow-up sessions may have also been beneficial, but the end of placement prevented this.
References


Core People with Learning Disability Placement
Placement details

Dates: April 2003 to September 2003

Supervisor: MATERIAL REDACTED AT REQUEST OF UNIVERSITY

Region: West Kent NHS and Social Care Trust (Dartford, Kent)

Summary of placement experience

The placement provided me with experience of working with people with learning disabilities within a community mental health learning disabilities team. I worked within a behavioural framework, as this was the approach my supervisor offered and it gave me an excellent understanding of this method of psychological theory and work. I worked with people with a range of learning disabilities (and physical abilities), their carers, families and other professional support systems. I used behavioural interventions to help clients presenting with challenging behaviour, working directly with clients or indirectly through carers. I also conducted neuropsychological assessments. I worked with clients who either lived in the family home, group homes or sheltered accommodation and my contact with them were in these settings. Client ages ranged from 18 to 46 years, were a mixture of male and female, and were mostly from a White-British background.

Clinical skills and experience

Clients referred to the team were mostly referrals for challenging behaviour, which also formed the majority of my work. Challenging behaviour ranged from inappropriate vocalisations to aggressive outbursts. I had direct contact with clients, where I carried out behavioural observations, but I worked mainly with carers,
whether they were family members or support staff, devising behavioural guidelines. Other direct client work included a psychosexual assessment and psycho-education with a man with Down’s syndrome. I was also involved in a client case that addressed issues of informed consent. For neuropsychological assessments I used the Wechsler Adult Intelligence Scale – 3rd edition (WAIS-III). I also helped conduct an Asperger syndrome assessment as well as an autistic spectrum disorder assessment. The majority of my work was conducted in the community. During my work I had contact with nurses and psychiatrists from the team as well as contact with other professionals, such as staff from day centres, care homes, and specialist schools. I also had contact with social workers.

Meetings, seminars, visits and research

I attended to weekly team meeting where ongoing client work and new referrals were discussed. I was able to observe my supervisor and other members of the team, which included nurses and a Speech and Language Therapist. I also had the opportunity to engage in a session of intensive interaction therapy. I visited the local Social Education Centres, day centres, group homes and sheltered accommodation being able to talk to some members of staff about their roles and experiences.
Case Report Summary

Behavioural assessment and intervention with an 18-year-old woman presenting with challenging behaviour

Some details have been changed to preserve anonymity of the client and their family

Referral

Ms Cox was referred by her Care Manager for challenging behaviour.

Presenting problem

A number of behaviours identified by Ms Cox’s parents were noted to be causing difficulties. These were when Ms Cox would slap, hit, scratch, pinch and bite other people. Additionally, when out she would either grab at other people or at goods on shop shelves. Her parents also thought that some of her vocalisations could be very loud. Ms Cox was also known to have epilepsy.

Assessment

I gathered information about Ms Cox’s behaviour from a number of sources. I interviewed her parents, her Care Manager, her schoolteacher and her previous respite care worker. I was unable to interview Ms Cox as she has no verbal language. A functional analysis of Ms Cox’s behaviour was completed. This is where a record of her challenging behaviour was made; this involved noting what the antecedent or setting events to the behaviours were, the target or challenging behaviours themselves were recorded as well as what the consequent events were (Emerson, 1995; Murphy &
Oliver, 1987). This is also known as an A-B-C analysis. The topography of Ms Cox’s challenging behaviours were also explicitly described to allow accurate monitoring; these behaviours became known as target behaviours. It was decided that Ms Cox’s mother complete the monitoring because if I had done this I may have disrupted Ms Cox’s environment so that we would not have recorded an accurate baseline of her target behaviours. Mrs Cox was coached on how to accurately record the target behaviours.

**Formulation**

The first three weeks of Mrs Cox’s behavioural monitoring was used as a baseline of Ms Cox’s target behaviours. Seventy-seven behaviours were recorded, averaging to 25 a week and around 3½ a day. Approximately one half of these behaviours were Ms Cox slapping and around 40 per cent were scratching. The antecedents to these target behaviours were what I labelled ‘care-taking’ behaviours, where other people were in close proximity to Ms Cox and carrying out such activities as bathing or providing meals. The main consequence of the target behaviours was that Ms Cox received social attention in some way, for example, she could be reprimanded or her arms physically put down. Mrs Cox was the recipient of 90 per cent of the behaviours.

For the formulation I hypothesised that the setting condition for the challenging behaviour was the family home and the close proximity of carers. The carers and the care-taking activities they were engaged in acted as the discriminative stimulus. This stimulus signalled the availability of the positive reinforcers, such as social interaction and carer attention. However, this was contingent on the presentation of the target behaviours. It was found that the positive reinforcers were not provided on each
presentation of the target behaviours, hence I believed the reinforcers were on an intermittent reinforcement schedule.

**Intervention**

A behavioural approach was used to intervene with Ms Cox's challenging behaviour. This approach has been demonstrated to be an effective intervention strategy, particularly for challenging behaviour with people with learning disabilities (Emerson et al., 2000). It is based on behaviourist principles, namely those of operant behaviour, where behaviour is shaped or maintained by its environmental consequences (Emerson, 1995). Following recommendations of a socially valid intervention, costs and benefits of intervening were considered (Emerson, 1995) and it was decided that some form of intervention would be beneficial. Consent was also considered.

Behavioural guidelines were drawn up and Mrs Cox was given the responsibility of carrying them out. I closely supported her to help solve any difficulties or offer any guidance. A number of behaviourist techniques were employed. The environment of the antecedent stimuli was changed, this was where carers would position themselves in relation to Ms Cox to reduce the chance of the target behaviours occurring, but still being able to carry out care-taking activities. Differential reinforcement of other behaviour was also used, where Ms Cox received reinforcement for not engaging in the target behaviours. Maintaining contingencies of the target behaviours was also modified. This is where if Ms Cox engaged in the target behaviours, the expected positive reinforcers were not given.
Outcome

Though Mrs Cox continued to monitor Ms Cox’s behaviour throughout the intervention, lapses did occur. So in the last week of my involvement I asked Mrs Cox to closely monitor and record all target behaviours. Over the week, five behaviours were recorded, averaging to less than one a day, which was a reduction from the baseline.

Critique

On the whole, the intervention appeared to be successful. The behavioural guidelines were given to Ms Cox’s new respite care. Two points need to be made about the intervention. Firstly, the target behaviours became ‘squeezed’ into one care-taking activity, which was giving medication. This remained an issue for ongoing work. Secondly, Mrs Cox reported that though Ms Cox’s target behaviours had reduced she was vocalising more. Though this behaviour was present form the outset, it was never considered to be a target behaviour. It is possible that the vocalisations served the same function as the target behaviours, which questioned whether a constructional approach, where a person’s behavioural repertoire is increased, was strictly adhered to in the intervention.

References


Core Child, Adolescents and Families Placement
Placement details

Dates: October 2003 to March 2004

Supervisors: MATERIAL REDACTED AT REQUEST OF UNIVERSITY

Region: South West London and St George’s Mental Health NHS Trust
(Wimbledon, South London)

Summary of placement experience

This placement offered me good experience of working with toddlers, children, adolescents and their families. On placement I worked mainly within a cognitive behavioural and behavioural framework, but also being able to use systemic ideas. My method of working largely depended on who I was engaged with, their age and type of presenting problem. My clinical work included assessment interviews, individual psychological interventions, psychometric assessment, joint work with colleagues and co-facilitating a group. I was able to work over two settings; Tier 2, where children and families with milder difficulties are seen, and Tier 3, where more complex difficulties are managed. The clients I had contact with had a mix of ethnic origin, all came from the community and ranged in age from 18 months to 15 years old.

Clinical skills and experience

Presenting problems of clients I worked with included, low mood, anxiety, behavioural problems, toileting problems and sleeping difficulties. When I worked with adolescents on an individual basis, reviews meetings were often held which included parents and carers. With younger children presenting with behavioural
problems, I mainly worked with parents, sometimes colleagues were also involved in this work. With another clinical psychologist I worked with a family, taking a more systemic approach. I helped co-facilitate a self-esteem group with another clinical psychologist. This group was for children aged between 6 and 11 years old. For psychometric assessment I used the Wechsler Preschool and Primary Scale of Intelligence – 3rd edition (WPPSI-III), Wechsler Intelligence Scale for Children – 3rd edition (WISC-III), Wechsler Objective Reading Dimensions (WORD) and the Rey-Osterrieth Complex Figure. I also used the Beck Youth Inventories, the Beck Depression Inventory – 2nd edition (BDI-II) and was exposed to the Connors ADHD scale. All of my work was conducted within the Tier 2 and Tier 3 team bases. As well as working with my supervisors I was able to observe them, as well as observing a paediatrician and nurse therapist.

Meetings, seminars, visits and research

I was able to meet up with a number of different professionals to discuss their roles, these included, a paediatrician, a specialist nurse therapist, a family psychotherapist, psychiatrists and a music therapist. I attended regular team meetings of the Tier 2 service, during one of which I gave a presentation regarding one of my clients. I also attended some Tier 3 referral meetings. I also had the opportunity to visit a school and help with an autistic spectrum disorder assessment. I also had the chance to attend child protection training.
Case Report Summary

Cognitive behaviour therapy with a 14-year-old adolescent with low mood: difficulties experienced in the process of engagement and intervention

Some details have been changed to preserve anonymity of the client and their family

Referral

Dee was referred by her G. P., who noted that she engaging in self-harming behaviour, and having difficulties at school and with her relationship with food.

Presenting problem

Dee described thoughts and feelings of low mood. She also reported thoughts of low self-efficacy and low self-esteem. She described occasional symptoms of anxiety and panic. She expressed feelings of anger towards herself, saying she was fat and ugly. She admitted to harming herself, mostly cutting her forearms. She felt pressures from her peer group to fit in and conform.

Assessment

My supervisor conducted the first assessment session with Dee and her parents, Mr and Mrs Evans, a meeting which I was unable to attend. I was present at the second assessment meeting, which was attended by my supervisor, Dee and Dee’s older sister, Fiona. Information was gathered from these face-to-face interviews. Mrs Evans reported no problems with Dee’s birth and pregnancy and that Dee growing up was a lively, sociable child. Difficulties emerged when Dee started to attend school;
problems were noted with literacy skills. She was also bullied. She was found to have
dyslexia and in Year 10 she began attending a specialist school for children with
dyslexia, and at the time of assessment she was making good progress. She described
a two-year history of low mood ascribing this to pressures of schooling and peer
relationships. She completed a Beck Depression Inventory – 2nd edition (BDI-II; Beck
et al., 1996) and scored within the severe range of low mood. Both parents were
concerned for Dee. Mrs Evans reported that she herself had suffered from low mood
in the past.

**Formulation**

A cognitive behavioural led formulation was used based on the work of Beck *et al.*
(1979) and Beck (1995). However, I choose to add factors into this conceptualisation
in order to place Dee into some context. In my formulation, I suggested that Dee’s
early experience of being bullied and teased at school fostered development of core
beliefs about herself that were along the lines of, ‘There is something wrong with me’
and ‘I have to be kind to other people so that they like me’. Critical incidents and
trigger events I suggested involved Dee’s life events and transitions, such as changing
school, peer pressure and entering adolescence. These events led Dee to have negative
automatic thoughts such as ‘I am useless’ and ‘People don’t like me’ leading to
symptoms of low mood and self-harming behaviour. In the formulation I also added
considerations of vulnerability factors to her low mood, the impact of Dee’s social
environment, and how her low mood was maintained in her family context, as she felt
guilty for causing her parents to worry. I also added consideration of protective
factors, in recognition that she was a caring, supportive, loyal person.
**Intervention**

Though there are only a limited number of clinical trials investigating the efficacy of cognitive behavioural therapy (CBT) it has been shown to be effective in treating adolescents with low mood (Harrington *et al.*, 1998; Reinecke *et al.*, 1998).

In my case report I chose to discuss themes of my intervention, whilst staying within a CBT framework. As noted in the literature the therapeutic relationship is important determinant of outcome (Wright & Davis, 1994). Dee and I experienced difficulties in our relationship. I turned up late for our first session, she turned up late for our fifth session. I also questioned Dee’s motivation to change, wondering if there were more gains staying as she was. She was very embedded into the low mood. I also discussed relational issues, speculating how Dee and I felt towards each other. Dee also found it very difficult to talk about herself, which would often interrupt the flow of the sessions, she also refused to discuss her self-harming behaviour. There was also a sense that Dee felt out of control within her family environment.

**Outcome**

Dee did not attend our final session together. Mrs Evans phoned up saying she was ill. As I left the placement, my supervisor made arrangements to see Dee. Dee completed another BDI-II, which my supervisor gave me a copy of, she again scored with the severe range, but her score had increased from the assessment.

**Critique**

At times it felt like I spent too much time trying to build a relationship with Dee rather than engage in CBT work. Though her mood changed within sessions, I neglected to
'chase the affect' there and then, this would have been useful as it could have allowed the examination of the thinking and feeling process *in vivo*. I could have used techniques from motivation enhancement (Miller & Rollnick, 2002) to help Dee consider change. Finally, in my formulation I did not consider anxiety, which may have been a useful place starting work with Dee.

**References**


Core Older People Placement
Placement details

Dates: April 2004 – September 2004
Supervisor: MATERIAL REDACTED AT REQUEST OF UNIVERSITY
Region: Surrey Oaklands NHS Trust (Redhill, Surrey)

Summary of placement experience
This placement offered me with experience of working with older people, their families and the their carers. I was based within an Older People Community Team, caring for clients based in the community, but which also had close links with an older people in-patient unit. I worked within a cognitive behavioural model of intervention. My clinical work included assessment interviews, individual psychological interventions and psychometric assessments. The age of clients ranged from 47 to 86 years old, were a mix of male and female and were all from a White-British background.

Clinical skills and experience
The majority of my work was conducted in the community, this is where I visited clients in either their own home, in warden-assisted accommodation, in sheltered accommodation or in care homes. I also spent some time working on the in-patient unit. Presenting problems of clients I worked with included, low mood, anxiety, obsessive-compulsive disorder, post-traumatic stress disorder and sleep difficulties. Often these difficulties could be seen in the context of physical conditions. I also had the opportunity to work with a couple. My work also involved me carrying out psychometric assessments; referrals were made for dementia assessments or self-
reported memory difficulties. I was able to use the following assessment tools: WAIS-III, Wechsler Memory Scale – 3rd edition (WMS-III), Wechsler Test of Adult Reading (WTAR), Repeatable Battery for the Assessment of Neuropsychological Status (RBANS), Mini Mental State Examination (MMSE), Graded Naming Test, Graded Work Reading Test, the Hayling test, Controlled Oral Word Association Test (COWAT), Trail Making Test (TMT), Stroop Neuropsychological Screening Test (SNST). I also used the Geriatric Depression Scale, HADS and the BAI. During some of this work I was able to interview client family members. I was also able to observe my supervisor on occasion.

Meetings, seminars, visits and research

I attended the weekly team meeting, made up of members of the community team, which included psychogeriatricians, psychiatrists and community nurses. In the meeting discussion of ongoing client work and new referrals took place. As part of my clinical work I was able to visit the types of accommodation listed above, as well as the in-patient unit.
Case Report Summary

Neuropsychological assessment with a 70-year-old woman. Assessment for indications consistent with a dementia type process.

Some details have been changed to preserve anonymity of the client and their family

Referral

Mrs Hammond was referred by her G.P. It was noted that she was experiencing mild symptoms of low mood, that she was socially withdrawn and also experiencing feelings of loneliness. The anti-depressant medication she was prescribed appeared not to be helping her mood. The G.P. had also spoken to one of Mrs Hammond’s daughters, who felt her mother was becoming increasingly confused, but the G.P. found no evidence of this.

Presenting problem

When I met Mrs Hammond at her warden-controlled accommodation I found little clinical evidence to suggest that she was depressed. She did report though that she was having difficulty with her memory, something that was in evidence when I asked her some orientation questions. During my visit, Mrs Hammond’s daughter, Mrs Ingle, arrived. Mrs Ingle expressed her concerns regarding her mother’s memory and how this impacted upon Mrs Hammond’s ability to care for herself. I was concerned that Mrs Hammond’s poor memory was of clinical significance so I took the decision to offer a neuropsychological assessment, to help investigate if this was a result of ageing or a possible dementia process.
Pre-assessment information

Mrs Ingle and one of Mrs Hammond’s other daughters, Mrs Johnson, confirmed that previously their mother did present low in mood, this was four years prior to my assessment. There was no evidence of depression before this. Around three to four years prior to my assessment Mrs Hammond’s memory difficulties first emerged and overtime she had become increasingly prone to confusion. Mrs Hammond had been diagnosed with non-insulin dependent diabetes, both daughters were concerned that with their mother’s memory difficulties, how effectively she could manage this. Mrs Hammond had also been diagnosed with ischaemic heart disease, deep vein thrombosis, atrial fibrillation, hypertension, balance disorder, urinary urgency and migraine. Mrs Ingle reported that her mother had also had a couple of cerebrovascular accidents, though not much was known about these and a cerebral scan had not been carried out. These medical conditions are associated with an increased risk of dementia (Jacques & Jackson, 2000), which can be defined as a cognitive decline in memory and two or more cognitive domains, as established by neuropsychological testing (Roman et al. 1993).

Mrs Hammond had already had prior contact with the older people service 32 months prior to my assessment. She was given the Mini-Mental State Examination (MMSE; Folstein et al., 1975) and achieved a score of 23 out of 30, a score which may indicate cognitive dysfunction. She also completed the Geriatric Depression Scale (Yesavage et al., 1983), she scored 19 indicating a mild level of depression. She was offered follow-up appointments, but refused to attend and so was discharged.
Assessment

To assess for possible signs of dementia I gave Mrs Hammond the following neuropsychological assessments: Wechsler Adult Intelligence Scale – 3rd edition (WAIS-III; Wechsler, 1999), Wechsler Memory Scale – 3rd edition (WMS-III; Wechsler, 1997), Wechsler Test of Adult Reading (WTAR; Wechsler, 2001), Repeatable Battery for the Assessment of Neuropsychological Status (RBANS; Randolph, 1998), MMSE, Graded Naming Test (GNT; McKenna & Warrington, 1983), Graded Word Reading Test (GWRT; Schonell, 1955), the Hayling Test (Burgess & Shallice, 1997), Controlled Oral Word Association Test (COWAT; Ruff et al., 1996), Trail Making Test (TMT; Soukup et al., 1998), Stroop Neuropsychological Screening Test (SNST; Trenerry et al., 1989), and the GDS.

I completed these assessments over 5 sessions, Mrs Hammond remained motivated throughout and hence I believed the results were an accurate reflection of her cognitive abilities.

Findings

Mrs Hammond’s intellectual ability fell within the borderline range. Her memory ability fell within the extremely low range. An estimate of these pre-morbid abilities could not be calculated. Her language abilities fell within the low average to borderline range. Executive functioning tests demonstrated levels of impairment. Impairments were also suggested on the dementia screening tools. Her score on the GDS suggested no low mood.
Discussion

Given Mrs Hammond's neuropsychological profile, I concluded that she was exhibiting signs consistent with a dementia process. I found that I was unable to distinguish if this was a vascular dementia or Alzheimer's disease. I fed back my results to Mrs Hammond and Mrs Ingle. In my report I recommended contact with the older people service be re-established and that a nursing and possibly occupational therapy assessment be carried out. I also recommended that she have a cerebral scan.

Critique

I carried out a lot of testing with Mrs Hammond this was possibly too much. I also had to take care when interpreting certain tests, making sure I was using age-appropriate standardised norms. I paid no attention to possible effects of medication upon Mrs Hammond's performance, as she was taking a number of tablets. I also neglected to take full account of some of the qualitative aspects of assessment.

References


Specialist Neuropsychology Placement
Placement details

Dates: October 2004 – March 2005

Supervisors: MATERIAL REDACTED AT REQUEST OF UNIVERSITY

Region: North West Surrey Mental Health Partnership (Woking, Surrey)

Summary of placement experience

This, my first specialist placement, gave me the opportunity to work within a neuropsychology setting. On placement I mainly worked on a rehabilitation unit within a multidisciplinary team. This team was made up of a number of different professionals, including, specialist doctors in rehabilitation medicine, nurses, rehabilitation assistants, occupational therapists, physiotherapists, and speech and language therapists. I had contact with in-patients, when they were resident on the unit, completing neuropsychological assessment and rehabilitation work, but also had the chance to follow them up, as out-patients, when they were discharged. I also spent time at a psychology department based at the local General Hospital conducting outpatient neuropsychological assessments. Clients I had contact with had different neuropsychological presentations and ranged in age from 18 to 63 years old, were a mix of male and female and were mostly from a White-British background.

Clinical skills and experience

Conditions clients presented with included: cerebral trauma following a road traffic accident, other kind of accident or a fall; the cognitive effects following of either a cerebrovascular accident, chronic fatigue syndrome or multiple sclerosis; the cognitive
effects of a genetic condition, which in this case was Klinefelter syndrome. Clients presented with a range of problems, which included memory difficulties, executive functioning difficulties, language problems, as well as the physical difficulties associated with the conditions noted above. On placement I used the following assessments: WAIS-III, WMS-III, WTAR, the Hayling and Brixton tests, COWAT, TMT, SNST, Adult Memory and Information Processing Battery (AMIPB), Behavioural Assessment of Dysexecutive Syndrome (BADS), Test of Everyday Attention (TEA), Modified Wisconsin Card Sort Test (MWCST) and the Orientation Log (O-Log). I also used the HADS, BDI-II and BAI. I was able to observe both my supervisors, I also observed occupational therapists, physiotherapists and speech and language therapists in their work. As I worked as part of the team I also had a role in the rehabilitation of in-patients. Here I consulted with other professionals in regard to rehabilitation methods as well as active work in the rehabilitation of memory and executive functioning difficulties. As part of my assessment and rehabilitation work I consulted with client family members as well as other professionals when clients were out-patients.

Meetings, seminars, visits and research

I attended the weekly in-patient team meeting. Here, ongoing client work was discussed, as well as new referrals and unit business. I also attended client goal planning meetings as well as client case conferences.
Case Report Summary

Neuropsychological assessment and the early stages of rehabilitation with an 18-year-old man following a head injury

Some details have been changed to preserve anonymity of the client

Referral

Kenny was referred to the rehabilitation unit where I was on placement from the local General Hospital. He was initially admitted to the General Hospital following a road traffic accident in which he sustained a serious head injury.

Presenting problem

Kenny had his accident whist travelling at around 60 miles per hour. When emergency services arrived on the scene, they took 30 minutes to extract him from his car. On arrival at the local Accident and Emergency department, he had a Glasgow Coma Scale (GCS; Teasdale & Jennett, 1974) of seven, indicating a severe head injury. He had an open head wound on the left side of his skull, exposing his brain. He was immediately transferred to the regional brain injury unit and underwent an operation. The accident had performed a partial left-sided craniotomy. The operation resected his skull and surrounding cerebral area. Radiology reports revealed that he had sustained multiple skull fractures, damaged his seventh cervical vertebra, fractured the ulna bone in his right forearm, and had a number of cerebral haemorrhagic contusions. He was cared for in the intensive treatment unit. Two weeks after the accident his GCS was 11, he was unable to make any verbal responses; he was transferred back to
the local General Hospital. Three weeks after the accident another CT scan was taken of his head; extensive oedema within the deep white matter of his cortex was found and there were suggestions of extensive left cerebral inflammation and abscess formation within his left frontal lobe. His lack of spontaneous speech did improve.

Kenny was transferred to the rehabilitation unit one month after his accident. On admission he was walking unaided. He wore a neck brace and also a splint on his right forearm and wrist. There was no purposeful movement of his right arm and hand. He was speaking and had good comprehension, though was experiencing word finding difficulties. He reported experiencing memory difficulties. His shorter-term memory was problematic. He had retrograde amnesia of around three weeks and reported post-traumatic amnesia of a couple of weeks.

When anyone was admitted to the unit an extensive assessment was always carried out by the multi-disciplinary team. The results of this then go on to structure the person’s rehabilitation. My role within this procedure was to assess Kenny’s cognitive abilities.

**Pre-assessment information**

King and Tyerman (2003) highlight four possible areas of impairment associated with severe head injury. The first is memory, the second is attention, the third is executive functioning, and the fourth is language. I planned to assess Kenny in these areas. On assessment he had very limited use of his right hand (he was usually right-handed) and was still experience language difficulties, I had to consider these limitations when I came to test selection and interpretation.
Assessment

I conducted the following assessments with Kenny: Adult Memory and Information and Processing Battery (AMIPB; Coughlan & Hollows, 1985), Behavioural Assessment of Dysexecutive Syndrome (BADS; Wilson et al., 1996), Test of Everyday Attention (TEA; Robertson et al., 1994), the Hayling and Brixton tests (Burgess & Shallice, 1997), Controlled Oral Word Association Test (COWAT; Borkowski et al., 1967), Modified Wisconsin Card Sort Test (MWCST; Nelson, 1976), Wechsler Test of Adult Reading (WTAR; Wechsler, 2001), the Arithmetic, Digit Span and Matrix Reasoning sub-tests from the Wechsler Adult Intelligence Scale – 3rd edition (WAIS-III; Wechsler, 1999), the Spatial Span test from the Wechsler Memory Scale – 3rd edition (WMS-III; Wechsler, 1997), Hospital Anxiety and Depression Scale (HADS; Snaith & Zigmond, 1994).

Kenny remained engaged in all the assessments, showing effort in his performance, therefore I regarded his results as reliable measures of his then cognitive functioning.

Findings

Results suggested he was experiencing significant difficulties with verbal memory, both longer and shorter term. He scored within the average range of visual memory. He demonstrated significant impairment in all areas of attention. His performance on the executive functioning tests was variable. When these involved a language component, impairment was found, otherwise he scored within the average range. Significant impairment was found with his information processing speed, even when motor speed was taken into account. He reported no clinically significant anxiety related or depressive symptoms.
Rehabilitation

The results of my assessment, as well as other professional assessment, suggested that Kenny was experiencing extensive cognitive difficulties, as well as other physical difficulties. My role in his rehabilitation, as part of a team, was to discuss memory strategies and aids with him; as well as problem solve any difficulties his cognitive abilities were causing him. Regular team meetings reviewed Kenny’s progress as well as setting goals for his continued rehabilitation. Just before I left the placement Kenny had just returned to college, which I helped plan.

Critique

One of the difficulties in educating people about memory strategies is whether they become generalized to everyday life. Though Kenny could use strategies, it was not clear if he used them outside of the unit. Even though he did start keeping a diary, he chose to stop after a couple of weeks, feeling it did not suit him. It would have been useful to complete some follow-up assessments with Kenny as he made good progress. It was also difficult to judge the prognosis of the head injury for Kenny himself and his family.

References


Placement details

Dates: April 2005 – September 2005

Supervisor: Rhona Trotter (Consultant Clinical Psychologist)

Region: South West London and St George’s Mental Health NHS Trust
(Kingston upon Thames, Surrey)

Summary of placement experience

This second specialist placement offered me good experience of working within a primary care mental health setting, working alongside clinical and counselling psychologists. I mainly worked within a cognitive behavioural model, but was able to integrate ideas from a psychodynamic, systemic and mindfulness perspective. I had contact with clients who presented with a range of mental health difficulties, conducting assessment interviews and engaging in therapeutic interventions. I had the opportunity to work across two settings, the first being the primary care team base, and the second was working in a local G.P. surgery. I also co-facilitated two groups with my supervisor. Client ages ranged from 20 to 62 years, were mostly female and predominantly came from a White-British background.

Clinical skills and experience

Clients I had contact with presented with the following mental health difficulties: low mood, anxiety disorders, including panic attacks and obsessive-compulsive disorder, and eating problems. Being a primary care setting I learnt how to deliver therapy within a 12-session or less period. One group I co-facilitated was called the Stress Management Course and ran for seven weeks. It was aimed at helping group members
manage stress in the context of low mood and different forms of anxiety. The second group was a 4-week specialist panic disorder group. I used the BDI-II, BAI, GHQ, MOCI and Stirling Eating Disorders Scale (SEDS) as assessment tools on my placement.

Meetings, seminars, visits and research

When I have been available I have attended the weekly team meeting. Usually at these meetings seminars are held, such as perspectives of mindfulness and the work and referral system of the psychotherapy service. I was able to observe a G.P. conducting his morning consultation surgery. Additionally, I discussed the role of psychology within the primary care setting with different professionals. I also helped in assessing the efficacy of the Stress Management Course.

No case report was written whilst on this placement.
RESEARCH DOSSIER

Overview

The research dossier is made up of the research assignments that were completed through the course of clinical training. It is made up of the Service Related Research Project that was completed in Year One and the Major Research Project that was completed in Year Three. It also includes the logbook of my research experience.

A Qualitative Research Project was also completed in Year Two, as it was a compulsory piece of work. However, as it does not form part of the formal process of assessment on the course I have not included it here. The project was completed in collaboration with five of my colleagues, it was formally assessed and received a pass grade.
An investigation into the current practices of a Community Mental Health Team in providing early intervention services for individuals with a first-episode of psychosis.

June 2003

Year 1
Abstract

An investigation into the current practices of a Community Mental Health Team in providing early intervention services for individuals with a first-episode of psychosis.

Objective. The study aimed to carry out an audit and service evaluation of a Community Mental Health Team (CMHT). This was in relation to Department of Health led guidelines concerning the initial contact with an individual experiencing their first-episode of psychosis. In particular, the duration of the untreated psychosis, use of hospitalisation, use the mental health act, and details of the first CMHT assessment were investigated. Pathways into care were also examined.

Design. A retrospective casenote study.

Method. Members of the CMHT were asked to identify those individuals on their current caseload who had their first psychotic episode and been under the care of the team within the last four years. Twenty-seven potential participants were identified, 23 of which were entered into the study. All participants’ casenotes were examined and data extracted.

Results. Two measures of the duration of untreated psychosis were taken. The first, from the onset of psychotic symptoms to initiation of treatment, had an average length of 15 months. The second, from the onset of symptoms to symptom remission, had an average length of 18 months. The data was found to be positively skewed, hence the data was reanalysed excluding two outlying cases. Of the sample, 57% were
hospitalised during their first-episode of psychosis. Nearly all of these participants needed to be sectioned during this time, making up 48% of the total sample. Concerning the pathways into CMHT care, 61% of the sample came from GP referrals, 26% came from a hospital admission and 13% came from another healthcare body referral. For the CMHT’s first assessment four locations were identified with only 17% of them being conducted at the participant’s own home. Parental involvement in the first assessment was found in 39% of cases.

**Conclusion.** The CMHT demonstrated positive practice in regard to the duration of untreated psychosis. However, more consideration is needed in the use of hospitalisation and use of the mental health act, as well as in the location of the first assessment and parental involvement.
Introduction

In the NHS Plan the Department of Health (DoH, 2000) set out an agenda for the provision of mental health services for those individuals experiencing their first-episode of a psychotic breakdown. It outlines that a number of specialist teams should be set up within the National Health Service (NHS), with the mandate to provide care for these individuals and offer support for their families.

The recognition for providing early intervention services (EIS) was first outlined in the National Service Framework (NSF) for Mental Health (DoH, 1999). Here it was maintained that the early assessment and treatment of individuals who show the first signs of a psychotic illness can reduce the level of morbidity.

This position is based on research evidence demonstrating the benefits of early intervention by mental health teams, particularly in the reduction of the duration of untreated psychosis (DUP), which is the time between the onset of frank psychotic symptoms and their treatment. Studies have shown that a shorter DUP was associated with lower levels of behavioural disturbance and family difficulties (Johnstone et al., 1986), a shorter length of time to remission and a higher level of remission (Loebel et al., 1992; Malla et al., 2002). This suggests that a shorter DUP leads to better outcomes (McGlashan, 1998).

Further research, however, has questioned this link. Ho et al. (2000) found no association with DUP and quality of life, symptom severity and remission. Barnes et al. (2000) found no relationship between DUP and deterioration in the psychotic
illness. This has led reviewers to conclude that DUP may be related to the ease of reducing psychotic symptoms in first-episode individuals (Norman & Malla, 2001). However, Verdoux (2001) claims the evidence is still unclear demonstrating the need for further research as well as leaving the question open that reducing DUP leads to better outcomes (Larsen et al., 2001).

This current state of the literature does not negate the possible benefits of early intervention and reducing the DUP. These benefits include reducing unnecessary suffering and chaos (McGlashan, 1999; Norman & Malla, 2001) both for the individual and their family when facing a psychotic illness, and the possibility in establishing a good therapeutic alliance with services (Larsen et al., 2001).

Following the NHS Plan (2000), the DoH published their Mental Health Policy Implementation Guide (2001) detailing how EIS should be set up and what they should aim to achieve. For the purposes of this study some of these guidelines have been examined. In particular, regarding the DUP the Guide states that services should reduce the length of time individuals remain untreated. Though the Guide does not state how long this should be other authors have recommended that it should be, on average, less than three months and not exceed 6 months (The Newcastle Declaration, 2002).

Following standard one of the NSF (DoH, 1999), which aims to reduce discrimination of those with mental health problems, the Implementation Guide states that stigma associated with psychosis should be reduced. The effects of stigma are often experienced by people with psychosis (Dickerson et al., 2002) and by those caring for
them during a first-episode (Czuchta & McCay, 2001). The DoH (2001) recommends that this should be achieved in a number of ways, particularly through the decreased use of both the Mental Health Act (MHA; DoH, 1983) and hospitalisation; two experiences which can be stigmatising for the individual involved, especially when labelled as mentally ill during a first-episode (DoH, 1999; Verdoux 2001). Additionally, the DoH (2001) also recommend that the first assessment of an individual showing first signs of psychosis should be carried out in a low stigma setting, preferably their own home.

The Implementation Guide also recommends that family and carers should be involved in the assessment process as early as possible, preferably from first contact. This aligns with standard six of the NSF (DoH, 1999) where the assessment of carer’s needs are encouraged and steps are taken to foster a collaborative approach to care.

Given the issue of DUP, it is important to establish how those individuals with first-episodes come into contact with services and how this pathway of care led them to the service that handles their ongoing treatment, which would be a Community Mental Health Team (CMHT). Research has shown that General Practitioners (GPs) play an important role here (Lincoln et al., 1998).

Aims

The aim of this study was to carry out a service evaluation and audit of a CMHT. It aimed to assess how current levels of care compare to DoH guidelines and recommendations for a service during initial contact with an individual experiencing their first-episode of psychosis. Current practice in relation to the guidelines detailed
above was examined, specifically concerning issues regarding DUP, stigma and involvement of family.

The research questions were generated from the CMHT, to ascertain the effectiveness of the current service in meeting the needs of those experiencing their first-episode. The reason behind using the DoH (2001) guidelines is that these provide useful benchmarks to which a service should aspire. Therefore findings from the study will be useful to the CMHT in knowing where to improve the service, if they are falling behind DoH standards; as well as continuing and consolidating good practice, particularly in the absence of an EIS, where skills can be transferred to. Whilst it is recognised that the CMHT under study is not a specialist EIS, evaluation is needed as it studies the only available service.

Research questions

Specific areas examined were;

- What was the length of the DUP?
- What was the pathway into care?
- Was the individual hospitalised during their first-episode of psychosis and was the MHA (DoH, 1983) used during this time?
- Where was the first assessment carried out by a member of the CMHT? Also, were family members or carers involved in this assessment?
Method

Setting

A CMHT based in North Surrey with a catchment population of approximately 67,600 people. Within the regional NHS Trust an audit into the establishment of an EIS for psychosis was already being undertaken. This study was a separate project from this audit, but aimed to compliment it providing additional information for service providers.

Procedure

All members of the CMHT were asked to identify those service users on their caseload who had had their first psychotic episode and had also been under the care of the CMHT in the last four years. This four year time span was chosen as it is approximately the amount of time an EIS should care for an individual following their first-episode (DoH, 2001). Additionally, the CMHT also kept a first-episode file holding names of those who have had their first breakdown. This file was inspected. Once service users were identified their casenotes were retrospectively examined. If data was missing from the casenotes or was unclear then care co-ordinators were approached to provide further information.

Participants

Twenty-seven participants were originally identified. Two first entered into services via a different CMHT and subsequently moved into the catchment area, therefore their first contact details were unavailable. One individual’s casenotes were with another team and one was found to have their first-episode over seven years ago. This left 23
participants who were entered into the study. Demographic variables are shown in Table 1.

Table 1. Characteristics of the participant sample.

<table>
<thead>
<tr>
<th>Variable</th>
<th>Sample characteristics</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sex</td>
<td>16 male&lt;br&gt;7 female</td>
</tr>
<tr>
<td>Current age (years)</td>
<td>Mean 25.3 years (standard deviation 5.06) &lt;br&gt;Range 18-35 years</td>
</tr>
<tr>
<td>Ethnic origin</td>
<td>16 White British&lt;br&gt;1 Mixed race (White and Black Caribbean)&lt;br&gt;1 Bangladeshi&lt;br&gt;5 Not officially recorded</td>
</tr>
<tr>
<td>Current living arrangements</td>
<td>10 Living at home with parent(s)&lt;br&gt;1 Living with adopted parents&lt;br&gt;6 Living at home with parent(s) and sibling(s)&lt;br&gt;2 Living independently with partner and child(ren)&lt;br&gt;1 Living independently with partner&lt;br&gt;1 Living independently alone&lt;br&gt;1 Living alone with children&lt;br&gt;2 Resident on hospital ward</td>
</tr>
<tr>
<td>Current daytime activity</td>
<td>5 in education&lt;br&gt;8 in employment&lt;br&gt;10 unemployed</td>
</tr>
<tr>
<td>Length of time under care of CMHT (months)</td>
<td>Mean 25.25 months (standard deviation 15.45)&lt;br&gt;Median 22.17 months&lt;br&gt;Range 0.2-47.97 months</td>
</tr>
</tbody>
</table>

Measures

To answer the research questions, the following data was extracted;

- date of emergence of first positive psychotic symptoms,
- date when first seen by a member of the CMHT,
- where and who was in attendance at this first assessment,
- date when and if the participant was first hospitalised, and details if the MHA (1983) was used,
- the pathway of care into the CMHT,
• date when the participant was stabilised on medication.

The data extracted from the casenotes was recorded on a data collection form (see Appendix 1).

**Duration of Untreated Psychosis**

According to Norman and Malla's (2001) review DUP has been interpreted in a number of ways. In this study DUP was defined in two ways; firstly, the time between the onset of frank psychotic symptoms and the initiation of treatment (DUP-I). Initiation of treatment was defined either as, the first time the participant was assessed by a member of the CMHT and came under CMHT care, or when the participant was first hospitalised. Secondly, the time between the onset of frank psychotic symptoms and the point where the participant was stabilised on medication (DUP-S), namely, when symptoms were treated and went into remission.

This study deliberately avoided the concept of the prodromal phase of a psychotic illness, which comprises of pre-psychotic symptoms (Yung & McGorry, 1996). Since their onset is more difficult to assess than discrete psychotic symptoms (Beiser et al., 1993) and are often unreliable indicators of a psychotic episode (Malla & Norman, 1994) it was believed that their onset and measurement would be difficult to assess.

It was expected that data from the casenotes could be missing or unclear and that time data may not be exact. In light of this some time span data was ordered into months.
Results

Duration of untreated psychosis

Of the 23 participants, onset of psychosis could be ascertained in 22 cases. Table 2 shows details related to DUP-I and is broken down into male and female participants. It also shows details of the DUP-S analysis. Of the 22 participants whose onset was ascertained, 21 were tried on anti-psychotic medication and are included in the DUP-S.

Table 2. DUP-I and DUP-S analysis of the male and female participants, and of the entire sample (standard deviations are in parentheses).

<table>
<thead>
<tr>
<th></th>
<th>Males</th>
<th>Females</th>
<th>Overall participants</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age at emergence</strong></td>
<td><strong>of first psychotic</strong></td>
<td><strong>of first psychotic</strong></td>
<td><strong>of entire sample (standard deviations are in parentheses)</strong></td>
</tr>
<tr>
<td>symptoms (years)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>n=15</td>
<td>Mean 21.81 years</td>
<td>Mean 23.11 years</td>
<td>Mean 22.22 years</td>
</tr>
<tr>
<td></td>
<td>(4.6)</td>
<td>(8.9)</td>
<td>(6.09)</td>
</tr>
<tr>
<td></td>
<td>Median 20.75 years</td>
<td>Median 26.42 years</td>
<td>Median 21.38 years</td>
</tr>
<tr>
<td></td>
<td>Range 16.33-30.92 years</td>
<td>Range 8.08-32.25 years</td>
<td>Range 8.08-32.25 years</td>
</tr>
<tr>
<td><strong>DUP-I (months)</strong></td>
<td>n=15</td>
<td>n=7</td>
<td>n=22</td>
</tr>
<tr>
<td></td>
<td>Mean 4.22 months</td>
<td>Mean 39.09 months</td>
<td>Mean 15.32 months</td>
</tr>
<tr>
<td></td>
<td>(4.38)</td>
<td>(61.81)</td>
<td>(37.16)</td>
</tr>
<tr>
<td></td>
<td>Median 3 months</td>
<td>Median 4.4 months</td>
<td>Median 4.2 months</td>
</tr>
<tr>
<td></td>
<td>Range 0.23-17.77 months</td>
<td>Range 0.23-134.4 months</td>
<td>Range 0.23-134.4 months</td>
</tr>
<tr>
<td><strong>DUP-S (months)</strong></td>
<td>n=14</td>
<td>n=7</td>
<td>n=21</td>
</tr>
<tr>
<td></td>
<td>Mean 7.12 months</td>
<td>Mean 40.93 months</td>
<td>Mean 18.39 months</td>
</tr>
<tr>
<td></td>
<td>(4.86)</td>
<td>(62.6)</td>
<td>(38.18)</td>
</tr>
<tr>
<td></td>
<td>Median 5.4 months</td>
<td>Median 5 months</td>
<td>Median 5.3 months</td>
</tr>
<tr>
<td></td>
<td>Range 2-20.5 months</td>
<td>Range 0.6-138.5 months</td>
<td>Range 0.6-138.5 months</td>
</tr>
</tbody>
</table>

Table 2 shows the average age of onset for the first-episode was just over 22 years for the sample. Males and females differed slightly with males entering their first-episode...
before females. The average DUP-I was 15.32 months, with a median of 4.2 months. For DUP-S, the average was 18.39 months, having a median of 5.3 months. Females had a longer average DUP on both measures. Given such a difference between the mean and median both DUP measures were examined graphically (see Figures 1 and 2).

**Figure 1.** A histogram of the DUP-I (n=22).

![Figure 1: Histogram of DUP-I](image)

**Figure 2.** A histogram of the DUP-S (n=21).

![Figure 2: Histogram of DUP-S](image)
Figures 1 and 2 show that DUP-I and DUP-S were positively skewed, two cases having a long DUP. Both of these participants are female and had very early onset, one at 8 years old, one at 13 years. Both of these participants experienced one discrete psychotic symptom at their onset and by strict inclusion criteria should be included in the study. However, they did not display a constellation of symptoms that are used to diagnose a psychotic episode, which all other participants did present. Therefore their first-episode onset is not clearly defined. It was decided to exclude these two cases and reanalyse the DUP (see Table 3).

Table 3. DUP-I and DUP-S analysis of the sample excluding outlying cases (standard deviations are in parentheses).

<table>
<thead>
<tr>
<th>Participants</th>
<th>DUP-I (months) (n=20)</th>
<th>DUP-S (months) (n=19)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean 3.91 months (3.9)</td>
<td>Mean 6.39 months (4.48)</td>
</tr>
<tr>
<td></td>
<td>Median 3.5 months</td>
<td>Median 5 months</td>
</tr>
<tr>
<td></td>
<td>Range 0.23-18 months</td>
<td>Range 0.6-20.5 months</td>
</tr>
</tbody>
</table>

With the exclusion of the two outlying cases, the average DUP-I was 3.91 months, with a median of 3.5 months. The average DUP-S was 6.39 months, with a median of 5 months.

Of the 22 cases, it was found that 77% had a DUP-I under six months, including 45% who had a DUP-I under three months. The remaining 23% had a DUP-I over six months (see Appendix 2).
Pathways into CMHT care

Table 4 shows that the majority of referrals (52.2%) came from the participant’s GP after they were seen by them. A further 8.7% also came from the GP, but the participant was not seen directly. Another 26.1% of referrals came via hospitals as the CMHT was contacted to continue their care following discharge. The final 13% were referred from another healthcare service.

<table>
<thead>
<tr>
<th>Referral route</th>
<th>Number of sample (percentage)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(n=23)</td>
</tr>
<tr>
<td>GP</td>
<td>12 (52.2%)</td>
</tr>
<tr>
<td>GP but no personal contact</td>
<td>2 (8.7%)</td>
</tr>
<tr>
<td>Admission to hospital</td>
<td>6 (26.1%)</td>
</tr>
<tr>
<td>Other healthcare body</td>
<td>3 (13%)</td>
</tr>
</tbody>
</table>

Hospitalisation during first-episode and use of the MHA (1983)

Thirteen participants, representing 56.5% of the sample, were hospitalised during their first-episode of psychosis. Of these, five were sectioned and admitted under the MHA (1983) and eight were informally admitted. However, of these eight participants six were converted to a section. Therefore 47.8% of the total sample were sectioned during their first psychotic episode.

Of the 13 participants who were hospitalised, seven were done so before seeing a member of the CMHT and five were admitted after.
CMHT first assessment

Tables 5 and 6 give details of the first assessment after the participants had been referred. The majority of assessments were carried out by a Psychiatrist, with 30% of the other assessments carried out by different team members. In terms of location of the assessment, only 17.4% were carried out in the participants’ own home.

Table 5. Which member of the CMHT carried out the first assessment?

<table>
<thead>
<tr>
<th>Member of CMHT</th>
<th>Frequency (percentage) (n=23)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychiatrist</td>
<td>16 (69.9%)</td>
</tr>
<tr>
<td>Community Psychiatric Nurse</td>
<td>4 (17.4%)</td>
</tr>
<tr>
<td>Mental Health Worker</td>
<td>2 (8.7%)</td>
</tr>
<tr>
<td>Social Worker</td>
<td>1 (4.3%)</td>
</tr>
</tbody>
</table>

Table 6. Location of the first assessment by the CMHT.

<table>
<thead>
<tr>
<th>Location of first assessment</th>
<th>Frequency (percentage) (n=23)</th>
</tr>
</thead>
<tbody>
<tr>
<td>CMHT base</td>
<td>10 (43.5%)</td>
</tr>
<tr>
<td>Health centre/GP</td>
<td>5 (21.7%)</td>
</tr>
<tr>
<td>Hospital out-patients</td>
<td>4 (17.4%)</td>
</tr>
<tr>
<td>Home</td>
<td>4 (17.4%)</td>
</tr>
</tbody>
</table>

At the first assessment one or both parents attended in the case of nine participants (39.13% of the sample). Thirteen participants (56.52%) did not have their parents in attendance. In one case the information was unclear.
Discussion

Twenty-three participants were entered into the analysis of this study. The results are discussed in relation to the research questions outlined in the introduction. The findings are also discussed in regards to service delivery recommendations.

Duration of Untreated Psychosis

The DUP-I was found to have an average duration of 15.32 months and a median of 4.2 months. The DUP-S was found to be, on average, 18.39 months and having a median of 5.3 months. These results can be compared to other studies of DUP. According to Malla and Norman’s (2001) review they found that the average DUP can range from 5.4 to 26.35 months, with median DUPs ranging from one to six months.

It was found that the distributions of the DUP-I and DUP-S were positively skewed as there were two outlying cases. The data was reanalysed excluding these cases. The DUP-I then had an average of 3.91 months and median of 3.5 months. The DUP-S had an average of 6.39 months and median of 5 months. With such short DUPs, the CMHT are performing well in picking up first-episode cases and fall within the DoH (2001) guidelines and recommendations of The Newcastle Declaration (2002). As about three quarters of the sample were picked up within six months of the emergence of their psychotic symptoms and just under a half of the sample were seen within three months. These results are encouraging as individuals experiencing their first-episode appear to be detected and treated quickly. Such practices should be transferred to an EIS.
Pathways into care

The majority of the referrals came from the participant’s GP, though some participants were not directly seen by them. As around one quarter of referrals came from hospital admissions it shows that this proportion of the sample are not being picked up by their GP or the CMHT during their first-episode, but the episode is severe enough to warrant hospital admission. The remaining participants were referred from other healthcare bodies, where their care was being undertaken until they showed signs of psychosis.

These results show that GPs are playing a major role towards the recognition and referral for treatment in first-episode psychosis. Such work helps reduce the DUP. However, some cases remained undetected and were only picked up once they had been admitted to hospital. Closer working links with GPs could help overcome this problem, as well as increasing mental health awareness in the catchment population, which should include points of contact should someone be suspected of having a breakdown.

Hospitalisation and the MHA (1983)

It was found that over half of the entire sample were hospitalised during their first-episode. This number is made up of those who were admitted to hospital before contact with their GP or CMHT, but also those who, after seeing a member of the CMHT, were felt ill enough to require a stay in hospital. It was also found that nearly half of the sample were sectioned during their first-episode.
Given that both being hospitalised and sectioned can cause stigma and be traumatic for the young person involved, this finding requires further investigation. Maintaining the individual at home should be considered carefully and admission to hospital needs careful planning to optimise treatment and reduce the impact upon the person.

**CMHT first assessment**

Most of the first assessments were carried out at the CMHT base. In total around four-fifths of these assessments were conducted in medical settings. Only one-fifth of assessments were carried out in the individual’s own home. Seeing new clients within healthcare settings may be the usual practice for the CMHT. However, with individual needs being considered, more flexibility in contact may be required to help foster a more collaborative approach and comply with DoH (2001) guidelines.

Psychiatrists conducted over two-thirds of the initial assessments. One or both parents attended less than half of these assessments. Considering that a joint collaborative approach should be undertaken, this figure may be too low. Parental or carer involvement should be encouraged as well as parents being contacted for their help and guidance.

**Limitations of the study**

The data collected for this study relied upon the quality of the reporting in the casenotes. Where data was either missing or unclear it lowered the accuracy of the study, especially when time frames were needed.
Potential participants could have been missed. One of the inclusion criteria for this study was the selection of those who were on the current caseload. This could mean that cases that were closed, but fulfilled other inclusion criteria, were neglected. This could have led to a sample bias and skewed the results, if closed cases differed from current cases on the studied variables.

Parental attendance at the first CMHT assessment is a poor measure of parental involvement. It is likely that more parents were involved than the results would suggest. Future studies should investigate if parents were independently seen by members of the CMHT, where they were seen and how they were contacted.

**Conclusions**

From the outset it was recognised that the CMHT under study was not a specialist EIS. However, given that it is the only service available to individuals with first-episode psychosis, it’s practices concerning this significant life event deserved investigation, using DoH guidelines as a benchmark. Results from the DUP show that the practices of the CMHT are encouraging. However, there are certain procedures that are in practice that could cause stigma for the individual as well as overlooking possible needs of their family. These issues may need to be addressed.
Acknowledgements

I would like to thank all members of the CMHT in North Surrey that I have had the opportunity to work with, including the Team Co-ordinator, CPNs, Social Workers and Mental Health Workers.

I would also like to thank the team's Consultant Clinical Psychologist, my field supervisor, for her time, guidance and patience. Thanks too to my university research supervisor.

The results of this project were fedback to the CMHT from where the data came (see Appendix).
References


## Early Intervention Audit: Data Collection Form

### Demographic Information

<table>
<thead>
<tr>
<th>Information</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date of data collection</td>
<td></td>
</tr>
<tr>
<td>Participant identification code</td>
<td></td>
</tr>
<tr>
<td>Date of birth</td>
<td></td>
</tr>
<tr>
<td>Age (years, months)</td>
<td></td>
</tr>
<tr>
<td>Sex</td>
<td>male/female</td>
</tr>
<tr>
<td>Ethnic origin</td>
<td></td>
</tr>
<tr>
<td>Current living arrangements</td>
<td></td>
</tr>
<tr>
<td>Current daytime activity</td>
<td></td>
</tr>
</tbody>
</table>

### Emergence of first positive psychotic symptoms

<table>
<thead>
<tr>
<th>Information</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date of emergence of psychotic phenomena</td>
<td></td>
</tr>
<tr>
<td>Symptoms of psychotic phenomena</td>
<td></td>
</tr>
<tr>
<td>Age (years, months) at first symptoms</td>
<td></td>
</tr>
<tr>
<td>Living arrangements</td>
<td></td>
</tr>
<tr>
<td>If family home, both parents present</td>
<td>yes/no</td>
</tr>
<tr>
<td>Siblings present (in family home)</td>
<td>yes/no</td>
</tr>
<tr>
<td>How many</td>
<td></td>
</tr>
<tr>
<td>Daytime activity</td>
<td></td>
</tr>
</tbody>
</table>

### First seen by GP for psychotic symptoms

<table>
<thead>
<tr>
<th>Information</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date when first seen by GP</td>
<td></td>
</tr>
<tr>
<td>Indication who initiated GP contact</td>
<td>yes/no</td>
</tr>
<tr>
<td>Who</td>
<td></td>
</tr>
<tr>
<td>Indication if anyone else attended at GPs</td>
<td>yes/no</td>
</tr>
<tr>
<td>Who</td>
<td></td>
</tr>
<tr>
<td>GP offer medication</td>
<td>yes/no</td>
</tr>
<tr>
<td>What kind</td>
<td></td>
</tr>
<tr>
<td>Date of referral letter from GP to CMHT</td>
<td></td>
</tr>
</tbody>
</table>
### First assessment with a member of the CMHT

<table>
<thead>
<tr>
<th>Information</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date when first seen by member of CMHT</td>
<td></td>
</tr>
<tr>
<td>Location of first assessment</td>
<td></td>
</tr>
<tr>
<td>Which member of the CMHT</td>
<td></td>
</tr>
<tr>
<td>Anyone else attending</td>
<td>yes/no</td>
</tr>
<tr>
<td>Parents attending</td>
<td>yes/no</td>
</tr>
<tr>
<td>Who</td>
<td></td>
</tr>
<tr>
<td>Symptoms noted</td>
<td></td>
</tr>
<tr>
<td>Diagnosis given</td>
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### Intervention offered by CMHT

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<td>Which ones</td>
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<td>If not accepted, reasons given</td>
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Service Related Research Project 200
## Appendix 1: Data collection form

### Duration of untreated psychosis (DUP)

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<td>Time between emergence and CMHT</td>
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<td>Time between GP and CMHT</td>
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</tr>
<tr>
<td>Time between emergence and 1st hospitalisation</td>
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<tr>
<td>Member of CMHT seen before 1st hospitalisation</td>
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</tr>
<tr>
<td>Date when stabilised on medication</td>
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<td>Time between emergence and stabilised</td>
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### Hospitalisation and use of the Mental Health Act (1983)

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<td>Number of days under section</td>
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</tr>
<tr>
<td>If MHA (1983), which section</td>
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</tr>
<tr>
<td>Length of section</td>
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<tr>
<td>Length of hospital stay</td>
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</tr>
<tr>
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<tr>
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<td>Length of section</td>
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<tr>
<td>Length of hospital stay</td>
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Appendix 1: Data collection form

**Delays in treatment**

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<td>Where did these delays occur</td>
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<td>Causes to these delays</td>
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**Create timeline**
## Appendix 2: Frequency count for the Duration of Untreated Psychosis

### Frequency count for the Duration of Untreated Psychosis

#### Duration of untreated psychosis (emergence to initiation of treatment) (DUP-I)

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<th>Valid Percent</th>
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#### Duration of untreated psychosis (emergence to stabilisation on medication) (DUP-S)

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<th>Valid Percent</th>
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</table>
Mr Peter Bray

KT/VG

9th June 2003

Dear Peter

I am writing to you to confirm that your small Scale Research Project that you carried out with us is an audit. This complies with the BPS and University regulations regarding such pieces of work.

Additionally, I am confirming that you will be feeding back your results to our service at a time to be arranged in July, when you will be coming in to give a presentation. This is also in compliance with the requirements of carrying out your project.

We look forward to seeing you again then.

Yours sincerely

Consultant Clinical Psychologist
East Elmbridge Community Mental Health Team
Appendix 4: Ethical confirmation of the project

University of Surrey
PSYCHD CLINICAL PSYCHOLOGY
Service Related Research Project
Ethical Scrutiny Form

The nature of the proposed project is such that I am satisfied that it will not require scrutiny by the trust's ethical committee.

Name of supervisor:....

Signature of Supervisor:

Name of Trainee:

Title of SRRP: AN INVESTIGATION INTO THE CURRENT PRACTICES OF A COMMUNITY MENTAL HEALTH TEAM IN PROVIDING EARLY INTERVENTION SERVICES FOR INDIVIDUALS WITH A FIRST-EPOSCD EPISODE OF PSYCHOSIS

Date: 09.06.03
Dear Peter

I am writing to thank you on behalf of the team for coming last week to present the findings of your small scale Research Project to our service here.

It has been of great interest, and will help with the future planning of Early Intervention in Psychosis Services. We look forward to receiving a copy of the shortened report to use in our services here.

Best wishes

Yours sincerely

Consultant Clinical Psychologist
East Elmbridge Community Mental Health Team

Surrey Oaklands
NHS Trust

East Elmbridge Community Mental Health Service
Joseph Palmer Centre
319a Walton Road
West Molesey
Surrey
KT8 2QG

Tel: 020 8873 4300
Fax: 020 8873 4356

11th August 2003
An investigation into the effects shame has on the recovery style of those individuals with a diagnosis of psychosis.

July 2005

Year 3
Abstract

Background
Two different kinds of recovery style from a psychotic episode have been identified, these are, integration and sealing over. Shame is a negative affect characterised by a global evaluation of the self, previous research has suggested that feelings of shame may be associated with the type of recovery style an individual adopts. Additionally, following a psychotic episode some individuals experience vulnerability in developing symptoms of low mood, this may also be associated with recovery style.

Aims
This study tested the hypothesis that those individuals who adopt a sealing over recovery style will report elevated levels of both internal and external shame, and also report more symptoms of low mood. It was also hypothesised that measures of shame and low mood will positively correlate.

Design
An independent group design was used comparing recovery style on measures of shame and low mood.

Method
Twenty-six participants all with a diagnosis of psychosis who had recovered from their most recent episode were recruited into the study. All were given self-report measures of recovery style, internal shame, external shame and low mood. A researcher rated measure of current psychopathology was also used.
Results

No significant differences were found between types of recovery style and measures of shame and low mood. Participants who had adopted a more integrative recovery style did report higher levels of shame, though this did not reach statistical significance. A tentative finding was that those participants who reported a more mixed recovery style reported elevated levels of shame and low mood. Significant positive correlations were found between both measures of shame and low mood. High levels of low mood and shame were found in the sample.

Conclusion

This study failed to support suggestions that shame and low mood are associated with one particular recovery style. Elevated levels of low mood were found in the sample, in line in previous research; elevated levels of shame were also found, a finding that may need to be addressed therapeutically.
Introduction

Recovery and psychosis

Since schizophrenia first became a distinct mental illness in the late 19th and early 20th centuries recovery from the condition has always been an important area of interest. Generally, these early accounts describing the schizophrenic process suggested a chronic decline in functioning (Bleuler, 1950). Current accounts offer a more balanced view of how a person recovers from a psychotic episode, claiming that decline and poor outcome is not an inevitable part of the illness (McGorry, 1992; Warner, 1994). Since the advent of early psychosocial interventions, anti-psychotic medication and more latterly atypical anti-psychotics and modern psychological interventions (for example, cognitive behavioural therapy; Morrison, 2002; Tarrier & Wykes, 2004) recovery from psychosis has been shown to be possible (Falloon et al., 1998). The term psychosis will be used throughout this study, as it is the preferred term in the current literature, this is instead of schizophrenia as this continues to be controversial diagnostic label (Hirschfeld et al., 2005).

This then begs the question of what exactly is recovery? This is difficult to answer and on the whole depends on the measures that researchers use over the study period to assess change. Recovery can mean a return to the previous levels of functioning before the psychotic episode. This can be broadly defined in two ways (Liberman et al., 2002); firstly, in terms of psychotic symptoms, where no symptoms remain. Secondly, social functioning, where the individual returns to social roles, such as vocational functioning, and social living, where there is a degree of independent
livelihood and maintenance of relationships. However, social functioning is a culturally defined phenomenon and can vary from one social group to another. Additionally, researchers have found wide heterogeneity in the outcome of psychosis (Harding et al., 1987) and for some full symptom recovery may never occur (Karitorgalsboen & Rund, 2002). It is estimated that between 16 percent and 38 percent reach full recovery from psychosis (Harrison et al., 2001). This suggests that recovery for the majority of people is never ultimately reached and that the illness is an ongoing process that needs to be managed in a person’s day-to-day context. There may be times when there is a return of psychotic symptoms and a decline in functioning, but other times when symptoms are absent or not so prominent and social functioning is at a level the individual expects.

**Recovery style**

Though recovery has played a central role in the research on psychosis, it tends to lack personal meaning. Consideration on how an individual come to terms with a psychotic illness, considering that it can be very disruptive, or adjust to its existence, especially when symptoms can be ongoing is often ignored. Essentially, what sort of sense is made out of the psychosis? Though not central to the outcome literature, personal meaning and methods of adaptation have been addressed; such examples are, sense of self in recovery (Davidson & Strauss, 1992; Shahar et al., 2004; Spaniol et al., 2002) and narratives of recovery (Forchuk et al., 2003; Thornhill et al., 2004). The first person accounts included in *Schizophrenia Bulletin* as well as other journals also demonstrate this. Authors often write about their struggles with the illness, the enlightenment it can offer, the sense they make of it, how they adjust to it and how
they have made their recovery possible (for example, Chadwick, 1997; Chapman, 2002; Fekete, 2004; Lovejoy, 1984). In a recent study Hirschfeld et al. (2005) carried out a qualitative investigation into what psychotic experiences mean for young men during their recovery period. One of the themes that emerged was in how the men coped with the experiences; they could either avoid the experiences by preventing or blocking them out, or by finding expression for the experiences, such as talking to friends, creating an internal dialogue or engaging in artwork. Hirschfeld et al. related these two methods of coping back to earlier work of McGlashan and his colleagues (for example, McGlashan et al., 1975) who originally found two distinct forms of coping or as they called it recovery style when individuals come to terms with a psychotic episode.

McGlashan and colleagues (Levy et al., 1975; McGlashan, 1987; McGlashan et al., 1976; McGlashan & Levy, 1977; McGlashan et al., 1975; McGlashan et al., 1977) from a research point of view looked at recovery style and how psychological adjustment is made to a psychotic illness (Tait et al., 2004). McGlashan et al. (1975) first highlighted two distinct forms of recovery style that may be adopted following an acute episode of psychosis. They labelled one recovery style as ‘integration’ and the other as ‘sealing over’. These labels grew from the psychoanalytic tradition of how an individual copes with the stressful events associated with a mental health difficulty (Levy et al., 1975). Though the authors viewed the integration and sealing over styles as distinct, they fell on a continuum (McGlashan et al., 1977), where an individual is more likely to adopt one style over another (McGlashan et al., 1975).
Integration

An individual who adopts an integrative recovery style is characterised by being more aware of continuity of their thinking, feelings and cognitive processes throughout their entire psychotic experience. This continuity spans from before the psychosis, during the psychosis to the eventual recovery period. The person takes responsibility for their thoughts and actions during the psychotic episode and recognise that the psychotic experience involves both pleasure and pain. The individual can use the experience as a source of information. Information that beforehand has not been readily available to them and that can help inform them about their own inner world as well as relationships with others and the world, which can allow them to re-evaluate personal conflicts and can cause an impetus for change. A curiosity about the illness is also fostered, as well as the person enlisting the help of other people to help understand the illness experiences. At recovery, the individual holds flexible attitudes towards the illness (McGlashan, 1987, p. 681). The person is more interpersonally involved with their illness (McGlashan & Levy, 1977) and there is a need to place it into some coherent perspective (McGlashan et al., 1976).

Sealing over

The individual who seals over has a tendency to isolate the psychotic experiences and symptoms. The psychotic mental activity is cut off from non-psychotic mental activity. The illness itself is seen as alien and is a source of interruption to everyday life. The cause of the illness is seen as something different from personal problems. Once the psychotic episode has gone, the individual keeps an awareness of the negative aspects of the illness and the pain associated with it; they have no desire to explore the aspects of the illness and so do not become emotionally invested with it. In
a sense the illness is consciously suppressed and repressed (McGlashan, 1987, p. 681). The person does not want to talk about their illness, as it offers no new information about the self and they fail to place it within a personal context. There is a strong inner push for the person to return to premorbid personality, which can be quite successful (McGlashan et al., 1977). McGlashan et al. (1976) characterise the sealing over style as, ‘the less said the better’ (p. 325).

McGlashan and Levy (1977) say that the recovery style adopted is a result of internal and environmental forces. Pain is often associated with the psychotic experience as it not only disturbs the individual’s thinking, it can also cause a disturbance in the relationships with other people; the person can experience the negative beliefs that are associated with mental illness, not only the beliefs that are internally held, but also the beliefs that are communicated from society at large. The person can either assimilate or integrate the illness or deny or seal it over in some way (ibid.). How an individual responds and adapts to their illness and the recovery style that is taken has implications for any intervention strategies (Thompson et al., 2003).

**Research and recovery style**

By clearly defining these recovery styles McGlashan and colleagues were able to clinically assess whether an individual recovering from a psychotic episode adopted an integrating or sealing over style. This was achieved through the use of 13 concepts of recovery, concepts that assessed how a person reacts, copes, thinks and feels towards the illness. These concepts are as follows (all descriptions are taken from McGlashan et al., 1977, p.184). Continuity, this is how the individual regards the
thoughts and feelings during the psychotic episode in relation to the emotional conflicts prior and subsequent to the episode. Ownership, whether the psychotic episode is experienced as personal or believed to be alien. Responsibility, how responsible the individual feels for the thoughts and actions during the psychotic episode. Curiosity, this concept looks at whether or not the individual is curious about the psychotic experiences. Education, this is how the individual treats the psychotic experiences as a new source of information about themselves. Help-seeking, this is whether the individual enlists the help of others in resolving the conflicts related to the psychosis. Blame, whether the illness is blamed on personal difficulties in coping with problems in life or blamed upon others or the environment. Cause, this is how the individual views the cause of the illness, whether an emotional or nervous breakdown or a medical type illness. Optimism, this is to what extent the individual sees positive aspects to the psychotic episode. Impact, this is how much of an impact the illness is regarded to have had on the individual’s life. Fear, this is how much the individual views the psychosis with fear and negativity. Liking, this is whether the individual liked some of the unusual experiences of the psychotic episode. Finally, satisfaction, this is how much the individual sees the psychosis in helping them move towards a more satisfied life.

These 13 concepts were operationalised into a research interview called the Integration Sealing Over Scale (ISOS; McGlashan et al., 1975). According to how an individual is assessed during the interview in relation to each of the concepts it can be determined whether they are either adopting an integrative or sealing over style. The ISOS also allowed further research to be carried out.
McGlashan *et al.* (1976) expanded on the ideas of integration and sealing over by presenting two contrasting case studies. The authors discussed how the psychosis is experienced and explored consequences on social relationships, both in terms of the person and the illness and the person and their environment. McGlashan and Levy (1977) found that those individuals who seal over were believed to be less vulnerable by staff when they were discharged from a therapeutic community. When interacting with people who seal over, staff felt more effective in their work as they believed that they helped the individual deal with problems, which allowed them to move on. Whereas interacting with more integrative individuals coping with the difficulties of coming to terms with the illness tended to arouse more difficult affect within staff members.

McGlashan (1987) in a long-term follow up study of mental illness found that those participants who had experienced a psychotic episode were more likely to adopt a sealing over style, compared to those individuals with a mood disorder. Unfortunately he offers no explanation why this may be the case. He also suggested that the recovery style adopted is a relatively enduring trait across the study follow up period, which was on average 15 years. McGlashan *et al.* (1977) endorsed this finding and found that day-to-day stress had little influence on recovery style. These authors also predicted that people who use an integrative recovery style would be more likely represent themselves and their illness with greater expression and with more ideas in their art work then those who seal over. Results supported these predictions.

McGlashan (1987) in his long-term follow up study also found that type of recovery style was associated with functional outcome. He found that the integrative style was
associated with better outcomes, which was defined by time in employment, social relationships and presence of symptoms at follow-up. Sealing over was associated with poorer outcomes. However, this study included a number of mental health problems that included, not only psychotic disorders, but also mood disorders and personality disorders. Though the strongest association between recovery style and outcome was found with mood disorders, the weakest association was found with psychotic disorders. This mirrors the findings of McGlashan and Carpenter (1981) who found that neither the integrative style nor the sealing over style related to outcome. Outcome was measured by presence of symptoms, need of hospitalisation, frequency of social contacts and employment over a follow up period of 12 months. However, they did find that not holding a negative attitude towards the psychotic illness led to more positive outcomes, but that holding positive attitudes did not lead to positive outcomes. Holding negative attitudes towards the illness is often found in the sealing over style, which can suggest some interaction between recovery style and outcome, though the relationship between the two appears to be complex. Warner et al. (1989) also suggest that acceptance of the mental illness label, which can be seen as part of the integrative style, is associated with better functioning.

Using a modified version of the ISOS, a self-report recovery measure called the Recovery Style Questionnaire (RSQ; developed by Drayton et al., 1998) Thompson et al. (2003) found that recovery style did relate to outcomes in a sample of individuals experiencing their first psychotic episode. These authors found that over a 12-month period, those people who adopted the integrative style were found to have better outcomes. Outcome was assessed using measures of quality of life and symptom scales. Thompson et al. also found that over the follow-up period around half their
sample changed recovery style, where the majority tended to shift towards a more integrating style. This suggests that recovery style is not a stable trait. The two findings from this study, style relating to outcome and changing styles, disagree with the earlier findings of McGlashan (1987), McGlashan and Carpenter (1981) and McGlashan et al. (1977). Differences between the studies are found in the sample studied and the therapeutic interventions used. Thompson et al. (2003) studied a younger first-episode sample where it is possible that recovery style in the early stages of the illness process is more fluid. This factor combined with modern and more intense therapeutic approaches, such as cognitive oriented therapy, appears to have led to the differences. Cognitive oriented therapy does appear to encourage the adoption of an integrating style as a more adaptive way of coping with a first episode of psychosis (Jackson et al., 1998).

Tait et al. (2003) found that recovery style was associated with service engagement. The authors measured recovery style, psychotic symptoms, insight and service engagement over three time points: onset of acute psychosis, and later at 3 months and 6 months. They found that the sealing over recovery style at 3 months predicted lower service engagement at 6 months. Insight or psychotic symptoms did not predict engagement, as well as insight not predicting recovery style. This suggests that recovery style has important clinical implications.

Tait et al. (2003) also found that recovery style changed over the six months, mirroring Thompson et al. (2003) findings, though the recovery style went in the opposite direction. It was found that over the first 3 months recovery style shifted from integration to sealing over, this occurred independently of insight and presence
of symptoms. Additionally, sealing over between 3 and 6 months was associated with improvement in psychotic symptoms. Tait et al. (2003) speculate as to the cause of this shift, they say that in the early stages the integrative recovery style is adopted as in the early treatment there is the attempt to constructively cope with the demands of the psychotic episode. However, as recovery continues, the individuals become aware of the negative impact and consequences of psychosis (as discussed by Will, 1987), hence there is an increased motivation to seal over.

It is interesting to speculate on the difference between changes in recovery style in the Tait et al. (2003) and Thompson et al. (2003) studies. It is possible that if Tait et al. (2003) followed up their sample for another 6 months then the recovery style could have shifted again and it is unfortunate that changes in style are not known in the early months of the Thompson et al. (2003) study. Difference may also be due to the sample studied, the Tait et al. (2003) sample consisted of individuals who had experienced multiple episodes of psychosis, rather than the first-episode of the Thompson et al. (2003) sample. Adoption of recovery style may be a result of many, possibly negative, experiences with the illness.

Up until now discussion has focused on what recovery style is associated with or what it leads to. There are only a few studies that address the causes in adopting one particular recovery style over the other. Why does one person adopt an integrative style over a sealing over style?

Drayton et al. (1998) found that the sealing over recovery style was associated with early insecure attachment with caregivers. Tait et al. (2004) replicated this finding of
early attachment difficulties and suggested that these early childhood experiences influence the psychological resources an individual can call upon in order to cope in the face of a traumatic event. When resources are impoverished and a traumatic event occurs, such as a psychotic episode, the person in coping is more motivated to seal over. Drayton et al. (1998) go on to highlight the clinical implications of recovery style in therapeutic treatment. They say that those who integrate may prefer an approach that fosters insight into the illness and how it might affect their lives, for example utilising relapse prevention. Those that seal over may be better suited to those approaches that reduce stress and build on skills that help in everyday living.

Tait et al. (2004) also found that early attachment difficulties extended into adult relationships. Participants reported more anxiety concerning interpersonal rejection and experiencing discomfort with closeness and dependence in relationships. The authors say that such interpersonal difficulties can explain low service engagement in those who seal over, as found by Tait et al. (2003). People who seal over, the style associated with insecure attachment, are going to find it more difficult to engage with mental health professionals.

Drayton et al. (1998) found that those individuals who seal over were more likely to be depressed and report negative self-evaluations. Tait et al. (2004) failed to replicate these findings, but found that those who sealed over, due to interpersonal difficulties, were more vulnerable to believe that other people viewed them in a negative way.

Birchwood et al. (2000) and Iqbal et al. (2000) found that the way a person appraises the psychotic episode in how they see it affecting their future and identity was critical
in how a person recovers. They say that the development of depression was associated with appraisals of loss and of shame. This led Tait et al. (2003) to speculate that those people who perceive more loss and more shame were more motivated to seal over in their recovery. This speculation leads to the current study. Looking particularly at shame this investigation hopes to examine if there is indeed a link between recovery style and shame. Aspects of shame will now be discussed, which will be followed by a brief discussion on psychosis and depression, which this study also aims to investigate.

**Shame**

The concept of shame was first clinically recognised by Freud (1905). He hypothesised that feelings of shame are related to the exhibition of sexual impulses. However, Freud was more interested in guilt, which he felt shame fell under. As he believed guilt was more closely linked to psychopathology, he paid little attention to shame. Though largely ignored by Freud shame has, until recently, been discussed mainly within the psychoanalytic tradition (Erikson, 1950; Lewis, 1971; Morrison, 1983). Over the last 15 years there has been an increased research interest in the clinical aspects of shame (Gilbert, 1998a) and it has taken on a more cognitive perspective. Shame has been recognised as a negative experience, one that is inherently painful and potentially destructive (Kaufman, 1989; Tantum, 1998). Gilbert (1997) says that shame ‘can be seen as an affective state that relates to perceptions of social standing and social status’ (p.113). Gilbert (2002) reports that shame has five components and can be experienced in a multifaceted way. The first of these is a social or external cognitive component. This is where other people or other groups of
people can induce shame, where feelings of inferiority, inadequacy and being flawed are generated. In this way shame is socially mediated. The second is an internal self-evaluative component, where global negative judgements are made about the self. The third is an emotional component. This is where feelings and emotions become part of the shame experience; these can include anger, anxiety and disgust (Kaufman, 1989). The fourth is a behavioural component. Here Gilbert (2002) points out defensive and submissive behaviours that indicate shame, such as averting eye gaze or running away. The final component is a physiological one, where shame is associated with a stress response.

Isolating shame

Modern researchers have struggled with defining shame and how it distinguishes itself from other affective states, such as guilt and humiliation. While the debate continues (see Gilbert, 1998b) there is some agreement as to what constitutes shame. The biggest challenge researchers have faced comes from distinguishing shame from guilt. It was Lewis (1971) who first noticed that the role of the self was important in differentiating shame from guilt. Reviewing modern research Tangney and Dearing (2002) were able to draw out similarities and differences between shame and guilt. The authors say that shame and guilt have the following in common; they are both moral affective states, referring to how a person perceives right and wrong; they are affective states that refer how the self is feeling; they are negative affective states; and on the whole they are experienced in interpersonal contexts.

According to Tangney and Dearing (2002, p.25) shame and guilt differ in the following areas. Concerning the focus of evaluation and impact on the self, shame is a
global self-evaluation, which is a negative global devaluation of the self, characterised by 'Who I am'; guilt focuses more on a specific behaviour where the self is not part of a global devaluation, and centres around 'What I did'. The authors maintain that shame is a more painful experience that guilt. Being in the shame experience evokes feelings of worthlessness, powerlessness and feeling small. There are motivational features of wanting to hide, escape or fight back. The guilt experience gives rise to tension, remorse and regret, where there is a need to confess apologise or repair. In regard to other people, shame provokes the concern of other people's evaluation of the self; guilt is more concerned about the effect the self has had on other people. On the whole, these conclusions mirror Gilbert et al. (1994) and Lewis' (1971, 1988) formulations of shame and guilt.

Though not as well researched as shame and guilt, attempts at delineating shame and humiliation have also been made. Gilbert (1997, 1998b) provides useful guidelines for the distinction. Shame and humiliation do share the effects of rumination, increased arousal and a desire to protect the self; there are also key differences. Noted from above there is the idea that something internal is bad or flawed that causes shame, though in humiliation, something external has caused the affect and that external source is bad. Shame heightens self-conscious feelings, whereas in humiliation, the focus is more centred on the other. Humiliation also generates a sense of injustice, but there is no obvious sense of injustice in shame.

*Origins of shame*

Gilbert (1997) proposes the evolutionary aspects of shame. He proposed that a lot of human activities in the social world are aimed at eliciting positive attention from
others. This helps gains an interpersonal image so that the person can be seen as attractive and acceptable to others, which allows positive social bonds to be created. The aim is to avoid negative attention and negative judgement from others. However, if social desirability and social attractiveness does decline or at least become threatened, shame can then be felt, as it is a reminder that can trigger rumination on the negative aspects of the self. Shame can act as a defensive signal to hide away those negative aspects in order to maintain the positive thoughts in other people. Shame can also act as ‘an involuntary response to an awareness that one has lost status and is devalued’ (Gilbert, 1998b, p.22).

Gilbert (1997) points out that shame can be induced by groups in order to gain conformity. This is an important point for this research as it relates to three connected points. The first concerns mental illness, which breaks down the ideas of conformity, the spoiled identity as Goffman (1968) calls it. In particular psychosis is well known to be a stigmatised condition (Dickerson et al., 2002; Rabkin, 1974; Schulze & Angermeyer, 2003). In this way the individual can become aware of the negative judgements from others that a psychosis can entail. This then connects to the second point of social and external shame, namely, to what extent does an individual believe that other people are thinking negatively about them and how much does it threaten them in a social world. Gilbert (1998b) labelled external shame as feelings associated with what the self thinks other people see as inferior, inadequate, bad and weak or ‘how one lives in the eyes of others’ (p.17). Stigma can be a very powerful trigger to this and can ‘down-rank’ an individual in a social context (Birchwood et al., 2002). Thirdly, knowing about and fearing these negative evaluations that could trigger feelings of shame, how does the individual react to and cope with this, especially
when they are recovering from psychosis, do they seal over or integrate? However, just because someone does have a stigmatised condition it does not automatically lead to self-devaluation (Crocker & Major, 1989; Goffman, 1968). People may recognise the external source shame of stigma, but it may not be internalised (Camp et al., 2002), it can possibly depend on how the individual evaluates the importance of other’s judgements (Gilbert, 1998a).

Gilbert (1998b) defined internal shame as seeing the self as being personally inferior, inadequate and bad; the person devalues the self. Vulnerability to internal shame has been proposed to start from early childhood experiences with caregivers (Cook, 1991; Kaufman, 1989; Schore, 1991). Children, through their behaviour, learn what feelings they evoke in others namely, approval or disapproval, which facilitates the development of an internal sense of shame (Gilbert, 2002; Gilbert et al., 1996). Internal shame has also been associated with early experiences of caregiver indifference, abandonment and rejection (Claesson & Sohlberg, 2002)². Though there is an element of socially mediated external shame, it is proposed that it is the early years that help to decide how much of the shame becomes internalised and how much shame becomes part of the self. Concepts of internal and external shame do overlap and both involve the idea of comparison. Comparisons are made on dimensions of same/difference and inferior/superior, with external shame this is made in comparisons with others, for internal shame the comparison mainly involves the self-ideal (Allan & Gilbert, 1995). External shame revolves around feeling shame in a social judging world, the recognition of being unattractive in the eyes of others, and

² This point is important as it helps thread together two parts of this study; the finding that early experience is associated with internal shame relates to Drayton et al. (1998) and Tait et al. (2004) findings, in that insecure early attachment could lead to the sealing over style.
can exist without internal shame. Internal shame is shame that is internally generated and is characterised by global self-evaluation, such as ‘I am inferior’, it is the self judging the self and falling short of some internal standard (Gilbert, 1998a). It is not currently clear how internal shame and external shame interact.

Shame has been found to have clinical implications. It has been associated with a number of mental health problems (Tangney & Dearing, 2002). These include alcoholism (Cook, 1988), depression (Allan et al., 1994; Tangney et al., 1992), eating disorders (Frank, 1991; Gilbert and Miles, 2002), social anxiety (Crozier, 2003) and suicide (Baumeister, 1990; Mokros, 1995). Shame can also be found in the therapeutic environment (Gilbert, 1997) as manoeuvres can be made by all parties to avoid exposing inadequacies and hence being shamed (Kaufman, 1989). This underscores the need to recognise shame in any therapeutic intervention, as engaging with this affect may lead to other clinical improvements in other areas.

Measuring shame

There are a number of measures of shame, the most popular being Cook’s (1988) Internalised Shame Scale (ISS) and Tangney and colleagues Test of Self-Conscious Affect (TOSCA; Tangney & Dearing, 2002). The TOSCA is a scenario based measure and includes a scale of guilt. The ISS is a self-report measure and will be used in this study. The ISS views shame as part of an individual’s identity where there is a sense of inferiority and inadequacy (Cook, 1993) and employs the use of global self-evaluative statements. The ISS has been criticised for lack of specificity (Gilbert, 1997) as earlier versions of the scale correlated quite significantly with measures of self-esteem (Tangney, 1996). However, Cook (1993) claims that later versions only
correlate modestly with self-esteem, but some overlap still remains (Gilbert, 1998b). Andrews (1998) also says that though it seems the ISS measures dispositional shame, it is not clear if this is influenced by negatively affective states like low mood and hence may not capture the full affect of shame.

As this study also aims to measure external shame, it will do this by using the Other As Shamer scale (OAS; Goss et al., 1994). The OAS is a self-report measure and is based on the ISS. It uses global evaluative statements but rewords items from the ISS to allow the individual to consider what other people think about them.

**Depression**

Clinical signs of depression are sometimes found in those following an episode of psychosis (Johnson, 1981; Sands & Harrow, 1999). In the past this has been labelled as post-psychotic depression, though this label appears to have lost some favour as researchers grapple with what it actually is (Carpenter & Price, 2000). Though incident rates vary widely, from 7 percent to 75 percent, there is agreement that there is a modal rate of around 25 percent (Siris, 2000). The onset of low mood following a psychotic episode occurs in no particular time frame (Green et al., 1990) and appears not to be associated with negative symptoms of psychosis nor medication (Barnes et al., 1989). Nor is it associated with side effects of medication (Johnson, 1981) or positive symptoms (Birchwood et al., 2000). Though there are indications that it can be associated with poorer social support and increased incidence of life events (Chintalapudi et al., 1993; Roy et al., 1983). When low mood does occur in the recovery period it has been associated with poor outcome, in terms of ability to work,
lowered activity and suicidal ideation (Sands & Harrow, 1999) and higher relapse rates (Carpenter and Price, 2000).

This finding of clinically low mood following an acute episode of psychosis is an important consideration for this study, as recovery may also intersect with depression. Returning to the concept of shame, it can be seen that the ideas of shame, particularly internal shame, overlap with the concept of depression and low mood, as both involve negative evaluations of the self. Indeed there is evidence to show that depression and shame are significantly correlated (for example, Gilbert et al., 1994). Additionally, Iqbal et al. (2000) found that those people who developed low mood in their recovery felt greater loss and entrapment by their illness, which may have an impact upon recovery style. It is feasible that to protect themselves from these appraisals people may seal over. However, it is also feasible that the integrative style can be associated with low mood, as individuals struggle to come to terms with their illness and all the challenges this presents. Lowered self-esteem has also been found in those recovering from a psychotic episode, which is also associated with depression (Gureje et al., 2004). However, low mood and low self-esteem have not been associated with the acceptance of the psychosis label (Birchwood et al., 1993), which can be part of the integrative style, though others have not been able to fully substantiate this finding (Warner et al., 1989). So it is of interest to investigate if low mood is associated with one particular recovery style.

**Aims**

The sample recruited into this study will come from a population of those people who have a diagnosis of psychosis and have recovered from their most recent episode. The
main aim of this research is to examine recovery style and how it is associated with shame. Both internal shame and external shame will be measured and whether higher levels of shame are associated with either integration or sealing over will also be investigated. Additionally, levels of depression will be assessed and then examined to see if low mood is associated with one particular recovery style.

Hypotheses

Given the above discussion, some hypotheses can be generated.

To bring this research in line with previous investigations, it is hypothesised that the participants in this study will report clinical levels of depression. It is unclear as to which recovery style will be associated with more severe low mood. There is evidence to suggest that the sealing over is associated with higher levels of depression (Birchwood et al., 2000; Iqbal et al., 2000; Tait et al., 2003), but this is not universally found (Tait et al., 2004). However, on balance of the previous research it is hypothesised that sealing over will be associated with higher levels of depression.

With regard to shame, it is hypothesised that those who seal over will experience higher levels of shame. This would be for both internal shame, as suggested by Drayton et al. (1998) and Tait et al. (2003), and for external shame attaching it to the fear of negative evaluation from others found by Tait et al. (2004) and suggested by Gilbert (1998b). As shame is a negative emotion, those who feel it more are more likely to seal over to protect themselves from it. However, this is a caveat to this position. Given that sealing over is a position of denial, it is conceivable that ideas of shame are also denied. So those who seal over may not report any shame at all.
Additionally, by integrating the psychosis more shame may be felt as it means coming to terms with a stigmatised condition. However, as noted above, there may be a divergence between internal and external shame. The individual may recognise the negative evaluations from others and be aware of external shame, but may not internalise this shame. This research aims to clarify these possibilities.

As well as shame measures positively correlating with each other, it is also predicted that these will positively correlate with measured levels of low mood.
Method

This study follows a non-experimental, cross-sectional correlation, one-way, independent groups design. The investigation uses recovery style as the independent variable, and the dependent variables being levels of shame and level of low mood.

Participants

The sample comprised of 26 participants all with a diagnosis of psychosis, confirmed on ICD-10 criteria (World Health Organisation, 1994). Participants were recruited from community mental health services, which were either continuing needs services or rehabilitation services. Table 1 (see results section) outlines the demographic characteristics of the sample.

Inclusion criteria for participants were:

1. a diagnosis of psychosis,
2. over 18 years of age,
3. English as their first language,
4. under the care of a mental health team with a named care co-ordinator,
5. have recovered from their most recent episode of psychosis.

As noted in the introduction the concept of recovery is not a fixed phenomenon and may never be fully achieved. Therefore this study defined recovery with some flexibility. As a minimum, the criteria for recovery was that participants were not in the acute phase of their illness and were able to live with some level of independence in the community. It was acceptable for participants to be experiencing residual
psychotic symptoms at the time of study and steps were taken to assess this. No participant was excluded from the study due to clinically significant expression of symptoms. Exclusion criteria for participants were either a diagnosis of drug-induced psychosis, schizo-affective disorder, or a definite organic cause to the psychotic condition. The diagnosis of schizo-affective disorder was excluded because a measure of mood was being used and results could be biased by the presence of an affective disorder.

Assessments

Four questionnaires and one psychiatric interview were used as assessments in this study.

Recovery Style

Recovery style was measured using the Recovery Style Questionnaire (RSQ). It is a self-report questionnaire developed by Drayton et al. (1998) and based on the ISOS, a semi-structured clinical interview, as used by McGlashan (1987). The ISOS was originally created to assess the recovery styles outlined by McGlashan et al. (1975), that of integration or sealing over. The ISOS is regarded as reliable and valid in measuring these recovery styles (McGlashan, 1987).

McGlashan et al. (1977) outlined 13 concepts of recovery that can be assessed to help the clinician decide which path of recovery style the individual is taking. These 13 concepts are: continuity, ownership, responsibility, curiosity, education, help-seeking, blame, cause, optimism, impact, fear, liking, and satisfaction. Descriptions of the 13 concepts can be found in the Introduction. Using these concepts, the ISOS interview
was created. The RSQ was developed to be a 39-item self-report questionnaire in which participants either agree or disagree with each statement, such as, ‘I am not interested in my illness’, thus reflecting the internal attitude towards their illness. The wording of the statements on the RSQ were carefully chosen by Drayton et al. (1998) to accurately reflect the 13 recovery concepts originally defined by McGlashan (1987). Each concept was assigned three statements, thus making up the 39 items.

According to how the participant responds to each group of three statements, each concept can then be assigned as either integration or sealing over. For example, if the participant scores in an integrating way on two or three of the statements then the concept is considered to be integrating. Using the example statement given above, an integrating style would be the participant disagreeing with it, whereas a sealing over style would be an agreement with it. Out of the 13 concepts the percentages of how many concepts fall into the integration style and how many fall into sealing over style is calculated. According to these percentages the RSQ then maps onto the global rating recovery style rating that was used with the ISOS, where there is a continuum from integration to sealing over. This continuum spans a 6-point scale, where a score of 1 is labelled as ‘integration’, 2 is labelled as ‘tends towards integration’, 3 is called ‘mixed picture in which integration predominates, 4 is ‘mixed picture in which sealing over predominates, 5 is ‘tends toward sealing over’ and 6 is ‘sealing over’. In their original paper, Drayton et al. (1998) used these six categories. So for example, after completing the RSQ the participant is found to have five integrating concepts. In the integrating calculation, 5/13 concepts equates to 38 percent and is mapped onto a
score of 4 on the ISOS, which is considered to be a mixed picture with sealing over predominating.

In later papers, Tait et al. (2003, 2004) used four categories: integration; mixed picture in which integration predominates; mixed picture in which sealing over predominates; sealing over, where the two categories at either end of the continuum were collapsed into one category. Drayton et al. (1998) also divided their sample into two categories: integration and sealing over, where the continuum was split in half down the middle.

The RSQ has been found to possess good test-retest reliability \((r = .81)\), where first and second administrations were within a month of each other. It also has acceptable internal reliability (alpha coefficient = .73). It has also been found to possess good validity when measured against the ISOS, achieving a correlation of scores \(r = .92\), and also in terms of how it can differentiate those who have a sealing over recovery style from those who have an integration style (Drayton et al., 1998). The authors also note that the RSQ is quick to use and can potentially be helpful with the research into the psychological adjustment to psychosis.

**Internalised Shame**

Internalised shame was assessed using the Internalised Shame Scale (ISS; Cook, 1994). The ISS is a 30-item self-report questionnaire, where 24 of the items contribute to a shame score and the other six items are taken from the Rosenberg Self Esteem

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3 Drayton et al. (1998) divided the 6-point ISOS continuum into the following integration percentages; a integration percentage between 0-17 per cent was equivalent to a 6 on the ISOS scale, indicating sealing over; 18-33 percent was a score of 5; 34-49 per cent was a score of 4; 50-67 per cent was a score of 3; 68-82 percent was a score of 2; 84-100 per cent was a score of 1.
Inventory (Rosenberg, 1989). The ISS was first devised by Cook (1988) to measure shame in people with alcohol difficulties. Since then it has undergone some revisions and has been administered to non-clinical samples as well as clinical samples (Cook, 1993).

Completion of the ISS requires participants to read the 30 statements, such as, 'I feel as if I am somehow defective as a person, like there is something basically wrong with me' and rate how often they feel this way on a five-point scale, from never to almost always. The 24 shame statements are then summed and make up the shame score; higher scores indicate higher levels of internalised shame. Cut off scores have been suggested (Cook, 1994), scores above 50 indicate possibly problematic levels of internalised shame and scores above 60 indicate high levels of shame and may be associated with symptoms of depression and anxiety.

Cook (1993) reported a psychometric analysis of the ISS using a student population and a clinical population, which included individuals with a diagnosis of alcohol problems, depression, anxiety disorders and eating disorders. Internal reliability for the non-clinical and clinical sample were high, with coefficients of .95 and .96 respectively. Test-retest reliability in a subset of the non-clinical sample over seven weeks was .84. Cook also reports that some validity exists for the ISS as it correlates significantly with other measures of shame. Rybak and Brown (1996) also found similar psychometric properties and some additional evidence of construct validity in the way the ISS differentially correlated with theoretically linked constructs. Such as positively correlating with negative affect measures.
As far as published studies are concerned, the ISS has not been given to a clinical sample diagnosed with psychosis. However, a dissertation abstract has been published (Stockwell-Byde, 2001). This study used a mixed sample of individuals with either a diagnosis of schizophrenia, bipolar disorder and major depression with psychotic features. The findings of the study suggested that internalised shame and low mood are closely linked.

**External Shame**

External shame was measured using the Other As Shamer scale (OAS; Goss et al., 1994), an 18-item self-report questionnaire. The OAS is based on the ISS, but where the ISS focuses on internal shame the OAS investigates how the individual perceives the way others judge or evaluate them; the focus is on how ‘others see me’ (*ibid.*). Items on the OAS are taken from the shame items on the ISS and reworded to allow statements to refer to the other as evaluator. Using the example given above for the ISS, this statement on the OAS then becomes, ‘Other people see me as somehow defective as a person.’ Like the ISS, participants when completing the OAS read the statements and record how often they feel that way on a five-point scale.

The OAS significantly correlates with the ISS, $r = .81$ (Goss *et al*., 1994). Similar to the Rybak and Brown (1996) study, Allan *et al.* (1994) found that the OAS correlated with theoretically linked constructs, such as depression. In performing a factor analysis of the OAS Goss *et al.* (1994) found a three-factor structure. The first factor they labelled as being seen as inferior, the second as emptiness and the third factor they termed as mistakes, how other people behave when mistakes are made. The OAS
used a student population as its normative group and there are no known studies where it has been used with clinical samples.

Depression

Low mood was assessed using the Beck Depression Inventory – 2nd edition (BDI-II; Beck, Steer & Brown, 1996), a 21-item self-report questionnaire. The BDI-II is an updated version of the original Beck Depression Inventory and is highly correlated with it ($r = .93$; Beck, Steer, Ball & Ranieri, 1996). Items explore different areas of thinking and behaviour that are often associated with low mood, such as guilty thoughts and sleeping. On each item the participant chooses one of four options, of increasing severity, with regard to how they have been feeling over the previous two weeks. For each item a score of 0 to 3 is achieved. Higher scores indicate increasing depression. Beck, Steer and Brown (1996) provide cut off scores for levels of severity; a score from 0-13 indicates minimal depression, 14-19 indicates mild depression, 20-28 indicates moderate depression, 29-63 indicates severe depression.

The BDI-II has good internal reliability (alpha coefficient = .91) and all items correlate positively with self-reported depression (Beck, Steer, Ball & Ranieri, 1996).

Psychotic symptoms

Psychotic symptoms were measured using the Structured Clinical Interview – Positive and Negative Syndrome Scale (SCI-PANSS; Kay et al., 1992). The SCI-PANSS is a 30-item semi-structured clinical interview measuring severity of psychotic symptoms as well as general psychopathology, such as hallucinatory behaviour, blunted affect, and lack of judgement and insight. The 30 items are then clustered into nine indices:
Positive, Negative, Composite scale of Positive minus Negative, General Psychopathology, Anergia, Thought Disturbance, Activation, Paranoid/Belligerence, and Depression. These composite scales are then used to create a profile for each participant. Comparing with a normative sample, clinically significant symptomatology on the nine indices can then be highlighted. The SCI-PANSS was used to assess the participants' current level of psychotic symptoms and explore any possible influences on shame and recovery.

The SCI-PANSS demonstrates good psychometric properties (Kay et al., 1992). Four indices, Positive, Negative, Composite and General Psychopathology, have all shown a normal distribution pattern. Internal reliability coefficients for these indices range from .73 to .83. Test-retest reliability for unremitting symptoms for these indices ranged from .77 to .89 over three and six months. Inter-rater reliability ranged from .83 to .87 (Kay et al., 1988). Construct validity was shown in how the Positive and Negative indices did not overlap once General Psychopathology was partialled out. Discriminant and convergent validity was shown in how the indices did and did not correlate with other assessments (Kay et al., 1987). Predictive validity has also been found. Factor analysis of the 30 items also supports the creation and structure of the nine indices (Kay et al., 1992).

**Procedure**

In the initial phase of the recruitment process, the care teams within the mental health services were approached. The teams were given a Care Team Information Sheet and asked to nominate suitable potential participants. Once identified, these individuals were approached by a member of the care team and asked if they were interested in
taking part in the research. If interested, they were given the Participant Information Sheet. If they remained interested and agreed to take part in the study, arrangements were then made with the researcher for the research interview to take place.

At the start of the research interview each participant was informed of their rights, the structure and content of the interview, and any questions they had were answered. They were informed of the events under which research confidentiality would be broken, such as safety and risk issues. Each participant gave signed consent. They then provided demographic information.

The four questionnaires discussed in the Assessments section were then given to each participant. The order in which the questionnaires were presented was varied. This was done to help counterbalance any potential response effects one questionnaire could have on the responses to subsequent questionnaires. Each participant was given the option to either fill out the questionnaires themselves or have the researcher read out the questions so that they could respond verbally. The majority of participants chose the latter and answers were recorded by the researcher. Once the questionnaires were completed the SCI-PANSS was then conducted.

On average each research interview lasted around 60 minutes. All data provided by participants was anonymised, as each participant was given a participation number that could not be traced back to them. If any of the assessments caused any concerns this was addressed with the researcher. At the end of the interview each participant was debriefed and any further questions or signs of distress were explored. No participant reported any distress. If any problems subsequent to the interview did
arise, or if the participant wanted to withdraw their data, the researcher gave details of how they could be contacted. Finally, each participant was asked if they wanted an information sheet outlining the general findings of the research, but were told that individual feedback could not be provided.

Statistical analysis

Data was analysed using the Statistical Package for Social Sciences for Windows, version 12.0.1. The \( \chi^2 \) test was used to analyse categorical data. Independent t-tests were used to compare recovery style group mean differences on measures of shame and low mood. Descriptive data was also used to examine group mean differences on these measures. Pearson correlations were used to examine associations between shame and mood measures. Parametric tests were chosen because it was believed that the data fulfilled parametric requirements; it was at least of an interval level and there was an equal level of variance for comparisons. The data was also tested for skew and kurtosis and as no statistically significant variance from normality emerged, normal distributions were assumed. However, it should be noted that data from the BDI-II was close to being positively skewed.
Results

Participant characteristics can be seen in Table 1.

Table 1. Participant characteristics (n = 26)

<table>
<thead>
<tr>
<th>Variable</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Sex (percentage)</td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>19 (73%)</td>
</tr>
<tr>
<td>Female</td>
<td>7 (27%)</td>
</tr>
<tr>
<td>Mean age in years (range; standard deviation)</td>
<td>41.3 (25-63; 11)</td>
</tr>
<tr>
<td>Ethnic origin (percentage)</td>
<td></td>
</tr>
<tr>
<td>White-British</td>
<td>23 (88%)</td>
</tr>
<tr>
<td>Asian</td>
<td>2 (8%)</td>
</tr>
<tr>
<td>Black-British</td>
<td>1 (4%)</td>
</tr>
<tr>
<td>Employment (percentage)</td>
<td></td>
</tr>
<tr>
<td>In work</td>
<td>7 (27%)</td>
</tr>
<tr>
<td>Voluntary work</td>
<td>2 (8%)</td>
</tr>
<tr>
<td>No employment</td>
<td>17 (65%)</td>
</tr>
<tr>
<td>Mean age at onset in years (range; standard deviation) (n = 24)</td>
<td>24.3 (13-42; 7.9)</td>
</tr>
<tr>
<td>Mean duration of illness in years (range; standard deviation) (n = 24)</td>
<td>16.5 (1.5-42; 12)</td>
</tr>
<tr>
<td>Mean number of admissions (range; standard deviation)</td>
<td>5.5 (0-15; 4.2)</td>
</tr>
<tr>
<td>Mean time since last admission in years (range; standard deviation) (n = 24)</td>
<td>2.9 (0.08-10; 2.5)</td>
</tr>
<tr>
<td>Medication (percentage)</td>
<td></td>
</tr>
<tr>
<td>Atypical antipsychotics</td>
<td>19 (73%)</td>
</tr>
<tr>
<td>Typical antipsychotics</td>
<td>7 (27%)</td>
</tr>
</tbody>
</table>

All data in Table 1 is reported directly from the participants, including age of onset, duration of illness, number of admissions, time since last admission and medication. Two cases are missing from mean age of onset, one did not believe he had an illness and the other could not remember. One other participant did not believe he had a
mental illness and others were unsure, however, they were able to say when they first came into contact with mental health services, and so here this is taken as a rough approximation of age of onset. Twenty-five cases are included in the mean time since last admission, as one participant had never been admitted into hospital.

*Measures of shame and low mood*

The clinical characteristics of the sample can be seen in Table 2; this table gives descriptive scores for the ISS, OAS and BDI-II. According to Cook (1994) scores above 50 on the ISS start to indicate possible problematic levels of shame, 31 percent of participants scored above this level. Using Beck, Steer and Brown's (1996) criteria for cut off scores on the BDI-II, 23 percent of the sample scored within the mild range of depression, 23 percent scored within the moderate range and 15 percent scored within the severe range. There are no known cut off scores for the OAS.

| Table 2. Clinical characteristics of the sample (n = 26) |
|-----------------|-----------------|-----------------|-----------------|-----------------|
|                | Mean            | Standard deviation | Minimum | Maximum |
| ISS             | 44.1            | 23.6             | 10      | 86     |
| OAS             | 31.9            | 15.97            | 2       | 63     |
| BDI-II          | 17.9            | 12.1             | 3       | 56     |

*Recovery style*

For this study McGlashan and colleagues' (for example, McGlashan *et al.*, 1977) original six categories on the recovery style continuum were kept to describe the data. Drayton *et al.* (1998) also kept this categorisation when they devised the RSQ. The following number of participants were found within each category; two participants
were in the integration category (8 percent of the sample); eight participants were in
the tends towards integration category (31 percent of the sample); nine participants
were in the mixed picture with integration predominating category (34 percent of the
sample); five participants were in the mixed picture with sealing over predominating
category (19 percent of the sample); no participants fell within the tends toward
sealing over category; two participants fell with the sealing over category (8 percent
of the sample). Using a chi-square analysis, differences in the numbers in each group
almost reaches significance ($\chi^2(4) = 8.2, p = .08$).

If the sample is collapsed into the two basic recovery styles of integration and sealing
over, 19 participants were categorised as those who integrate (73 percent of the
sample) and seven were classed as those who seal over (27 percent of the sample).

**Recovery style and clinical measures**

Table 3 shows the sample divided up into the six categories of recovery style and the
mean scores within each of these groups on the ISS, OAS and BDI-II. Due to the
small number of participants in each of the recovery style categories it was decided to
examine for differences between the two broad recovery style categories of integration
and sealing over. Table 4 shows the sample divided up into these two broad groups.
Using an independent groups t-test, there are no significant differences on the
measures of shame and low mood (ISS: $t(24) = 1.1, p = .3$, 2-tailed; OAS: $t(24)= 1.1,$
$p = .25$, 2-tailed; BDI-II: $t(24) = -.1, p = .9$, 2-tailed). Though it can be seen on both
the internal and external shame measures the integration group did achieve higher
scores. There was virtually no difference between the groups on the BDI-II.
Table 3. Recovery style (6 categories) and mean scores on the ISS, OAS and BDI-II (standard deviations in parentheses)

<table>
<thead>
<tr>
<th>Recovery Style</th>
<th>Integration (n = 2)</th>
<th>Tends towards integration (n = 8)</th>
<th>Mixed - integration predominates (n = 9)</th>
<th>Mixed - sealing over predominates (n = 5)</th>
<th>Tends towards sealing over (n = 0)</th>
<th>Sealing over (n = 2)</th>
</tr>
</thead>
<tbody>
<tr>
<td>ISS mean score</td>
<td>22.5 (17.7)</td>
<td>48.9 (20.6)</td>
<td>50.9 (26.7)</td>
<td>45.6 (18.6)</td>
<td>-</td>
<td>12 (0)</td>
</tr>
<tr>
<td>OAS mean score</td>
<td>16 (11.3)</td>
<td>37.4 (11.8)</td>
<td>35.2 (17.2)</td>
<td>32.2 (13.7)</td>
<td>-</td>
<td>10.5 (12)</td>
</tr>
<tr>
<td>BDI-II mean score</td>
<td>7 (1.4)</td>
<td>18.6 (10.9)</td>
<td>19.3 (14.9)</td>
<td>22.2 (11.2)</td>
<td>-</td>
<td>9 (8.5)</td>
</tr>
</tbody>
</table>

Table 4. Recovery style (2 categories) and mean scores on the ISS, OAS and BDI-II (standard deviations are in parentheses)

<table>
<thead>
<tr>
<th>Recovery Style</th>
<th>Integration (n = 19)</th>
<th>Seal over (n = 7)</th>
</tr>
</thead>
<tbody>
<tr>
<td>ISS mean score</td>
<td>47.1 (24)</td>
<td>36 (22.4)</td>
</tr>
<tr>
<td>OAS mean score</td>
<td>34.1 (15.3)</td>
<td>26 (16.2)</td>
</tr>
<tr>
<td>BDI-II mean score</td>
<td>17.7 (12.6)</td>
<td>18.4 (11.7)</td>
</tr>
</tbody>
</table>

Figures 1, 2 and 3 show the mean distribution of scores for the ISS, OAS and BDI-II across the categories of recovery style. Caution should be noted when looking at these figures, firstly, it can be seen that one category of recovery style is missing from the bar charts, this is the tends towards sealing over category and has been deliberately left out as no participants fell within this particular style. Secondly, there are very few participants at the two extreme ends of the recovery style continuum.
Figure 1. Mean score distribution of ISS scores across recovery style

Figure 2. Mean score distribution of OAS scores across recovery style
From the figures it can be seen that at either end of the recovery style continuum, namely integration and sealing, the lowest levels of internal shame, external shame and low mood are reported. It is the categories that are found in the middle of the continuum, tends towards integration and the mixed styles that higher levels of shame and low mood are found.

*Post hoc power analysis*

Using the RSQ to divide the sample up into the two general categories of integration and sealing over, a post hoc analysis of effect size was undertaken, using scores from the ISS, OAS and BDI-II. Effect size was calculated using the formula $d = \frac{\text{integration mean} - \text{sealing over mean}}{\text{standard deviation of the population}}$. A medium effect size was found for internal shame on the ISS ($d = .47$) and for external shame on the OAS ($d = .52$). No effect size was found for low mood on the BDI-II ($d = .06$). A post hoc
power analysis was calculated using the GPower program (Erdfelder et al., 1996) for internal and external shame; alpha was set at .05 for a 2-tailed test. For internal shame analysis revealed: power = .18, \( t(24) = 2.1 \), delta = 1.1. External shame analysis revealed: power = .2, \( t(24) = 2.1 \), delta = 1.2.

Correlations of shame and low mood

Table 5 shows the correlation matrix between the ISS, OAS and BDI-II. As can be seen all measures were significantly correlated with each other. The highest correlation was between the ISS and OAS. The ISS also correlated with the BDI-II, as did the OAS, but to a slightly lesser extent.

Table 5. Correlation matrix between the ISS, OAS and BDI-II

<table>
<thead>
<tr>
<th></th>
<th>ISS</th>
<th>OAS</th>
<th>BDI-II</th>
</tr>
</thead>
<tbody>
<tr>
<td>ISS</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>OAS</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

\[ r = .85^* \]
\[ r = .67^* \]
\[ r = .51^* \]

* correlation \( p < 0.01 \)

Psychopathology

The SCI-PANSS was included in the study as a measure of psychotic symptoms and general psychopathology. On the three main indices of the SCI-PANSS, three participants scored above the clinically significant cut off point on the positive symptom index; one participant scored above cut off on the negative symptom index; two participants scored above cut-off on the general psychopathology index. Even though these participants did score above the conventional cut off points, their data is still included in the study, as their scores were only just above cut off. It was also
believed that they were considered sufficiently recovered from their most recent psychotic episode to take part if the study and provide informed consent and that the SCI-PANSS was detecting residual symptoms.

Virtually no significant correlations were found between the three main indices of the SCI-PANSS (positive, negative and general psychopathology) and scores on the ISS, OAS and BDI-II; apart from a significant correlation between scores on the BDI-II and the general psychopathology index ($r(26) = .65, p < 0.01$, 2-tailed). For each participant the percentage of integrative responses on the RSQ was calculated. As a sample this integrative percentage did not significantly correlate with the three main indices of the SCI-PANSS.

_Further analyses_

On further analysis recovery style was not associated with sex of participant ($\chi^2(4) = 4.2, p = .39$), participant reported duration of illness ($t(22) = .6, p = .55$, 2-tailed), participant age ($t(24) = .3, p = .77$, 2-tailed), or number of hospitalisations ($t(23) = 1, p = .31$, 2-tailed). Recovery style was also not associated with researcher rated positive symptomatology ($t(24) = -.4, p = .68$, 2-tailed), negative symptomatology ($t(24) = -.6, p = .55$, 2-tailed) or general psychopathology ($t(24) = -1.7, p = .11$, 2-tailed). There is the suggestion that researcher rated general psychopathology may have a slight relationship with recovery style; to help examine this symptom scores across the different recovery style categories are shown in Table 6. Table 6 also includes data across the recovery style categories for each of the other variables listed above.
Table 6. Recovery style (6 categories) and mean scores on the three main indices on the SCI-PANSS, mean reported duration of illness, mean age and mean number of reported hospitalisations (standard deviations in parentheses)

<table>
<thead>
<tr>
<th></th>
<th>Integration (n = 2)</th>
<th>Tends towards integration (n = 8)</th>
<th>Mixed – integration predominates (n = 9)</th>
<th>Mixed – sealing over predominates (n = 5)</th>
<th>Tends towards sealing over (n = 0)</th>
<th>Sealing over (n = 2)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Duration of illness (years)</strong></td>
<td>15 (9.9)</td>
<td>15.6 (12.2)</td>
<td>19.8 (13.4)</td>
<td>15.4 (13.3)</td>
<td>-</td>
<td>6.2 (0)</td>
</tr>
<tr>
<td><strong>Age (years)</strong></td>
<td>36.5 (6.4)</td>
<td>34.8 (10.6)</td>
<td>49 (9.9)</td>
<td>40.9 (10.2)</td>
<td>-</td>
<td>38.6 (7.9)</td>
</tr>
<tr>
<td><strong>Number of hospital admissions</strong></td>
<td>2 (2.8)</td>
<td>5.3 (3.5)</td>
<td>7.7 (5.1)</td>
<td>4.8 (3.3)</td>
<td>-</td>
<td>2.5 (.7)</td>
</tr>
<tr>
<td><strong>Positive symptom score</strong></td>
<td>7.5 (.7)</td>
<td>13.9 (3.5)</td>
<td>12.4 (5.4)</td>
<td>11 (2.8)</td>
<td>-</td>
<td>19.5 (6.4)</td>
</tr>
<tr>
<td><strong>Negative symptom score</strong></td>
<td>10 (2.8)</td>
<td>12.9 (5.5)</td>
<td>15.2 (4.3)</td>
<td>14.6 (3)</td>
<td>-</td>
<td>15.5 (.1)</td>
</tr>
<tr>
<td><strong>General psychopathology score</strong></td>
<td>20.5 (2.1)</td>
<td>29.1 (5.3)</td>
<td>28.7 (8)</td>
<td>31.2 (7.2)</td>
<td>-</td>
<td>37.5 (2.1)</td>
</tr>
</tbody>
</table>

Again, caution should be taken when interpreting this data, as there are a small number of participants in some categories. Table 6 suggests that for the general psychopathology score it can be seen that on the whole as the recovery style category moves from integration to sealing over scores increase (the cut off score for clinical significance is 40). Also of note with Table 6 is that those participants in the mixed categories of recovery style are generally older than those found in the other
categories. Additionally, the positive symptom score of participants in the sealing over category were found to be the highest (the cut off score for clinical significance for this index is 20), the integration category achieved the lowest score and the other three categories had roughly similar scores.

To summarise, no differences were found between the integration recovery style and sealing over recovery style on measures of internal shame, external shame and low mood low. Though it did not reach statistical significance, the data suggested that those participants who adopted the general category of integration reported elevated feelings of internal and external shame; there was virtually no difference between the integration and sealing over style on the low mood measure. It was found that type of recovery style was not significantly associated with any other variable used in the study. The measures of shame and low mood all significantly correlated with each other.
Discussion

This study aimed to look at recovery style in those individuals who had recovered from their most recent episode of psychosis. In particular, it investigated whether internal shame, external shame and low mood were associated with one particular recovery style. In an additional aim, the study also investigated whether internal shame, external shame, and low mood all positively correlated with each other. These aims guided the creation of hypotheses that were outlined in the introduction, each of which will now be examined in turn.

Recovery style and shame

Previous research has suggested that those individuals who seal over will experience higher levels of shame, both for internal shame (Drayton et al., 1998; Tait et al., 2003) and external shame (Tait et al., 2004; Gilbert, 1998b). The idea here was that as shame is a negative affect, an affect that could be triggered or invoked by having a mental illness, people in response would be more likely to protect themselves from it by sealing over. However, it was recognised that as sealing over is a position of denial, shame may also be denied, so those individuals who seal over may not report any shame at all. There was also the added possibility that those people who integrate may report experiencing more shame as they come to terms with what is generally regarded as a stigmatised condition. Connected to this point was the possibility that there may be a divergence between internal and external shame, as individuals may be aware of the external shame (as measured on the OAS), but may not internalise it (as measured on the ISS).
This study failed to find support for the hypothesis that those individuals who seal over experience more shame than those people who were found to have a more integrating recovery style. Similarly, the idea that those who integrate may report more shame than those who seal over was also not supported. However, there was the suggestion that those people who did integrate reported higher levels of internal and external shame, though this was not statistically significant. There also did not appear to be any divergence between reports of internal and external shame as they followed the same scoring profile and the measures were highly correlated.

Recovery style and low mood

There is evidence to suggest from previous research that the sealing over recovery style is associated with low mood (Birchwood et al., 2000; Iqbal et al., 2000; Tait et al., 2003), however some authors have failed to support this idea (Tait et al., 2004). This study hypothesised that those people who could be categorised as sealing over would report higher levels of low mood. On analysis, this hypothesis was not supported. When the sample was divided up into the two general categories of integration and sealing over, very little difference was found on the measure of mood. Therefore no particular recovery style is associated with low mood, supporting Tait et al.’s (2004) findings.

Differences in recovery style, shame and low mood

The following short discussion is very tentative as it is based upon suggestions made by the data, which often involve a small number of participants. However, the following findings are worth noting as they may open up avenues of future research.
As noted above, there was no significant difference between those individuals who were grouped in the integration recovery style and those in the sealing over style on both measures of shame, with the integrating group scoring higher levels of shame. This runs counter to the idea that those people who seal over feel more shame, hence shame being one of the motivating factors to the sealing over style. However, this is based on the assumption that those who experience shame will report shame. As already outlined, sealing over is akin to being in a position of denial, so it is possible that the shame affects is also repudiated in some way. Likewise, if a person does not believe they have an illness, or finds it difficult to believe they have an illness they will not experience the negative consequences of the illness that can cause them to be ashamed. By whatever method, there appears to be something about integration that makes struggling with internal and external shame more apparent. In the introduction it was suggested that stigma may play a role in this, as negative evaluations from others may be feared or actually experienced. This negative evaluation may also be internally generated as an individual struggles to come to terms with the illness, which is part of the process of integration and all the consequences and meanings this holds.

This discussion can be expanded by looking at Figures 1 to 3 in the results section. It can be seen that at either end of the recovery style continuum, namely full integration and full sealing over, lower levels of shame and low mood are reported. Obviously, not many participants fall into these two categories and these findings may not be reliable, but it is worth some speculation if these results do reflect some underlying process. It has been discussed above why individuals who seal over at the extreme end may report low levels of shame and hence low mood. It may be that individuals who fully integrate have come to terms with their illness and have come to some sort of
resolution, one that does not engender feelings of shame and low mood, they accept the illness for what it is.

It appears from the figures that those people who are in the middle of the recovery style continuum report higher levels of shame and low mood, these are the categories of tend towards integration and the two mixed picture categories. Unfortunately, no participant in the study fell within the tending towards sealing over category. Being in these middle categories means that there are elements of both integration and sealing over within the person; some aspects of the illness are recognised and accepted, whilst others are not. This mix of styles may reflect some kind of ambivalence towards the illness. As people come to terms with their illness, there may be some aspects that are difficult to confront, hence the possible need to pull back or seal over; but also, as this struggle continues they may become vulnerable to feelings of shame and low mood. This may continue until they reach full acceptance of the illness in the complete integration position, or are able to fully separate off the illness as in the sealing over position. This vulnerability to shame may stem from a person’s early experiences, as Gilbert (2002) and Schore (1991) propose. This vulnerability then becomes activated or triggered in the face of a traumatic event, such as mental illness (Tait et al., 2004).

It is suggested that feelings of shame and low mood are a sign of the person adapting to or coping with the illness, mainly evident when they are in the more mixed styles of recovery as this ambivalent position presents more of a struggle for them. As well as being a consequence of these mixed recovery styles it is also possible that vulnerability to shame may be a precipitating factor in the adoption of these styles.
Correlations between shame and low mood

Given the close conceptual links between low mood and shame, it was expected that measures of these affects would be significantly correlated with each other. Indeed, previous work has shown this (for example, Gilbert et al., 1994) so the hypotheses for this study were that shame would positively correlated with low mood, and that the two shame measures would also positively correlate with each other. These hypotheses were confirmed.

The strongest correlation was found between the ISS and OAS. The correlation coefficient found in this study (r = .85) was very similar to that found in Goss et al.'s (1994) original study (r = .81). The size of this correlation is unsurprising as the OAS is based on the ISS. In the Goss et al. study, both measures were given to a student population, this study is a small contribution to standardising the OAS on a clinical population. It also shows that internal shame is strongly related to external shame.

The ISS was also significantly correlated with the BDI-II mood measure. This would be expected as both are theoretically linked and both involve a value judgement on the self. In the sister study to the Goss et al. (1994) investigation, Allan et al. (1994) found that the original Beck Depression Inventory (BDI; Beck et al., 1988) achieved a correlation coefficient of $r = .72$ with the ISS, this study found a similar coefficient of $r = .67$. Cook (1993) in a review of previous research reports that correlations between the BDI and ISS range from $r = .59$ to $.79$.

The weakest correlation, but still significant, was found between the OAS and BDI-II ($r = .51$). This is weaker than the BDI-II correlation with the ISS, but this would be
expected given the nature of the OAS. The OAS considers what the self believes other people think of the self, whereas the ISS involves what the self thinks of the self, the same as the BDI-II. Allan et al. (1994) again found a similar correlation coefficient between the BDI and OAS \( r = .58 \). Gee and Troop (2003) found a correlation coefficient between the OAS and BDI-II of \( r = .58 \) in a female, non-clinical sample, again similar to this study.

These results provide further information to the evidence base demonstrating that shame and low mood are closely related. This was done using a sample drawn from a clinical population, showing similar correlation coefficients to non-clinical samples. It also adds to the debate outlined by Andrews (1998) which questions whether mood and shame measures are in fact assessing the same underlying concept, such as diffuse negative affect, given their close association. It is beyond the scope of this study to provide clarification to this debate, although whilst the correlations are strong, they may be weak enough to allow for differentiation between shame and low mood. Difficulties may be more to do with problems in the method of assessment rather than the similarities of shame and low mood as concepts within themselves, a criticism that has been levelled at the ISS (Tangney, 1996).

*Further analysis*

It was found that no other variable included in this study was associated with recovery style. Though not statistically significant, there were suggestions that there might be differences in participant age in the recovery style that is adopted, with those in the mixed categories being older than those in the other categories. It is difficult to
interpret this finding, as the reported length of illness had little suggestion of being related to recovery style.

Again, not significant and interpreted with caution, higher levels of positive symptoms and general psychopathology were found in those participants who were noted to seal over. This is inconsistent with findings of Tait et al. (2003) who tracked changes that as symptoms improved participants moved into the sealing over style. However, as Tait et al. used time as a variable, which this study did not, they could have been detecting significant interactions, rather than just absolute symptoms relating to recovery style. However, this study may be suggesting that current presence of symptoms may motivate people to seal over; this could be a response to the symptoms, either good or bad, that the illness presents. It could also be part of the illness process that shuts down recognition that an illness is occurring, but Tait et al. do say that recovery style is not associated with insight into the illness. It should be remembered though that strictly statistically speaking this study does not disagree with Tait et al.

Clinical implications

Previous research has found that individuals can become vulnerable to experience symptoms of low mood following a psychotic episode (for example, Sands & Harrow, 1999). This study found that 38 percent of the sample reported at least moderate to severe levels of low mood, with another 23 percent reporting mild symptoms. This rate of low mood falls within the range outlined by Siris (2000) in his review. The average BDI-II score for this sample was 17.9, which is at the top end of the mild depression range. This is similar to the findings of Birchwood et al. (2000) who found
that their sample had a mean score within the mild range on the BDI in the recovery period following a psychotic episode\textsuperscript{4}. It is clear from this study and previous research that following a psychotic episode a person has a good chance of developing depressive symptoms. Whilst some confusion exists as to what may be causing it (Carpenter & Price, 2000), this study suggests that shame may have a role to play in this given the significant correlations. However, as these are correlations, no causal link can be established, so it is unclear if shame creates the vulnerability to low mood or if it is the other way around, or there could be a third underlying mechanism which gives rise to both shame and low mood.

Turning to the issue of shame, high levels of internal shame were found in the sample for this study with a mean ISS score of 44.1. This compares to other studies that found average ISS scores of 29.8 and 31.1 (in two studies; Claesson & Sohlberg, 2002) using a student population, 32.1 (Goss \textit{et al.}, 1994) using a mostly female student population, 33.1 (Murray & Waller, 2002) and 34.8 (Murray \textit{et al.}, 2000) both using a female student population. Cook (1993) reported an average ISS score of 41 in a clinical sample of people with a diagnosis of major depression and bipolar disorder. The mean score for this study is fairly close to Cook's cut off score of 50 which indicates possible problematic levels of shame, indeed around one third of the sample score above this cut off. Twenty-seven percent of the sample scored above 60 which Cook reports is indicative of high levels of shame and can be associated with symptoms of depression and anxiety.

\textsuperscript{4} In a comparison study of the original BDI and BDI-II Beck \textit{et al.} (1996) found that correlations of scores was highly significant. Mean scores on the BDI-II were about two points higher than on the original BDI.
A mean score of 31.9 was found in this study on the OAS external shame measure. Two other studies using the OAS with student populations found an average of 20 (Goss et al., 1994) and 22.2 (Gee & Troop, 2003).

This study appears to have found elevated levels of internal and external shame, as well as low mood, in a sample of individuals following an episode of psychosis. If this finding is representative of people with a diagnosis of psychosis, then this would have implications for therapeutic contact. It is likely that there are many people with psychosis experiencing elevated levels of shame, which may need to be addressed therapeutically. If shame is linked to low mood then therapeutic techniques used to treat depression may also have efficacy intervening with issues of shame, for example, within a cognitive framework shame can be seen as being made up of negative views about the self and beliefs about negative judgements from others (Gilbert, 1998a). However, the cognitive approach is based on the idea that thoughts and beliefs are faulty; Iqbal et al. (2000) point out that depressive symptoms, and by implication shame, may not be based on faulty cognitive processes but are based on the realities and context of psychosis that individuals with this diagnosis often find themselves in (see also Rooke & Birchwood, 1998). The authors recommend that any negative appraisals of the psychosis itself should be re-evaluated and day-to-day management should be promoted. Gilbert (1998a) further warns that the shame affect may need more than just intervening with the cognitive component alone. This suggests that behavioural strategies may be useful, as well as recognising shame as the affect that it is; where shame is labelled directly along with the emotions that are associated with it. Deliberate attempts should also be made to avoid the behaviour associated with
shame, such as running away and being submissive, suggesting that social skills interventions may be useful.

Unfortunately, little has been written on how to approach shame and treat it. It is hoped that as research into shame continues, insights may occur as to methods that help reduce shame or shame intensity; this may involve individual work but can extend to cultural changes in attitudes towards psychosis. At this stage, it may be that mental health professionals just need to recognise that shame may be part of the psychotic recovery experience and be aware of any actions that may increase feelings of shame. An open dialogue should be fostered, one that proceeds at the individual’s pace and should be empathic, recognising that some experiences are painful (Gilbert, 1998a). As Claesson and Sohlberg (2002) found internal shame was associated with parental experiences of indifference, abandonment and rejection, mental health professionals should therefore take a warm, accepting and validating approach, an approach that is based on collaboration rather than authority. Attention should always be paid to the achievements of the individual and the strengths they can draw upon when coping with the illness.

Issues of stigma may need to be approached directly, as well as providing coping mechanisms if negative reactions are received from others (Gilbert, 2002). The type of contact an individual has with mental health teams may also be a shaming experience, such as receiving a fortnightly injection or being forcibly detained. As shame has a behavioural component, this may lead some individuals to avoid contact with mental health services, efforts should be made to reduce the possibility of this kind of shame (ibid.) with the suggestions made previously.
As noted above only a small part of the sample reported a pure recovery style, that of full integration or full sealing over. Just over half the sample fell within the two mixed picture categories, a further third of the sample were in the tend towards integration category. Whilst there may a skewing towards the integrative style, this still shows that the majority of the sample cluster around the middle of the recovery style continuum. As noted previously being in the middle means there are elements of both the integrative and sealing over styles. This may present a struggle for the individual as they come to terms with the illness, which may increase feelings of low mood and shame, as has been suggested by this study. This mixed picture may raise uncomfortable feelings within the individual as they struggle with different aspects of the illness.

The clinical implication of this finding is that people should be supported in wherever they are on the recovery style continuum. Whilst recovery may be an individualistic and personal journey, mental health professionals may be able to play a role upon this journey, providing support and assistance where necessary. This discussion so far has tried not to place any value judgements on the types of recovery style, not favouring integration over sealing over as a better position to be in. However, it was noted in the introduction that cognitive oriented therapy does appear to encourage the adoption of a more integrative style in therapy (Jackson et al., 1998). Indeed, in mental health settings there may be encouragement for individuals with a psychosis diagnosis to take a more integrating style which may be perceived as more consistent with interventions for effective management, such as regularly taking medication and devising a relapse prevention plan. Whereas people who seal over may constitute a
greater challenge for mental health teams when following them up, as the sealing over style predicts lower service engagement (Tait et al., 2003). In many of the personal accounts and qualitative studies of recovery from psychosis authors discuss the progression toward the integration of the illness and the growth opportunities this provides (Hirschfeld et al., 2005). Does this mean that the integration style is the best position to be in following a psychotic episode or just that the voice of the people who seal over is not being heard? This latter idea is an interesting point and forms a limitation to the current study (see below). Some individuals simply may not be ready to adopt an integrative position, as it may be too painful. Even the journey towards integration, as recovery style is a changing process (Tait et al., 2003), may be painful, which would be suggested by the higher levels of shame and low mood found in this study.

Clinicians may be able to help in this process of recovery by adapting interventions to the individual needs of clients. In was noted in the introduction that Drayton et al. (1998) suggested that those who have an integrative recovery style may prefer an intervention that helps examine the impact the illness has on their lives and discuss ways to more effectively manage it in future. Those who seal over may prefer an approach that looks at stress reduction and focuses on skills that help in everyday living. Tait et al. (2004) expand upon this saying that those individuals who seal over may prefer a service that is low-key and informal, one that keeps the client in control and allows a focus on their broader aims in life; whereas demanding interventions may alienate the client. Though these suggestions are useful they offer methods of intervention at the extreme ends of the recovery continuum. This study found few people at these extremes as the sample was more likely to fall somewhere in between.
It could then be suggested that a mix of the interventions provided by Drayton et al. (1998) and Tait et al. (2004) be used. However, it would seem that this would require a very delicate balancing act requiring the clinician to know where the client is on the recovery style continuum, but also in what direction they are moving, either towards integration or sealing over. This then makes the relationship between the client and clinician vitally important, and that the service should be organised in a way that adaptively respond to the needs of the client.

Limitations of the study

The biggest limitation of this study is the sample size. Given the small number of participants the power of this study is very limited. In regard to the main hypotheses of the study, no support for them was found; it is conceivable that this is a Type II error. The current finding is that there is no association between recovery style and shame and low mood, although there is the tentative suggestion that those who fall within the general category of integration are more likely to report higher levels of internal shame, external shame and low mood, though this was not statistically significant, which would reject the hypotheses outright.

The majority of participants in this study were those who adopted an integrative style; fewer participants were found to have a sealing over style. This skewing of recovery style appears to stem from a volunteer bias and relates to the point made above about the voices of people who seal over not being heard. In recruiting to the study a number of individuals refused to take part saying that that the illness was in the past and that they did not want to go over old ground, others were fearful that discussing the illness could even bring it back. It is clear that these are sealing over positions. It should have
been recognised from the outset of the study that given the very nature of sealing over it would be difficult to recruit people who adopt this recovery style. Tait et al. (2003) also noted this point in those people who refused to take part in their study, though their refusal rate was fairly low. Unfortunately, refusal rates for this study are not known precisely, but it is estimated to be at least eight people. Refusal rates may have contributed in some part to why Tait et al. (2003, 2004) chose to collapse the original six recovery categories into four. Nevertheless, the two Tait et al. studies and the Drayton et al. (1998) study were able to recruit around twice the number of participants in their studies with roughly equal numbers of participants spread across integration and sealing over.

It would have been more useful to have an objective measure of duration of illness and number of hospital admission, rather than the participants' reports, which can be prone to memory bias and recognition bias to when they first realised they had a mental illness. With this a more accurate analysis of how recovery style related to these two factors could have been carried out.

The ISS has been criticised for not being a pure measure of internal shame and could be biased towards measuring self-esteem (Andrews, 1998; Tangney, 1996). Another measure, such as the TOSCA (Tangney & Dearing, 2002) could have been used in addition to the ISS or as a replacement.

The sample in this study was also fairly heterogeneous. Whilst this in itself may not be a limiting factor, it may have introduced uncontrolled bias into the study. Both of the Tait et al. (2003, 2004) studies recruited a heterogeneous sample, though the sample
in this study was generally older and had a longer duration of illness. It may have been useful to focus on a particular group of people, such as first episode psychosis or those who had been discharged from hospital within a particular time frame. However, this may have not been practicable for this study, given the already existing difficulties in recruitment. Besides, as the hypotheses were set up as general principles, it would have been expected that age or duration of illness would not have an effect on recovery style, shame or low mood, which was found.

Future directions

The finding that those people who have recovered from an episode of psychosis report high levels of shame needs to be replicated. This is the first study to show that individuals with a diagnosis of psychosis experience elevated levels of internal and external shame, future research can help to verify this finding. Given that high levels of shame have been found research into possible ways of intervening with shame could be devised and tested, as well as looking at how current approaches could be modified. Such work would not only be applicable to a psychotically diagnosed population, but also other populations that can experience elevated levels of shame, such as those people with depression.

It may also be useful investigating the possible shameful events that individuals may experience whilst being cared for by mental health teams, such as being compulsorily detained, and the attitudes they hold towards them. Links between these shaming experiences and self-reported shame could be examined, to help investigate whether perception of shaming experiences leads to reported shame, or if there is some
underlying vulnerability to shame, regardless of experience. Qualitative methodology may be useful in trying to understand this process.

It was found that shame and low mood were closely associated, though the causal nature of this relationship could not be determined. A future study, not just focusing on individuals with a diagnosis of psychosis, could help examine this relationship, trying to understand whether shame leads to low mood or vice versa. A longitudinal study could be of benefit here, to help examine whether shame precedes low mood and also to track if they undergo any change. A regression analysis may also be useful here, predicting how much one variable, say shame, predicts another variable, in this case low mood.

It was found that internal shame, as measured by the ISS, and external shame, measured by the OAS, was highly correlated. Though these concepts are expected to correlate (Goss et al., 1994), they may be too closely correlated suggesting that they may be measuring the same underlying concept. The distinction between internal and external shame may not be necessary. Future work may be needed to further define external shame and its usefulness as a distinct concept.

There was the tentative finding in this study that suggested that those individuals who adopted a more integrating recovery style reported more shame than those who had a more sealing over style, this needs to be examined further. This would require a larger sample than in this study with more participants falling within the sealing over categories. However, it would be difficult to guarantee that people who seal over would want to take part in future studies. One approach could be to ensure the safety
of these individuals, offering them reassurance and follow up contact, so they can feel secure in taking part in a study.

Summary

This study set out to investigate whether elevated levels of internal shame, external shame and low mood were associated with the sealing over recovery style. No evidence of this was found. Though not statistically significant, and contrary to the hypothesis, those participants who adopted the more general integrative recovery style reported higher levels of internal and external shame. Few participants in the study were found to have a pure recovery style, where the vast majority were found to have styles involving both sealing over and integration. Those individuals with the mixed styles were shown to have higher levels of shame and low mood, though caution was taken when interpreting these findings given the low numbers of participants. As hypothesised, the measures of shame and low mood significantly correlated with each other. High levels of shame, as well as low mood, were found in the sample, and therapeutic implications of this were discussed, as well as possible avenues of future research.
Acknowledgements

Special thanks go to all the participants who gave me their time and patience to take part in this study. I am also very grateful to all the care teams I approached in Surrey and West Sussex, thanks go to them for their time, help and support.

I would also like to thank field supervisor Sophie Holmes, Consultant Clinical Psychologist, especially for her enthusiasm and encouragement. Finally, thanks to my University supervisor Mark Hayward, Clinical Psychologist; we have spent about a year on this together, sometimes it has been tough and at times there were fears this wasn’t going to happen at the time it was meant to. At last it’s here.

Thank you.
References


Appendices
Appendix 1. Ethical approval from East Surrey, Crawley and Horsham LREC

East Surrey, Crawley & Horsham Local Research Ethics Committee
Peach Hut 2
Bournwood House
St Peters Hospital Site
Guildford Road
CHERTSEY, Surrey
KT16 0QA
Telephone: 01932 722952
Facsimile: 01932 722953
Email: sarah-jane.richards@surreypct.nhs.uk

07 December 2004

MATERIAL REDACTED AT REQUEST OF UNIVERSITY

Dear Mr Bray

Full title of study: An investigation into the effects shame has on the recovery style of those individuals with a diagnosis of psychosis.

REC reference number: 04/Q1910/46

The Chairman of the East Surrey, Crawley & Horsham Local Research Ethics Committee reviewed the above application on the 06 December 2004.

Ethical opinion
Study amendments reviewed by Chair. All points answered and study given full ethical approval.

The favourable opinion applies to the research sites listed on the attached form.

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

Approved documents
The documents reviewed and approved at the meeting were:

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An advisory committee to Surrey and Sussex Strategic Health Authority

Major Research Project 281
Appendix 1. Ethical approval from East Surrey, Crawley and Horsham LREC

Management approval
The study should not commence at any NHS site until the local Principal Investigator has obtained final management approval from the R&D Department for the relevant NHS care organisation.

Notification of other bodies
The Committee Administrator will notify the research sponsor that the study has a favourable ethical opinion.

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

04/Q1910/46 Please quote this number on all correspondence

With the Committee's best wishes for the success of this project,

Yours sincerely,

Sarah-Jane Richards
RESEARCH ETHICS COORDINATOR

E-mail: sarah-jane.richards@nsurreypct.nhs.uk

Enclosures: Standard approval conditions
Site approval form (SF1)
### Appendix 1. Ethical approval from East Surrey, Crawley and Horsham LREC

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<td>Mr. Peter Bray</td>
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<td>East Surrey, Crawley &amp; Horsham Local Research Ethics Committee</td>
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**List of Sites with a Favourable Ethical Opinion**

For all studies requiring site-specific assessment, this form is issued by the main REC to the Chief Investigator and assessor with the favourable opinion letter and following subsequent notifications from the site assessors. For issues covering all sites with a favourable opinion are noted, including the date the REC has the final decision on the site.

**Full title of study:**

A study into the clinical needs and the recovery style of those individuals with a diagnosis of psychosis.

**Date of issue:**

07 December 2004

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Major Research Project
Appendix 2. Surrey Oaklands NHS Trust Research & Development approval

Surrey Oaklands NHS Trust

SURREY OAKLANDS NHS TRUST

RESEARCH AND DEVELOPMENT OFFICE

R&D RESEARCH PROJECT AGREEMENT

Parties to this agreement:-

Surrey Oaklands NHS Trust, Oaklands House, Coulsdon Road, Caterham CR3 5YA

and Mr Peter Bray (Researcher/Clinician)

Title of Project: An Investigation into the effects shame has on the recovery style of those individuals with a diagnosis of psychosis.

Project Identification Number:

1. The Researcher may only carry out this project after having gained agreement from the Trust. This is contingent on obtaining written agreement from both the Local Research Ethics Committee and the Surrey Oaklands Research Steering Group (Part of the Clinical Governance framework).

2. The Researcher agrees to carry out the project as described in the approved application, and to meet the terms and conditions outlined below. Researchers must ensure strict adherence to the agreed research protocol especially in relation to obtaining consent from participants, and agreed funding. Participants must receive a copy of their signed consent form.

3. The Trust agrees to allow the research to be carried out by the Researcher, subject to the terms and conditions outlined below.

4. The researcher will ensure that the research is carried out in adherence to the Trust policy and procedures for R&D and all other relevant Trust policies e.g. Confidentiality, Serious Untoward Incidents.

Major Research Project 284
Appendix 2. Surrey Oaklands NHS Trust Research & Development approval

Supervision of the work

5. The Researcher where applicable shall be responsible for ensuring the satisfactory supervision of the project.

6. The Trust expects the Researcher to have in place adequate supervision / peer-review arrangements for the specific project and to inform the Lead Research and Development Officer (LRDO) of these in writing prior to beginning the research.

Management of the project

7. The researcher will commence the project within three months of the agreed start date unless the LRDO agrees otherwise in writing.

8. The Grantholder shall obtain all insurances necessary in connection with the project and accepts full liability for the project and its operation.

9. The researcher will ensure the safety and well being of all those involved in this project and will abide by the Trust's Health and Safety Policy.

10. The researcher must ensure the highest standards of research and not be guilty of research misconduct or fraud. This includes financial probity. The LRDO may ask the researcher to provide evidence that they are adhering to all aspects of the protocol and the R&D policy at any time.

Confidentiality

11. The Researcher must comply with the Data Protection Act (1998) and Caldicott requirements, together with any specific conditions set by the ethical agreement.

12. The Researcher must safeguard the confidentiality of the research Data at all times and ensure that it is stored securely and guard against unauthorised access.

13. The Researcher must ensure that all basic factual data is anonymised as and when it is received and that the key to personal identities of persons involved in the research is kept in a separate and secure place.

14. The Researcher must ensure that no information that could lead to the identification of an individual shall be included in any publication without the prior agreement, in writing, of that individual.

Service Confidentiality

15. The Researcher must respect the confidentiality of the service/s in which the research is carried out. Any concerns about a service must be discussed with the relevant
Reporting on the Project

16. For Culyer funded projects the Researcher will provide quarterly progress and monthly finance project statements to the LRDO.

17. For non-Culyer funded projects the Researcher will provide quarterly progress reports and annual financial statements concerning the project to the LRDO, unless otherwise required by an external contract.

18. The Researcher will provide a summary report and financial statement (where applicable) at the end of the project to the LRDO. The researcher will provide a full final report within three months of the end of the project. This should include details of publishable material and those which may give rise to exploitable Intellectual Property.

19. The Trust will provide to the Researcher guidelines describing its requirements on reports. (See Attached)

20. These reports will be reviewed by the R&D Steering Group and the Clinical Governance Sub-Board

Changes to / difficulties with the Project

21. The Researcher will inform the LRDO promptly in writing of any:
   - change of address or telephone number
   - change of relevant staff
   - difficulties or delays in the recruitment of relevant staff
   - events which may have implications for the viability of the project

22. The Researcher will seek the prior written agreement of the LRDO to any:
   - proposed change of the Researcher
   - proposed change of the Supervisor
   - proposed change of employing organisation
   - proposed change in the direction or aims of the project
   - proposed alterations to the timetable for the project
   - proposed alterations to costs/funding for the project.

23. These will also need to be notified to the Ethics Committee and may result in the need to resubmit for approval.
24. The Researcher will inform the Administrator of the Ethics Committee who approved the project of any serious untoward incident immediately the incident occurs and inform the Trust and the LRDO within 24 hours using the Trust's SUI procedure.

Publicity and Media coverage

25. Culyer funding recipients must refer to the appropriate wording when ascribing funding for the project and Surrey Oaklands NHS Trust must also be credited.

26. Other projects must acknowledge any relevant funding/support and Surrey Oaklands NHS Trust whenever and wherever possible.

27. The Researcher will submit any press releases concerning the project to the LRDO for approval in advance of submission for publication.

28. The Researcher and the LRDO will inform each other promptly of any media enquiries or reports concerning the project.

Publication and dissemination

29. Internal research must comply with Trust Intellectual Property Policy (see attached).

30. External research must comply with funding source policy and Trust IPR policy, where appropriate and inform LRDO.

31. The Researcher is expected to write up the research for publication in a peer-reviewed journal.

32. The Researcher will inform the Trust in advance of the publication of any report, article or book relating to the project, and will ensure that any published materials or public statements acknowledge the relevant funding source and the Trust. This should apply even if the researcher does not work for the Trust or has left the Trust at the time of publication.

33. The Researcher will send a copy of any published report concerning the project to the LRDO for dissemination to relevant Clinical Governance areas.

34. Researchers agree to work with the Trust for the purposes of publicising and disseminating the work of the project.

Variations to Agreement

35. Under special circumstances the LRDO may agree, in writing, to vary the terms of the agreement.
Agreement

Signed on behalf of the Trust Executive (LRDO or Chief Executive)

Name: K. DOOD Date: 15/12/04
Position: LRDO

Signed by the Researcher: M. HAYWARD
Name: M. HAYWARD Date: 10/1/05
Position: CLINICAL PSYCHOLOGIST

FOR STUDENTS ONLY

Signed by the Academic Supervisor:
Name: _________________________
Position: ____________________________
Date: ____________________________
Academic Institution: ____________________________

Signed by the Clinical Supervisor: Sophie Holmes
Name: SOPHIE HOLMES
Position: CLINICAL PSYCHOLOGIST
Date: 21.12.04
Employer: Surrey Oaklands

KD/2004
Appendix 3. Ethical approval for West Sussex Health and Social Care NHS Trust

As can be seen ethical approval for West Sussex came from the East Surrey, Crawley and Horsham LREC; ethical approval was extended into West Sussex.

28 February 2005

Mr Peter Bray
University of Surrey
Trainee Clinical Psychologist
University of Surrey
PsychD Clinical Psychology, Department of Psychology
University of Surrey, Guildford
Surrey GU2 7XH

Dear Mr Bray

Full title of study: An investigation into the effects shame has on the recovery style of those individuals with a diagnosis of psychosis.

REC reference number: 04/Q1910/46

The Research Ethics Committee reviewed the above application at the meeting held on 06 December 2004.

Ethical opinion
Study amendments reviewed by Chair. All points answered and study given full ethical approval.

The members of the Committee present gave a favourable ethical opinion of the above research on the basis described in the application form, protocol and supporting documentation.

The favourable opinion applies to the research sites listed on the attached form.
[Confirmation of approval for other sites listed in the application will be issued as soon as local assessors have confirmed they have no objection.]

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

Approved documents
The documents reviewed and approved at the meeting were:

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An advisory committee to Surrey and Sussex Strategic Health Authority
Appendix 3. Ethical approval for West Sussex Health and Social Care NHS Trust

Management approval
The study should not commence at any NHS site until the local Principal Investigator has obtained final management approval from the R&D Department for the relevant NHS care organisation.

Notification of other bodies
The Committee Administrator will notify the research sponsor [Optional: and the R&D Department for NHS care organisation(s)] that the study has a favourable ethical opinion.

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

04/Q1910/46 Please quote this number on all correspondence

With the Committee's best wishes for the success of this project,

Yours sincerely,

SARAH-JANE RICHARDS
RESEARCH ETHICS COORDINATOR

E-mail: stephanie.mizzi@nsurreypct.nhs.uk

Enclosures
Standard approval conditions
Site approval form (SF1)
East Surrey, Crawley & Horsham Local Research Ethics Committees

LIST OF SITES WITH A FAVOURABLE ETHICAL OPINION
For all studies requiring site-specific assessment, this form is issued by the main REC to the Chief Investigator and sponsor with the favourable opinion letter and following subsequent notifications from site assessors. For issue 2 onwards, all sites with a favourable opinion are listed, adding the new sites approved.

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</table>

This study was given a favourable ethical opinion by East Surrey, Crawley & Horsham Local Research Ethics Committees on 06 December 2004. The favourable opinion is extended to each of the sites listed below. The research may commence at each NHS site when management approval from the relevant NHS care organisation has been confirmed.

<table>
<thead>
<tr>
<th>Principal Investigator</th>
<th>Post</th>
<th>Research site</th>
<th>Site assessor</th>
<th>Date of favourable opinion for this site</th>
<th>Notes (*)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mr Peter Bray</td>
<td></td>
<td>West Sussex Health and Social Care NHS Trust</td>
<td>West Sussex Local Research Ethics Committee</td>
<td>09/01/2005</td>
<td></td>
</tr>
</tbody>
</table>

Approved by the Chair on behalf of the REC:

(Signature of Chair/Administrator)

(Name)

(*) This notes column may be used by the main REC to record the early closure or withdrawal of a site (where notified by the Chief Investigator or sponsor), the suspension of termination of the favourable opinion for an individual site, or any other relevant development. The date should be recorded.

SF1 Site approval form, version 2, September 2004
Appendix 4. West Sussex Health and Social Care Research & Development

approval

Sussex NHS Research Consortium

Mr Peter Bray, Trainee Clinical Psychologist
PsychD Clinical Psychology
Department of Psychology
University of Surrey
Guildford
GU2 7XH

27 May 2005

Mr Peter Bray, Trainee Clinical Psychologist
PsychD Clinical Psychology
Department of Psychology
University of Surrey
Guildford
GU2 7XH

ID: 0523/NOCI/2005 An investigation into the effects shame has on the recovery style of those individuals with a diagnosis of psychosis.

Further to my letter of the 17th May 2005. The Chairman on behalf of the RAMC has considered your response to the issues raised by the committee’s initial review. The documents considered were as follows:

* NHS REC form parts A, B, and C (signed and dated 29/03/05)
* NHS REC R&D form (signed and dated 22/03/05)
* Copy of protocol (version 2.2 dated 02/09/05)
* Copy of lay summary (version 1.0 undated)
* CV for Peter Bray (signed and dated 29/03/05)
* Letter from Mrs S A Jubb re: indemnity (dated September 2004)
* East Surrey, Crawley and Horsham LREC approval and SSA approval letters (dated 07/12/04 and 28/02/05)
* E-mails from Peter Bray re: clarifications (dated 07/04/05, 13/04/05 and 15/04/05)
* E-mail from Kevin Brenton re: permission (dated 25/04/05)
* E-mail from Steve Brooks re: permission (dated 10/05/05)
* E-mail from Peter Bray with final clarifications (dated 27/05/05)

I am pleased to inform you that this study has now been approved by ‘Chairman’s action’, and so may proceed. This approval is valid in the following Organisations:

* West Sussex Health and Social Care NHS Trust

Your RAMC approval is valid providing you comply with the conditions set out below:

1. You commence your research within one year of the date of this letter. If you do not begin your work within this time, you will be required to resubmit your application to the committee.
2. You notify the RAMC by contacting me, should you deviate or make any changes to the study protocol.
3. You alert the RAMC by contacting me, if significant developments occur as the study progresses, whether in relation to the safety of individuals or to scientific direction.
4. You complete and return the standard annual self-report study monitoring form when requested to do so at the end of each financial year. Failure to do this will result in the suspension of RAMC approval.
5. You comply fully with the Department of Health Research Governance Framework, and in particular that you ensure that you are aware of and fully discharge your responsibilities in respect to Data Protection, Health and Safety, financial probity, ethics and scientific quality. You should refer in particular to Sections 3.5 and 3.6 of the Research Governance Framework.

Please contact the Consortium Office if you wish this approval to be extended to cover other Consortium Organisations; such an extension will usually be agreed on the same day. We also have reciprocal arrangements for recognition of Research Governance approval with some other NHS
Appendix 4. West Sussex Health and Social Care Research & Development approval

Organisations; such an extension can usually be arranged within five working days.

Please note that if your work involves South Downs Health NHS Trust, this approval means that you now have your Research Passport.

Good luck with your work.

Yours sincerely

Helen Barber
Research Governance Assistant
Appendix 5. Ethical approval from the University of Surrey

22 December 2004

Mr Peter Bray
21 Bracken Close
BOOKHAM
Surrey KT23 3ER

Dear Mr Bray

An Investigation into the effects shame has on the recovery style of those individuals with a diagnosis of psychosis (EC/2004/126/Psvch) - FAST TRACK

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

Date of confirmation of ethical opinion: 22 December 2004

The list of documents reviewed and approved by the Committee under its Fast Track procedure is as follows:-

Document Type: Application
Version: 1
Dated: 14/12/04
Received: 15/12/04

Document Type: Insurance Proforma
Version: 1
Received: 15/12/04

Document Type: Letter of Approval from East Surrey & Horsham LREC
Dated: 07/12/04
Received: 15/12/04

Document Type: MRP Protocol
Version: 2.2
Dated: 02/09/04
Received: 15/12/04
This opinion is given on the understanding that you will comply with the University’s Ethical Guidelines for Teaching and Research.

The Committee should be notified of any amendments to the protocol, any adverse reactions suffered by research participants, and if the study is terminated earlier than expected with reasons.

You are asked to note that a further submission to the Ethics Committee will be required in the event that the study is not completed within five years of the above date.

Please inform me when the research has been completed.

Yours sincerely

Catherine Ashbee (Mrs)
Secretary, University Ethics Committee
Registry

cc: Professor T Desombre, Chairman, Ethics Committee
Dr M Hayward, Supervisor, Department of Psychology
Appendix 6. Participant Information Sheet

Information Sheet

Title of project: Shame and recovery style in psychosis.

Introduction

My name is Peter Bray. I am training to become a Clinical Psychologist. As part of my training I am going to carry out a research project. I would like you to take part in my project. Before you decide on this, it is important for you to understand what the project is about and what you will have to do if you take part. Please read this information sheet carefully so you can learn more about the project and decide if you want to take part. You can discuss it with your friends, family, or a member of your care team. You can also discuss it with me if you want. Take time to decide if you want to take part or not. Thank you for reading this.

What is the project about?

Mental health problems can be very distressing. They can be very difficult to get better or recover from. Often when people recover they can have mixed feelings towards their mental health problems and can also be very confused by them. This project will look at how people feel about having mental health problems and how they recover.

Do I have to take part?

It is up to you whether you take part or not. Just because you have been asked to think about taking part and are reading this sheet does not mean you have to take part. It is up to you. You do not have to take part in the project.

If you do decide to take part then you will be asked to sign three consent forms when we meet. You will keep one consent form, I will keep one, the final form will go the notes held by your care team. This form says that you freely and voluntarily wish to take part in the project. If during or after the project you decide not to take part you are free to do this as well. You can withdraw from the project at any time without giving any reason. Withdrawing from the project will not affect you in anyway.

What would I have to do?

If you decide to take part in the project I will arrange to meet you at a time that is convenient for both of us. I would like to meet you at the clinic you come to when you visit members of your care team. If you do not come to a clinic and you are seen at home then I will accompany a care team member when they next come and visit you.

I would like to meet you one time only. However, if you would like to meet me first and then arrange a second time to meet to take part in the project this is fine.

I hope to see you for no more than 60 minutes. At the start I will ask you a few questions about yourself, such as your age. I will then ask you a few more questions about your mental health problems. After this I will give you some short questionnaires for you to fill out. I will stay with you while you complete these questionnaires just in case you have any questions.
Appendix 6. Participant Information Sheet

Will taking part affect my care?

Taking part in the project should not affect the care you receive from your care team. If you decide not to take part this will also have no impact on your care.

What happens to the results of the project?

Any information you provide that is part of the project will be kept strictly confidential. I will not write your name on any piece of paper, instead I will give you a participant number that will ensure your anonymity. All the information you provide and the questionnaires you have answered will be kept in a safe and secure place by me. Only myself and my project supervisor will have access to this information.

The information you have provided will be added to the information other people who have taken part in the project have provided. I will then analyse all this information and the results will be written up in a report that goes towards my training.

If you want to know the results from my analysis and what I have found let me know and I will provide you with a feedback form after the project has ended.

You can withdraw from the project even after you have finished seeing me. If you decide this then contact a member of the care team who will then contact me. Once I confirm you are withdrawing then I will destroy the information you have given me.

What are the benefits of taking part?

By taking part in the project you will be adding to the understanding of how people recover from their mental health problems. This will help people in the future who find themselves having the same difficulties you have had.

What happens if there are difficulties?

If you take part, there is the chance that you may find some of the questions I ask you or some of the questions in the questionnaire upsetting or distressing. If this happens you should tell me straight away and I will stop the interview. You will then have the chance to talk to me about what you find worrying. If you want to carry on we will do this, but if you want to stop and withdraw from the project you can do so and I will destroy the information you have provided so that it cannot be used. If I find you are really upset then I may feel it is necessary to talk to a member of your care team. I will tell you beforehand if I need to do this.

When you take part in the project you may tell me something that members of your care team do not know and may need to know. If I feel this information is important and affects your well-being and care I may find it necessary to talk to a member of your care team. If this does come up I will talk to you about this.
Appendix 6. Participant Information Sheet

What happens next?

If you decide to not take part in my project after you have read this sheet then nothing happens next. I will not approach you and you will continue your contact with your care team as usual.

If you would like more information on the project before you decide to take part or not you can speak to me. Tell the member of your care team who has told you about this project. They will then let me know and we can arrange a time and place to meet.

If you do decide to take part in the project then tell the member of the care team who has told you about the project. They will then let me know you are interested. I may then contact you directly, or via the member of the care team member, to arrange a time when we can meet.

Thank you for reading this information sheet, which you are free to keep.

Peter Bray  
26th November 2004  
Version 1.3

Contact details

MATERIAL REDACTED AT REQUEST OF UNIVERSITY

If you have any concerns about how the project is being conducted you are welcome to contact , R&D Co-ordinator, on
Appendix 7. Care Team Information Sheet

Care Team Information Sheet

Title of project: Shame and recovery style in psychosis.

Introduction

My name is Peter Bray and I am a Trainee Clinical Psychologist currently studying on the University of Surrey PsychD Clinical Psychology training course. As part of my course I am required to carry out a major research project. In this sheet I am requesting your help and input so my project can be carried out.

Details of the project

I plan to investigate how shame may be associated with how individuals recover from an episode of psychosis. I will do this by recruiting individuals with a diagnosis of psychosis, who are recovered from their most recent episode, and give them some assessments that measure their levels of shame, mood and recovery style. I will need your help in recruiting potential participants for my project.

Recruitment

I am contacting you now as my project has been passed by the local committee of ethics. Additionally, your Team Leader has given me permission to approach you.

Can I ask you to review your caseload and identify those clients who would potentially be suitable for my project. Those who would be suitable should fulfil the following criteria,

- Have a diagnosis of psychosis. This could be schizophrenia or a psychotic disorder.
- Be an adult over the age of 18 years.
- Have English as their first language. Due to resource limitations I am unable to provide interpreters.
- Be recovered from their most recent psychotic episode. This can sometimes be difficult to define, so at the very least clients who are in the acute phase of their illness would not be suitable. The presence of residual symptoms would be acceptable, but will need to be reviewed.
- Be under the continuing care of your team with a named care co-ordinator, or key-worker, and have a responsible medical officer.
- In your opinion, be willing to be approached and asked to participate in the project.

The following criteria will make clients unsuitable for my project,

- A diagnosis of a drug-induced psychotic episode.
- A diagnosis of a schizo-affective disorder
- A diagnosis of an organic cause to the psychotic condition.

Once you have identified suitable clients can you then contact me letting me know you have potential participants, my contact details are below. You can also contact me if you are unsure about the suitability of some of your clients.

If your client is suitable then I will give you a Participant Information Sheet and ask you to approach them to participate in my study. Please ask the client if they are interested in participation. If yes, please read through the information sheet and leave it with them. Can you then let me know if the client remains interested and then we can decide if it appropriate for me to approach your client directly to arrange a time when we can meet up.
Appendix 7. Care Team Information Sheet

The research interview

I plan to meet with potential participants at the appropriate out-patient clinic. The aim is to combine the research after a regular visit to a member of the care team. If this is not possible then I will consider visiting your client at home. I will only do this when I accompany a member of the care team that is known to the client. Again, this will be planned so that it coincides with a usual and regular review visit.

I plan to meet your client on only one occasion, but I am willing to meet them twice if they want to. Overall, my time with them should take no longer than 60 minutes. I will conduct a short interview with them and ask them to complete four questionnaires. I plan to stay with them whilst they complete the questionnaires, to answer any questions or respond to any difficulties.

Taking part in the project is entirely voluntarily and participants can withdraw at any time without the need to give any reason. If the participant chooses to withdraw after I have collected data I will destroy their data.

I know that you are probably very busy, but I would appreciate any help you can offer. I will always endeavour to take up as little of your time as possible and work with your schedule.

Contact details

I can be contacted in a number of ways.

My postal address is;

My e-mail address is;

My mobile telephone number is;

I will be in regular contact with your team, so if you have any questions or any additional suitable clients, please feel free to approach me.

Confidentiality and anonymity

Please do not use your client's name in any of the contacts with me. All I need to know is that you have potential people who you feel would be suitable for my project. I will only ask for and use names when I speak to you in person.

The anonymity of your client is ensured. I will give each client a participant number, their name will not be recorded anywhere.
Appendix 7. Care Team Information Sheet

Due to research confidentiality, I will not be able to tell you anything that your client has told me in connection with the research project. However, I may feel it is necessary to break this confidentiality under certain circumstances. Firstly, if your client becomes distressed during the project interview to the extent where I feel that this may affect his or her well-being or care I will inform you. I will tell them that I am going to do this. Secondly, your client, in the research interview, may inform me of a clinically relevant issue that may affect their care, well-being or be a risk issue. In the event of this happening I will discuss this with them. I will advise them to approach you themselves, but if I feel this issue is of important concern I will contact you. Again, informing them first that I am taking this course of action.

If you have any further questions or comments please do not hesitate to contact me.

Many thanks for your help and support.

Peter Bray
Trainee Clinical Psychologist

26th November 2004
Appendix 8. Participant Consent Form

Participant Identification number:

CONSENT FORM

Title of project: Shame and recovery style in psychosis.

Name of researcher: Peter Bray

Please initial box

1. I confirm that I have read and understand the information sheet dated 26.11.04 (version 1.3) for the above study and have had the opportunity to ask questions.

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

3. I understand that sections of any of my medical notes may be looked at by responsible individuals from the Surrey Oaklands community team or from regulatory authorities where it is relevant to my taking part in research. I give permission for these individuals to have access to my records.

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

Name of person taking part (please print) Date Signature

Name of researcher (please print) Date Signature

1 for participant; 1 for researcher; 1 to be kept with Community Team notes
Appendix 9. Recovery Style Questionnaire (RSQ)

RSQ

Written below are a list of statements about your illness. Please read them carefully and tick the box to show if you agree or disagree.

1. There was a gradual build-up to me becoming ill.    Agree □  Disagree □
2. My illness is not part of my personality.            □ □
3. I am responsible for what I think when I am ill.     □ □
4. I am not interested in my illness.                   □ □
5. My illness taught me new things about myself.        □ □
6. I need help to solve the problems caused by my illness. □ □
7. My illness was caused by my difficulties in coping with life. □ □
8. I have had a nervous breakdown.                      □ □
9. I can see positive aspects to my illness.            □ □
10. My illness has had a strong impact on my life.      □ □
11. I am not frightened of my mental illness.           □ □
12. I liked some of the experiences I had when I was ill. □ □
13. My illness has helped me find a more satisfying life. □ □
14. My illness came on suddenly and went suddenly.      □ □
15. My illness is part of me.                           □ □
16. I am not responsible for my actions when I am ill.  □ □
17. I am curious about my illness.                      □ □
18. I understand myself better because of my illness.   □ □
19. I can manage the problems caused by my illness, alone. □ □
20. Others are to blame for my illness.                 □ □
21. I have had a medical illness.                       □ □
## Appendix 9. Recovery Style Questionnaire (RSQ)

<table>
<thead>
<tr>
<th></th>
<th>Agree</th>
<th>Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>22. Nothing good came from my illness.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>23. My illness has had little effect on my life.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>24. I am frightened of my mental illness.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>25. I didn't like any of the unusual experiences I had when I was ill.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>26. It's hard to find satisfaction with life, since I was ill.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>27. My illness came on very suddenly.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>28. My illness is alien to me.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>29. I am responsible for my thoughts and feelings when I am ill.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>30. I don't care about my illness, now that I am well.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>31. I want to be the person I was before my illness.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>32. Others can help me solve my problems.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>33. My illness was caused by stress in my life.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>34. I have suffered an emotional breakdown.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>35. Being ill had good parts to it.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>36. I'm not really interested in my illness.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>37. I liked some of the unusual ideas I had when I was ill.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>38. My life is more satisfying since my illness.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>39. My attitude to mental illness is better now, than before I was ill.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Appendix 10. Internalised Shame Scale (ISS)

Below is a list of statements describing feelings or experiences that you may have from time to time or that are familiar to you because you have had these feelings and experiences for a long time. Most of these statements describe feelings and experiences that are generally painful or negative in some way. Some people will seldom or never have had many of these feelings. Everyone has had some of these feelings at some time, but if you find that these statements describe the way you feel a good deal of the time, it can be painful just reading them. Try to be as honest as you can in responding.

Read each statement carefully and circle the number to the right of the item that indicates the frequency with which you find yourself feeling or experiencing what is described in the statement. Use the scale below. DO NOT OMIT ANY ITEM.

<table>
<thead>
<tr>
<th></th>
<th>Never</th>
<th>Seldom</th>
<th>Sometimes</th>
<th>Often</th>
<th>Almost always</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>I feel like I am never quite good enough</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>2.</td>
<td>I feel somehow left out</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>3.</td>
<td>I think that people look down on me</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>4.</td>
<td>All in all, I am inclined to feel that I am a success</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>5.</td>
<td>I scold myself and put myself down</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>6.</td>
<td>I feel insecure about others' opinions of me</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>7.</td>
<td>Compared to other people, I feel like I somehow never measure up</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>8.</td>
<td>I see myself as being very small and insignificant</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>9.</td>
<td>I feel I have much to be proud of</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>10.</td>
<td>I feel intensely inadequate and full of self doubt</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>11.</td>
<td>I feel as if I am somehow defective as a person, like there is something basically wrong with me</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>12.</td>
<td>When I compare myself to others I am just not as important</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>13.</td>
<td>I have an overpowering dread that my faults will be revealed in front of others</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>14.</td>
<td>I feel I have a number of good qualities</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>15.</td>
<td>I see myself striving for perfection only to continually fall short</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>
### Appendix 10. Internalised Shame Scale (ISS)

<p>| | | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Never</td>
<td>Seldom</td>
<td>Sometimes</td>
<td>Often</td>
</tr>
<tr>
<td>16. I think others are able to see my defects</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>17. I could beat myself over the head with a club when I make a mistake</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>18. On the whole, I am satisfied with myself</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>19. I would like to shrink away when I make a mistake</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>20. I replay painful events over and over in my mind until I am overwhelmed</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>21. I feel I am a person of worth, at least on an equal plane with others</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>22. At times I feel like I will break into a thousand pieces</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>23. I feel as if I have lost control over my body functions and my feelings</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>24. Sometimes I feel no bigger than a pea</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>25. At times I feel so exposed that I wish the earth would open up and swallow me</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>26. I have this painful gap within me that I have not been able to fill</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>27. I feel empty and unfulfilled</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>28. I take a positive attitude toward myself</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>29. My loneliness is more like emptiness</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>30. I feel like there is something missing</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>
Appendix 11. Others As Shamer (OAS) scale

OAS SCALE

DIRECTIONS: Below is a list of statements describing feelings or experiences that you may have from time to time or that are familiar to you because you have had them for a long time. Most of these statements describe feelings and experiences that are generally painful or negative in some way. Some people will seldom or never have any of these feelings. Everyone has had some of these feelings at some time, but if you find that these statements describe the way that you feel a good deal of the time, it can be painful just reading them. Try to be as honest as you can in responding.

Read each statement carefully and circle the number to the right of the item that indicates the frequency with which you find yourself feeling or experiencing what is described in the statement. Use the scale below.

SCALE

0 = NEVER  1 = SELDOM  2 = SOMETIMES  3 = FREQUENTLY  4 = ALMOST ALWAYS

1. I feel other people see me as not good enough. 0 1 2 3 4
2. I think that other people look down on me. 0 1 2 3 4
3. Other people put me down a lot. 0 1 2 3 4
4. I feel insecure about others opinions of me. 0 1 2 3 4
5. Other people see me as not measuring up to them. 0 1 2 3 4
6. Other people see me as small and insignificant. 0 1 2 3 4
7. Other people see me as somehow defective as a person. 0 1 2 3 4
8. People see me as unimportant compared to others. 0 1 2 3 4
9. Other people look for my faults. 0 1 2 3 4
10. People see me as striving for perfection but being unable to reach my own standards. 0 1 2 3 4
11. I think others are able to see my defects. 0 1 2 3 4
12. Others are critical or punishing when I make a mistake. 0 1 2 3 4
13. People distance themselves from me when I make mistakes. 0 1 2 3 4
14. Other people always remember my mistakes. 0 1 2 3 4
15. Others see me as fragile. 0 1 2 3 4
16. Others see me as empty and unfulfilled. 0 1 2 3 4
17. Others think there is something missing in me. 0 1 2 3 4
18. Other people think I have lost control over my body and feelings. 0 1 2 3 4
Appendix 12. Beck Depression Inventory – 2nd edition (BDI-II)

Name: ___________________________ Marital Status: _______ Age: _____ Sex: _______

Occupation: __________________________ Education: __________________________

Instructions: This questionnaire consists of 21 groups of statements. Please read each group of statements carefully, and then pick out the one statement in each group that best describes the way you have been feeling during the past two weeks, including today. Circle the number beside the statement you have picked. If several statements in the group seem to apply equally well, circle the highest number for that group. Be sure that you do not choose more than one statement for any group, including Item 16 (Changes in Sleeping Pattern) or Item 18 (Changes in Appetite).

1. Sadness
   0 I do not feel sad.
   1 I feel sad much of the time.
   2 I am sad all the time.
   3 I am so sad or unhappy that I can't stand it.

2. Pessimism
   0 I am not discouraged about my future.
   1 I feel more discouraged about my future than I used to be.
   2 I do not expect things to work out for me.
   3 I feel my future is hopeless and will only get worse.

3. Past Failure
   0 I do not feel like a failure.
   1 I have failed more than I should have.
   2 As I look back, I see a lot of failures.
   3 I feel I am a total failure as a person.

4. Loss of Pleasure
   0 I get as much pleasure as I ever did from the things I enjoy.
   1 I don't enjoy things as much as I used to.
   2 I get very little pleasure from the things I used to enjoy.
   3 I can't get any pleasure from the things I used to enjoy.

5. Guilty Feelings
   0 I don't feel particularly guilty.
   1 I feel guilty over many things I have done or should have done.
   2 I feel quite guilty most of the time.
   3 I feel guilty all of the time.

6. Punishment Feelings
   0 I don't feel I am being punished.
   1 I feel I may be punished.
   2 I expect to be punished.
   3 I feel I am being punished.

7. Self-Dislike
   0 I don't feel particularly guilty.
   1 I feel I am a total failure as a person.
   2 I dislike myself.

8. Self-Criticalness
   0 I don't criticize or blame myself more than usual.
   1 I am more critical of myself than I used to be.
   2 I criticize myself for all of my faults.
   3 I blame myself for everything bad that happens.

9. Suicidal Thoughts or Wishes
   0 I don't have any thoughts of killing myself.
   1 I have thoughts of killing myself, but I would not carry them out.
   2 I would like to kill myself.
   3 I would kill myself if I had the chance.

10. Crying
    0 I don't cry anymore than I used to.
    1 I cry more than I used to.
    2 I cry over every little thing.
    3 I feel like crying, but I can't.
Appendix 12. Beck Depression Inventory – 2nd edition (BDI-II)

<table>
<thead>
<tr>
<th>11. Agitation</th>
<th>17. Irritability</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 I am no more restless or wound up than usual.</td>
<td>0 I am no more irritable than usual.</td>
</tr>
<tr>
<td>1 I feel more restless or wound up than usual.</td>
<td>1 I am more irritable than usual.</td>
</tr>
<tr>
<td>2 I am so restless or agitated that it’s hard to stay still.</td>
<td>2 I am much more irritable than usual.</td>
</tr>
<tr>
<td>3 I am so restless or agitated that I have to keep moving or doing something.</td>
<td>3 I am irritable all the time.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>12. Loss of Interest</th>
<th>18. Changes in Appetite</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 I have not lost interest in other people or activities.</td>
<td>0 I have not experienced any change in my appetite.</td>
</tr>
<tr>
<td>1 I am less interested in other people or things than before.</td>
<td>1a My appetite is somewhat less than usual.</td>
</tr>
<tr>
<td>2 I have lost most of my interest in other people or things.</td>
<td>1b My appetite is somewhat greater than usual.</td>
</tr>
<tr>
<td>3 It’s hard to get interested in anything.</td>
<td>2a My appetite is much less than before.</td>
</tr>
<tr>
<td></td>
<td>2b My appetite is much greater than usual.</td>
</tr>
<tr>
<td></td>
<td>3a I have no appetite at all.</td>
</tr>
<tr>
<td></td>
<td>3b I crave food all the time.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>13. Indecisiveness</th>
<th>19. Concentration Difficulty</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 I make decisions about as well as ever.</td>
<td>0 I can concentrate as well as ever.</td>
</tr>
<tr>
<td>1 I find it more difficult to make decisions than usual.</td>
<td>1 I can’t concentrate as well as usual.</td>
</tr>
<tr>
<td>2 I have much greater difficulty in making decisions than I used to.</td>
<td>2 It’s hard to keep my mind on anything for very long.</td>
</tr>
<tr>
<td>3 I have trouble making any decisions.</td>
<td>3 I find I can’t concentrate on anything.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>14. Worthlessness</th>
<th>20. Tiredness or Fatigue</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 I do not feel I am worthless.</td>
<td>0 I am no more tired or fatigued than usual.</td>
</tr>
<tr>
<td>1 I don’t consider myself as worthwhile and useful as I used to.</td>
<td>1 I get more tired or fatigued more easily than usual.</td>
</tr>
<tr>
<td>2 I feel more worthless as compared to other people.</td>
<td>2 I am too tired or fatigued to do a lot of the things I used to do.</td>
</tr>
<tr>
<td>3 I feel utterly worthless.</td>
<td>3 I am too tired or fatigued to do most of the things I used to do.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>0 I have as much energy as ever.</td>
<td>0 I have not noticed any recent change in my interest in sex.</td>
</tr>
<tr>
<td>1 I have less energy than I used to have.</td>
<td>1 I am less interested in sex than I used to be.</td>
</tr>
<tr>
<td>2 I don’t have enough energy to do very much.</td>
<td>2 I am much less interested in sex now.</td>
</tr>
<tr>
<td>3 I don’t have enough energy to do anything.</td>
<td>3 I have lost interest in sex completely.</td>
</tr>
</tbody>
</table>

| 16. Changes in Sleeping Pattern | |
|-------------------------------| |
| 0 I have not experienced any change in my sleeping pattern. | |
| 1a I sleep somewhat more than usual. | |
| 1b I sleep somewhat less than usual. | |
| 2a I sleep a lot more than usual. | |
| 2b I sleep a lot less than usual. | |
| 3a I sleep most of the day. | |
| 3b I wake up 1–2 hours early and can’t get back to sleep. | |

NOTICE: This form is printed with both blue and black ink. If your copy does not appear this way, it has been photocopied in violation of copyright laws.
Appendix 13. Structured Clinical Interview – Positive and Negative Symptom Scale (SCI-PANSS)

What is shown here is an excerpt from the SCI-PANSS. This measure has a large interview booklet, shown here are the general scoring sheets.

<table>
<thead>
<tr>
<th>Patient Name or ID:</th>
<th>Rater:</th>
<th>Date:</th>
<th></th>
</tr>
</thead>
</table>

**PANSS QuikScore™ Form**


*Use this scale for all items:*  
1 = Absent  
2 = Minimal  
3 = Mild  
4 = Moderate  
5 = Moderate/Severe  
6 = Severe  
7 = Extreme

- P1. Delusions
- P2. Conceptual disorganization
- P3. Hallucinatory behavior
- P4. Excitement
- P5. Grandiosity
- P6. Suspiciousness/persecution
- P7. Hostility
- N1. Blunted affect
- N2. Emotional withdrawal
- N3. Poor rapport
- N4. Passive/apathetic social withdrawal
- N5. Difficulty in abstract thinking
- N6. Lack of spontaneity and flow of conversation
- N7. Stereotyped thinking
- G1. Somatic concerns
- G2. Anxiety
- G3. Guilt feelings
- G4. Tension
- G5. Mannerisms and posturing
- G6. Depression
- G7. Motor retardation
- G8. Uncooperativeness
- G9. Unusual thought content
- G10. Disorientation
- G11. Poor attention
- G12. Lack of judgment and insight
- G13. Disturbance of volition
- G14. Poor impulse control
- G15. Preoccupation
- G16. Active social avoidance
- S1. Anger
- S2. Difficulty in delaying gratification
- S3. Affective lability
### Appendix 13. Structured Clinical Interview – Positive and Negative Symptom Scale (SCI-PANSS)

<table>
<thead>
<tr>
<th>Patient Name or ID:</th>
<th>Rater:</th>
<th>Date:</th>
<th>SUMS</th>
<th>Positive</th>
<th>Negative</th>
<th>Composite</th>
<th>Positive minus Negative</th>
<th>General</th>
<th>Anergia</th>
<th>Thought Disturbance</th>
<th>Activation</th>
<th>Paranoid / Belligerence</th>
<th>Depression</th>
<th>Supplemental</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>SUMS</td>
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</tbody>
</table>

**PANSS QuikScore™ Form**

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800/456-3003 (U.S.); 800/268-4011 (Canada)
P.O. Box 950, Norwalk, CT 06856-0950

800) 268-4011, International: +1-416-492-2627,
Fax: +1-416-492-2627, ext. 200, 800-268-4011.

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## Positive and Negative Syndrome Scale (PANSS) Profile Form

<table>
<thead>
<tr>
<th>Name: _____________________________</th>
<th>Date: ________</th>
</tr>
</thead>
</table>

- **Raw Score on PANSS Scales**

<table>
<thead>
<tr>
<th>Scale</th>
<th>Positive</th>
<th>Negative</th>
<th>General Psychopathology</th>
<th>Anergia</th>
<th>Thought Disturbance</th>
<th>Activation</th>
<th>Paranoid Delirience</th>
<th>Depression</th>
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</thead>
<tbody>
<tr>
<td>99</td>
<td>100 -</td>
<td>37 or higher</td>
<td>67 or higher</td>
<td>27 or higher</td>
<td>21 or higher</td>
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<td>13</td>
</tr>
</tbody>
</table>

Log of Research Experience
## Log of research experience

The research log provides information that demonstrates research skills and experiences that I have developed and acquired through my training. With each research skill and experience a description of my relevant research activity is given. The activities mentioned outline as well as add to the experience contained in my research dossier.

<table>
<thead>
<tr>
<th>Research skill/experience</th>
<th>Description of how research skill/experience acquired</th>
<th>Date research skill/experience acquired</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conduct a literature search</td>
<td>During my clinical training I conducted literature searches for all my essays, case reports and research projects. I also completed searches for various aspects of my clinical placements. I used computerised online databases such as, PsycINFO, Medline and the Cochrane Library. I also utilised online information, using search engines and special interest websites. I used the University library extensively for relevant texts to help me in my studies. Evidence of the literature searches for my essays, case reports and research can be found in this volume. However, here I will also give some examples of search topics undertaken during some of my placements. On my adult placement I completed searches on areas such as: low mood, obsessive-compulsive disorder and other anxiety disorders, psychoanalytic approaches, attention deficit hyperactivity disorder, and commonalities of the cognitive behavioural approach across different disorders. On my people with learning disabilities placement I conducted searches on sexuality, informed consent, and types and methods of behavioural approaches. In regards to my child, adolescents and families placement I carried out searches for autism, Asperger’s syndrome, self-esteem, and ways of adapting therapeutic approaches to suit children. On my older people placement I researched sleep, relaxation and connections between physical conditions and low mood. On my specialist neuropsychology placement I completed searches such as: the neuropsychological and psychological apects of multiple sclerosis, Klinefelter syndrome and the rehabilitation of executive functions. On my second specialist placement in primary care I carried out searches on mindfulness, behavioural experiments in CBT and group approaches to CBT.</td>
<td>September 2002 – July 2005</td>
</tr>
<tr>
<td>Conduct a literature search (continued)</td>
<td>I have also been able to pursue my own interests looking into such topics as roadblocks in therapy, the therapeutic relationship, and the scientific and empirical status of psychoanalytic theory. I have also accessed the British Psychological Society and Department of Health Websites for practice recommendations, current thinking and research, as well as professional development.</td>
<td></td>
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<tr>
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</tr>
<tr>
<td>Critically review the literature</td>
<td>I have critically reviewed the literature and this work has been an integral part of all my essays and case reports, see both these volumes for evidence of this. I have also critically reviewed the literature for my Service Related Research Project (SRRP) and Major Research Project (MRP). In doing this I feel I have developed some critical evaluation skills, so when I now read treatment literature, for example, I can evaluate this work within its context.</td>
<td>September 2002 – July 2005 and ongoing</td>
</tr>
<tr>
<td>Formulate a specific research question</td>
<td>I formulated a specific research question for both my SRRP and MRP. I feel I can review the existing literature and know how to develop new areas of inquiry, for example in my MRP I took suggestions made by the literature and formulated further research questions; as well as being able to develop my own interests. I also contributed in helping formulate a research question as part of a small group for the qualitative research project.</td>
<td>November 2002 and November 2003 – March 2004</td>
</tr>
<tr>
<td>Write a brief research proposal</td>
<td>I wrote a brief research proposal for my SRRP and MRP. In doing so I feel I have gained some skills in being able write clearly and communicate large and sometimes complex amounts of information for other professionals.</td>
<td>November 2002 and November 2003 – March 2004</td>
</tr>
<tr>
<td>Write a detailed proposal/protocol</td>
<td>I wrote a detailed protocol for my MRP. Again I used written skills in order to communicate clearly and concisely. I also had to write in a way, which included details, rationale and methods that gave sufficient information to allow informed ethical approval, research and development (R&amp;D) approval, and understanding by clinical teams.</td>
<td>March – September 2004</td>
</tr>
<tr>
<td>Obtain appropriate supervision/collaboration for research</td>
<td>I consulted my clinical supervisor on my adult mental health placement to help carry out my SRRP. In this consultation we discussed the process of data collection as well as how this work could fit in with the audit that was already underway within the Trust. For my MRP I approached a university supervisor who had an interest in the field I was proposing to carry out research in. Similarly I approached clinicians who were working in the field I was planning to research, to become my field supervisor. I held regular meetings with my university and field supervisors to update them on the progress of the research, this was to seek advice and discuss any problems or difficulties.</td>
<td>November 2002 – July 2005</td>
</tr>
<tr>
<td>Write a participant information sheet and consent form</td>
<td>I wrote a participant information sheet and consent form for my MRP. Both were written in discussion with my university supervisor. Both forms were approved by the East Surrey, Crawley and Horsham LREC, and West Sussex LREC, as well as the local R&amp;D committees. The forms were also approved by the University ethics committee. I also wrote a care team information sheet that was approved by the appropriate committees.</td>
<td>August – September 2004</td>
</tr>
<tr>
<td>Judge ethical issues in research and amend plans accordingly</td>
<td>I considered the ethical issues relevant to my SRRP with my placement supervisor. For my MRP I considered ethical issues in the process of setting up and planning my research. I discussed ethical issues with both my supervisors and governance officers from the relevant R&amp;D department. I also read previous research to help judge appropriate and acceptable ethical and research standards. Following these discussions and reading I modified my plans accordingly ensuring that my research would be conducted to a high ethical standard. After submitting to the ethics committee I had to make a minor modification to my consent form. Submitting to R&amp;D I had to also ensure that I complied with their standards.</td>
<td>November 2002 and August 2004 – March 2004</td>
</tr>
<tr>
<td>Obtain approval from a research ethics committee</td>
<td>I initially obtained ethical approval from the East Surrey, Horsham and Crawley LREC, after making the slight modification noted above, as well as provided the committee with an up to date indemnity form and proof of my employment contract. I also gained approval from the local R&amp;D department. As I wanted to extend my research into a different geographical region I then gained ethical approval from the West Sussex LREC. The East Surrey LREC remained my principle.</td>
<td>September 2004 and January 2005</td>
</tr>
<tr>
<td>Ethical approval (continued)</td>
<td>Log of research experience</td>
<td></td>
</tr>
<tr>
<td>-----------------------------</td>
<td>---------------------------</td>
<td></td>
</tr>
<tr>
<td>Collect data from research participants</td>
<td>January – March 2003 and January – July 2005</td>
<td></td>
</tr>
<tr>
<td>I collected data for my SRRP from retrospective case note files held at a community mental health team base. For my MRP I collected data directly from research participants, seeing them either at their care team base or their own home. Before they took part I provided potential participants with information about my project as well as gaining written consent. During my time with participants I informed them of everything I was doing and allowed them time to ask any questions. I also gave them details of how to contact me following the research interview in case of any questions or concerns.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Set up a data file</td>
<td>March 2003</td>
<td></td>
</tr>
<tr>
<td>I set up a data file for my SRRP using the Statistical Package for Social Sciences (SPSS), a computer program. I created a data file to allow me to enter the data gathered into a standardised format. Similarly, I created the data file for my MRP using SPSS Again I set up the file to allow me to enter the data gathered from questionnaires and semi-structured interviews in a standardised format.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Analyse quantitative data</td>
<td>May 2003 and July 2005</td>
<td></td>
</tr>
<tr>
<td>I analysed quantitative data using the SPSS computer package, this was both for my SRRP and MRP. The methods I used to do this can be seen in this portfolio.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Analyse qualitative data</td>
<td>May – June 2004</td>
<td></td>
</tr>
<tr>
<td>I analysed qualitative data as part of the qualitative research project that I undertook within a small group with five of my colleagues. We each gathered data separately, then came together to analyse the data using interpretive phenomenological analysis (IPA), we discussed possible themes that emerged from our participant’s narrative. As an outcome, we as a group wrote up a joint report.</td>
<td></td>
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</tr>
<tr>
<td>Summarise results in figures/graphs</td>
<td>June 2003, September 2003 and July 2005</td>
<td></td>
</tr>
<tr>
<td>I have summarised results for my SRRP and MRP, figures and graphs can be seen in this portfolio. I also summarised results for my people with learning disabilities case report.</td>
<td></td>
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</tr>
<tr>
<td>Log of research experience</td>
<td>Interpret results from data analysis</td>
<td>Present research findings/plans to an audience</td>
</tr>
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<td></td>
<td>I have interpreted results from both my SRRP and MRP, these interpretations can be seen in this portfolio. I also helped interpret data for our qualitative project in discussion with my group colleagues.</td>
<td>I presented the findings of my SRRP to the community team from where I drew the data in a specially organised team meeting. In preparation for gathering data for my MRP I visited teams from where I hoped to recruit participants and presented my proposed research to them. I plan to present the findings from my MRP to the teams that were involved in my research and helped me to recruit participants. I also plan in some way to present my MRP results to my participants.</td>
</tr>
</tbody>
</table>
| Influencing practice (continued) | From my first year a book written by Wells (1997) helped me gain early understanding of anxiety disorders as well as providing intervention options. In my second year I discovered a book edited by Leahy (2003), which helped me gain an understanding of roadblocks in therapeutic situations and how to work with them. In my third year I have used a book edited by Bennett-Levy et al. (2004) to help me devise behavioural experiments in a CBT framework with my clients.  


Postscript

It feels strange now that it is all done.

And really that it is, it is all done, all this work. The funny thing is that it was all for me, for me to achieve something, but I am guessing if you are reading this then maybe it is for you too. I say this because I have seen so many portfolios, shelves after blue hard bound shelves of them. I bet you after they have all been placed there they haven't been read again or even looked at. It's a shame that. After all so much hard work, after all so much effort, the results go onto a shelf and allowed to gather dust, until offices are moved and the portfolios are moved with it, possibly to somewhere more anonymous.

Of course, it's not all for nothing, this portfolio allows me to practice as a fully-fledged clinical psychologist, so it is worth so very much, especially to me. But again, it is a shame that no one else will now read it. That's where you come in though. Can I presume that you have read at least some of my portfolio? Why did you choose to look at my portfolio? I will leave you to answer that question. I hope you have found the answers to your questions, or maybe enjoyed just doing a bit of reading. I hope I have helped you in maybe the same way this portfolio has helped me.

Oh, if you are reading this tell your friends that my portfolio reveals the secrets of the universe and of life. Naturally it doesn't (apart from the fact that everything has some sort of meaning), but a belief, or a hope in a belief, has to start somewhere. If you are reading this and soon to write your own portfolio can I ask that when you finish it you write your own postscript, giving your own thoughts and feelings. Maybe we can start a trend.

Thank you for your time and thanks for looking at the end. Best wishes.

Peter
(I won't call myself doctor – it still doesn't feel quite right yet)

October 2005