A Portfolio of Academic, Therapeutic Practice & Research Work

Including an exploration of the differences in beliefs, attitudes & behavioural intentions of two nursing staff groups towards clients who deliberately self-harm, working within an accident and emergency department or a community mental health team.

By

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I would like to thank my family - the French's and Huggett's for all their help, support and guidance throughout these three long years of training. This portfolio is dedicated to Richard, my husband, for his love and encouragement without whom I would have never completed this course.
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Introduction

Year 1: Literature Review
Care professionals’ and clients’ attitudes towards the management of deliberate self-harm in accident and emergency departments, general hospitals and general psychiatric hospitals: have they changed over 25 years?

Year 2: Empirical Study
An exploration of the differences in beliefs, attitudes and behavioural intentions of two nursing staff groups towards clients who deliberately self-harm working within an accident and emergency department or a community mental health team.

Year 3: Empirical Study
An evaluation of the usefulness of the CORE in a cognitive behavioural therapy group for depression.
Introduction to the Portfolio

This portfolio represents a selection of work carried out in fulfilment of the PsychD in Psychotherapeutic & Counselling Psychology at the University of Surrey. It is divided into three dossiers each represents the core areas of training: academic work, therapeutic practice and research.

Given the confidential nature of therapeutic work, where personal material is cited or referred to, the names of individuals have been changed, and any identifying information altered in order to preserve confidentiality and anonymity. Practice-related reports or studies are located in a confidential appendix, submitted separately and not publicly available.
Academic Dossier

This dossier contains a selection of papers and reports submitted over the duration of the course. The first paper comes from the course module on "theoretical models of therapy" and addresses the topic of anger from the perspective of Freud and Klein. The other two papers come from the course module on "advanced theory and therapy". The first focuses on neutrality as a controversial component of the therapeutic frame. The second discusses relationship versus technique factors in the process of change in cognitive therapy. Finally, a psychopathology report is submitted which examines the various possible diagnoses that might be considered in a particular case history that is included with this piece.
Compare and Contrast the Theoretical Aspects and Clinical Implications Regarding Anger of Any Two of the Following Analysts: Freud, Klein and Winnicott.

This essay will focus on the two theorists Freud and Klein comparing and contrasting their contributions from a theoretical and a clinical point of view regarding anger. Anger can be defined as extreme annoyance or displeasure, with aggression being the expression of this in real or phantasy behaviour (Maddi, 1989). Freud viewed aggression as the agent of death stating that; "we are born with death in our hearts, its manifestation, directed outwards as a defence, is in aggression" (p. 25, Frosh, 1987). He believed all persons possess life, death and sexual instincts, the last being the most important (Maddi, 1989). Klein's contributions are rooted in basic Freudian discoveries but she took his theory of the death instinct further and challenged his ideas about aggression (Segal, 1996). In contrast to Freud's emphasis on both sexual and aggressive drives, Klein believed the aggressive were the most important (Hinshelwood, 1996). For the purposes of this essay discussion will focus on Freud and Klein's work in respect of; aggression and the Id versus the primitive ego, the death instinct, the Oedipal complex and difficulties in its resolution, phantasy, and finally, self-destructive behaviour.

The Id versus the primitive ego

Freud and Klein both emphasised the importance of the unconscious, highlighting how unconscious determinants mould and affect the way we perceive ourselves and others (Kline, 1990). Both agreed that our primitive instinctual thoughts were shaped by aggressive impulses and feelings of which we are not aware. Similarly they focused on early childhood experiences in their explanations of aggressive instincts. Freud (1923) believed the Id consisted of the instincts these being the original content of the mind. He stated that the Id was where aggressive feelings, fantasies and drives became repressed and it was a very dominant psychic force in early childhood with aggressive drives seeking expression. Freud (1923) further asserted that the Id becomes more subordinate to the developing and more powerful ego as the child gets older. The ego is the dream sensor
and agent of repression keeping the aggressive fantasies and drives locked in the unconscious. The superego is the conscience or ego ideal and, in regards to anger, Freud (1923) stressed that it develops from the child assimilating the moral precepts held and taught by the parents. The Id, ego and superego are in constant dynamic interaction with aggressiveness more likely expressed if the Id is stronger than the ego and superego. However, the ego, constantly striving to restore equilibrium and establish authority over the Id, uses methods of repression, denial and rationalisation. For the main part the ego does restore its authority over the Id and we do not act out our aggression. However, Freud (1923) believed that when it failed neurosis could develop.

In contrast Klein (1928) did not focus on the Id and ego like Freud but on mental processes which can help the child cope with the ambivalence of the external world. Klein (1928) also assumed that at birth there was a primitive ego, relatively unformed but with the capacity to experience anxiety, which can be caused by fears of the power of one's own aggressiveness. This is different to Freud's theory that the ego develops with experience after birth where anxiety can occur if the ego is under threat of aggressive or sexual drives. Klein explained how aggressive instincts are represented in mental life as "phantasies", a means by which the primitive ego tries to ensure satisfaction of those instincts. Kleinian theory also differs from Freud in stating that objects exist from the start of a child's life, and their instincts are always directed towards them. The first object of desire is the mother's breast, the child initially has relationships with the breast embedded in their phantasy world. In the child's mind there is a splitting of the good breast (the life instinct) and the bad breast (death instinct) (Segal, 1996).

The death instinct
Klein (1933) took Freud's theory of the death instinct; "The hatred of life", seriously because of the emphasis on aggression she found in the material of young children. Klein (1933) believed at the centre of infants experience was the battle between life versus death (love versus hate). She elaborated from Freud's (1920) view of the death instinct as a
person's drive towards death itself and hence a self-directed form of destructiveness (and a factor to be addressed in treatment of all self-destructive and self-harm attitudes). Instead, Klein (1932, 1933) believed from the first moments of life the death instinct becomes modified so instead of a self-directed destructiveness, the infant experiences an object that is intent on destroying them. That is, the ego copes with the threat of the death instinct by deflecting it outwards towards the breast. The breast is felt to be aggressive and threatening to the ego giving rise to a sense of persecution and hence fear of the persecuting object. The effect of the life instinct is to redirect aggression from life itself towards an external object, initially mother's breast. Rather than hating life, the baby turns its hatred and anger on the mother (Bateman and Holmes, 1995). Klein (1946) developed independent of Freud the concept of "persecutory anxiety", where she observed small children's fears of attacks by a revengeful mother/breast due to their hatred and own aggressive impulses towards the mother. By clearly interpreting the child's own destructiveness and anxiety during play therapy Klein demonstrated how, (as in the case of "Trude" (1924)), the child's anxiety could be reduced and an acceptance of their anger could begin (Klein, 1975).

Later, Klein (1957) extended her theories of the death instinct even further from Freud's to include envy. This is where the aggression directed against the life of the subject is directed against an object that is intent on keeping the subject alive. This she called "envy", which is an attack on anything that is the source, or support, of life (Hinshelwood, 1996). This aggression, Klein (1957) asserted, is initially towards the mother whereby envy is unavoidable since if the breast is unsatisfactory the child hates and envies it as a mean breast and if satisfactory it is envied for its goodness and wish to be owned. Envy is the interplay between love and aggressive derivatives of the death instinct. Klein (1957), unlike Freud, highlighted envy as the "worst sin" believing that many adults difficulties arose out of envy since it attacks all virtue and pleasure in life. She warned that envy could limit the effectiveness of analyses since it destroys pleasure in the self as well as in others. Thus, the benefits of truth and understanding cannot be enjoyed by the envious person (Segal, 1996).
Klein (1957) also stressed that therapy should include helping the client understand their envy which can also reveal where they are in development. This is important since aggressive envy in infancy can inhibit development of object relations thereby effecting the growth of the capacity to love. Klein (1957) also stressed that envy influences the Oedipal complex, later in development. If envy is too powerful it can destroy the successful resolution of the Oedipal phase as in psychotic states.

The Oedipal complex

Freud also linked the Oedipal complex with envy, whilst his theory primarily focused on sexual drives, Klein's focused on aggressive ones (Kline, 1990). In relation to aggression and the Oedipal complex, Freud's theory of the generation of the superego is important, and will be explained in the case of males. Frosh (1987) explained that; "The superego appears at the culmination of the Oedipal complex when the prohibitions and symbolic aggression of the father is internalised by the child as part of a new series of identifications brought into play by the castration complex" (p. 28). Here two aggressive elements combine. Firstly, aggression with which the child feels himself threatened (i.e. by the castrating father), and, secondly, the aggression the child feels against his father, an aggression generated by the father's prohibition and repressed due to fear of retaliation by the father. The child cannot destroy the father he also loves so the internalised aggression is experienced as guilt. Aggression is thus mastered and incorporated into the punitive superego. Freud (1915), in contrast to Klein, explained that this needs to happen for society, in that by repression we control and suppress our externalised aggression and thus people protect themselves against the aggressive nature of each other. Since we turn our aggression inwards it acts as a control over our behaviour and we are less likely to incite aggressive acts on others (Frosh, 1987).

Freud (1925) stated that unsuccessful resolution of the Oedipal complex can cause the development of neurosis. He believed repression to be inextricably linked with anxiety. Repression being the distinctive characteristic of hysteria (the original psychoanalytic
neurosis). In the development of neurosis the ego's function of repressing the aggressive drives is, with the formation of symptoms, receiving aggressive material in a distorted fashion. In order to cope with these symptoms and ensure original aggressive impulses are not freed, it adapts and incorporates these symptoms into its organisation. Freud (1925) stressed that analyses of the form of the symptoms and the experiences they are linked to, is important. In this way therapist and client can gain a clear understanding of the underlying conflicts and their causal relationships to the symptoms experienced. Freud also explained that when material is brought up by the client allowing emotional expression of any anger that may accompany it is also an important part of treatment (Drydan, 1990).

It is not surprising that Klein's version of the Oedipal complex is different to Freud's especially considering his theory in relation to females development of penis-envy. How girls leave the Oedipal complex is also never fully explained by Freud who only stated that it was "difficult" and "incomplete" leading to weaker superegos and vulnerability to neurosis (Kline, 1990). In contrast to Freud, Klein believed the seeds of the Oedipal complex began in infancy and in the oral (not genital) phase (Britton, Feldman and O'Shaugnessy, 1989). Klein (1921) explained that separation from the mother symbolised the father's existence and, the child's aggressive phantasies aroused by this separation were projected onto the father. This stage was linked to movement from the paranoid-schizoid to the depressive position. Here, good and bad are only separated when the child can accept a sense of guilt that both their good and bad feelings are directed towards the same person. Similarly, resolution of the Oedipal complex requires the child's acceptance of their temporary exclusion from the parents to allow them to come together. Klein (1945) further explained that reparation was an important way of working through aggressive, destructive feelings. This involves a variety of processes by which the ego feels it "undoes" harm done in phantasies (such as aggressive phantasies destroying the mother). In this way it restores, preserves and revives objects through the formation of loving relationships. If resolution of the Oedipal complex is successful the child learns to tolerate envy without being overwhelmed by it or using it to destroy. However, when envy is too strong, thus the
Oedipal complex left unresolved then Klein, in contrast to Freud, believed psychotic states can develop (Hinshelwood, 1991).

Klein (1948), unlike Freud, stressed in psycho-analysis the importance of interpreting the Oedipal complex as a priority, picking up on the child's rivalry, jealousy and aggressiveness. Klein demonstrated this in the documented cases of Richard, Peter, Trude and Erna (Segal, 1996). She discovered aggressive phantasy typical to those stuck in this complex, and interpreted them in a direct, supportive manner. These phantasies, such as Erna's (analysed by Klein between 1924-1926), often included how from the parents loving, exclusive relationship enters a third person who, being excluded like the child, attacks the couple. The aggression of the excluded figure in the Oedipal complex is, like intercourse, orally conceived including killing and devouring (such as in Erna's roasting and eating of her parents).

Klein (1948) also emphasised that analyses of the Oedipal complex involves interpretation of the projection of the child's aggression onto the father. Klein (1946) explained that introjection (taking the goodness of objects in) and projection were defence mechanisms that we use throughout our lives. She stressed that the latter offers a way that the child can deal with their own aggression by disowning it. One way in which both Freud (1895) and Klein (1946) used the term "projection" was to state that it is when one attributes someone else as having the same states of mind as ones own. However, Klein (1946) developed what was initially Freud's idea further to include, "projective identification". This term defines a more active getting rid of something belonging to "the self" onto someone else, evoking in that person aspects of the self which one cannot bear. It involves a deep split where aspects of "the self" are deeply denied. It can be used to communicate or attack with aggressive, destructive parts of "the self" evoked in others in order to destroy their comfort and happiness. In contrast to Freud, the concept of projective identification is crucial to the work of Kleinian analysts. The idea that parts of the self can be forced into others in phantasy has many ramifications, particularly when working with psychosis. Klein (1946)
believed that very extreme forms of paranoia laid at the basis for psychotic illness in later life. That is, when crises of fear and aggression are prolonged in childhood they become a way of life and an established part of the personality. Klein (1946) stated that people with such personalities live out their habitual attitudes of brutish aggression, or their phobic fearfulness of others. In 1930 Klein's analyses of "Dick" (believed to be psychotic although today would probably be diagnosed as autistic) was revolutionary. Freud and other analysts believed that it was impossible to do analysis with people who had psychosis due to their lack of emotional contact. Klein demonstrated, through her method of clearly interpreting Dick's phantasies during play therapy, that this lack of emotional contact could be overcome by sufficient understanding on the therapists part. She found that there was a healthy and sane part of Dick's personality which could make contact with her. Klein (1946) believed her conclusions about psychosis were validated by the evidence she produced from her interpretations of psychotic children (and one adult) during play therapy. However, these have remained under constant debate (Tyson and Tyson, 1990).

Phantasy

Within practice the interpretation of "Phantasy" was important to both Freud and Klein (Segal, 1996). "Phantasy" refers to the psychic representation of instincts (Hinshelwood, 1991). Klein (1948) believed that the external world was perceived and related to through a screen of the child's internal drives and phantasies. She stressed that even if the early experience is good all the child's desires can never be met so the child will experience anxiety and fear and will suffer aggressive and destructive emotions. Thus, Klein believed that good experience would lessen the anger, but never wholly take it away. Klein's work on phantasies was built on the insights of Freud's work on dreams and symbolism (Segal, 1996). Freud, however, in practice focused on dreams believing them central to psychoanalytic thought, whereas Klein focused on play therapy, following her discovery that children's play could be interpreted in the same way that dreams could in adults (Segal, 1996).
Freud's psychoanalytic interventions were aimed at making the unconscious conscious and he believed dreams offered a rich and endless source of unconscious material (Freud, 1940). He discovered from hypnosis of neurotic patients that the contents of their unconscious minds derived from childhood upsets, traumas, and frightening, aggressive phantasies. Freud (1900) then developed free association from his discovery that dreams could be decoded as sets of personal symbols. He asserted that when thoughts related to recent experiences help to generate a dream they do so by arousing a related infantile wish. These wishes, he believed, were based on sexual or aggressive drives. In, "The Interpretation Of Dreams", (1900) Freud stated that the Oedipal complex is a combination of loving and hostile wishes and the interplay between these two wishes gets played out in dreams. As Freud (1900) stressed, they are the; "Dreams of the death of persons of whom the dreamer is fond" (p. 234). Smith (1990) used Freud's approach in a case study of a man suffering from outbursts of extreme rage which he feared would one day get out of control and lead him to kill someone. The client was encouraged to recall a dream in which he was plagued with a dreadful sense that his head would explode after seeing his mother breast-feeding a baby. He would then run to her in panic. The analyst interpreted this stressing that witnessing the breast feeding had stirred powerful erotic longings for his mother, which in turn, stimulated fears of his father's violent punishment. The head exploding was interpreted as a disguised portrayal of castration. Other themes were then also found characteristic of the Oedipal complex : the wish for his mother's affection and the hatred of his father. This led to an exploration of his rage which was directed towards people reminding him of his father. Once the client had gained insight into the source of his difficulties and understanding as to what his dreams meant, his rage soon began to cease.

Similar to Freud, Klein interpreted the Oedipal complex in her patients phantasies. However, in contrast to Freud the interpretations were mainly to young children who played out aggressive phantasies during therapy (Mitchell, 1986). Klein was criticised by Anna Freud (1927) and other therapists for this practice (Greenson, 1974; Kernberg, 1980). They argued that Klein could not compare her technique of play analysis to that of...
Freud's free association because the latter involves a co-operation with the analyst for the purpose of a psychoanalytic venture whereas the former involves a child who has a different purpose behind play and cannot understand the nature of psychoanalysis. Klein (1927) argued that both play and free association were comparable as both involved a symbolic expression of the mind. Furthermore, she argued that the child, from the first interpretation, has an "unconscious" understanding of the nature of psychoanalysis. Anna Freud (1927) also argued that such explicit and deep interpretations on the aggressive aspects of the child's phantasies could alienate the parents and stop the child feeling good about themselves thus, preventing any useful work to be done with them. An example of Klein's interpretations can be seen in the case of Dick (1930) whereby, after pieces of black wood (representing coal) were cut out of a cart and Dick threw the cart away Klein interpreted to Dick that he was "cutting faeces out of his mother" (p. 103, Mitchell, 1986). Dick then attacked the cart which Klein interpreted as his mother's body.

Klein (1927) was certain that aggressive phantasies were far less dangerous when analysed than when left alone. She found that the child's aggressiveness was in constant conflict with loving and reparative drives. In order to help the child with this conflict acknowledgement of aggression was essential. Within Dick she found not only cruel sadism but empathy and love. Since the aggression was aimed at a distorted version of the parents, bringing it into consciousness by interpretation made it possible for a more realistic view to develop causing the aggressiveness to be modified. This process strengthened the ego by enabling it to own the hated parts of itself which were attributed to the hated parents. Dick who had developed a strong transference relationship with Klein and a new interest in things around him through play began to develop a firm relation to objects with an ability to tolerate his anxiety and express his feelings not only of anger but of empathy and love towards his parents. Klein (1948) also stressed how children fear the power of their own aggressiveness especially in phantasies of attack on the mother. Thus allowing children to play out aggressive phantasies is important. She highlighted this in her work with "Trude" (1924). Klein (1948) explained that as the angry feelings directed towards a therapist are
not exactly the same as those directed towards the parents, Trude was not as frightened of attacking her as she was her mother. Fears of her aggressiveness, damaging and destroying the therapist were not as strong. Klein (1948) stressed that this meant aggressive phantasies could be expressed more easily in therapy than outside and therefore worked through and understood in safety.

Self-destructive behaviour

Both Freud and Klein explored the link between self-aggression and mental illness. Freud located the original source of the death instinct in the subject's own self, thus making self-aggression into the essence of all aggressiveness (Frosh, 1987). The clinical manifestation of mourning and melancholia, unconscious guilt feelings and negative therapeutic reaction, are phenomena all seen by Freud as representative of aggression directed against the self (Tyson et al., 1990). Particularly with depressive patients Freud thought the component of aggressiveness and hatred inevitable in any relationship, was strong. He stressed that even the slightest rebuff makes depressed patients feel they have lost a loved one and have gained a hated one. Their attention then draws towards self, relating to the other with intense hatred. This turns into self-hatred (and can result in self-destructive behaviour) with the person stuck in a hostile self-relationship (Frosh, 1987). Freud (1917) described depression as a process of mourning gone wrong due to the especial strength of hatred towards the object. This hated object is absorbed into the identity of the ego, (the process of introjection) causing self-hatred.

Freud (1920), similar to Klein, treated the emergence of aggressiveness as an essential feature of psycho-analytic treatment. Important in this was making the patient's hostile motives and underlying reasons for self-aggressiveness conscious and being aware of transference in the form of resistance. Freud (1920) stressed that resistance was largely due to negative transference which could be directed towards the therapist. The aim of interventions would be to work through the transference helping the client to gain insights
Klein (1940), similar to Freud, viewed aggression as a major part of the mourning process. She stressed the importance of loss of a parent in any form (including a breast or hand) and its link to separation anxiety, grief and mourning. If the normal processes of childhood are disrupted in this way then phantasy becomes reality. When the loved object dies, leaves, neglects, batters, reacts too obsessionally or possessively, it is likely a pathological course follows in later life. Klein (1940) explained that this leads to an aggressive stance, not only toward society but also self-aggression and abuse. Similar to Freud, Klein (1940) believed that working through the transference was the focus. She argued that feelings and attitudes once associated with the parents, with a strong therapeutic alliance, can become attached to the therapist and thus aggressive and other feelings can be expressed, interpreted and understood. This Klein argued lead the way for positive feelings to then be constructed.

In conclusion, Freud and Klein both gave great importance to aggressiveness in psychoanalysis, showing it to be at work in the early stages of children's development. However, whereas Klein focused on aggressive drives and how aggression is experienced both inwards and outwards, often being accused of being too pessimistic and placing to much emphasis on this, Freud viewed aggressiveness directed inward and outward as fused with sexuality, often being accused of placing too much emphasis on sexual drives. Klein also focused more on very early infancy than Freud. Kline (1990) argued that much of Klein's theorising was based on how the infant projects its own aggression on to the mother. The mother is then perceived as aggressive which, frightens the infant. In defence the mother is introjected with the good and bad parts becoming split off in the infants unconscious. The impact of this is stressed as far-reaching but as Kline (1990) stated defies simple exposition. That is, her theorising was mostly on the analysis of toddlers, using their games rather than their words as the data source. Adducing evidence of early infants mental activity based on Klein's work is difficult. Similarly, Freud is criticised due to his theories
lacking refutability (Popper, 1959). The data used for Freud's theories is criticised by Eysenck and Wilson (1973) as coming mostly from his recollections of sessions with Jewish women suffering with neurosis. It would be difficult to find contrary evidence on Freud's claims regarding the death instinct where Maddi (1989) summed up Freud's explicit statement on aggression as follows: "A portion (of the death instinct) is placed directly in the service of the sexual function, where it has an important part to play. This is sadism proper. Another portion does not share in this transportation outwards; it remains inside the organism and becomes libidinally bound. It is in this position that we have the original, erotogenic masochism" (p. 52). The differences between Freud's interpretation of aggression with its fusion to sexuality, thus distinct from Kleins, can be seen in both their theories and practice, especially highlighted by their contrasting views of the Oedipal complex. This essay has examined some of the work of Freud and Klein on aggression where, due to their insights, the awareness of the influence aggressive drives have on a client's development and its importance in treatment is viewed as crucial in the process of psycho-analysis.
References


Discuss an Aspect of the Therapeutic Relationship in Relation to Psychoanalytic Ideas

This essay will focus on one aspect of the frame that is, neutrality. The frame is the ground rules and boundaries of the therapeutic setting. This plays an important part in the relationship between therapist and client. Milner (1952) introduced the metaphor of the frame stating that; "The frame (of a picture) marks off the different kind of reality that is within it from that which is outside it; but the temporal spatial frame also marks off the special kind of reality of a psychoanalytic session. And in psychoanalysis, it is the existence of this frame that makes possible the full development of that creative illusion that analysts call transference" (p. 183). Neutrality is an important component of the frame which Dorpat (1977) stated means acting in accordance with three fundamental values of psychoanalysis which include: "the love of truth, unfailing respect of the patient's autonomy and a patient-centred orientation" (p. 39). This essay will firstly discuss the development of the frame thus placing neutrality in context with the other components that make up the frame. Secondly, the communicative approach to psychoanalysis, founded by Langs (1970s), is discussed where neutrality is viewed as being of central importance in the psychoanalytic process and is strictly adhered to as with all components of the frame. Arguments opposed to this will also be addressed with support for a more variable attitude towards neutrality where it is managed in a more relaxed manner giving importance to analyst's personal judgements (Renik, 1996).

The frame

Freud first introduced the concept of the frame in his papers on technique written from 1911 to 1915. These began to address the use of ground rules in analysis (Kline, 1990). Freud's interest in the frame had several facets which included; a wish to create an atmosphere of safety for patients to bare their souls to him, a relatively contamination-free "space" to facilitate analysable transference, an exclusion of non-cognitive influences or "suggestion" in order to maintain autonomy and insight, and, possibly to give fixed parameters to psychoanalysis so that hypotheses could be tested in a scientific manner.

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(Freud, 1912, 1913). He discussed many issues, such as neutrality and abstinence, offering recommendations based on his trials and errors in practice. Winnicott (1954) built on Freud's work by helping to define the elements of the frame. In the same way that Freud viewed the frame as allowing for transference Winnicott believed that the frame invited therapeutic regression. Winnicott (1954) and Bleger (1967) viewed the frame as a representation of the early mother-child relationship. Furthermore, Winnicott (1954) stressed the importance of the management of the frame for deeply regressed clients with the setting viewed as a crucial aspect of the therapy. If it was appropriately managed it encouraged the client to risk revealing their true self.

Bleger (1967) developed the frame on different lines to Winnicott. He viewed it as a symbol of symbiosis, providing basic support for the client. A secure frame made space available for the disturbed elements of the client's personality to be analysed. He believed that deviations from the frame repeated the neurotic interaction of the client's childhood whilst maintaining it made it possible to reach their psychotic core (i.e., the permanent elements in the client's personality). He stressed that the frame helps to re-establish the original symbiosis in order to modify it and thus allows for the deepest level of interaction between therapist and client. Bleger (1967) viewed the frame as a constant that structures the flow of the process of analysis. Based upon this Codignola (1987) stressed that the frame had a logical role in psychoanalytic interpretation. The "true" elements of the psychoanalytic situation from the frame form a stable enough background for interpreting the "false" elements (i.e., interpretable elements from the analytic exchange).

Smith (1991) stated that after many clinical observations communicative theorists conclude that the frame is the "single most powerful factor" in the psychoanalytic situation and therefore it should be given central importance theoretically and technically. He stressed that a therapist's management of the frame shows the type of relationship they wish to establish with a client both implicitly and explicitly. The frame is likened to a mould which surrounds, contains and structures the psychotherapy. In psychotherapy a client is
embedded in a system comprising of the client, therapist and the frame. Whatever comes into the client's mind during the therapeutic situation is therefore a function of the total client/therapist system (Langs, 1976).

According to Langs (1976), the unconscious system has adapted to understand intersubjective reality and is much more in tune to emotional reality and less entangled with self-deception and defences than our conscious system. Therefore, taking into account the client/therapist system, rapid and highly accurate inferences about the therapist's unconscious motives, defences and reasons for their behaviour will be made by the client. Freud's belief that the unconscious indirectly influences the conscious impacted upon communicative theorists who also believe that the unconscious can evoke conscious ideas. Smith (1991) stated that evidence of this can be seen in practice by the lawful relationship that exists between stimulus in the psychoanalytic setting and derivative response. This is due to people's deep unconscious system being very consistent, thus certain ways of structuring the frame are constantly validated or not. This means predictions can be made which are open to falsification. For example, breach of confidentiality is predicted to bring about themes of intrusion, violation and disruption. According to this theory if the therapist does not interpret the clients negative derivatives and understandable concerns then there will be no positive "validating" derivative imagery. Smith (1991) stressed that these are very clear predictions and whether they come about or not can be easily tested.

Smith (1991) stated that according to communicative theory there are eleven components of the frame that are known to be consistently validated by clients these are; 1. Use of the couch, 2. Creating space for free association, 3. Absence of physical contact, 4. The analyst's anonymity, 5. Total privacy, 6. Consistency of setting, 7. Set fee, 8. Set frequency and duration of the session, 9. Clients responsibility on termination, 10. Total confidentiality, and 11. The analyst's neutrality. This essay will now focus on neutrality highlighting arguments for and against deviating from this.
Communicative psychoanalysts' view of neutrality

In regards to Dorpat's (1977) definition of neutrality, stated earlier, communicative psychoanalysts have taken this to mean offering hypothesis and interpretation that foster genuine insight and refraining from mechanisms used for change such as praise, intimidation, advice, promises of cure, reassurance, influence, moral judgement and confrontation (Smith, 1991). This is linked to respecting the client's autonomy as the therapist does not seek to run the client's life. All interventional errors go against keeping neutrality where clients unconsciously inform the therapist if they have not remained neutral. Smith (1991) stressed that communicative analysts, unlike other forms of psychoanalysis, interpret neutrality much more strictly and regard interpretation that takes into account the client's immediate reality as the only intervention that is accepted as adhering to the concept of neutrality. Therapist's questions, requests for free associations, educative interventions and interpretations purely based on the analysts chosen theories (i.e., psychoanalytic clichés), are seen as not receiving unconscious validation and therefore are not accepted. Smith (1991) stated that neutrality is also linked to anonymity in that therapist's self-revelations violate the "client-centred" aspect of neutrality with the therapist taking the centre in the therapeutic space and possibly causing a role reversal by implicitly appealing for therapeutic help from the client.

Arguments for deviations from neutrality

Within psychoanalysis there is no consensus as to what constitutes an appropriate reason for deviating from neutrality. Modifications have been advocated in order to; enhance the therapeutic alliance and promote the therapeutic relationship, support the client, allow expression of the "real" relationship between client and therapist, make the therapist appear more human and flexible, avoid a trauma that a client may go through, resolve a stalemate or dilemma a client has come to, and prevent the client feeling unnecessarily frustrated (Hoag, 1992). Analysts that support the need for deviations from neutrality include; Eissler (1953, 1958) who argued that deviations are needed with clients who have ego defects to enhance their ego's achievement of mastery by encouraging this. Stone (1961), Zetzel
(1966), Greenson and Wexler (1969) advocated a range of non-neutral deviations thought to help foster a therapeutic alliance, most of which were based on their impressions on how productive certain modifications appeared to be for the client. Such theorists argued that clients respond variably to the frame due to individual differences whereas, some may need a strict frame others require a more flexible one. For example, Kris (1993) argued that a more flexible approach was needed to neutrality with clients who had harsh superego's. He stressed that confronting such clients about how they were persistently and severely critical of themselves and their abilities could help challenge their highly self-critical beliefs and lead to productive therapeutic work towards changing them.

A further argument put forward by many is that neutrality for the analyst is impossible (Greenberg, 1991; Hoffman, 1996; Renik, 1995; Singer, 1977; Stolorow, 1990). Lorand (1963) stated that complete neutrality was a myth with giving advice and opinion being a part of every analytic situation. He described one client where offering her advice and alternative perspectives to her view of her situation appeared to be beneficial. Raphling (1995) and Shapiro (1984) argued that every interpretation is a departure from neutrality and perhaps all therapists can do is strive toward it in order to minimise the extent to which their subjective judgements hinder the patient's autonomy.

Analysts at the extreme end of the controversy believe neutrality is not useful even if it were possible and should be abandoned. Hammet (1954), Sterba (1975) and Lomas (1987) view it as showing an "inhuman detachment" to the client, stating that analysts expressions of emotion contribute to analytic work by giving the client a sense of being understood and supported. Renik (1996) argued that neutrality does not facilitate a dialectical learning process arguing that non-neutral interventions do this by the analyst putting forward new perspectives whilst helping to challenge those of the client's that are fundamental to their problems. It is through negotiation of the different perspectives that the process of learning takes place, this benefits the client contributing to resolution of the problem. He stressed that neutrality is the cause of therapeutically unproductive relationships and that we
should focus on what level of participation is most useful for the client in regards to the analyst contributing with their personal judgements and feelings.

Arguments for strict neutrality
Langs (1975) stressed that therapists who use non-neutral interventions often neglect to address the unconscious influence of these on the clients. He stated that, "The expected effects are too often taken at face value, while the latent and implicit content and meanings of the deviation and its consequences are ignored" (p. 114). He continues by stating that the use of basic psychoanalytic methodology in examining the meanings of their deviations along with the clients responses is also neglected. Instead he believed that such therapist's considerations rely on preconceived theories or "naive, surface-oriented assessments of manifest meanings and reactions" (p. 114, Langs, 1975).

Langs stressed that analysing a client's response to deviations without recognising their basis in reality and the deep unconscious meanings of them with their effects on the client is insufficient. He believed that this was because clients have identifiable, predictable and universal unconscious responses to slight deviations in the framework of the therapeutic relationship, whereby, the therapist can use data which can establish the usefulness of deviations from neutrality. He argued that when a client proposes a modification of the frame the analyst can wait for unconscious guidance from them knowing that it offers more reliable information that is more in touch with reality than the conscious system which often has radically different values and commitments. By listening to unconscious feedback in the form of derivatives, which offer an encoded way of advising the analyst, whether to deviate or not can be established. Langs (1975) stated that evidence suggests that almost always the client urges the therapist to maintain a secure frame. Hence, he advocates that keeping strictly to neutrality and clear interpersonal boundaries offers, in the long term, a deeper level of client-therapist interaction which has a more profound effect on the client and gives a more effective and thorough psychoanalytic "cure". Smith (1991) also stressed that the argument put forward that each individual has different requirements regarding the
flexibility of the frame is not supported by evidence suggesting clients have consistent unconscious responses regarding its management. Furthermore, he argued that neutrality is important for learning where the therapist acts as a translator of the client's deep unconscious system. This allows clients to learn about themselves from their own "storehouse" of psychological wisdom (Smith, 1991).

Langs (1975) argued that deviations in neutrality bring momentary gratification and symptom relief to clients. For this reason they are often consciously accepted and further modifications sought. He stressed that clients can also show marked productivity following a deviation due to the intense adaptive efforts that they make in response to its traumatic, anxiety-provoking and disruptive impact. For this reason such deviations may appear useful. However, he warned that if neutrality is not restored and maintained and the clients reactions to the deviation fully explored, then their unconscious awareness of the mutual corruption from this deviation brings mounting guilt and anxiety. Following this it is likely they will terminate treatment or withdraw from the therapist in some way and act-out in keeping with the model offered by the therapist. Thus a secure frame is stressed by Langs (1975) as helping to establish a more secure, sane image of the therapist where feelings of safety, trust, support, and a sense of being contained are possible for the client in the therapeutic relationship. Smith (1991) stressed that this also helps provide a situation where appropriate frustration and satisfaction can be felt.

Smith (1991) argued that critics of neutrality sometimes wrongly define it as meaning an indifferent or inhuman detachment to the client. He stressed that neutrality is not an "inhuman detachment" from the client if Dorpat's (1977) definition is upheld. This requires the therapist to have a client-centred attitude keeping the inner truth and autonomy of the client a primary concern. Smith (1991) stressed that if a therapist does not keep neutrality the client will unconsciously perceive such deviation as promoting a loss of their autonomy. Langs (1979) argued that regard for the consequences of deviations shows human concern. He stressed that deviations can reflect, inappropriate and destructive
mothering, feelings of persecution, a lack of clear barriers, mistrust, encouragement of pathological acting-out and relating to one another, a sense of the therapist as someone suffering identity confusion, emotional instability and finding perverse gratification or satisfaction from the deviation. Cheifetz (1984) also stated that deviations from neutrality, and the frame in general, are unconsciously perceived by clients as the therapist showing concern for themselves, or their setting and personnel, and not for providing a secure environment in order to help the client's efforts to gain insight.

Smith (1991) gave examples of themes produced by deviations from neutrality including; a) an analyst's confrontation which was unconsciously perceived by the client as "faeces", (i.e., something nasty that the analyst wanted to get rid of onto the client), b) use of psychoanalytic clichés which the client unconsciously expressed disappointment at and described it as "feeling poisoned", and, another example where the therapist was likened to the patient's sick father who needed help due to his unacknowledged fear of death, c) a therapists non-insightful reflection which offered relief to their tension brought images from the client of chemical intoxication. And, d) a therapist bombarding a patient with questions is described in derivative communication as resembling her violent, persecutory father attempting to trap, push and shut her up. Smith (1991) argued that questions are never unconsciously validated as they are experienced as attempts to shut down derivative communication by encouraging conscious rumination. In addition, he stated that environmental themes almost always relate to the state of the frame and violation of any components of the frame often brings about behaviours such as late arrival, non-attendance, and long silences.

Experiences of adhering to and deviating from neutrality within the NHS

One example from my experience within an NHS placement of deviating from neutrality was to reassure a client that I did not think she was stupid and there was hope for her depression. This deviation came early on in my training and stemmed from my anxieties that I did not want the client to think that I thought she was stupid or that I could not help
her with her depression. This deviation appeared to offer her instant relief but I found that in accordance with Langs (1975) and Smith (1991) it was not unconsciously validated by the client as offering any benefit. The client by using relationship themes where she spoke about her problems with her doctor appeared to be giving me unconscious feedback that my intervention was in fact damaging to the therapeutic relationship and I was not sticking to my job but was on a path to failing her. Langs (1975) stressed such deviations by analysts could be avoided by undergoing self-analysis with any problems that they bring to the therapeutic relationship fully considered and controlled.

An experience of deviating from neutrality which I believe was crucial in my practice was with a client who appeared to be at risk of suicide. After discussing his suicidal feelings I explained that I was concerned about his safety and that I would need to telephone his GP to express these concerns, (my need to do this if I felt he was at serious risk of hurting himself had been explained to him at assessment). I also gave advice that I thought he should not go home alone as he had planned to do but instead stay in company until he could be seen by the psychiatrist on call. I asked him how he felt about this and listened also for unconscious feedback. The client stated that he felt relieved that I had taken his fears that he might kill himself seriously and that he would not have to deal with this alone. After seeing the psychiatrist the client was given a bed on a psychiatric ward over the weekend. In following sessions I aimed to mend any damage that may have occurred to the frame by discussing how the client felt about my non-neutral intervention. I also continued to listen for unconscious feedback to this deviation. However, I was not aware of unconscious messages that invalidated my intervention or behaviours such as withdrawal. Instead a stronger therapeutic relationship appeared to develop with the client feeling safely supported through a difficult and frightening time. This deviation did not also appear to prevent a deep level of interaction in our following work. My actions of addressing any damage that may have been caused in the frame could be argued as having been essential in our continued work. It may also be argued that I failed to pick up any unconscious invalidating messages and that I was unaware of the damage that my deviation had on our
work. However, I believe that sometimes deviations from neutrality are necessary and the above actions also had to be taken in line with the NHS trust's policy on risk management which regard these steps as good practice.

Clarkson and Gilbert (1990) argued that adopting any one attitude, such as neutrality towards a client, is in opposition to an approach which values uniqueness and difference, and requires from the therapist a range and flexibility. At times a therapist may need to be very active, such as in crises intervention or with a client suffering from severe depression. At other times, they may need to adopt a position of objective neutrality, for example with certain client's who have borderline personality disorders. Clarkson and Gilbert (1990) stated that, "the involvement of the person of the therapist will vary from client to client and depend on the stage of psychotherapy. This may range from using humour and personal experience to giving information, confrontation or a determined neutrality" (p. 213). According to Dorpat's (1977) definition of neutrality tailoring such interventions to a particular client's needs can still be argued as abiding with the love of truth, unfailing respect of the client's autonomy and a client-centred approach although, not under the terms to which Langs (1975) and Smith (1991) understand these. There is also a lack of research evidence that objectively examines if clients do have consistent unconscious responses regarding the management of neutrality where deviations from this are unconsciously viewed by the client as violating their autonomy. Such evidence is important since Langs and Smith's arguments for abiding to strict neutrality stand upon this.

Finally, setting up and managing a secure frame in the NHS can be extremely difficult. Pestalozzi et al (1998) stated that maintaining some level of neutrality is important even if staff about you are largely deviating from this and clients attempt to undermine it. She stressed that the reason why this is important is because unconsciously clients hope they do not succeed in their attempts to significantly undermine it as this would bring loss of their autonomy and failure to the therapy. Pestalozzi et al (1998) suggested that at least a secure frame as possible can be upheld by use of "secure frame moments". This involves
keeping in mind the state of the frame and especially if this is damaged addressing this in therapy to repair any damage. She stated that this can have a constructive effect where a useful therapeutic relationship can be accomplished and effective work accomplished. Hoag (1992) found from maintaining as secure a frame as possible whilst still allowing for some flexibility for her clients within a general practice surgery that over six months there was a 5% decrease in failed appointments and 9% decrease in clients terminating.

In conclusion, the neutrality component of the frame has caused great controversy as to whether it should be employed in psychoanalysis flexibly or strictly and to what affect it has on the therapeutic relationship. Langs (1973, 1975) and Smith (1991) argued that advocates of a relaxed approach to neutrality often focus on the conscious reactions of their clients and do not take into account the deep unconscious system which consistently supports a secure frame. They therefore support that neutrality should be strictly observed with deviations from this only by accordance with the deep unconscious requirements of the client. Smith (1991) stressed that communicative analysts have evolved a stringent method for falsifying hypothesis which it consistently deploys against itself, thus is open to refutation. In addition, he believes that deviations from neutrality are not unconsciously validated and if not dealt with appropriately can be damaging to the therapeutic relationship (Langs, 1975, 1988; Smith, 1991). However, there is little communicative data at present to confirm this belief and more is needed to attempt to falsify the communicative approach in a systematic way. Such research could help to establish the importance of adhering to neutrality by examining whether or not clients consistently unconsciously validate neutrality whilst invalidate deviation from it. More research is also needed to examine the impact on the therapeutic relationship when neutrality is strictly adhered to as opposed to when a more relaxed approach towards neutrality is taken.
References


In Cognitive Therapy, Therapeutic Change is Not Dependent Upon the Therapeutic System of Delivery But on the Active Components Which Directly Challenge the Client's Faulty Appraisals. Discuss.

Traditionally in the cognitive approach the way that the therapist delivered the therapy was not viewed as the crucial factor for producing therapeutic change. Beck, Rush, Shaw and Emery (1979) emphasised that although a good therapeutic relationship was necessary it was not sufficient for change. Instead, the active ingredients for change were believed to be the cognitive tools or techniques employed in a direct way to challenge the client's dysfunctional thinking pattern. However, with the development in therapy of an understanding of the underlying processes of therapeutic change within the therapeutic relationship, cognitive therapists began to acknowledge its importance. Many studies began to demonstrate how the therapeutic relationship could be actively integrated and used in the service of cognitive therapy (Horvath, 1995; Person and Burns, 1985; Ryan and Gizynski, 1971; Wright and Davis, 1994; Young, 1994). This has led to the contemporary viewpoint that the therapeutic relationship is just as central in the process of change as are the cognitive tools. This essay will focus on the arguments for and against the traditional viewpoint of the importance of the therapeutic relationship. Evidence will then be discussed that suggests therapeutic change in cognitive therapy is not dependent on the "delivery of therapy" (which impacts on the therapeutic relationship) or on the "active components" (i.e., cognitive tools) but instead both go hand in hand to offer the most effective way of producing change.

The working alliance

Three important components, which are common to all therapies, are influenced by the way the therapist "delivers" the therapy these are, the working alliance, real relationship and transference relationship. The working alliance involves the contractual elements such as agreement of therapeutic goals and the means of achieving them (Bordin, 1979). Similarly to the psychodynamic tradition concerned with the "analytic frame", in cognitive
therapy this too is an important step in building rapport. The manner in which information about the nature of therapy is conveyed is important as it provides the basis for security in the therapeutic environment and the client's first sense of feeling whether they will be able to work constructively with the therapist. As part of the delivery of therapy, the therapist has to use therapeutic skills (such as, listening, empathising, reflecting and summarising) to build a good working alliance. This is essential since without these skills the client would be unlikely to share their inner world with the therapist and the idea of being able to use cognitive tools to identify and challenge their dysfunctional beliefs or thoughts would not get off the ground.

At the outset of therapy the therapist provides a case conceptualisation of each client's situation (Wills and Saunders, 1997). A conceptualisation often brings about therapeutic change in cognitive therapy whilst not specifically designed to challenge the validity or conviction in the content of cognitions. A case conceptualisation offers the client an account of their difficulties and often reduces distress as it enhances their sense of understanding and control over their problem. The therapist explains that it is the client's interpretation and evaluation of an event that is the major influence on their emotional response rather than the event per se. For example, with a client suffering from panic attacks due to fears of going out, the therapist will put forward that it is their perception of major physical threat, together with their underestimation of their ability to cope with this threat, that maintains their panic symptoms and not the actual threat itself in going out. Explaining a case conceptualisation is not an easy technical task and includes the fundamental process of building a good working alliance with the client. It has to be tailored to their subjective account of their problems and incorporate their ideas and language in order that they feel understood. The therapist must also use empathetic skills and treat the client as a co-worker. Effective delivery of the therapeutic system therefore involves the therapist working on establishing a bond with the client. This will allow both parties to use the conceptualisation as a basis for treatment. Agreement can then be found
on the goals for therapeutic change and an agenda set with relevant tasks in and outside therapy to achieve these goals.

The real relationship

The real relationship refers to rapport between therapist and client. One major element of cognitive therapy is that it should be delivered in such a way that it encourages collaboration between therapist and client. Traditionally, the task would be to resolve the client's problem by both therapist and client working together using the tools of cognitive therapy and not the therapeutic relationship per se. The active ingredients of change were seen to be the technical aspects of therapy (Wills and Sanders, 1997). These include techniques such as, socratic questioning to identify maladaptive beliefs, challenging the beliefs where the client and therapist explore objective evidence for and against them (this may include psycho-education), setting up experiments to test them out and, deciding on more appropriate ways of behaving in the future (this may include teaching skills such as relaxation or anger management). The techniques used to challenge and modify maladaptive beliefs are stated by Alford and Beck (1997) as the main goal of cognitive therapy for therapeutic change to occur. The client is given more responsibility later on in therapy to challenge their own unhelpful thoughts and use learnt skills in order to maintain change. Raue, Castonguay and Goldfried (1993) stated that this provides clients with a sense of empowerment over their own problems where they take on the role of therapist for themselves and hence have the necessary skills to make continued improvements.

Rogers (1957) core conditions are viewed as essential in the therapist's delivery of therapy. However, traditionally they were only seen as the platform upon which "real work" could be done. As Beck (1976) stated, "if the therapist shows the following characteristics, a successful outcome is facilitated: genuine warmth, acceptance, and accurate empathy" (p. 221). Beck (1991) in comparing cognitive therapy to other psychotherapies appeared to emphasis the importance of the cognitive tools over the therapeutic relationship in order for therapeutic change as stated below:
"The active ingredient of many "common factors" amongst various psychotherapies, including the therapeutic relationship, is the end result of cognitive change. Cognitive therapy aims to produce the same result but by a more direct route. I certainly consider the therapeutic alliance as a common factor shared with other therapies. But I also believe that the shared and explicit focus on changing belief systems, reinforcing and refining reality testing, and developing coping strategies makes for a more robust therapy" (p. 194).

Gelso and Carter (1985) stated that cognitive therapists believe a good therapeutic relationship is not central in itself to change but instead it can be described as an "interpersonal leverage" upon which to base strategies that can then create the change. Raue and Goldfried (1994) also stated that it is like the anaesthetic in a surgical procedure. The primary focus is the surgical procedure but if there are problems in the anaesthetic this becomes the prime focus of attention. Thus, in delivering therapy the therapist monitors the relationship regularly and attends to it at times when resistance is encountered. The relationship therefore is described as providing a means of overcoming resistance (i.e. any attitude or behaviour of the client that counters the change process). A good therapeutic relationship has also been viewed as helping the process of change firstly, by increasing the reinforcement value of the therapist. This allows the therapist to have greater ability to influence the client's behaviour and ensure they engage in therapy. Secondly, by helping the therapist to influence the client into modelling alternative or appropriate behaviour, for example in assertiveness training. And thirdly, by helping the therapist's work of promoting positive expectancies and preparing the client for change such as, when attempting to increase motivation or instil hope that change is possible (Wills and Sanders, 1997).

In the 1970s many studies began to focus on the delivery of cognitive therapy, exploring the importance of the therapeutic relationship itself as a mechanism for therapeutic change. Ryan and Gizynski (1971) were the first to suggest that the client-therapist relationship may contribute even more to therapeutic change than the cognitive techniques. The
cognitive techniques were even associated with negative effects towards change. They found that when much greater emphasis was placed on the techniques than the relationship client's reported that this produced less liking for the therapist and the view that they were less competent. More studies began to support these findings (Alexander, Barton, Schiavo and Parsons, 1976; Burns and Nolen-Hoeksema, 1992; Mathews, Johnston, Lancashire et al., 1976; Persons and Burns, 1985). These studies found that although clients recognised the importance of specific techniques, they placed greater weight on the therapeutic bond in accounting for their improvements. It is important to note that these studies were retrospective and relied on self-report. However, they did provide many client accounts of the importance of the delivery of therapy where they believed their successful outcome was due to receiving elements such as empathy, encouragement and genuine interest. Lambert (1986) and Lambert, Shapiro and Bergin (1980) on review of empirical data estimated 15% of the variance in outcome could be attributed to the technical factors whereas 45% was attributed to non-specific factors including quality of the therapeutic relationship. The early development of a good therapeutic relationship was also shown to be a good predictor of low drop-out rate, high patient commitment and immediate positive change on outcome (Raue and Goldfried, 1994). However, evidence for the predictive power of cognitive therapy techniques on therapeutic change was not found (Castonguay, 1992). Safran and Segal (1990) and Safran and Wallner (1991) also found that cognitive therapy with an emphasis on communication about the therapeutic relationship itself was positively related to global measures of success in treatment by client and therapist and positive change in severity of the client's problems by the therapist. These findings helped to bring about changes in that rather than viewing difficulties in the therapeutic relationship as needing to be resolved before real therapeutic work could start, working on these relationship difficulties in themselves were viewed as likely to be central in bringing about therapeutic change (Wills and Sanders, 1997).

The argument for the need in cognitive therapy to work with the relationship itself for therapeutic change was also supported as crucial with clients who had long-term
difficulties, personality disorders, more complex problems or interpersonal problems. Cognitive therapy that placed more emphasis on the cognitive tools than the relationship per se was being criticised as falling short of providing the sensitivity and depth of focus to issues and difficulties in the therapeutic relationship needed for clients whose core conflicts were interpersonal in nature. Such treatment was not producing the depth of change that these clients required (Persons, Gross, Etkin and Madan, 1996; Wills and Sanders, 1997). Safran (1990) explained that the modification of peripheral cognitive structures results in symptom remission but this still leaves the client vulnerable to relapse because fundamental structures predisposing the client to the problem remain intact. As a result humanistic concepts, of warmth and understanding, and psychodynamic concepts, of transference and countertransference, needed to be translated into cognitive work. There is now a growing cognitive model of the interpersonal process of the therapeutic relationship (Layden, Newman, Freeman and Morse, 1993; Safran and Segal, 1990; Young 1994). Actively using the therapeutic relationship has particularly taken centre stage with clients who have personality disorders and schema-driven problems where the client's transference, the therapists countertransference and the experience of impasse in the therapeutic relationship provides crucial information about the client's dysfunctional behaviours and communication style. Once identified work on the modification of the core cognitive structures can bring about enduring change.

The transference relationship
The transference relationship has been argued as a critical aspect of the therapeutic work, rather than an obstacle to progress. Safran and Segal (1990) stressed that cognitive therapy no longer neglects the concepts of transference and countertransference but now use them as valuable aids to conceptualisation and therapeutic progress. The behaviour of a client within therapy provides valuable information about difficulties in the way he or she interacts with others (Goldfried and Castonguay, 1993). Safran (1990) created the concept of an "interpersonal schema" which is activated in relationships with others and then maintained by behaviours that evoke responses from others which are consistent with the
schema. Understanding about a client's schemas or core beliefs can be gained both from the client's reactions to the therapist or the therapy (transference) and also by the therapists feelings towards the client both at key times or generally (countertransference).

In the delivery of therapy the transference or countertransference can be used by the therapist as a starting point for cognitive exploration. When the therapist becomes aware of the feelings or cognitions they have relating to a client's repeated pattern of behaviour or communication they can then decide if this is a point where useful work can be done which, Safran (1990) terms as an "interpersonal marker". The therapist can then point out to the client what they noticed and ask what was happening to them at that time. Underlying mechanisms or maladaptive schemas can be discovered in this way. For example, the therapist can point out to a client that they continually miss sessions and come to therapy late. This can lead to an exploration about how the client does not feel they are worth making an effort for and the discovery of a maladaptive schema of worthlessness. Such a client may test out the therapist with a variety of "schema-driven" behaviours. For example, in the therapeutic relationship the client may start testing out the therapist to check for a good "fit" with their schema that they are "worthless" perhaps by selectively attending to any cues from the therapist that they find them unworthy of treatment. If the therapist through their relationship with the client is able to follow a process of disconfirming the client's schema this will lead to therapeutic progress and change as long as the disconfirmation is accepted and then integrated by the client thus allowing schema modification. However, if the therapist has a powerful anti-therapeutic reaction to the client this will feed into the client's propensity for mistrusting the therapist and any therapeutic change is thwarted. An example of this was with a therapist who worked with a client who had been abused and neglected. The client had difficulty trusting and a belief that the only way to get love was through being violated. The client craved the therapist's care but on receiving this withdrew. This caused the therapist to then act in a more reserved way. However this led the client to perceive this as confirmation of the therapist also abandoning and neglecting them. Layden et al (1993) stressed that clients
with borderline personality disorders are vulnerable to such a process where therapeutic change is not made unless the therapist works on such issues in the therapeutic relationship.

As therapists understanding and use of the countertransference can crucially help or hinder the process of therapeutic change, it is important therapists are aware of their rules, assumptions and schemata. This is because these may interfere with their ability to identify or work with particular client issues or difficulties in the therapeutic relationship. For example, if a therapist is finding it difficult to empathise with certain feelings of a client it may be because he or she cannot accept these within themselves. Layden et al (1993) stressed the importance in cognitive therapy of therapists paying attention to their own schemata particularly with clients who have interpersonal difficulties or personality disorders where their schemata along with the clients are likely to be activated in sessions. This offers valuable understanding and if used therapeutically it can help the client progress towards therapeutic change. Safran and Segal (1990) give an example of how in the delivery of therapy using countertransference led to therapeutic change. This was with a client who came across as constantly miserable. The therapist became aware of his thoughts towards her such as "who would want to be around such a misery guts". This led the therapist to explore with the client her relationships and then to an identification of an assumption that "I can only get love and help from others if I am miserable, otherwise they are not interested in me". After identification and discussion of this the sessions changed and the client began to express the variety of feelings she had both happy and sad.

Change brought about by using the therapeutic relationship itself

The therapist can use the therapeutic relationship itself to provide the client with new interpersonal experiences which bring about change. If the therapist refrains from acting in such a way that maintains the client's schema this not only provides a new experience for the client but also elicits new behaviours from them in response to the novel situation. A similar process in psychodynamic therapy is described as a "corrective emotional
experience". Therapeutic change is provided not by the cognitive tools but by the therapists response to the client which challenges their existing schema and encourages exploration of new ways of viewing themselves and the world. Carson (1982) described these interactions as opportunities for "generating maladaptive cognitive schemata and restructuring them into a more functional processing system" (p. 78).

There are many examples of how the therapeutic relationship itself can be used as an active ingredient towards change (Beck, Freeman and associates, 1990; Jacobson, 1989; Safran, 1990; Safran and Segal, 1990; Young, 1994). In order to use the therapeutic relationship effectively the therapist needs to adapt their delivery of cognitive therapy to the client's needs. Feedback from the client is crucial in this process. Their choice and opinions as to any intervention is essential and part of the collaborative nature of cognitive therapy. For example, the therapist and client can work together in creating a situation where the client can use the relationship as an arena to practice new or alternative behaviours, such as being assertive with the therapist. Young (1994) explained how the therapeutic relationship can be tailored to the client in order to offer them a form of re-parenting that they lacked. This intervention allows the clients schemata to be directly challenged in the relationship with the therapist. Jacobson (1989) described how the therapist, with careful self-disclosure, can offer experimental evidence for clients of the possible impact of their way of being on other people. Such feedback can be used to help the client identify and subsequently change aspects of their communication style that maintain their dysfunctional interactional cycle. Beck et al (1990) demonstrated this process with the case of "Sonja". This client would often weep in sessions about how difficult everything was, however this brought up for the therapist feelings of impatience. Sensitively feeding this back to Sonja led them to understand that the weeping was a cry for help. This led to their exploration of how she might more effectively get the help she wanted. She could then test out the therapist's reactions to the changes in her and eventually try out different ways of behaving outside the session. Her weeping was gradually replaced by more genuine expressions of sadness which led to more genuine and helpful responses from others.
Alford and Beck (1997) stressed that many studies were beginning to overplay the role of the therapeutic relationship whilst neglecting that of the cognitive techniques themselves as responsible for therapeutic change. They argued that for some studies there was no necessary reason for problems in the therapist-client relationship to be relevant to those that arose between the client and significant others in other contexts. They stated that it would be incorrect for the therapist to attribute therapeutic change solely to the therapeutic relationship and to negate the influences of other contexts such as those encountered during homework tasks.

The enmeshment of relationship and technical factors in the process of change

It appears that there is often a separation made between the active components and the delivery of therapy. However, recently there has been the development of a different perspective where the techniques of cognitive therapy are viewed as embedded within a strong interpersonal relationship. Recent research and development has been concerned with the use of the therapeutic relationship as an integral part of the therapeutic process (Safran, 1990; Safran and Segal, 1990). Safran and Segal (1990) argued that the therapeutic relationship is not something that either is or is not in place for the "real work" of therapy to begin, but instead it is a quality that continually fluctuates and which can be actively used in therapy. Similarly Wright and Davis (1994) stated that; "Findings of therapy process and outcome research suggest that the therapeutic relationship strongly influences treatment results and that interpersonal factors and technical applications interact in forming an effective alliance" (p. 25). Safran (1990) stressed that in the current debate about the importance of the delivery of therapy versus the importance of the techniques there has been a failure to recognise the inseparable nature of both technical and relationship factors in the change process. Safran (1990) stressed that every cognitive intervention is going to inevitably impact on the therapeutic relationship and any "relationship act" is ultimately a cognitive intervention. There is still limited research evidence concerned with how the delivery of therapy and cognitive techniques interact in cognitive therapy. Answers to questions such as, in what ways does a good or poor
therapeutic relationship help or hinder the efficacy of technique? And, how do choice of technique and its results affect the relationship? will enhance clinical efficacy (Raue and Goldfried, 1994).

Conclusion

In cognitive therapy there has been a shift from viewing a good therapeutic relationship as a "necessary condition" for change, to a "principle mechanism" of change. That arguments have been raised at all about the importance of the delivery of therapy versus the cognitive techniques suggests that the more subtle aspects of the change process in cognitive therapy have until now not been fully appreciated. Recent developments have acknowledged that both relationship and technique factors are enmeshed together in their impact on therapeutic change and that research is needed to gain a better understanding about this enmeshment (Safran, 1990).
References


Psychopathology Report: An Evaluation of the Diagnosis of a Client Taken From Their Case History

This report will firstly discuss the various possible diagnoses that might be considered in the case history of Alice Siegel (described as “Ms S” in this report. (See appendix I)). Secondly, the most likely diagnosis of borderline personality disorder will be outlined with reasons for the client meeting this category. Reference to The Diagnostic and Statistical Manual of Mental Disorders-Fourth Edition (DSM IV) and also to The International Classification of Mental and Behavioural Disorders (ICD 10) will be used in this report as they provide standard psychiatric classificatory schemes. Finally, further assessment and information necessary in diagnosing this case will be briefly discussed.

Possible Diagnoses Considered for Ms S:

Sexual and gender identity disorders
Ms S's sexual activities involved physical abuse towards her where the diagnosis of sexual masochism (DSM IV, F6.55) could be considered. However, it appears that Ms S passively accepted the abuse without being sexually aroused and therefore this diagnosis can be rejected. The diagnosis of sexual sadism (DSM IV, F6.55) can also be rejected because although Ms S's sexual activities involved inflicting pain on her partners this appears to be the result of their requests and not because she found it sexually exciting.

Depression
In Ms S's first admission to hospital she experienced feelings of emptiness and vegetative signs of depression such as appetite loss and insomnia. These particular symptoms are found in a major depressive disorder as specified by DSM IV or severe depressive episode as described by ICD 10 (F32.2). However, DSM IV states that for this diagnosis the client must have at least five or more symptoms of depression whereas Ms S is only described as having three. Given Ms S's angry outbursts the diagnosis of "depressive episode with
irritable mood" (DSM IV) or "agitated depression" (ICD 10) could be considered. However, it is unlikely Ms S is suffering from this since the symptoms do not seem to last for two consecutive weeks. Antidepressant drugs were found ineffective for Ms S who continued to experience rapid mood changes. In consideration of other diagnoses, antidepressant drugs do not appear to work in bipolar disorders (Copeland, 1992).

Bipolar affective disorder

A diagnosis that might be considered for Ms S is bipolar affective disorder. Such diagnosis would account for Ms S's behaviour by describing her as having periods of mania or hypomania and depression as specified by DSM IV or ICD 10. For example, Ms S is described as behaving in a flirtatious manner, asking inappropriate questions about the psychiatrist's sexual availability. DSM IV criteria for hypomanic or manic episodes states that there is an increase in goal-directed activity (including sexually) and excessive involvement in pleasurable activities that have a high potential for painful consequences such as sexual indiscretions. ICD 10 describes symptoms of hypomania including increased sexual energy and mania including loss of social inhibitions which may result in inappropriate behaviour. Furthermore, DSM IV (B.6) could account for Ms S partaking in goal-directed activity socially, helping patients with their problems and acting as a spokesperson for complaints and concerns to the administrators. Ms S also has impulsive bursts of anger at an intensity level that is out of proportion with the situation whereby, she is unable to stop periodically losing control of her anger. ICD 10 (F30.0) states hypomania can include irritability or boorish behaviour and similarly, DSM IV states it is associated with distinct periods of irritable mood. A hypomanic episode is also likely to include energised argumentativeness (seen by Ms S with the nurses).

Further symptoms associated with hypomanic episodes are observed in Ms S such as: a disturbance in mood and change in functioning that is observed by others including, her doctor and psychologist (DSM IV, D). And, an impulsiveness and involvement in pleasurable activities with potential for painful consequences (DSM IV B.7, or
"recklessness" as described by ICD 10). This is seen in Ms S's drug abuse, promiscuity and car theft followed by joy riding. However, DSM IV states that the client can only be considered as suffering from a hypomanic episode if they experience mood change lasting at least four days (and manic episodes as one week) whereas Ms S sustains this mood for only two days. For this reason bipolar affective disorder can be eliminated.

Cyclothymic disorder
A diagnosis of cyclothymic disorder could be considered (as described in DSM IV, 301.13 and ICD 10, F34.0). DSM IV states that cyclothymic disorder includes persistent instability of mood involving numerous periods of depression and elevated mood, none of which are severe or prolonged enough to justify a diagnosis of bipolar affective disorder. Ms S appears to suffer from numerous periods of depression and elevated moods. This is particularly seen in her first hospitalisation where she vacillated between outbursts of anger and depression. However, the severity of Ms S's illness to require hospitalisation means that it is unlikely that she has cyclothymic disorder. This is because cyclothymic disorder is less severe than hypomania which DSM IV (E) states does not necessitate hospitalisation.

Bipolar disorder not otherwise specified
The DSM IV criteria for a manic episode states that the mood disturbance is severe enough to cause marked impairment in occupational functioning (Ms S's functioning was impaired in college), or to necessitate hospitalisation to prevent self harm (Ms S had been cutting herself), or psychotic features are present (Ms S experienced her body as not real). "Bipolar disorder not otherwise specified" (DSMIV, 269.80) or "bipolar affective disorder, unspecified" (ICD10, F31.9) include these criteria. This diagnosis is associated with rapid alteration between manic and depressive symptoms and psychotic features as seen in Ms S. The diagnosis of "Bipolar disorder not otherwise specified", is also used in situations where the clinician has concluded that a bipolar disorder is present but is unable to determine if it is substance-induced. However, for Ms S it appears that stressful interpersonal events precipitate mood changes and also she has non-drug-induced episodes
of derealization. Therefore the use of drugs does not account for her symptoms. In addition, Ms S only meets two of the symptoms associated with a manic episode in DSM IV (B) when she would need to meet four for a clear diagnosis of this. Other symptoms such as her unstable and intense interpersonal relationships and fears of rejection or abandonment are also not accounted for by a diagnosis of bipolar disorder. Therefore, a diagnosis of any form of bipolar disorder is likely to be ruled out.

Psychosis

A cyclothymic-like pattern of fluctuating mood symptoms can sometimes be an associated feature of a psychotic disorder. A possible diagnosis that might be considered is "substance induced psychotic disorder" (ICD 10, F19.0 or 19.1) which includes alcohol and multiple drug use causing mental disturbances. Although there is evidence of non-drug-induced episodes of derealization, Ms S's first episode occurred under the influence of drugs which appeared to enhance this to feeling "ghost-like". In addition, Ms S is only reported as experiencing visual hallucinations or paranoia under the influence of drugs. On the projective test Ms S gave a number of bizarre and confused responses which are most commonly seen in schizophrenia. However, the use or withdrawal from illegal drugs and alcohol can also account for this. It appears that Ms S was aware that the hallucinations were drug induced. Therefore, Ms S does not have a substance induced psychotic disorder because DSM IV states that if the client is aware that their hallucinations are caused by drugs they do not fit this diagnosis. In addition, as Ms S's visual hallucinations and paranoia can be explained by her drug taking and other negative or positive symptoms of psychosis are not present, (e.g. Ms S is stated as always well dressed and groomed unlike the more psychotic patients on the ward), it is unlikely that she has any form of psychotic disorder. It appeared also that anti-psychotic medication was ineffective. A diagnosis of depersonalisation disorder (DSM IV 300.6) might be considered to explain Ms S's non-drug induced derealization experiences that are precipitated by actual or perceived stressful events. However, Ms S does not meet DSM IV (D) criteria since it can be argued that her depersonalisation experiences can be explained by her borderline personality disorder
which would, unlike depersonalisation disorder, also account for her other symptoms.

**Borderline personality disorder (BPD)**

Personality disorders have certain features in common and histrionic personality disorder (HPD) might be considered for Ms S. However she only meets three of the DSM IV criteria for HPD where five are required for this diagnosis and her symptoms do not totally match those in ICD 10 (F60.4) for HPD. Ms S does meet DSM IV (301.83) and ICD 10 (F60.31) criteria for a diagnosis of borderline personality disorder (BPD). DSM IV criteria for BPD is compatible with that of ICD 10 diagnosis of "Emotionally Unstable Personality Disorder, Borderline Type" thus, for the purposes of this report the criteria order in DSM IV will be used. This includes:

1) **Frantic efforts to avoid real or imagined abandonment.** The case history describes Ms S's fears of failing her exams and being expelled from college thus fearing rejection and abandonment from the relationships she has in college. A further account is of Ms S giving other patients illegal drugs feeling that she had no choice in the matter due to her need to avoid rejection from them which would be intolerable. This is followed by a derealization experience and self-mutilation. Self-mutilation is a typical response to rejections or disappointments in interpersonal relationships for people with BPD (Frances, First, and Pincus, 1995). Ms S also responded in this way after feeling abandoned by a male patient she idealised in hospital. Her self-harm and suicide threats can be seen as her attempts to avoid this abandonment. Ms S has early experiences of her father abandoning her. Her mother also only appeared to offer her support when she behaved in a childish, dependent, and regressive manner. Her therapist presumed therefore that Ms S feared abandonment from her mother if she acted in an independent manner, this being generalised on to other people. Later in Ms S's life she feared rejection and abandonment from friends following Michael's threats of telling them she was a "slut". She also appeared to fear rejection and abandonment from her peers if she did not comply with them. This meant that she felt unable to turn down sexual activities with them, leave her peer group, or avoid those
whose sexual activities were troubling to her. At sixteen years old Ms S did not want to spend time alone. DSM IV states that for people with BPD abandonment fears are related to intolerance of being alone and a need to have people with them.

2) A pattern of unstable and intense interpersonal relationships characterised by alternating between extremes of idealisation and devaluation. This is seen in Ms S's behaviour described with the admitting psychiatrist and nurses. DSM IV explains that a person with BPD can idealise potential caregivers or lovers at the first or second meeting. This appears to be the case with Ms S who flirts with the admitting psychiatrist and seeks to find out if any of the psychiatrist's girlfriends were in the hospital. On the other extreme the nurse-in-charge appears to be seen as all bad and is devalued. Several staff members were idealised by Ms S and she would demand to spend a lot of time with them whilst others felt devalued when she talked to them. However, if a member of staff that Ms S idealised confronted her about violating hospital rules this person would then be accused as being "just like the rest of them" (p. 291). DSM IV states that for people with BPD, "the confrontation reflects disillusionment with the caregiver whose nurturing qualities had been idealised or whose rejection or abandonment is expected" (p. 651). Ms S's early experience of idealising her abandoned father where she feels her life would be better if he were with her appears to impact on her relationships with men later in her life. For example, she idealises a male patient, fantasising about marrying him and spending most of her time with him. When he severed the relationship Ms S used suicide threats as a way of demanding he take her back. DSM IV also explains that people with BPD can empathise and nurture other people, as Ms S appears to do with other patients taking on a therapist role, however, it is also expected that these people will then meet their needs on demand.

3) Identity disturbance: markedly and persistently unstable self-image or sense of self. Ms S appears to shift from a patient role to acting like a staff member, playing the role of a therapist. She also appears to change from a role of a needy person wanting staff time and help to, as DSM IV states, "a righteous avenger of past mistreatment" (p. 651). That is,
Ms S consistently raises complaints about the inadequacies of other staff. Ms S's self-image becomes unstable with her school performance changing from doing very well to doing poorly. This change is explained by DSM IV as typical in BPD. However, more information is needed for Ms S to meet this criteria as the above examples could be seen as evidence of change in self-identity. There is insufficient evidence to suggest Ms S has a "persistent unstable self-image".

4) **Impulsivity in at least two areas that are potentially self-damaging.** Ms S shows persistent impulsivity with substance misuse, taking street drugs and alcohol. There are also accounts of her promiscuous behaviour, which included potentially self-damaging sexual activities and risk of the transmission of sexual disease particularly when carrying out fellatio. Furthermore, there is an incident of Ms S cruising in a stolen car that contains drugs. Evidence of her impulsivity in this situation is less certain as she reported being unaware that the car was stolen. More evidence is needed to find out if this type of activity was common for her.

5) **Recurrent suicidal behaviour, gestures, or threats, or self-mutilating behaviour.** Ms S's self-mutilation and threats of suicide are often precipitated by stressful interpersonal events (such as when her relationship finished with the patient she idealised leading to both of these occurring) or discussing emotionally charged issues in psychotherapy such as sexual abuse. Stressful events often led to Ms S's experiences of derealization and then she would use self-mutilation in order to "feel real again". For example, this occurred when Ms S feared she would fail at college and thus experience rejection and abandonment from her peers and when she felt rejected by staff and patients following admitting giving patients drugs. DSM IV states that suicidal threats or self-mutilation are often the reason people with BPD present for help as is the case with Ms S.

6) **Affective instability due to a marked reactivity of mood.** During the first hospitalisation Ms S's mood changes rapidly between outbursts of anger and feelings of emptiness and
depression. There are examples of extreme episodes of verbal abuse towards a close friend followed by feelings of guilt and regret on Ms S's part. From sixteen Ms S is stated as often experiencing boredom which appeared to result in her irritability, this is commonly experienced by people with BPD (Frances, First, and Pincus, 1995).

7) **Chronic feelings of emptiness.** When Ms S was sixteen she rarely wanted to spend time alone, often feeling bored and depressed. During Ms S's first and eighth hospital visit she experiences feelings of emptiness.

8) **Inappropriate, intense anger or difficulty controlling anger.** There are many examples of this such as, when the nurse-in-charge performs a routine search and Ms S expresses anger at an intensity level out of proportion with the situation. Ms S finds herself unable to stop periodically losing control of her anger becoming verbally abusive with close friends and on the ward where she also slams doors. In addition, Ms S breaks prized possessions in anger. ICD 10 describes this behaviour seen in Ms S as "an incapacity to control behavioural explosions and a tendency for quarrelsome behaviour or conflicts with others". DSM IV states that these angry episodes are often followed by feelings of guilt which Ms S experiences along with regret. Finally, her projective test results indicated a significant degree of underlying anger this being common in BPD.

9) **Transient, stress related paranoid ideation or severe dissociative symptoms.** Ms S's paranoia can be explained as drug-related so does not apply. However, she begins to experience non-drug induced dissociative symptoms which she describes as "feeling unreal". DSM IV explains that these often occur at times of stress in response to real or imagined abandonment and are transient. This applies to Ms S who experiences derealization after stress of exams and fear of rejection and abandonment at college, in hospital with peers and after the close male patient severed ties with her. Ms S shows associated features of BPD as stated by DSM IV including; a pattern of undermining herself before a goal is about to be realised (e.g. Ms S plays truant at a time
when she was doing well in school and self-mutilates close to taking college exams). Ms S's childhood experiences include; a chaotic life with parental separation, loss of contact from her father, neglect from her mother (being left largely unattended), physical abuse with her peer group and sexual abuse from Michael. These types of experiences are more common in the childhood histories of people with BPD. Furthermore, BPD is diagnosed predominately (75%) in females and its onset is most commonly found in young adulthood, this being applicable to Ms S.

Further assessment

The Millan Clinical Multi-Axial Inventory (MCMI-3) or the International Personality Disorder Examination (IPDE) could be used to assess Ms S. These parallel with the DSM IV classification scheme for personality disorders and help to distinguish between them. These measures have good reliability and criterion validity. The MCMI-3 provides information crucial for treatment planning and outcome. The IPDE provides a number to questions to ascertain if the client has a "markedly and persistently unstable self-image or sense of self". As there was not enough evidence to establish if Ms S met this BPD criteria this test would be useful for her. The questions on the IPDE explore 1) If the client is consistently not sure of what kind of person they are because their behaviour is so different at various times or with different people that they do not know what to expect of themselves. 2) If the clients' ideas about long-term goals or career choice remain persistently uncertain or erratic. 3) If the client is persistently uncertain about ethics, values and morality. If they are unaware of their uncertainty about this, examples of extremely erratic or inconsistent behaviour regarding values can be explored. 4) If the client has persistent uncertainty about the type of friends to have or describe frequent and erratic changes in friends. And, 5) If the client has persistent significant doubt or uncertainty about their sexual orientation, causing distress or problems with others.

The Dissociative Experiences Scale (DES) (Bernstein and Putman, 1986) can help in diagnosing BPD's and also dissociative disorders. The Minnesota Multiphasic Personality
Inventory - second edition (MMPI-2) (Graham, 1989; Greene, 1991) can also help to differentiate BPD from schizophrenia (Meyer and Deitsch, 1996). This differentiation is made between the emphasis given to schizophrenia with symptoms of delusions and hallucinations in comparison to the high level of BPD's responsiveness towards other people.

Meyer and Deitch (1996) stated that The Cattell Sixteen Personality Factor Test - fifth edition (16PF-5) (Cattell, 1993) is an effective measure in diagnosing BPD. This measures variable self-assertion, avoidance behaviour, mood, and suspiciousness all characteristic in BPD. Avoidance of being alone is also measured as this is characteristic of BPD. This is seen in Ms S. This is found if scale A as well as Q4, O and I are high and Q2, C, H, and Q3 are low.

Rozensky, Sweet and Tovian (1997) and Vain (1981) highlighted that "primitive splitting" is characteristic of BPD. The Rorschach (Exner, 1991, 1995) or Thematic Apperception Test (TAT) (Bellak, 1993; Morgan and Murray, 1935) can determine this where if the characters are seen as either all good or bad, for examples as angels or devils, this would suggest primitive splitting. Separation-anxiety themes are also common in BPD and may be revealed by Ms S. Her last report on these tests at thirteen which revealed bizarre responses characteristic of psychosis could be accounted for by her previous drug use, repeating these tests whilst she is drug-free could determine more true responses.

Finally, discussions with Ms S's psychologist, psychiatrist and other professional members involved in her care such as her GP would be necessary for assessment and it appears that Dr Swenson and Dr Smythe have had much contact and experience of working with Ms S. Interviews with family members, (particularly her mother), would also be useful to gain an understanding of Ms S's behaviour at home and her relationships with them.
References


MATERIAL REDACTED AT REQUEST OF UNIVERSITY
Therapeutic Practice Dossier

This dossier includes a short description of the three work placements undertaken throughout the PsychD course. An essay on how I integrate theory, practice and research is also included in this section.
Description of Placements

First Year Placement: An NHS Adult Inpatient Psychiatric Unit

October 1998 - August 1999

My first year placement took place in an adult inpatient psychiatric unit which was attached to a general hospital. The twenty eight bedded ward served a client group aged between 16 and 65 and included a wide range of mental health problems such as, alcohol and drug addiction, chronic depression, personality disorders, psychosis, and anxiety disorders.

Client's varied greatly in severity of illness, length of stay and to whether they were familiar with the ward having been a patient before or not at all. The multi disciplinary team included psychiatrists, registrars, a nurse team manager, nurses, nurse assistants, an occupational therapist, social workers, community psychiatric nurses, and a consultant clinical psychologist.

My responsibilities included attending weekly ward rounds, daily nurse handovers (which focused on the day to day progress of all inpatients), and running therapeutic groups with clients on the ward. The latter included a music therapy group, dance therapy group, relaxation group (focusing on teaching different relaxation techniques) and a focus group which aimed to provide for all inpatients the opportunity to focus on difficult issues. The latter group used a humanistic framework with an emphasis on providing a supportive environment in which clients could share with and listen to others. This group was co-facilitated by a consultant clinical psychologist where we would assess the requests and current needs of the clients on the ward before choosing a theme. Themes for example included, building self esteem, coping with low days and dealing with anger. Members and the size of the group changed each week, on average it included five to eight clients.

This placement also provided experience working with adult primary care clients in the clinical psychology department attached to the general hospital. My responsibilities included providing individual therapy for clients with panic attacks, anxiety disorders,
relationship difficulties and bereavement issues. The psychology department included clinical and counselling psychologists which were attached to a community mental health team (CMHT), primary care services, and specialist services such as an eating disorders service and an alcohol and drugs addiction service.

Supervision was provided by the consultant clinical psychologist who was part of the multi-disciplinary team on the inpatient ward. Group work included humanistic and cognitive behavioural approaches. Supervision for individual therapy was provided by a chartered counselling psychologist where although a humanistic approach prevailed, I also began to apply psychodynamic and cognitive approaches when appropriate. This placement also included fortnightly group supervision which provided experience in systemic therapy.
Second Year Placement: An NHS Clinical Psychology Department

October 1999 - August 2000

For this placement I was based in a psychology department, which was part of a general hospital. I mainly worked with adult primary care clients who were referred by general practitioners within local surgeries. Client's had a variety of mental health problems from mild to moderate. Presenting problems for example included depression, anxiety disorders, bereavement issues and relationship difficulties. My responsibilities involved conducting individual therapy sessions and attending primary care staff meetings. I also had the opportunity to work as part of the CMHT. This involved attending CMHT meetings and conducting individual therapy with two CMHT clients, one diagnosed with a borderline personality disorder and the other with chronic depression. Furthermore, I also worked on an inpatient adult psychiatric ward, located in the general hospital, running a "coping with depression group" which used a cognitive approach.

The department comprised of clinical and counselling psychologists which were attached to different areas of the service including; two CMHT's serving two different regions, primary care, and specialist services for post traumatic stress disorder, eating disorders, learning disabilities, the elderly, and physical symptom management.

Supervision was conducted weekly by a clinical psychologist who was also psychoanalytically trained. From supervision I gained experience in how to conduct long term psychoanalytic psychotherapy. I also learnt how to integrate different psychoanalytical perspectives, where appropriate for the client. Supervision for the inpatient therapy group was given by a consultant clinical psychologist where in the development of the group we worked on integrating theory, research and practice. Group supervision fortnightly was also provided where the theoretical orientation of the group was psychoanalytic. Finally, this placement provided me with a number of workshops and seminars organised by the psychologists in the trust.
I also had the experience of presenting my research on the attitudes and behavioural intentions of nurses towards clients who self-harm. This led to discussions with the CMHT managers, Accident & Emergency department (A/E) managers and nurses about providing a new service for this client group. Following this, several nurses attended a self-harm training programme and now offer a specialist service within A/E for clients that self-harm as well as training and regular supervision for other nursing staff.
Third Year Placement: An NHS Adult Eating Disorders Service

September 2000 - August 2001

This placement was within a specialist service for clients' with eating disorders. Cognitive behavioural therapy was the primary orientation and the length of contracts were flexible. Client referrals were taken from primary care services based at two district hospitals. The most predominant clients were females aged between 16 to 35. Presenting problems of clients included: binge-eating, bulimia nervosa, anorexia nervosa, EDNOS (eating disorder not otherwise specified), multi-impulsive bulimia, and clients who had both an eating disorder and a personality disorder. A monthly supervision group for five psychologists working within this service was run by a consultant clinical psychologist, in charge of the service, and was used to discuss client cases. This specialist service is one of several which are attached to a psychology department responsible for primary care services, adult inpatient services, community mental health services, elderly services, child & adolescent services and learning disability services.

Supervision in this placement was provided by a clinical psychologist with a special interest in therapeutic treatments for eating disorders. Due to my supervisor leaving in March I was then supervised by the consultant clinical psychologist in charge of the eating disorder service. Both supervisors incorporated a cognitive behavioural and an integrative approach. This placement therefore provided me with experience in how to integrate interventions from different theoretical paradigms. Group supervision fortnightly also provided experience in systemic narrative therapy. Continuing on from last year I also co-ran the cognitive therapy group "Coping with Depression", for inpatient and CMHT clients. This gave me the opportunity to further develop the group with the other co-facilitator therefore integrating reflective practice and research knowledge about what constitutes effective group therapy practice.
Introduction

Implicit in the practice of counselling psychology is the concept of integration. This paper aims to explain how my own approach to integration is developing by discussing the ways I integrate theory and research into practice. Firstly, I explain the theoretical approaches that I have learnt and adapted into my practice. Secondly, my understanding of integration and how I have begun to integrate in practice is discussed. Thirdly, what advantages I believe an integrative approach has is explored and a case example used to highlight this. My use of the therapeutic relationship is then discussed. A case example is presented to show the precedence I give to the establishment, maintenance and use of the relationship. The attention in my work to multiple factors that impact on the individual is then addressed. Finally, my development as a scientist-practitioner is discussed. This includes addressing the importance of supervision for reflective practice and evaluation of therapy. As there is a word limitation for this paper the attention given to different aspects will vary. In order to protect the confidentiality and anonymity of my clients pseudonyms have been used in the case examples and any identifiable featured have been removed so that no client can be recognised.

learning through the training course

The main theoretical approaches that I have learnt and adapted into my practice include, in my first year, a humanistic approach (Rogers, 1957, 1961). Working from this perspective gave me an understanding of the importance of developing a strong therapeutic alliance, being open and receptive to the way in which clients experienced themselves and their problems and letting the client guide the direction of the therapeutic process. I found that humanistic "techniques" such as reflecting, paraphrasing and clarifying were essential in helping me to establish whether my explanations were consistent with the client's experience. These ways of engaging, along with the core conditions of empathy, unconditional positive regard and congruence, helped me to convey to the client that they
had been heard and understood, and provided me with the foundations in which to build a trusting and open relationship with them.

In my second year, I gained experience in working from a psychodynamic approach (Bowlby, 1991; Freud, 1913; Kahn, 1997; Klein, 1975; Kohut, 1971; Langs, 1973; Smith, 1991; Winnicott, 1954). This perspective enabled me to become aware of issues such as the centrality of early trauma on clients' development of their psychopathology. I began to understand the role of transference and countertransference in the therapeutic relationship as well as the power of the unconscious in determining behaviour and its role in the client's presenting problem. I also learnt how to become more attuned to the client's unconscious communications which helped me gain insight into what they felt about the therapeutic relationship and process of therapy. In addition, I learnt how to work with resistance and client's defence mechanisms. Consistent with a humanistic perspective, many psychodynamic writers emphasised the value and use of the therapeutic relationship (Kohut, 1979; Langs, 1973; Winnicott, 1954). I particularly learnt the need to provide a secure environment in order for the client to feel a sense of safety and containment in which to explore their issues.

Finally, in my third year I learnt to work within a cognitive approach (Beck, Rush, Shaw and Emery, 1997; Hawton, Salkovskis, Kirk and Clark, 1996; Roth and Fonagy, 1996; Wills and Saunders, 1997; Young, 1999). Working from a cognitive perspective I learnt how to use an array of techniques in order to help clients identify negative automatic thoughts and at a deeper level, core beliefs and maladaptive schemas in order to re-evaluate and modify them. This approach offered me a way of working with clients collaboratively and openly and I was reassured to find that recent developments in cognitive therapy also emphasised the importance of the relationship (Horvath, 1995; Safran and Segal, 1990; Young, 1994). Training and supervision in the three years gave me the opportunity to learn from other theoretical perspectives such as systemic, narrative and cognitive-analytic (CAT). Awareness of multiple perspectives, applying them in practice
and reflecting upon my therapeutic work has assisted me towards learning how to integrate
different theoretical frameworks at both a conceptual and technical level (Alford and Beck,
1997; Clarkson, 1996, 1997; Safran, 1990; Safran and Segal, 1990; Norcross and
Goldfried, 1992; Ryle, 1995; Woolfe and Dryden, 1997).

What integration means to me
I can reflect upon many changes and developments in my therapeutic practice that
occurred during my training in different models and work settings. Most obvious to me is
my growing confidence in practice which has been essential in being able to experiment
with, and be creative in, the use of a range of theories and perspectives in order to
integrate them into effective therapy.

At first I was confused at what it meant to work integratively. This confusion also
appeared to me to be reflected in the literature where integration was viewed in many
different ways with different approaches existing as to the integration of theoretical
frameworks. I needed a clear idea of what was involved in order to begin my process into
developing my own integrative style. Hollanders (2000) helped me understand that
integration takes place at three levels and combining these leads to an "integrated
response".

The first level is "externally", i.e. integration occurring "outside" the therapist. This has
three versions. One version is theoretical integration which seeks to find a meta-theory by
bringing together elements of different theories into a coherent whole (e.g., CAT, Ryle
(1995)). The other two versions are: "technical eclecticism", which involves the
development of an eclectic/integrative framework within which techniques can be brought
together in an effective way; and a "common factors" approach, which seeks to integrate
the commonalities across all therapies into a new integrative approach.
Hollander's second level of integration is "internally", i.e. integration occurring "within" the therapist. This involves the therapist developing their own form of integration and continually doing so over and over again with each new client. Central to this is reflective practice, where following the session the process of choice of intervention, application and outcome are reflected upon by the therapist both individually and in supervision. Integration is typically considered not as a position but as an ongoing process. Clarkson (1992) stated: "it is by its very nature perpetually questioning its own assumptions, developing its own ideas and responding to developments in the wider field" (p. 290). Although the therapy may go in very different directions with each client the process of reflective practice remains the same, so that the therapist is able to give a coherent account for what is being done which is consistent over time.

Hollander's third level of integration is "within the relationship", i.e. occurring "between" therapist and client. As the relationship develops the client indicates what their needs are by how they relate to the therapist and hopefully the client's relationship needs are sensitively responded to by the therapist in a way that facilitates therapeutic change. Such needs are naturally continually changing as therapy progresses. To gain a thorough understanding of the unfolding relationship (and what the appropriate responses are) the therapist may well be taken beyond using a single therapeutic approach.

The role of supervision in my professional development as an integrative practitioner has also been especially important. My supervisors have assisted me in being able to critically evaluate my integrative work. Eliciting their feedback has been essential in ensuring that core internally consistent theoretical frameworks have existed to guide my work and an understandable rationale has laid behind any integration and choice of interventions that I made. My integrative practice has thus begun by tentatively and gradually incorporating one or two selected aspects from other approaches and using supervision to reflect upon the purpose and intended impact of an integrative intervention and how it relates to my underlying theoretical framework.
Why integrate?

The main advantage of an integrative approach is the provision of a flexible response in order to tailor therapy to the client's needs. Human experiences are widely varied, multidimensional and complex, and in working with clients I have found having multiple perspectives helps take this into account. An integrative approach allows me to propose a variety of strategies and incorporate a greater breadth of conceptualisation and intervention into the client's treatment. An example of this was with Mr S.

A case example

Mr S presented with debilitating panic attacks. In the assessment he appeared extremely apprehensive stressing that when he had panic attacks he feared that he might go mad, lose control and hit someone. He openly discussed his background history which enabled me to develop a cognitive conceptualisation. Mr S described his parents and grandparents as being prone to anxiety and it is possible he may have learnt "how to get" anxious from an early age. A sensitive emotional nervous system may have also run in the family with his body's arousal response being triggered more quickly and taking a longer time to calm down. Mr S idealised his older brother who he believed was strong, never showing his emotions. He tried to be like him. His father also compared him negatively to his brother which caused Mr S to become self-critical, developing a low self-esteem. This appeared to lead to schemas such as, "If I make an error it means I am incapable" and "I must remain in control at all times". The latter developed into a deep fear of losing control and "going mad". This appeared to be reinforced by experiencing his mother having an emotional breakdown and his father losing control and acting aggressively when angry. Thus, it is probable that he learnt from his parents that he was vulnerable to suddenly losing control with the devastating consequences of becoming aggressive.

Mr S's first panic attack came whilst under pressure at work. His first thoughts were that he was losing control and going mad. These thoughts continued to worry him and led to fears of further panic attacks. His anxiety was therefore triggered much more easily. At
such times when under pressure it appeared that underlying schemas and dysfunctional beliefs about his self-esteem which he had in childhood were triggered. These schemas were followed by acute awareness of his bodily reactions and the catastrophic misinterpretation that he was losing control and going mad. This in turn led to his panic attacks and this vicious circle was maintained.

I decided from the assessment that CBT would be the best treatment of choice. This was because a CBT approach reflected his goals to learn techniques to reduce his anxiety and panic attacks and he expressed his motivation to do self-help assignments. Mr S appeared able to understand and work within a CBT approach. His panic attacks were also extremely debilitating and were impacting on his career therefore it felt important to offer him immediate help in reducing them. Research supported that a directive CBT psycho-educational approach was the best suited to achieve maximum results quickly (Roth and Fonagy, 1996). Outcome studies also suggested the efficacy of CBT for anxiety disorders (Durham and Allen, 1993; Hawton, Salkovskis, and Clark, 1996; Roth and Fonagy, 1996; Wilson, 1996). I began by tentatively offering Mr S my formulation and explained the vicious cycle of his panic attacks (Clark, 1986). The aim of this was to offer him a framework in which he could make sense of what was happening to him and thus gain a sense of control over his problem (Hawton et al, 1996). Feedback from Mr S also informed me that he had felt an instant relief at being understood and reassurance that I did not think he was going mad. Mr S used CBT techniques effectively to help gain a sense of mastery over his symptoms and hence reduce them. In particular, he found a diary helped him to recognise the onset of his symptoms and then having an action plan involving relaxation and challenging his dysfunctional thinking helped him to offset the symptoms. However, he continued to be distressed at not being able to eradicate his anxiety.

Mr S's dysfunctional belief that he must gain total control over his anxiety appeared to be reinforcing and maintaining it. His need for total control was also apparent in his management of his anger. For instance, he remained controlled and unemotional as he
explained past unkind treatment from his father and unrealistic demands being placed on him by his girlfriend and at work. Since his worst fear when having panic attacks was becoming aggressive I used supervision to explore possible links between his anxiety and aggression. A CBT conceptualisation appeared limited in helping to understand the impact of Mr S’s suppressed aggressive drives on his anxiety and I decided that thinking psychodynamically could offer a useful new perspective.

A psychodynamic conceptualisation helped my understanding of Mr S’s anxiety in terms of an expression of underlying conflicts and repressed feelings of anger. Freud explained that anxiety can occur if the ego is under threat of aggressive drives that seek expression from the Id (Freud, 1923). The ego uses methods of repression, denial and rationalisation to try to restore authority over the Id but if tensions between the Id, ego and superego remain unresolved anxiety prevails. It is likely that in childhood Mr S suppressed his aggression for fear of retaliation from his father. It appeared that anxiety became a way of avoiding conflict, and suppression of feelings about avoiding others resentment and anger. His anxiety can also be understood as fearfulness over his own unconscious aggressive feelings (Klein, 1975). He began to fear the power of his own anger as being an extremely destructive and dangerous, out of control force (Butler, 1985). This helped me realise that it was crucial to normalise his emotions, particularly anxiety and anger. This was important as I did not want to collude with his notion of eradication or his unhelpful belief that uncontrolled emotions were dangerous and can lead to "going mad" and hurting someone. I shifted from a focus on helping Mr S to use CBT techniques as these could have been reinforcing the message that such emotions must be controlled. Instead I began to focus on helping Mr S to express his emotions in order that he could learn to tolerate low levels of anxiety or anger. I hoped that this would help him view emotional expression as a natural, healthy part of human experience and not a sign of dysfunction or weakness.

Psychodynamic contributions were therefore usefully integrated into a CBT framework where Mr S was helped to gain a deeper insight into his underlying fears about his
emotions which developed from childhood and work through these in order that they could be alleviated. This intervention was also compatible with Mr S's feedback that he had come to realise he had difficulty expressing his emotions and wanted to explore and overcome this. I aimed to provide a safe, holding environment for Mr S as I was aware that working through emotional issues, learning to express and tolerate his emotions, was a new and frightening experience where in order for Mr S to do this he needed to feel that I could contain his emotions (Winnicott, 1954). Mr S was encouraged to experiment with an exploration of his feelings and especially, the links between his anxiety and anger towards his father. At first Mr S feared that if he loosened his control of his feelings he would go "mad" and attack someone. We therefore decided to explore these fears in order to understand and alleviate them. As we did so Mr S began to grow in confidence realising he could express his feelings without this happening. Mr S fed back to me that he realised that he no longer needed to always be in control in the way that he felt he had to be as a child. And, he now could also understand anxiety and anger as an integral part of human experience rather than a defect in himself.

Reality testing was also important as Mr S needed to confront rather than avoid his feared situation which was dealing with his anxiety and anger as it arose with an individual. Mr S was encouraged to use the therapeutic relationship as an experimental ground where he could express his frustration or anger when he felt these towards me and subsequently gain the experience of realising he did have the ability to cope with the anxiety this brought. Mr S slowly began to express his frustrated and angry feelings towards me and learned that he could cope with any anxiety this brought. Furthermore, he realised that instead of destroying our relationship it helped build it. He was then able to put this into practice outside therapy with his girlfriend and colleagues. Mr S gave me feedback that as he began to trust himself to let down his guard, he experienced an improvement in his relationships and subsequently a drop in his anxiety.
I used supervision during my work with Mr S to discuss how to help him feel able to express his anger. I became aware that in order for Mr S to be able to express his anger towards me he had to feel that I could deal with this without being hurt or overwhelmed. I also came to understand my difficulties in dealing with people who are angry with me and used my own therapy to work through this. From this work I developed a sense of feeling more comfortable when others expressed anger or frustration towards me. This work enabled me to use the above intervention with Mr S which proved useful to him.

The above case highlights the problem of CBT's emphasis on outer and not inner standards of well-being where behavioural changes are made but the client still maintains distress at a lack of improvement. In such cases I have found that the integration of psychodynamic therapy can assist where unconscious feelings are explored and insights gained. In this way inner aspects of the clients psyche are addressed leading also to an inner sense of well-being (Douglas, 1989).

In order to meet clients needs I have begun to use different types of integrative frameworks. For example, with Ms S I used a humanistic framework where I integrated a gestaltist approach and successfully used the "empty chair" technique to help her work through issues of loss of her father. And, with Ms T I worked within a psychodynamic framework to help her understand her issues of anger towards men, integrating a more structured CBT approach with the use of anger management skills and, ideas from feminist models of therapy (Morrow and Hawxhurst, 1998), to enable her to work effectively with male colleagues.

My use of the therapeutic relationship

Gelso and Carter (1985) were the first to highlight the centrality of three relationship stances in therapy; the working alliance, the real relationship and the transference relationship. Clarkson (1990, 1995) stated that the therapeutic relationship is the main area of integration and that all therapeutic relationships, across all approaches, can be
understood as forms of: working alliance, transference/countertransference relationships, developmentally needed or reparative relationships, person-to-person or real relationships, and transpersonal relationships. From this perspective, instead of focusing on the incompatibilities between different psychotherapies, we can focus on the different priorities and emphasis that they place on these forms of relationships. Hinshelwood (1990) stressed that by taking this perspective a way is left open for the beginnings of a possible integration of psychotherapies.

I have come to realise that each perspective with its different emphasis offers something of value in understanding how to establish, maintain and use the therapeutic relationship in order to help the client. For example, the humanistic perspective's emphasis on being deeply respectful of the client and abiding by core conditions is integrated into my practice regardless of approach. I have found focusing on this is essential in establishing and maintaining a good therapeutic relationship. I always try to give top priority to the establishment of the relationship following the evidence from research that if the relationship is not developed early on in therapy the likelihood of a successful outcome diminishes (Horvath, 2000). I have also learnt from experience that I need to give the same top priority to the relationship in group therapy as with individual therapy in order for clients to achieve a successful outcome.

Kohut's (1979) work which emphasised the importance of both humanistic and psychodynamic approaches regarding empathy has also been useful in my practice. I have therefore worked on building empathic-therapeutic relationships with my clients. This has been of great value particularly when working through and surviving ruptures that have occurred in the relationship. I attempt to give immediate and careful attention to these in the relationship. From research on the therapeutic relationship Horvath (2000) explained that the resolution of ruptures not only smoothes the course of therapy but can also directly contribute to the resolution of the client's emotional difficulties.
I have found the cognitive approach valuable due to its emphasis on co-participation. I have learnt from this approach the importance of working towards the establishment of a partnership where clients view themselves as an active, respected participant. In particular I try to encourage openness about how we experience each other in the relationship (Horvath 2000). One aspect of my practice that I have particularly worked on is being careful to pay close attention to the detail of the client's language, using their words when reflecting, empathising and hypothesising. Awareness of the levels of meaning embedded in it has assisted me to work at a deeper level with my clients. For example, with Ms C, a client with an eating disorder, I could reflect to her how the words that she used to describe her eating were also those she used to describe her difficulties with her father; which could then be explored.

More recently the existential-phenomenological model which emphasises the primacy of the therapeutic relationship has helped me gain a useful "attitude" towards good therapeutic practice in general (Spinelli, 1997). The principle method of investigation underlying this model helps to clarify the underlying assumptions contained in all theoretical models (Spinelli, 1997). That is, it advocates a critical stance where I have found the use of suspending, or "bracketing", of my own biases and personal experiences has helped me in being able to more fully and clearly describe and challenge my clients experiences. And, fostering an attitude of not ruling out, or giving more significance to, any one aspect of experience described by the client over another, or "horizontilize", has enabled me to learn more about the client's world as we explore their meanings underlying their problems (Edwards, 1990). Current work has focused on the relationship between existential-phenomenological and cognitive-behaviour therapies (Corrie and Milton, 2000). These approaches both emphasise the importance of working with the meanings that the client has constructed about themselves in the world in order to bring about growth and change. Both approaches can be viewed as enriching each other and I have become more aware of the importance of gaining a balance between the CBT focus on "doing to" the
client (eg. teaching skills) and existential focus on "being with" the client, understanding their perspective.

Consistent with research (Arnkock et al, 1993; Beutler et al, 1994; Clarkson, 1990; 1995; 1996) my experience has suggested to me that the quality of the relationship more than any other factor determines the effectiveness of the therapy. The following is an example of the precedence I give to the establishment, maintenance and use of the relationship.

A case example
Ms D had been diagnosed as having bulimia nervosa (BN). In the assessment she became tearful as she stressed her lack of closeness to her mother. Part of our work, which I will now focus on, addressed the relationship problems that Ms D had with her mother which appeared to be maintaining her BN. The use of the therapeutic relationship became crucial in helping her overcome this, as well as her current interpersonal problems.

Following the assessment a CBT approach was chosen. As well as reflecting Ms D's goals of therapy, psychological understanding and motivation, I chose a CBT approach because many studies supported it as effective in the treatment of BN (Channon and Wardle, 1989; Cooper, 1995; Fairburn and Cooper, 1996; Fairburn and Wilson, 1993). Our therapeutic alliance appeared to be developing well. In particular, providing Ms D with a clear rationale as to the cause and maintenance of BN helped to give a good basis for the intervention to follow. Together we planned the details of her therapeutic goals and the means by which she could achieve them. I found this provided an important step in building our rapport. I also hoped that this planning would help to build Ms D's confidence in my commitment to engage in this treatment with her. However, following this planning stage I became aware that Ms D had a certain amount of ambivalence towards treatment. That is, Ms D seemed to have dramatic changes in response to me, she would stress how much she wanted help and appeared needy and dependent and then would appear to push me away having sudden outbursts such as, "I will leave if you try and control my eating".
These outbursts came at any time regardless of topic leaving her distressed and confused. Her responses made me feel controlled by her, not wanting to discuss any issues which might leave me feeling I was hurting or putting pressure on her.

This experience (and supervision) alerted me to the fact that a deeper understanding of what was happening in the therapeutic relationship was needed. CBT appeared limited by its lack of emphasis on understanding the way this client was making me feel and I decided to turn to psychodynamic literature. The integration within a CBT framework of a psychodynamic understanding using Klein's (1975) object relations theory (ORT) helped me gain a new perspective of how Ms D might be relating to me. This was viewed in terms of her innate intrapsychic processes of "good" and "bad" objects. That is, Ms D's internalised critical mother appeared to have been projected on to me with this being played out in the countertransference such that I would often feel I was pushing or attacking her. The ambivalent feelings she had about her mother (wanting but rejecting closeness), which appeared to be expressed symbolically through bingeing and vomiting, seemed to be played out within our relationship leading to strong countertransference feelings (Russell and Marsden, 1998). Franko and Rolfe (1996) stressed that strong transference-countertransference reactions are common in therapy with clients who have BN and need addressing to repair the relationship.

Integrating this understanding into my CBT framework helped highlight the importance of not repeating the same dysfunctional relationship that Ms D had experienced with her mother. It also helped me to gain a psychodynamic understanding of therapy with Ms D as a kind of "feeding". Therapy could be seen as offering Ms D another source of nurturance thus, she may have similar difficulties with therapy as she does with food. This helped me understand how she appeared to desperately want support from me but as soon as she had taken this in she seemed to want to get rid of it by pushing me away (Dana and Lawrence, 1988). Davis (1991) also explained the fear of giving into the desire for treatment such that the client may feel engulfed and overwhelmed by the loss of self and, with her need for
love and connection she may also fear that she would overwhelm me if she becomes attached.

I decided to use the above understanding but keep the coherency of a CBT approach. This decision was taken because we were still at an early stage in therapy where introducing a new approach could possibly be disrupting and damaging to our therapeutic alliance. Ms D's life as well as her eating pattern appeared chaotic and changeable so I felt it was important to keep our therapy consistent, with the CBT goals appearing to provide her with some sense of structure. As I was working within a CBT framework I also wanted to openly state how I experienced the relationship. I therefore chose to openly hypothesize to Ms D that perhaps her relationship with her mother was influencing her relationship with me. This led to her exploring how her fears of her mother taking her autonomy away had generalised on to me and that she had responded in the same defensive way. We also explored her fears of getting close to me and accepting treatment only to find she then loses her ability to cope. Furthermore, she feared that I would see her "bad" side and as a consequence would abandon her. Ms D gave me feedback that discussion of her underlying fears, needs and feelings was important in helping her trust that she could reveal these parts of herself to me without fear of abandonment and that I would respect her autonomy.

Addressing her ambivalence within a CBT framework appeared to have a reparative effect on our relationship, helped Ms D feel contained, and increased her commitment to therapy.

Ms D had very low self-esteem and sense of worth which appeared to have developed from childhood following her mother's constant criticism and negative judgement of her. Ms D's low self-esteem and worth now maintained her bingeing cycle so I felt it was crucial to work on this with her. Our therapeutic relationship had grown stronger and I used supervision to explore how this could provide a valuable tool in challenging her low self-esteem and dysfunctional beliefs about her worth. This proved useful. For example, during a session Ms D began to discuss how difficult it was to put herself first. I explored with her how she then found coming to therapy. She explained that it was difficult coming
and experiencing the attention that I gave her. We explored how she felt unworthy of this attention and how this related to her mother who never made her feel valued or worthy of attention. We then challenged her core schema around "unworthiness" where Ms D's experience of how I felt she was worth spending time with helped her to re-evaluate her belief. This enabled her to see that perhaps she was worth spending time with and that her needs were important. I also aimed to challenge her belief that she must maintain a happy, coping front in order to be accepted by others, encouraging her to express a whole array of feelings. I hoped that by receiving my value and acceptance even when she expressed sad or angry emotions this would help provide schema inconsistent information that would disconfirm her belief. Again this did help Ms D to re-evaluate her belief and following feedback from her about the usefulness of this intervention I decided to use the same method in exploring her fears that if she were assertive others would reject her. We used our relationship to test out her beliefs of what the consequences might be if she were more assertive with me. I reinforced that her assertive comments were valuable in our relationship and she found that instead of damaging our relationship it strengthened it as well as empowered her. This led to her putting this assertiveness into practice outside therapy. Ms D fed back to me that she found being assertive increased her self esteem, helped her gain more respect from others and, assisted her in obtaining a balance between her own and others needs.

As therapy progressed I became aware of how Ms D's arguments with her mother, often over issues of control, were increasing and often preceded bingeing episodes. She would also have depressive episodes triggered by her sadness at never having had a close relationship with her mother which she craved. During these episodes she would find it difficult to use the CBT techniques she had learnt in dealing with her bingeing and returned to her chaotic eating pattern. Ms D asked if I could help her with this problem. I therefore turned to research to find out an effective way of helping her. CBT appeared limited in understanding the dynamics and complex feelings experienced between Ms D and her mother and again I found integrating a psychodynamic approach within the CBT
framework offered an effective way of helping her. Tobin (1995) and Fairburn and Wilson (1993) also advocated this approach stressing that a CBT framework was useful in helping to enhance self-management of eating. However at times when difficulties arose in progress it was more effective to shift from focus on symptom change towards using the therapeutic relationship to work on interpersonal problems, with the eventual goal of overcoming the symptoms of BN.

Russell and Marsden's (1998) work based on ORT and its relevance to BN helped me to further understand Ms D's inter psychic functioning. I learnt how early childhood developmental experiences could be impacting on her psychopathology. Klein, Winnicott and Mahler place importance on the parents to adapt to the developmental maturational needs of the child, how mother and infant are able to manage the separation-individuation process is crucial to the child being able to develop independently (Gomez, 1998).

Winnicott (1965) emphasised the need for a "good enough mother" in order to develop an understanding of separateness from other people. If this understanding occurs gradually the frustration experienced does not go beyond the infants abilities to soothe and manage tension and they maintain a sense of emotional well-being. However, if the caretaker is too intrusive, neglectful and does not provide a reliable holding environment for the child this may cause them to retreat and difficulties in the separation-individuation process occur. I hypothesised that Ms D had difficulty completing the process of separation-individuation, experiencing her mother as controlling. Ms D felt unable to move away from her mother still hoping to find the love and nurturance she craved. She also did not appear to have developed the abilities to soothe and manage her own tension.

The above understanding made it clear to me that my role was to help Ms D continue with the process of separation-individuation from her mother so that she could develop her own independence and ability to manage her emotions and thus overcome her symptoms of BN. It was essential to provide a safe "holding environment" in which Ms D could feel contained and connected with me as this would allow her to feel secure enough to use our
therapeutic relationship to work through transference difficulties and unresolved problems with her mother. I became aware of how repeated experiences of being able to tolerate Ms D's emotions and hold them (thus being for her a "maternal container") led to her being able to internalise the containing/soothing function that I fostered. This helped her to gain a sense of having a mental space within herself capable of containing her internal world. This integration therefore helped me to be more attuned to Ms D's inter-psychic functioning as I observed how Ms D learnt to tolerate feelings such as anger and sadness as we worked through unresolved emotions concerning her mother (Hinshelwood, 1989).

Integrating ORT within a CBT framework also helped me to understand the internal processes which underlaid Ms D's cognitive and behavioural features effecting her interpersonal functioning. My awareness of possible primitive anxieties rooted in her early experiences with her mother helped me to hypothesis about latent meanings contained in the transference. This enabled me to empathically acknowledge some of Ms D's unspoken anxieties and fears which were then explored and relieved. This integrative work proved to be effective. Ms D was able to put back into practice the CBT skills she had learnt in order to maintain a normal diet. She also gave me feedback that when difficult experiences arose she felt more able to express and cope with her emotions without using food as a coping strategy.

Assisting me to work integratively has been my growing awareness of the convergences that exist among different theoretical perspectives which, allows me to work in a coherent way. For example, the need for the therapist to provide an empathic "mirroring" environment to help clients build new psychic structures can be understood as the therapist providing "schema inconsistent information" so clients develop a new working model of self-other interaction. Psychodynamic and cognitive theories also emphasise that developmentally deficient experiences with the caregiver may influence how the client currently reacts to and interacts with other people. Whilst cognitive theory explains this in terms of "maladaptive schemas", psychodynamic theory explains this in terms of the
projection of "bad object" relationships into the transference. Crucially, I view the therapeutic relationship as the main area of integration where developing a safe, supportive relationship to work on such issues is fundamental to all therapeutic approaches.

The importance of attending to multiple factors that impact on the individual

Being aware of the wider picture of social, cultural and political factors impacting on the individual is crucial. Clarkson and Nippoda (1997) stated that psychologists have a responsibility to learn all they can about the impact of these factors on the client evaluating how they may be associated with their mental or emotional problems. Guidelines for the Professional Practice of Counselling Psychologists (1998) also requires that social and political issues should not be ignored or obscured and sexist, racist or classist inequalities should not be maintained. I have found that an exploration with the client of social, cultural or political factors has often given me valuable information which has been essential in understanding their experiences and problems. I try to be sensitive, not only to issues of culture, but also to the concept of difference (e.g. in gender, sexuality, lifestyle). I attempt to integrate this into my practice by being aware of my assumptions about other groups and own value system, before exploring those of the client's or discussing issues of difference between us (Strawbridge and Woolfe, 1996; Sue, Arredondo and McDavies, 1992). A narrative approach (Bor, Leg and Scher, 1997) has assisted me in exploring the individual in the system of the family as well as the social, political and cultural forces that shape their context and experience. This approach has helped me gain important insights into the narratives clients use to make sense of their lives as well as their relationship to their problem. The history of their problem can be viewed as a story of "restraint" where through collaboration the restraints can be addressed, exceptions understood and alternative possibilities or "plots" generated (White and Epston, 1990).

My development as a scientist-practitioner

The scientist-practitioner model offers an interesting integrative approach to knowledge recognising the interdependence of theory, research and practice (Meara et al, 1988).
Thus, I attempt to work by integrating theory, research and practice using knowledge from all three to tailor therapy to the particular needs of the client (Mc Cullough, 2000). This can be seen in my work with Ms D where I integrated relevant research on bulimia and theory using ORT with my experience of "being with" this client. This assisted me in understanding her unique situation, needs and difficulties which, in turn, helped guide my treatment plan. I believe that self-reflective awareness is at the heart of what it means to be a scientist-practitioner and going through the reflection process over and over again with each client has been fundamental to my personal growth as a therapist. As Winter and Maisch (1996) stated, professional development is the accumulation of experiences through a "cyclical movement in which practice and reflection both develop by mutually informing one another" (p. 48). With Mr S and Ms D I reflected a great deal on interventions aimed at encouraging them to express and deal with their emotions using supervision for this reflection in order to improve my practice. This also involved my supervisor modelling how, for example, I could help Ms D deal with her emotions concerning her mother by encouraging her to express them whilst I showed her that I could accept and contain them without finding them overwhelming.

The importance of supervision in my development as a reflective practitioner

Supervision has helped my development as a reflective practitioner and using it for microanalysis of sessions has been paramount in understanding the process and progress of therapy. An example of this was with a client who held a core belief of helplessness. Listening in supervision to the tape-recording of a session with her I became aware that I responded by being overly sensitive and protective. Through reflection with my supervisor I became aware of my needs at that time of wanting to view myself as a "caring" therapist and found that this was reinforced by the client when I helped or "rescued" her from encountering difficult situations or dealing with painful feelings. My supervisor helped me to realise that my efforts of help were in fact preventing her from learning that she was not helpless and did have the ability to take care of herself as well as work through painful feelings. I believe by incorporating such work into my practice I am engaging in ongoing
research with each client with my supervisor acting as a co-researcher (Clarkson, 1996).

**My role as a researcher and consumer of research**

As a scientist-practitioner I consider myself to be both an active researcher and consumer of research. Research provides a data-base and guidelines for practice and is crucial in improving standards of practice. The integration of research into practice has greatly assisted me in working with clients particularly when the therapy has become “stuck” or there appears to be limitations in our progress. Research was also essential in being able to develop an effective therapeutic group for clients with chronic depression. Outcome research on group cognitive therapy showed that this was an effective approach for this client group (Bristow and Bright, 1995; Shapiro, Barkham and Rees, 1994). This approach also provided the structure I wanted for members who mostly were not used to attending groups. Research supported that for this client group there were particular benefits of integrating individual and group therapy. Individual therapy offers a more individualised approach whilst group therapy offers an atmosphere of acceptance and mutual support, a chance to learn from other clients by interaction and observation, a sense of being valued and understood by others, and an opportunity to develop relationship skills within the group (Free, 1999). The client feedback gained about the group I ran, which was elicited by questionnaires and interviews at the middle and end of therapy, supported these benefits.

**Evaluation of therapeutic practice**

To inform my practice, alongside supervision, I use self-administered measures (eg. BDI-II, BAI, and CORE) pre, mid and post therapy. These assist me in monitoring clients' progress and can alert me to areas where improvements need to be made. These measures also meet the requirements of clinical governance for evidence based practice. However, my third year research has made me aware also of the limitations of such measures which do not fully capture the complexity of the therapeutic encounter and can give over simplistic data regarding a client's problems (Reynolds, 2000). I therefore believe it is
essential to integrate these measures with consistent feedback from clients throughout their
treatment in order to evaluate my practice effectively.

Conclusion
This paper has aimed to demonstrate my evolving process as an integrative practitioner. I
believe personal integration is an integral part of the ongoing development of a therapist's
professional self (Horton, 2000). This involves a progressive internalisation of self and
orientation. That is, a process of gradual integration between my personality, value system,
philosophical base, theoretical orientation, methods and techniques (Skovholt and
Ronnestad, 1995). I believe my training has given me the skills to begin this ongoing
process where I will continue to develop and evolve my own unique style as an integrative
therapist.
References


Research Dossier

Three research reports are included within this dossier, one from each year of the PsychD course. The first two reports constitute a single research programme which investigated the attitudes of care professional's and client's towards the management of deliberate self-harm (DSH). A literature review was initially undertaken which reviewed care professional's and client's attitudes towards the management of DSH in accident and emergency departments, general hospitals and psychiatric hospitals. This formed the basis for the second research study which explored the beliefs, attitudes and behavioural intentions of two nursing staff groups towards clients who DSH. The nurses worked either within an accident and emergency department or a community mental health team. In order to gain research experience in a different topic the final paper stands alone and is, therefore, not related to the two previous projects. This paper evaluated the usefulness of the CORE (an outcome battery measure) for clients in a cognitive behavioural therapy group for depression.
Care Professionals’ And Clients’ Attitudes Towards The Management Of
Deliberate Self-Harm In Accident & Emergency Departments, General Hospitals
And General Psychiatric Hospitals: Have They Changed Over 25 years?
Care Professionals' and Clients' Attitudes Towards the Management of Deliberate Self-Harm in Accident & Emergency Departments, General Hospitals and General Psychiatric Hospitals: Have They Changed Over 25 years?

Abstract

This review brings together articles gathered from medline, psychlit and BIDS IBSS that focus on attitudes of hospital staff and self-harming clients towards the management of deliberate self-harm (DSH) over the last 25 years. Most studies report staffs' attitudes towards clients that self-harm (DSH clients) as negative stating that they feel unsympathetic, angry, frustrated and view them as unsatisfactory to treat. Physicians, who were viewed by DSH clients as least helpful, held the most negative attitude in comparison to psychiatrists and nurses. DSH clients claimed that staff were hostile, belittled their complex experiences and often categorised and stereotyped them. Professional staff and clients' attitudes towards treatment of DSH in casualty, general and psychiatric hospitals were found to be similar, remaining relatively constant over 25 years.

Although there are many studies exploring staff and client attitudes towards treatment of DSH the majority do not have a theoretical basis. Furthermore, most studies use questionnaires which only offer a limited method of studying attitudes and are flawed in assuming meanings are fixed and stable. It is suggested that future studies could employ qualitative methods providing more in-depth data and allowing respondents to express the categories and concepts they hold. In researching attitudes it is also crucial to use attitudinal theories; therefore a future study could employ Ajzen's (1987) three component model which links the theory of reasoned action and the theory of planned behaviour together. This could help increase our understanding of the beliefs, attitudes and behavioural intentions of different nursing groups towards DSH clients in order to improve education, treatment and management for this group.
Care Professionals' and Clients' Attitudes Towards the Management of Deliberate Self-Harm in Accident & Emergency Departments, General Hospitals and General Psychiatric Hospitals: Have They Changed Over 25 years?

Introduction

Deliberate self-harm (DSH) is the most common reason for admission to hospital for women and the second for men (Hawton and Fagg, 1992). Hospital attendance in England and Wales for DSH have fluctuated each year but have stayed above 100,000 for two decades (Owens, 1994; Gilbody et al., 1997). This does not include the estimated one half or more patients discharged directly from accident and emergency departments (A/E) (Hawton et al., 1998). Approximately 1% of people attending hospital after DSH die by suicide in the next year and 2 to 3% over the next five (Hawton and Fagg, 1988). With increased media attention it is predicted that there will be an increase in numbers of people with self-harming behaviours seeking treatment (Favazza, 1998).

DSH is defined by Hawton and Catalan (1987) as "Intentional self poisoning or self injury irrespective of the apparent purpose of the act" (p. 1) This definition is accepted in the field and used by House et al. (1998) in a bulletin written by staff at the NHS centre for reviews and dissemination, University of York. For the purposes of this review the focus will be on deliberate self-poisoning (the greatest majority of hospital attendees) and self-injury. There is an interchange of terms to describe DSH behaviour where Kahan and Patterson (1983) list 28 labels (e.g. self-injury, self-attack, self-mutilation). Therefore inclusion of research studies in this review will not be dependent on terminology used but on whether they fit the definition of DSH above. It is important also to note that Walsh and Rosen (1988) justified the separation of self-mutilation from self-poisoning because, in the latter, the resulting harm is uncertain and does not result in visible bodily disfigurement. Many studies show significant differences between these two groups (Taylor and Cameron, 1998). In the
following studies the distinctions are not always made thus it will not always be possible to separate the two.

Despite the scale of DSH, planning and service delivery are in a state of disarray locally and nationally (Owens, 1994). A survey revealed less than half of districts had written guidelines on management of DSH, or had a named psychiatrist responsible for the service (Renvoize and Storer, 1991). Those who DSH are a diverse group including clients with personality disorders, drug and alcohol addiction, eating disorders, anxiety/panic attacks, and depression, each group needing specific treatment regarding their DSH (Favazza, 1998). The management of DSH therefore varies and occurs in different settings such as prisons, day centres, A/E, general and psychiatric hospitals. This paper will focus upon the attitudes towards the management of self-harming adults (with no obvious learning difficulty or severe mental illness) who have received treatment in A/E, general hospitals and general psychiatric hospitals. This will include attitudes of DSH clients and health care professionals (focusing on psychiatrists, doctors and nurses).

Research on staff and client attitudes in Britain towards DSH began in the 1950s. Woodside (1958) reports staff attitudes to patients as very negative. Unfavourable attitudes of staff towards patients and patients towards staff are consistently reported in studies in the 1960s (Fulton, 1965) 1970s ((Patel, 1975; Ramon et al., 1975), 1980s (Goldney and Bottril, 1980; Ghodse et al., 1986) and continue into the 1990s with only a few exceptions. This review brings together studies across the settings where DSH clients are most likely to receive treatment.

The relevance of this review for counselling psychologists and other professionals
Many counselling psychologists and other therapeutic practitioners work within hospital teams and community mental health teams. It is therefore important to be aware of the theoretical premises and attitudes of others in the team such as psychiatrists, doctors and nurses. For example, counselling psychologists as well as other mental health professionals
are trained to critically evaluate existing theories and models of therapeutic practice and
can highlight to other team members different ways of understanding and working with
DSH clients. The role of counselling psychologists, like other mental health professionals,
also includes teaching and offering support such as running training programmes on DSH
or support groups for nurses and doctors working with DSH clients. A greater
understanding of health care professionals' attitudes and beliefs is essential for such a role
where psychologists and other mental health professionals are also trained to be able to
specify and explore the ways in which cultural, health status, sexual identity, age and other
differences impact on these. With awareness of such issues this paper seeks to highlight the
problems in the relationship between health care professionals and DSH clients, in order to
improve education, treatment and management for this group. Furthermore, mental health
professionals can play an important research role within this area by using and applying
appropriate theories from all areas of psychology (such as using attitudinal theories and
social models from social psychology) to gain a deeper understanding of the meanings and
explanations underlying health care professionals' beliefs and attitudes towards DSH
clients. Finally, mental health professionals can add to this area a critical analytical
approach towards existing research on attitudes towards DSH offering also their
reflections and evaluations to this area of knowledge.

The attitude construct: Definitions and conceptual distinctions

This section will discuss existing definitions, theories and models of attitude. The word
"attitude" is derived from the Latin word aptus, which means "fit and ready for action"
(Hogg and Vaughan, 1998. p. 118). This ancient meaning refers to something directly
observable. However, the concept of an attitude is now viewed as not directly observable
but preceding behaviour and guiding our decisions for action. There are two different
approaches to the definition of attitude with attitudes viewed either as one-dimensional or
three-dimensional. The latter is based on the idea that an attitude is made up of a
combination of three conceptually distinguishable reactions to a certain object (Hewstone
et al., 1996). These reactions include: 1. Affective, concerning emotions such as love, hate,
like and dislike. 2. Cognitive, concerning beliefs, ideas and opinions about the attitude object. And 3. Cognitive / behavioural, concerning behavioural intentions or action tendencies.

The three-component model became popular in the 1960s where attitudes were described as a cluster of feelings, likes and dislikes, behavioural intentions, thoughts and ideas (Rosenberg and Hoveland, 1960). Later, Himmelfarb and Eagly (1974) described an attitude as "a relatively enduring organisation of beliefs, feelings and behavioural tendencies, towards socially significant objects, groups events or symbols" (p. 1). This definition emphasises that attitudes are relatively permanent, limited to socially significant events or objects, generalisable and involve some degree of abstraction. More recently, Eagley and Chaiken (1993) defined attitudes as, "a psychological tendency that is expressed by evaluating a particular entity with some degree of favour or disfavour. Evaluating refers to all classes of evaluative responding, whether overt or covert, cognitive, affective or behavioural" (p. 1). Eagley and Chaiken's concept of attitudes was summarised in their three-component model (1993) where attitude was seen as an inferred state, with evaluative responses divided into three classes, that is, cognitive, affective and behavioural.

Figure 1. Eagley and Chaiken's Three-Component Model of Attitudes.

The view that there is a consistency between affective, cognitive and behavioural reactions has been controversial particularly because of the problem of making a link between
attitude and behaviour. Fishbein and Ajzen (1975), Petty and Cacioppo (1981), Pratkanis and Greenwald (1989) are among those that reject the three-dimensional definition of attitude in favour of the unidimensional. Unidimensional definitions view that the affective component is the only important one. For example, Petty and Cacioppo (1981) define attitude as referring to "a general, enduring positive or negative feeling about some person, object or issue" (p. 7). Within this definition attitudes are the positive or negative evaluations given to the attitude object whereas beliefs are the knowledge or thoughts someone has about an object and behavioural intentions are the predisposition to a certain kind of attitude-relevant action. In criticism of this theory, if beliefs are numerous, complicated and partly contradictory about an attitude object then a simple evaluative response will fall short of representing the whole attitude structure. In addition it does not take account of the individual's cognitive complexity for example the perceived norms, private self-consciousness and self-monitoring all relate to attitude and behaviour.

There are other definitions and conceptualisations of attitudes in the literature but the three-dimensional and unidimensional have received the most attention (Hewstone et al., 1996). Many studies have tested the three-dimensional theory which claims that the three defined components described above are moderately correlated together (i.e. appearing separate but not completely unrelated). However, results have been contradictory thus a definitive judgement on which theory is right cannot be made (Hewstone et al., 1996). As the studies on attitudes towards the management of DSH do not tend to make attitude behaviour links the above definition and model by Eagley and Chaiken (1993) will be used to assess the literature. Where studies do make these links the theory of reasoned action (Ajzen and Fishbein, 1975) will be used to assess them. The theory of reasoned action was developed to link normative and behavioural beliefs to behavioural intentions to behaviour (see figure 2). Ajzen and Fishbein (1975) stated that it is not the attitude itself but the behavioural intention that predicts behaviour. Two major components - attitude towards the behaviour and subjective norms - combine to produce a behavioural intention. An individuals' attitude toward the behaviour is a product of two factors: belief about the
consequences of that specific behaviour and an evaluation of those possible outcomes. These two factors vary among individuals. Subjective norms introduces a social element focusing on the person's belief about what others think they should do and the strength of the person's motivation to comply with those expectations.

Figure 2. A Schematic Diagram of Ajzen and Fishbein's Theory of Reasoned Action

The person's beliefs that the behaviour leads to certain outcomes, and, 2. evaluation of these outcomes

Attitude towards the behaviour

Intention

Subjective norms

The person's beliefs that specific individuals or groups think he or she should or should not perform the behaviour and his/her motivation to comply with the specific referents.

Behaviour
Ajzen's (1975) model has been subject to criticism at both the conceptual and methodological level. Eagley and Chaiken (1993) criticised the model for not clarifying the exact nature of the relation between intentions and behaviour. Intentions is left open to mean anything from vague formulated thoughts about future behaviour to clear cut plans about what one is going to engage in. Fazio (1990) argued that the components that make up behaviour are more complex than Ajzen's model accounts for. He stressed that behaviour involves multiple processes and developed the mode model which combines deliberative and spontaneous attitude-behaviour processes, both viewed important in forming ones behaviour. Furthermore, there are studies that have found Ajzen's model not effective in predicting behaviour (Bentler and Speckart, 1979; Sherman et al., 1982; Songer-Nocks, 1976).

However, Fazio (1990) does state that the model's attitudinal and normative components generally provide an excellent prediction of behaviour especially in situations where people are motivated and capable of thinking deliberately about their attitudes relevant to a specific behaviour. This is likely to apply to care professionals about their attitudes to the specific behaviour of treating DSH clients as well as clients and their attitudes towards receiving treatment for DSH. In addition, many researchers have found Ajzen's model particularly useful as a framework in understanding the links between attitudes and beliefs and their influence on behavioural intentions and hence behaviour (Hogg and Vaughan, 1998; Madden et al., 1992). Since it has proven to be a helpful model for this purpose and can be clearly applied to the articles within this area it has been used for this review.

Methodological criticisms

The measurement of attitudes is a research area with problems. Many studies as with the ones in this review do not use an operational definition or model of attitude to guide their research. This causes problems in that very often the attitude research presents a set of beliefs or cognitive statements and then uses a scaling technique to measure affect only. By ignoring cognitive and behavioural dimensions the researcher's findings are then an
oversimplification of a complex issue. A difficulty in making comparisons across attitude studies is that there is a lack of agreement about the definition of an attitude, lack of common methods for measurement and ways in which data is treated. This means that research findings in this area often conflict. Particularly with this topic there is also the difficulty of participants giving socially desirable answers. For example nurses may feel reluctant to reveal their true feelings towards DSH clients if they run counter to what they believe are the expected social or professional norms.

A major criticism of the studies in this review is that the majority use questionnaires often with Likert ratings. These do not allow for "yes but" answers and the method used assumes meanings are fixed and stable when staff may vary in attitudes at different times. Kelly and May (1982) criticised the names of characteristics and terms used to describe patients. It is not made clear whether they originate from hospital staff or researchers (eg. attention-seeking, manipulative, unsympathetic). Kelly and May (1982) stated: "Complex social reality is reduced to a set of statements concerning the characteristics or traits thought to reside within certain patients or medical staff. Social structure and social process are left out of the account....with a sociological explanation lost" (p. 153). This reductionism means that patient-staff interaction is overlooked. These studies also often look at attitudes from a one way perspective, staff to patient, (with patients depicted as passive recipients of nurse's labels). Thus, Kelly and May (1982) observed, "Clearly the network of relationships and the ensuing interaction are potentially complex - far more so than the literature generally allows" (p. 154).

A review of the attitude material used in research on professionals' and clients' attitudes towards the management of DSH

None of the studies in this area define attitude or employ attitudinal theory; also the majority focus only on the affective component of attitude. Typically questionnaires or semi-structured interviews will explore nurses' and clients' feelings such as sympathy, frustration and hostility. This has been useful in helping us to understand the affective
component of their attitudes. However, because these studies do not explore the cognitive and cognitive behavioural components of attitude we are only able to understand part of the picture of nurses' and clients' attitudes towards the management of DSH. Over the last 25 years of research in this area studies have not moved beyond their focus on affective responses. The few studies that do explore cognitive and behavioural responses either do this by hypothesising about what they may be or do not use theory to guide the questions they ask or the data collected. A possible reason for why authors in this field have failed to integrate attitudinal theories into their work could be due to their professional backgrounds where most have received medical or nurse training. This means that their conceptual frameworks are within medicine which would explain their emphasis on highlighting the problem (e.g., care professionals' feelings of anger and frustration) followed by their focus on offering solutions to remedy such problems. The reasons why it is important to gain a more complete picture of nurses' and clients' attitudes in this area is that it will help us to gain a deeper understanding of what influences their attitudes and also offers a way to predict and understand the behaviours of these groups. By understanding the attitudes and possible behaviours of professional staff towards DSH clients it offers an evidence base for therapeutic intervention and supports the government's commitment to quality services. This review will now focus on the details of the findings of the research in this area and will highlight studies in regards to particular points about their conceptual level or methodology.

The following includes studies on the attitudes of health care professionals and clients who self-harm towards the management of DSH and covers the last 25 years. This time period has been chosen as it was from 1975 onwards that studies in this area began. Before 1975 most writers only gave their subjective impressions about professionals' attitudes towards DSH clients.
Attitudes of health care professionals towards the management of DSH in A/E.

Morgan et al's (1975) study of DSH patients in A/E included a review of papers in the 1960s and 1970s which stated, "There is a distinct tendency to see the self-harming patient in pejorative terms, of which the stereotype is that of a histrionic young woman who is making a nuisance of herself and needs to pull herself together, preferably without psychiatric intervention (p. 564)". In a review of papers after 1975 to the present day evaluating A/E staff attitudes to DSH, the unpopularity of such patients was still highlighted by all studies.

Ghodse (1978) in a questionnaire survey of 1248 A/E staff across 62 London hospitals found that patients involved in self-poisoning incidents were viewed more unfavourably than those with physical illness or those who had taken an accidental overdose. Ghodse et al. (1986) confirmed these earlier findings concluding that attitudes of the A/E staff regardless of age, sex or experience appeared to be related to intention. In summary Ghodse (1978) only explores the affective component asking staff if they have a favourable, neutral or unfavourable response towards DSH clients. However, "attitude" and "favourable" are not defined and from this limited data Ghodse (1978) states; "patients who take an overdose deliberately seem likely to meet in the casualty department a fairly hostile attitude." (p. 345).

The hypotheses used by Ghodse (1978, 1986) to explain A/E staffs' unfavourable response towards DSH patients is that it is a reflection of the anxiety and frustration experienced by them in treating these patients, due to negative pre-existing attitudes or due to staff finding it difficult to empathise with a patient who is gambling with life and death. Ghodse (1978, 1986) further states that staff attitudes become more unfavourable the further a patient is from the image of a model patient. Overdose patients fall short of this image as they are believed to be more hostile, uncooperative, aggressive and ungrateful as opposed to passive, appreciative and conforming to treatment.
Ghodse (1986) found staff assume that DSH clients have deficient coping skills and hypothesised that there is a tendency to regard them as weak, irresponsible and inadequate. From his findings Ghodse (1986) also stated that staffs' negative attitude is linked to their failure to meet these patients' needs which may contribute to 50% of DSH patients not keeping follow up appointments and eventually repeating the overdose. In regards to Ajzen and Fishbein's theory of reasoned action Ghodse's links between the affective component of attitudes and behaviour of both staff and patients can be criticised. Ghodse (1986) fails to link staffs' and clients' normative and behavioural beliefs to behavioural intentions to behaviour in order to reach his conclusions.

Suokas and Lonnqvist's (1989) study of 322 participants found that all A/E staff had more negative attitudes towards DSH patients than staff in an emergency ward and intensive care unit. The questionnaire used had 41 statements measured by a Likert scale. The researchers acknowledged that this method of studying attitudes was deficient stating that; "The results primarily reflect the conscious feelings and operational facilities of the staff (p. 479)". This study explores the affective, cognitive and behavioural responses of staff but would have been greatly improved by using an attitudinal model in order to allow for behavioural predictions.
Table I. The responses of A/E staff towards DSH patients (Suokas & Lonnqvist, 1989)

<table>
<thead>
<tr>
<th>The Responses of the A/E Staff Towards DSH Patients</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agree that they are sympathetic and co-operative</td>
<td>25%</td>
</tr>
<tr>
<td>Disagree that attitudes &amp; behaviour of staff influence repetition of DSH</td>
<td>30%</td>
</tr>
<tr>
<td>Disagree repeaters of DSH are at greater risk of succeeding in attempts</td>
<td>33%</td>
</tr>
<tr>
<td>Agree that they let their irritation show</td>
<td>54%</td>
</tr>
<tr>
<td>Agree that DSH patients waste staff's time</td>
<td>76%</td>
</tr>
<tr>
<td>Agree that DSH patients misuse treatment facilities</td>
<td>50%</td>
</tr>
<tr>
<td>Agree that only severe cases should be concentrated on for treatment</td>
<td>63%</td>
</tr>
<tr>
<td>Disagree completely that special nurses are needed for this group</td>
<td>48%</td>
</tr>
<tr>
<td>Agree security guards are needed for DSH patients</td>
<td>60%</td>
</tr>
</tbody>
</table>

Soukas and Lonnqvist (1989) stressed that A/E staffs' negative attitude towards DSH patients is influenced by their setting where staff are obliged to work under extreme pressure whereby patients are given first aid with often no time for comprehensive discussion about their psychological distress. This may cause feelings of insufficiency and anxiety among staff who are mainly trained to treat physical illness. Staff receive no patient development and prognosis feedback denying them feelings of satisfaction towards treating this group. Staff efforts also appear seemingly in vain with the same patients making frequent visits due to recurrent attempts.

Suokas and Lonnqvist's (1989) finding that a common belief among staff was that only the more serious cases should be concentrated upon is an issue raised by the following authors. The following studies focus on behavioural responses of staff towards admittance to or discharge from hospital and record keeping and then speculate about the affective response associated with this. However, this approach does not accord with Ajzen and Fishbein's
theory of reasoned action which suggests that the link between attitudes and behaviour is not so straightforward.

Morgan et al (1976) found from 279 DSH patients that the 155 offered follow up appointments were those assessed as high risk, of which 110 attended; of these 68 were discharged. Owens et al. (1991) and Suokas and Lonnqvist (1991) also found that lower risk patients were not admitted to hospital. These researchers interpreted this as a reflection of staffs' negative attitude towards the treatment of low risk clients and their lack of knowledge about DSH since evidence suggests that lower risk patients can also benefit from a short hospital stay.

Recent studies discovered a lack of attention to people who DSH, whether chronic repeaters or first timers. Owens (1990), Pang et al. (1996), Thomas et al. (1996) and Kapur et al. (1998) have found up to one half of DSH patients were discharged without psychiatric assessment. Many studies revealed poor note taking by A/E staff for DSH patients (Black and Creed, 1988; O'Dwyer et al., 1991; Ebbage et al. 1994; Shepherd et al., 1995). Pang et al's (1996) audit indicated 40%-50% of files ignored psychiatric history, suicide intent and attempts. Whilst 75% of patients were found to have suicide intent they still failed to be referred for further treatment. Although Pang et al. (1996) stated that one reason for this behaviour was due to A/E staffs' lack of training on DSH they also argued that staff hostility and resentment causes a reluctance to further engage with DSH patients and influences the help which is offered.

In summary, A/E staff appear to make comparisons, viewing DSH patients more negatively than physically ill patients. It is also suggested that DSH patients are viewed as having deficient coping skills leading to a cognitive response that they are weak and irresponsible. The extreme work pressure and the constant returning of repetitive self-harmers is suggested as linked to the attitude in earlier studies that only high risk patients should be treated and more recently a reluctance to treat all DSH patients. The attitudes reported in
the 1970s by Ghodse are still highlighted by Pang et al in the 1990s with Morgan's (1979) warning, still relevant today, that A/E staff, faced with greater numbers of DSH patients requiring assessment, should not develop a wearied attitude of "yet another overdose", adopting a routine not suitable to all cases. Finally, the methods used to explore the attitudes of A/E staff have not improved, with many of the links between attitude and behaviour being hypothesised by the researcher. Future research must therefore take into account the complexity of attitudes and the attitude and behaviour link.

Attitudes of DSH clients towards their treatment in A/E
There are many accounts of DSH clients' experiences in A/E, the majority of which paint a very negative picture of the treatment received. Such accounts include being stitched without anaesthesia, feeling humiliated and degraded by staff hostility, being subject to name calling (e.g. a "time-waster" or "attention seeker") and being physically abused (Arnold, 1994; Harrison, 1996; Pembroke, 1994; Spandler, 1996). Pembroke and Smith (1998) collated DSH patients' perceptions of staff misunderstandings about DSH these included viewing it as; manipulative, self-inflicted therefore not serious, masochistic (or clients are unable to feel pain), a passing phase, and, indicating a borderline personality disorder (BPD). BPD is the commonest label used for DSH clients although there are others such as, "Multi-Impulsive PD". Such labels are perceived by DSH clients as carrying a stigma, explaining nothing, and preventing access to jobs, housing etc (Lacey and Evans, 1986). These personal accounts enhance our understanding of clients' experiences, highlighting the difficulties they face when going for treatment. However, how these experiences link to their attitudes and behaviours towards treatment is not explored.

Krietman and Chowdhury (1973) used semi-structured interviews with 93 self-poisoners where spontaneous discussion was encouraged to ascertain attitudes towards help-giving services. Most respondents gave explicit reasons for not seeking help. 81% claimed it was due to being critical of services, typical comments being, "I was disappointed and didn't want to go back". They felt staff had no time to listen and found it difficult to talk to them.

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Men were more critical of services than women. This study was supported by a research project by the Bristol Crisis Service (Arnold, 1995) finding that 69% of DSH responders who were users of A/E were dissatisfied with treatment. Krietman and Chowdury's (1973) study made links between the behavioural response of "not seeking help" and participants' affective and cognitive responses. In regards to the theory of reasoned action it would have been useful to look at other reasons for their behaviour such as the influences of normative and behavioural beliefs.

A further criticism of this study is sample bias where participants were only interviewed after they received a formal psychiatric examination. Staff awareness of the study may have affected their performance - a possibility which was not acknowledged in the study. Additionally, participants may not have been as critical as they wished, as they were in the environment of the hospital upon which they were reliant for treatment and may have feared some form of reprisal (Pembroke, 1994). If these criticisms are justified it could be that the negative attitudes are considerably understated.

Contrary findings to those above are reported in Pierce's (1986) questionnaire study which compared staff and patient attitudes. This highlighted that, whereas the majority of patients viewed the staff as being sympathetic towards them, the doctors and nurses reported feeling unsympathetic. However, Johnstone (1989) explained the difficulty patients have in criticising staff because of their fears in believing that staff may view this as hostility and a sign that they are still unwell, and this may have affected patients' responses. This study only investigated staff "sympathy" and neglected to explore other affective responses. Empathy is an important dimension which was not considered and would have been appropriate to evaluate. With only the affective component of attitudes investigated we do not gain a full picture of DSH clients' attitudes.

In summary, clients' dissatisfaction with A/E treatments reported by Krietman and Chowdary in the 1970s is reflected by Arnold in the 1990s, although Pierce (1986) found...
DSH patients believed staff were sympathetic. However, difficulties with these studies include clients' fears of being critical of treatment and small samples which were sometimes biased due to participants chosen being those in treatment thus reliant on the staff that they were expected to comment upon, or, being interviewed only after receiving a formal psychiatric examination by staff. It is possible that a vicious circle of poor communication is at play where DSH patients attending A/E meet with a negative attitude which makes it difficult for them to trust the staff. Staff then feel frustrated with the suspicion of the DSH patient and this reinforces their earlier beliefs about the difficulty in treating this group and their negative attitude.

Attitudes of health care professionals towards the management of DSH in general hospitals

In review of general hospital staff attitudes towards the management of DSH patients, an "unsympathetic" and "unfavourable" attitude was reported by studies in the 1970s and 1980s (Barber et al., 1975; Goldney and Bottril, 1980; Hawton et al. 1981; Kelly and May, 1982; O'Brian and Stoll, 1977; Patel, 1975; Ramon et al., 1975; Ramon, 1980).

Patel's (1975) survey of 66 doctors and nurses from four medical units found the majority felt these patients were unsatisfactory to treat and did not benefit from a hospital stay. 42% of junior doctors and nurses reported being unsympathetic towards patients who took overdoses, especially repeaters. Their attitudes towards this group were significantly less favourable in comparison to physically ill patients. A/E staff attitudes were reported similarly by Ghodse (1978, 1986). The general opinion of staff was that patients' DSH due to social problems (eg. poverty and unemployment) not psychiatric problems and they should attend a specialist ward. This response could be seen as a way to lighten their burden.

Patel (1975) addressed general staffs' affective and cognitive responses but not their behavioural ones. This would have given a fuller picture of their attitudes towards DSH clients. Also Patel only compares self-poisoning with physical illnesses; how this group
compares with other types of patients is unknown. Finally, the study's categorisation of attitudes into whether staff were "unfavourable, neutral, or favourable" constrained responses as did the yes/no questions.

Ramon et al. (1975), Ramon (1980) and Hawton et al. (1981) used a method of providing four different vignettes of self-poisoning cases to elicit attitudes of staff by interview. The vignettes were compiled out of real case-histories presenting categories of patients thought by the researcher to be typical of most cases. Motives generated from these cases were either "manipulative" (ie. aimed at eliciting a response from others) or "depressive" (ie. communicating despair and aimed at withdrawal, escape or death). Ramon et al. (1975) found doctors and nurses were least sympathetic to patients whom they perceived as self poisoning for manipulative reasons with doctors being less accepting and willing to help cases seen as having a "manipulative" motive rather than "suicidal".

Ramon (1980) and Hawton et al. (1981) confirmed their earlier findings of an ambivalent attitude toward self-poisoners with those having manipulative motives viewed most negatively by all staff. Similarly Ghodse et al's (1986) study found intention important to A/E staff's attitudes. They also found doctors expressed a more negative approach towards these patients than nurses and psychiatrists. This is supported by Barber et al. (1973) and Creed and Pfeffer (1981). Ghodse (1978) had similar findings regarding A/E staff. Reasons for differences between the professions were explored. Having accounted for gender differences and finding this had no direct impact, it was hypothesised that attitudes varied due to their different roles and professional images. Ramon (1980) stated that because physicians tend to lack understanding of mental illness, they are more likely than psychiatrists to blame DSH patients for inflicting harm upon themselves and also view them as taking their time and attention away from "genuinely" ill patients. Nurses have a more general caring role, not having to decide if the patient qualifies for help or not. Their less negative attitude may be due to their role being less challenged than the physicians,
although Suokas and Lonnqvist (1989) argued the nurses' role of a "carer" is threatened due to the extra time pressure DSH patients place on them.

Finally, the above studies report staff as viewing the aim of DSH as communication. Ramon (1980) discovered that the interpretation of DSH as a "cry for help" was accepted by all staff groups. Attitudes are also viewed as "ambivalent-stereotyped" as differentiation did not take place in regard to first-timers and repeaters or towards groups of patients that differ in their personal or social background. This is seen to meet the need not to have to rethink attitudes anew on every occasion of encountering such a patient.

Criticism of these papers focuses on the use of hypothetical cases which may not reflect attitudes towards real patients. To establish if face-to-face relationships and more personal information about the patient leads to a greater understanding and differentiating attitude, Ramon (1980) compared participants' attitudes towards hypothetical versus real cases. Physicians completed the same questionnaires for hypothetical and real cases over six months. The hypothesis of a more accepting, sympathetic and differential attitude in the face to face interactions was refuted. Little hesitation was shown in attributing the same labels to both hypothetical and real patients.

Samples for all three studies above were small with participants aware of the nature of the research which may have influenced results. Kelly and May (1982), Batey (1977) and Schrock (1981) criticised such studies for a failure in defining concepts rigorously. This is the case for the terms used such as "manipulative", "depressive motives" and "genuine". Researchers assume a common universe of discourse in which ideas like "manipulative" when applied to the patient are unambiguous. However, meanings of such terms will vary not only between patients and practitioners but also between different researchers.

In summary, general staffs' negative attitudes towards DSH patients is reported in the 1970s and 1980s; there are no studies in the 1990s. The focus of these studies is on staff's
affective and cognitive responses, again with behavioural responses not properly addressed. Similarly to A/E staff, general staff had a more unfavourable attitude towards DSH patients than physically ill patients. All staff were least sympathetic towards patients self-harming for manipulative reasons and viewed DSH as a "cry for help". Their attitudes appeared highly critical regardless of whether cases were hypothetical or real. Doctors expressed the most negative attitudes possibly due to DSH patients challenging their professional role. In conclusion, Barber et al. (1975) and Creed and Pfeffer (1981) found a link between doctors' negative attitudes and lack of training. House et al (1998) suggested that, "Service providers should work to improve attitudes towards self-harming patients through training aimed at increasing knowledge about DSH and through contact with service users" (p. 1).

Attitudes of DSH clients towards their treatment in general hospitals

Michel et al. (1994) reviewed literature on DSH in the 1970s and 1980s emphasising that communication problems between hospital staff and DSH clients were common, with clients not sure if their suicidal thoughts or DSH would be understood and accepted. Spandler (1996) observed that DSH clients found that professional medical reactions belittled their complex experience and they felt marginalised and not taken seriously.

Michel et al. (1994) interviewed 66 DSH responders who had been treated in either general hospital, psychiatric hospital or outpatient services and found most gave their reasons for DSH as due to a loss of control or wish to escape, whereas professional staff believed it was to communicate hostility, for manipulative reasons, or a "cry for help". Michel et al. (1994) stated that these different beliefs of staff and patients can seriously hamper therapeutic behaviour. These findings were supported by Bancroft et al. (1977), Grootenhuis (1993) and Favazza and Conterio (1988), the latter finding 125 DSH users of general and psychiatric services were mostly dissatisfied with treatment, 42% claiming it as unhelpful. This compares to Krietman and Chowdhury's (1973) findings of DSH respondents' disappointment with A/E services.
In criticism, these studies link beliefs about the reasons for DSH with the behaviour of staff and patients towards each other. In order to have made this link they would have had to produce data showing how participants' beliefs link to their attitudes towards the behaviour and subjective norms which then link to behavioural intention and behaviour. This process would have been in accord with Ajzen and Fishbein's (1975) theory which could have been used for the study. In addition these studies do not explore differences between general and psychiatric services. Favazza and Conterio's (1988) use of questionnaires following a television programme has also been criticised as unrepresentative of the population at large since it included self selected respondents, 96% being women. In addition, there were no checks about their authenticity (i.e. whether respondents did themselves DSH and use the hospital services).

In contrast Treloar et al. (1993) stated from a questionnaire study of 142 DSH patients that most had positive attitudes towards treatment received from general hospital staff. Nurses were found to be significantly more helpful and sympathetic than doctors or psychiatrists. This compares to Ramon's (1980) and Hawton et al's (1981) findings for general hospital staff. However, patients had to answer; "who was the most helpful", which did not allow them to discuss unhelpful attitudes and 34 patients did not complete the questionnaire which raises questions regarding the attitudes of the non-completers. Questionnaires were also given at discharge, although studies have shown that many DSH patients leave before being discharged, leaving their attitudes under-represented. This study explores patients' beliefs about staffs' helpfulness and sympathy but does not investigate patients' affective, cognitive and behavioural responses in return towards the staff which would have been useful to explore.

The studies above, apart from Treloar et al's (1993), support a negative attitude of patients from the 1970s to the 1990s due to communication difficulties with general hospital staff. However, these studies do not give a thorough exploration of patients' attitudes with only a limited number of cognitive, affective and behavioural responses investigated. In addition
all studies are on a small scale which limits generalisability. Studies have found DSH clients more satisfied with outpatient services than hospitalisation thus, it is important to continue research into attitudes towards hospital treatments in comparison to alternatives (Johnstone, 1997).

Attitudes of health care professionals towards the management of DSH in general psychiatric hospitals

Simpson (1976), in a review of literature on DSH in psychiatric units from the 1960s to 1970s stated; "All those who have written any account of this condition agree that it is very difficult to treat and can provide exquisitely awkward management problems.... such patients are almost always badly managed by the doctors and nurses they encounter, which arouses strong feelings of frustration and hostility" (p. 430).

Ramon (1980) studied the attitudes of 29 doctors and 50 nurses in psychiatric hospitals in Britain and Israel. Both doctors and nurses held negative views towards the management of DSH clients, doctors being less sympathetic and helpful. General doctors were less understanding than psychiatric doctors and psychiatric nurses less sympathetic than general nurses. The latter finding is possibly due to the different structural roles of the nurses. DSH patients gave general nurses a chance to use empathetic skills often lost in doing self-care tasks for the physically ill, whereas psychiatric nurses found DSH clients had a long term adverse effect on the wards atmosphere for which they are responsible (Bancroft et al., 1977; Ramon, 1980). Particularly competition between DSH clients and self-harming epidemics are reported as management problems for psychiatric nurses (Bancroft et al., 1977; Favazza, 1996; Haswell and Graham, 1996; Pawlicki and Gaumer, 1993; Walsh and Rosen, 1988).

Ramon (1980) found professionals in Britain and Israel had similar attitudes towards DSH clients despite different cultural views towards DSH. The impact of having similar medical training (influenced by the western world) and similar management of DSH clients in their
institutional settings appeared to have a greater influence on staffs' attitudes towards DSH than their different cultural views. Kroll (1978) found the more staff changes and conflicts there were on the ward the more DSH clients became hostile, increasing their DSH acts. This in turn affected staff attitudes viewing DSH clients as more destructive. Rosenthal et al. (1972) also found peak incidences on the ward when the clients' doctor was away which caused staff frustration. Kroll (1978) and Rosenthal et al. (1972) focus on clients' behavioural responses to their treatment but fail to examine their affective and cognitive responses in detail in order to gain a fuller picture of how their attitudes and behaviour may link. Ramon's (1980) study is criticised as having too small a sample for comparison between groups with only 18 doctors and nurses in Israel and Britain.

More recently, Gallop et al. (1993) found from 13 psychiatric nurses' and 8 doctors' ratings of 117 clients that two characteristics were associated with causing management problems: DSH and violence/behaviours sabotaging treatment. Respondents stated that DSH clients have an inability to form a therapeutic alliance and do not respond well to medication. This is supported by Neill (1979), Colson et al. (1985) and Gallop and Wynn (1987). Gallop et al's (1993) study is criticised as having a small sample where, due to rotation, four of the doctors in the first half of the study were replaced by four different ones for the second half of data collection. Possible effects of this on results are not discussed.

Many of the same themes arose as previously from staff in A/E and general hospitals. This included labelling issues where Johnstone (1997) and Fairbairn (1998) stated that attitudes are influenced by medical psychiatry which emphasises diagnosis where the associated labelling is unhelpful and misleading for DSH clients. Formal and informal labels allow staff to distance themselves from DSH clients (Barstow, 1995; Crowe, 1996; Favazza, 1996; Feldman, 1988; Haswell and Graham, 1996; Herman and Musolf, 1997). The view that psychiatric intervention is ineffective also arose. Many researchers stressed this pessimistic attitude that DSH is treatment resistant (Appleby, 1993; Hawton and Catalan, 1987; Hirsch et al., 1982; McNeil and Binder, 1997; Owens, 1994; Valenti, 1991). However,
House et al. (1992) and Hawton et al. (1998) found several interventions that were effective in reducing repetition of DSH. Yet still, the pervading view is that treatment benefits few, if any, and this impacts on psychiatric staffs' attitudes towards DSH clients (Brogan et al., 1998; Favazza, 1998).

In summary, the concept of attitude as comprising of three distinct responses is not considered and links between attitude and behaviour are accepted without understanding of attitudinal theory. DSH clients have over the last 25 years been seen as a management problem, with the psychiatric institutional setting seen as effecting this negative attitude. Often when a client has self-harmed several times the hospital staff begin to lose patience and see them as causing stress. Maltsberger (1994) stated; "Much of the anxiety repeaters of self-harm arise comes from the question of whether they should be admitted to the hospital and, once they have come into hospital, from the reciprocal: whether they should go out again" (p. 199).

Attitudes of DSH clients towards their treatment in general psychiatric hospitals

Harrison (1996, 1997) researched experiences of DSH clients in psychiatric hospitals, stating; "Many were contracted to stop cutting, they said this felt dreadful, impossible - as though they were being silenced and their method of survival condemned. Treatments seemed to do little more than find ways to enforce the containment of difficult behaviour. This heightened their feelings of powerlessness and led some to feel suicidal" (p. 69). Common themes of dissatisfaction with inpatient treatment emerged. These included; criticism of behavioural modification therapy, containment and contracts not to harm, not being listened to about feelings of wanting to DSH, believing staff view them as hopeless, and being categorised and stereotyped (Arnold, 1995; Chamberlin, 1988; Harrison, 1996,1997; Haswell and Graham, 1996; Pembroke, 1994; Spandler, 1996).

Arnold's (1995) survey of 23 female DSH clients found 96% dissatisfied with treatment. This is higher than dissatisfaction rates found for DSH users of A/E. However, this study
had a small sample with clients possibly choosing to reply to the survey due to strong negative views about the service. This study only explores the affective response of feeling dissatisfied and therefore neglects to give a complete picture of clients' attitudes. In addition the attitudes of self-harming men were neglected.

Catalan et al. (1980) found from 120 DSH clients' ratings of psychiatric nurses and doctors over 90% reported a good rapport and over 70% felt understood and able to confide. This more favourable cognitive/behavioural response is similarly reported by Pierce (1986) for users of A/E. However, attitudes were studied after assessment where the 8 doctors and nurses choosing to take part in the study were first trained for five weeks in assessment of DSH clients; thus results are not generalizable. However, it does provide evidence of the usefulness of DSH training.

There is a need to further investigate attitudes of DSH clients towards the treatment they receive in psychiatric hospitals. These studies need to employ attitudinal theories and models to help obtain a more complete picture of clients' attitudes. From the literature available, it appears that psychiatric hospital services are not offering this group the help and support they require. Chamberlin (1988) stressed that as people who DSH turn to each other to feel listened to and accepted and not staff, a patient controlled service would be of benefit. Arnold (1995) found the services this group requested included; crisis lines, drop in facilities, free counselling, support/self help groups and child-care provision. DSH clients were in favour of replacing the existing psychiatric services with the services above.

Attitude differences towards the management of DSH from people of different ages, genders and ethnic/cultural backgrounds.

The mean age for DSH is early 30s for both sexes (Hawton, 1998). There is no research about the differences in attitudes to treatment between adults of 20 to 65. DSH is now only slightly more common among women than men (Hawton, 1998). Males discharge themselves from hospital more often than females and are less likely to engage in
treatment. Treatments also appear to be less efficacious in males (Hawton et al., 1997). This could explain why they are more likely to complain about their treatment, although Ramon (1980) found medical staff were more sympathetic and expressed a greater desire to treat male DSH clients than female. To my knowledge there are no studies on the attitudes of clients of different cultural/ethnic backgrounds towards the management of DSH. Ramon (1980) found no difference in attitudes of professionals in Israel and Britain, despite different cultural and religious beliefs.

There is a lack of studies exploring attitudes of relatives or partners towards the treatment received by their partner or family member. This may be due to the lack of their involvement in the clients' care. Pierce (1986) found 75% of DSH clients regarded their families as unsympathetic towards their DSH and 50% found them unhelpful (Michel et al., 1994). Family ambivalence and aggressive feelings about helping the self-harming member are common (Wolk-Vasserman, 1986). Including families or partners in treatment is often overlooked although modification of family responses is central in reducing repetition (Treloar and Pinfold, 1993).

**Theoretical criticisms**

Although studies do not include attitude theories a few use theories of DSH to guide their hypotheses about why staff may hold certain attitudes. Most of these are based on cognitive behavioural theories. These include Ghodse's (1978, 1986) studies which argued that DSH was due to deficient coping skills which led staff to view self-harmers as inadequate and irresponsible. However, critics argue DSH clients can generate as many solutions as others (Orbach et al., 1990) and do not DSH due to having a problem solving deficit but due to it offering positive and negative reinforcement (Haines and Williams, 1990). Ramon (1980), Hawton et al. (1981) and Michel et al. (1994) use the theory that staff view DSH as communication either of hostility, to manipulate, or as a "cry for help". However, Michel et al. (1994) found DSH patients believed it was due to "loss of control" or a "wish to escape", the latter is in accordance with Baumeister's (1990) escape theory
which explains how DSH is used to achieve the goal of escape from aversive circumstances. In criticism, there is not enough accumulated evidence in support of the escape theory and there are other reasons underlying DSH not taken into account.

Future directions

Future studies should include; a widely accepted definition of attitudes and DSH, a theory of attitudes to guide the research and increase our understanding of how beliefs, attitudes, intentions and behaviours link, and a method for collecting attitudinal data that takes into account the underlying qualitative differences in respondents' attitudes.

Firstly, Hawton and Catalan's (1987) definition of DSH and Eagley and Chaiken's (1993) definition of attitudes (discussed earlier) would provide a useful basis for the research. Secondly, Ajzen's (1987) 3 component model of attitudes, which combines the theory of reasoned action (TRA) (explained earlier) and the theory of planned behaviour, ("TPB" accounts for how much control the respondent perceives they have over a particular behaviour. This helps increase the prediction that a certain attitude will lead to certain behaviour), offers a way of linking attitudes to behavioural intentions to behaviour. These theories will increase our understanding of the likely behaviours that occur in the treatment of DSH clients. Finally, the theory needs to be linked to a method that helps to gain a more in-depth picture of respondents' attitudes such as by using the qualitative methods of a card sort task and open ended interview. A card sort task allows respondents to express the categories and concepts that they hold whilst also producing data that can be analysed clearly using multi-dimensional scaling procedures (Wilson, 1994). This would increase our understanding of the meanings and explanations underlying the respondents' attitudes towards the management of DSH. An open-ended interview offers a way of collecting in-depth data and give participants flexibility in answering questions.

Further research is needed on staff attitudes towards DSH clients in a hospital setting compared to alternatives, and the links between staff training on DSH and attitudes. In regards to this, an investigation using a card sort task and open ended interview to explore
the beliefs, attitudes and behavioural intentions of nurse groups, working either within A/E or community mental health teams, towards DSH clients has not been undertaken. Given that community psychiatric nurses' training and work context is very different from A/E nurses' the effects of this on their beliefs, attitudes and behavioural intentions towards DSH clients could differ from the former. Furthermore, community psychiatric nurses' attitudes and behaviours towards DSH clients have not yet been explored.

By using the three components of Azjen's (1987) model linking TRA and TPB the investigation could be guided by theory which has received considerable support (Hogg and Vaughan, 1998). This model combines 1. Attitudes towards behaviour (the nurses' evaluation of their behaviour towards a DSH client, if they believe their behaviour has been beneficial in some way they are more likely to behave in this way again), 2. Subjective norms (the nurses' beliefs about how they think others expect them to behave towards DSH clients and their motivation to comply, if they are highly motivated to comply they are more likely to behave in that way). And 3. Perceived behavioural control (the nurses' beliefs about their control over their behaviour towards DSH clients which is influenced by the resources to train them in how to behave and interact with DSH clients and situational factors such as workload). The nurse is more likely to behave in the way they want if they can overcome all possible problems, such as workload and lack of training, which would prevent them from doing so. Ajzen (1987) stated that these three components combine to determine a person's intention to perform a certain behaviour. In order to apply this model questions on an interview schedule need to be designed to relate to these three components so that nurses behavioural intentions towards DSH clients can be better understood.

Researchers have found other variables not in Ajzen's (1987) model that also influence behaviour. In regards to this study two of which would be important to include; firstly, past behaviour which is often a good predictor of future behaviour (Deux et al., 1993). Since many nurses will have had contact with DSH clients it is important to ask them directly about their behaviour. Nurses can be asked about this in an interview and also in a less direct way in a card sort task which explores behavioural responses such as anger,
empathy, shock, frustration and disgust. And, secondly, attitudes towards the target (i.e. DSH clients) which Eagley and Chaiken (1993) propose should be included in Ajzen's (1987) model to increase predictability. This investigation could help in a greater understanding of the different nursing groups' commonly held beliefs, attitudes and likely behaviours towards DSH clients in order to improve education, treatment and management for this group.
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An Exploration of the Differences in Beliefs, Attitudes and Behavioural Intentions of Two Nursing Staff Groups Towards Clients who Deliberately Self-Harm, Working Within an Accident and Emergency Department or a Community Mental Health Team
An Exploration of the Differences in Beliefs, Attitudes and Behavioural Intentions of Two Nursing Staff Groups Towards Clients who Deliberately Self-Harm, Working Within an Accident and Emergency Department or a Community Mental Health Team

Abstract

This research explored the beliefs, attitudes and behavioural intentions of nurses working either within an accident and emergency department (A/E) or community mental health team (CMHT), towards clients who deliberately self-harm (DSH clients). Many studies report that A/E nurses' attitudes towards DSH clients are unsympathetic (Favazza, 1998; Ghodse et al. 1986; Owens, 1994; Suokas and Lonnqvist, 1989). However, most of these studies do not have a theoretical basis to guide their research, often assuming that attitudes and behaviour are directly related, and use questionnaires that only offer a limited method of studying attitudes. This study uses Ajzen's (1987) model of behaviour that focuses on the links between attitudes, behavioural intentions and behaviours. Added to this model were two additional variables that influence behaviour, that is "attitudes towards target" and "past behaviour". Ten A/E nurses and twelve CMHT nurses undertook a card sort task and semi-structured interview. These methods allowed for a greater understanding of underlying qualitative differences. The study found that A/E nurses were less likely than CMHT nurses to behave in accordance to their intentions towards DSH clients, this appeared associated with ambivalence as to the benefits of their behaviour and lack of control over how they wished to behave towards this client group. Possible reasons for these differences were explored along with solutions in helping nurses' work more effectively with DSH clients.
An Exploration of the Differences in Beliefs, Attitudes and Behavioural Intentions of Two Nursing Staff Groups Towards Clients who Deliberately Self-Harm, Working Within an Accident and Emergency Department or a Community Mental Health Team

Introduction

Hawton and Catalan (1987: 1) stated that "Deliberate self-harm (DSH) involves intentional self-poisoning or self-injury, irrespective of the apparent purpose of the act". This definition has been widely used, and is supported by House, Owens and Patchet (1998) who have written considerably on DSH. DSH is a frequent cause of hospital admission. It is the most common reason for admission of women and the second for men (Hawton and Fagg, 1992). Favazza (1998) stated that with an increase in media attention about self-harm, it is likely that the numbers of people seeking treatment will escalate.

Many studies report A/E nurses' attitudes towards DSH patients as "negative", which is described as unsympathetic, angry and frustrated (Favazza, 1998; Ghodse et al., 1986; Owens, 1990, 1994; Suokas and Lonnqvist, 1989; Walsh and Rosen, 1988). For example, Ghodse et al. (1986) found DSH patients were viewed more unfavourably than those with physical illness or those who had taken accidental overdoses. This suggests that the attitudes of A/E nurses towards DSH patients appear related to intention. Ghodse et al. (1986) discovered negative attitudes did not change with staff's age, gender or experience. Nurses also had a more negative attitude towards patients believed to be self-harming for manipulative reasons (i.e. aimed at eliciting a response from others) as opposed to depressive ones (i.e. to communicate despair or aimed at withdrawal or escape).

Pang et al. (1996) and Kapur et al. (1998) found A/E nurses lacked training on DSH. They argued that this led to a lack of understanding which, with the extreme work pressures and the constant returning of repetitive self-harmers, caused nurses to feel frustrated and reluctant to engage with this group. Although there are many studies exploring nurses' attitudes towards DSH patients, most do not employ attitudinal theories. This means that a
complete picture of nurses' attitudes and their links to behaviour is lost. Furthermore most studies use questionnaires, which only offer a limited method of studying attitudes with the underlying qualitative differences in nurses' attitudes towards DSH patients being ignored.

Counselling psychologists have a responsibility as part of hospital teams and CMHT’s to apply their skills to develop a greater understanding of what underlies professional staff's attitudes and behaviours towards DSH clients. Counselling psychologists, as well as other professionals, can achieve this by using appropriate theories from all areas of psychology to gain a more in-depth picture of the meanings and explanations that groups of professionals have towards DSH clients. Mental health professionals can add to this area, a critical analytical approach when evaluating existing research on attitudes towards DSH and add their reflections to this area of knowledge. A greater understanding of what underlies professionals' behaviours towards DSH clients can be used to train and develop staff in their psychological thinking about this client group. This would help staff work more effectively with a fuller understanding of the causes of DSH and most appropriate therapeutic approaches to use. Mental health professionals can emphasise the importance of reflective practice encouraging staff to think about their beliefs, attitudes and behaviours towards DSH clients. Awareness of this can help in being able to think more objectively about how ones position towards DSH clients can then effect the clients’ responses towards them. Awareness of what is happening in the therapeutic relationship and why is an important step towards changing to a more effective interactional and therapeutic approach.

Previous research into staff attitudes towards DSH clients has been limited by the assumption that the beliefs and attitudes measured were directly related to the behaviour of staff towards DSH clients. However, the link between attitudes and behaviour is not so clear. The theory of reasoned action (TRA) (Ajzen and Fishbein, 1980; Fishbein and Ajzen, 1975) was developed to link normative and behavioural beliefs to behavioural intentions to actual behaviour. The major feature in TRA is the proposition that the best way to predict a specific behaviour is to ask the person about their intentions. To increase
predictability of behaviour, TRA was also linked to the theory of planned behaviour (TPB) (Ajzen, 1985, 1987). The TPB approach suggests that predictions of behaviour from an attitude measure is improved if people believe they have control over that behaviour. Ajzen's (1987) model proposes that various components go together to shape behaviour. By using Ajzen's model the present study makes use of predisposing factors known to make up behaviours towards DSH clients. This research aims to use these theories to increase understanding of the likely behaviours of nurses towards DSH clients which is a crucial step in effectively changing any problematic behaviour nurses may have.

The three components of Ajzen's (1987) updated model linking TRA and TPB include:

1. Attitude towards the behaviour i.e. the nurses' evaluation of their behaviour towards a DSH client; if they believe their behaviour has been beneficial in some way they are more likely to behave in this way again.

2. Subjective norms i.e. the nurses' beliefs about how they think “others” expect them to behave towards DSH clients and their motivation to comply to this; if they are highly motivated to comply they are more likely to behave in that way. “Others” would include a wide social spectrum such as the public, family, friends, tutors etc. This study has specifically focused on nurse team colleagues to gain a more in-depth understanding of how nurses may influence each other in regards to behaviour towards DSH clients.

3. Perceived behavioural control i.e. the nurses' belief about their control over their behaviour towards DSH clients. The nurse is more likely to behave how they choose without feeling restricted in this choice if they can overcome all possible problems (such as lack of training and workload) that could prevent them from doing so. These three components combine to determine a person's intention to perform certain behaviour.

However, Ajzen's (1987) model has been subject to criticism at both the conceptual and methodological level. Eagley and Chaiken (1993) criticised the model for not clarifying the exact nature of the relation between intentions and behaviour. Intentions could mean anything from vague formulated thoughts about future behaviour, to clear plans. Sherman (1980) argued that asking respondents about their behavioural intentions might increase
the likelihood of them choosing the behaviour consistent with this. Thus a link between
behavioural intentions and behaviour is found due to the effect of assessment. In addition,
Fazio (1990) stated that Ajzen's model is limited to situations where people are motivated
and capable of thinking deliberately about their attitudes relevant to a specific behaviour.
Fazio (1990) argued that the components that make up behaviour are more complex than
accounted for by Ajzen's model. Fazio stressed behaviour involves multiple processes and
developed the “mode model” which combines deliberative and spontaneous attitude-
behaviour processes, both viewed important in forming ones behaviour. There are also
studies that have found Ajzen's model not effective in predicting behaviour (Bentler and
Speckart, 1979; Sherman et al. 1982; Songer-Nocks, 1976).

However, Fazio (1990) stated that the model's attitudinal and normative components
generally provide an excellent prediction of behaviour. Many researchers have found
Ajzen's model particularly useful as a framework to understand the influence that certain
components of behaviour have on a specific behaviour (Ajzen and Fishbein, 1980; Hogg
and Vaughan, 1998; Madden et al., 1992). Since it has proven to be an effective and
helpful model for this purpose it has been used in this study.

To increase predictability, some researchers have found other variables not in Ajzen's
(1987) model that also influence behaviour (Bentler and Speckart, 1979; Fazio, 1990;
Sherman et al., 1982). There are two variables that are important to include in regards to
this study. The first is that, according to Deaux et al. (1993), past behaviour is often the
best predictor of future behaviour. For example, how a nurse has behaved towards DSH
clients is likely to influence how they continue to behave. The second variable is “attitudes
towards target”, which Eagley and Chaiken (1993) propose should be included in Ajzen's
(1987) model as a crucial influence effecting ones behaviour.

The diagram below shows the model that will be used for this study in exploring nurses'
attitudes towards DSH clients. This has been designed by the researcher where Ajzen's
(1987) TPB model (in shade) has been combined with Deaux et al's (1993) variable of past behaviour and Eagley and Chaiken's (1993) variable of attitudes towards target:

Figure 1: Ajzen's (1987) model of a theory of planned behaviour - including Deaux et al's (1993) and Eagley and Chaiken's (1993) additions
This investigation explored the different beliefs, attitudes and behavioural intentions of A/E and CMHT nurse groups towards DSH clients. CMHT nurses' attitudes and behaviours towards DSH clients have not yet been explored and it follows that no comparison between these groups has been undertaken before. Given that CMHT nurses training and work context is very different from A/E nurses, the effects of this on their beliefs, attitudes and behavioural intentions towards DSH clients can, according to Ajzen’s model, be predicted to differ. Knowledge about the differences between the nurse groups could help in understanding some of the reasons for difficulties that may occur in working with DSH clients. This understanding can assist efforts to find solutions in helping nurses work more effectively with these clients.

Research Aims
The aim of this study is to provide a greater understanding of the differences between A/E nurse groups and CMHT nurse groups with regard to their beliefs, attitudes and behavioural intentions towards DSH clients in order to improve education, treatment and management for this group of clients.

Research Question
What are the differences between A/E nurses and CMHT nurses in their beliefs, attitudes and behavioural intentions towards DSH clients and what are the possible reasons for these differences?
Method Section

This study has linked the TPB to qualitative methodology and used the methods of a semi-structured interview and multiple card sort task in order to gain a more in-depth picture of nurses' attitudes, beliefs, and behavioural intentions towards DSH clients. A semi-structured interview allows nurses flexibility in answering questions and the sort tasks allow them to express the categories and concepts that they hold in relation to DSH clients.

Participants

The participants were nurses working within an A/E department context (i.e. 12 A/E nurses in a general hospital) and CMHT context (i.e. 10 community psychiatric nurses (CPN's) working within the same community as the A/E nurses). All nurses were approached by letter (see appendix I) and asked for their support to participate in this study. All nurses asked to participate accepted and none dropped out during the study. Due to the differences in ages and experience of the two groups it was not possible to stratify the sample according to these. However, participants were randomly selected and thus representative of nurses working within the A/E department or CMHT. Descriptive statistics for the two nurse groups are presented in table I below:
Table 1: Descriptive statistics of the A/E nurse group and the CMHT nurse group

<table>
<thead>
<tr>
<th></th>
<th>A/E nurses (12)</th>
<th>CMHT nurses (10)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td>10 females/2 males</td>
<td>7 females /3 males</td>
</tr>
<tr>
<td>Age</td>
<td>Mean 34 years</td>
<td>Mean 43 years</td>
</tr>
<tr>
<td></td>
<td>Range 22-54 (32 years)</td>
<td>Range 22-57 (35 years)</td>
</tr>
<tr>
<td></td>
<td>Standard deviation 8.94</td>
<td>Standard deviation 11.30</td>
</tr>
<tr>
<td>Most Common Grade</td>
<td>E Grade</td>
<td>F Grade</td>
</tr>
<tr>
<td>Years nursing</td>
<td>Mean 13.5 years</td>
<td>Mean 17 years</td>
</tr>
<tr>
<td></td>
<td>Range 2(months)–30 (29.8 years)</td>
<td>Range 2-35 years (33 years)</td>
</tr>
<tr>
<td></td>
<td>Standard deviation 9.95</td>
<td>Standard deviation 12.32</td>
</tr>
<tr>
<td>Years nursing with DSH clients</td>
<td>Mean 9 years</td>
<td>Mean 17 years</td>
</tr>
<tr>
<td></td>
<td>Range 2(months)–30 (29.8 years)</td>
<td>Range 2-35 years (33 years)</td>
</tr>
<tr>
<td></td>
<td>Standard deviation 9.78</td>
<td>Standard deviation 12.32</td>
</tr>
<tr>
<td>Training</td>
<td>8 Registered general nurses</td>
<td>7 Registered mental nurses</td>
</tr>
<tr>
<td></td>
<td>3 diploma in nursing</td>
<td>3 project 2000 nurses</td>
</tr>
<tr>
<td></td>
<td>1 midwifery training</td>
<td></td>
</tr>
<tr>
<td></td>
<td>8 nurses had other additional nurse training.</td>
<td>8 nurses had other additional nurse training.</td>
</tr>
<tr>
<td></td>
<td>4 nurses had DSH training on their courses</td>
<td>7 nurses had DSH training on their courses</td>
</tr>
</tbody>
</table>
Instruments

The instruments used in this study were:

1. Postcard size cards each with a different word printed on it relating to DSH clients. The words relating to DSH clients were generated in a pilot study by groups of general and psychiatric nurses (not included within the sample) where the researcher asked the nurses to brainstorm any beliefs, attitudes or responses they had towards DSH clients. These cards were put into three sets according to three questions, which made up the three sort tasks. Table II below shows the elements used.

<table>
<thead>
<tr>
<th>Elements for sort 1</th>
<th>Low self-esteem, relationship problems, child sexual abuse, rape, mental abuse, physical abuse, loss (bereavement), illegal drugs, alcohol, manipulation, emotionally needy, self disgust, attention seeking, psychosis, personality disorder, borderline personality disorder, copying (contagion), self-expression, rapid mood swings, self punishment, tension relief, unexpressed anger, rejection, hopelessness, depression.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Elements for sort 2</td>
<td>Disgust, sympathy, compassion, shock, hopelessness, overwhelmed, de-skilled, sadness, responsibility, anger, frustration, guilt, motivation, blame, time-wasting, distance, responsiveness, empathy, challenge, dread.</td>
</tr>
<tr>
<td>Elements for sort 3</td>
<td>Ashamed, guilty, responsible, relief, angry, lost, frustrated, self disgust, shock, hopelessness, sad, overwhelmed, apathetic, accepting, selfish, powerfulness, negativity, motivation (to stop self harming), self blame, uniqueness.</td>
</tr>
</tbody>
</table>

2. An interview schedule was used with nine questions about nurses' behaviours towards DSH clients. The nine questions used are shown in table III below:
Table III: The nine questions used in the interview schedule

<table>
<thead>
<tr>
<th>Question</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1  What do you think are the standard / most common ways that CPN's (or A/E nurses) behave towards clients who self-harm?</td>
<td></td>
</tr>
<tr>
<td>2  Within the sub-culture of CMHT's (or A/E teams) are there any other ways nurses behave towards clients who self-harm?</td>
<td></td>
</tr>
<tr>
<td>3  a) What are the ways in which you think other nurses that you work with expect you to behave towards clients who self-harm and, b) how much, if at all, do you feel motivated to comply to these behaviours?</td>
<td></td>
</tr>
<tr>
<td>4  How have you behaved towards clients who self-harm?</td>
<td></td>
</tr>
<tr>
<td>5  How do you intend to interact and behave towards clients who self-harm when you meet them?</td>
<td></td>
</tr>
<tr>
<td>6  How have you dealt with clients who self-harm in regards to referral for further treatment and advice regarding services they can use?</td>
<td></td>
</tr>
<tr>
<td>7  In regards to your behaviour towards clients who self-harm that you have discussed, how beneficial do you think these behaviours are?</td>
<td></td>
</tr>
<tr>
<td>8  Taking into account the demands of your work, how much control do you feel you have over the ways in which you want to behave towards clients who self-harm?</td>
<td></td>
</tr>
<tr>
<td>9  You have described your standard interactions with clients who self-harm, is this the same or different in any ways from other clients who you work with?</td>
<td></td>
</tr>
</tbody>
</table>

Fixed prompts were used to help with clarification or elicit more information. These included;
Can you tell me more about that?
What do you mean?
Can you tell me the reason for that?

3. A data collection form was used to gain background information about the participants and record data on the sort tasks (see appendix II).

Procedure
Participants were asked to sign a consent form for their agreement in participating in the research which included being tape-recorded (see appendix III). The tape recorder was then turned on. The interview and sort tasks were performed at a time suitable for the participant and in a convenient room within the hospital. Participants were seen
individually with only the researcher present. Duration of the sort tasks and interview was 25 minutes.

The researcher explained to participants that for the purposes of this study deliberate self harm would be defined as "intentional self-poisoning or self-injury, irrespective of the apparent purpose of the act" (Hawton and Catalan, 1987: 1). This was to make sure that all the participants and the researcher shared the same understanding of the term “DSH”. Background information about the nurses was then collected.

The researcher read aloud the instructions as follows:
I am carrying out this study to explore nurses’ beliefs, attitudes and behaviours towards clients that DSH. I am asking a number of A/E and CMHT nurses to do the following:
1) Complete three card sort tasks. This involves sorting sets of cards, with different words printed on them relating to DSH, into groups in accordance to the questions I will be asking you, and, 2) Answer questions about your behaviour towards clients that DSH. There are no right or wrong answers, it is your views that count. All responses will be confidential. Please feel free to tell me any thoughts or ideas you have about the sort tasks or questions as they occur to you.

Participants then undertook the three card sort tasks, which included:
1) A free sort – The participant was given the set of cards for sort 1 (as listed in table II). The researcher then read out to the participant the following instructions: The words on these cards describe possible causes of DSH. Can you sort the cards into groups in such a way that in any one group the cards share something in common. You are free to use any ideas you have in order to sort the cards and you can create as many groups as you like. When you have completed this task I will ask you to explain the theme/s you chose in order to sort the cards into different groups and to give a name (or heading) to describe each group that you have made. I will then ask you to repeat the task, this time finding a new way to sort the cards into different groups.
2) A structured sort - The participant was given the second set of cards for sort 2 (as listed in Table II). The researcher then read out to the participant the following instructions. Can you sort these cards into groups of "yes", "no", or "maybe" in accordance to the following question: What are the attitudes that you most strongly hold towards clients who DSH?

3) A structured sort – The participant was given the third set of cards for sort 3 (as listed in Table II). The researcher then read out to the participant the following instructions. Can you sort the following cards into groups of "yes", "no" or "maybe" in accordance to the following question: What do you confidently think the attitudes are of clients who DSH towards their self-harming behaviour?

All nurses were asked about their reasons for placing each element within a "yes", "no" or "maybe" group. They were then asked if they had any further comments about the sort tasks.

Participants then undertook the semi-structured interview. The questions (see Table III) were developed to satisfy the three main components in Ajzen's (1987) model. Questions therefore related to subjective norms (based on normative beliefs, i.e. questions 1, 2, and 3), attitudes towards behaviour (based on behavioural beliefs, i.e. question 7) and perceived behavioural control (based on beliefs about resources and opportunities in relation to training and work demands, i.e. question 8)). In accordance with the model participants were also asked about their behavioural intentions (i.e. question 5). Questions about "past behaviour" (Deaux et al., 1993) were also included (i.e. questions 4, 6 and 9).

The rationale for using a semi-structured interview was that it allowed for the development of a relaxed, "conversational" approach, which was essential in order to explore this sensitive topic in-depth. A "semi-structured" approach also helped keep the interview focused in order to gain the information about nurses' attitudes and behavioural intentions needed for this research. Finally, participants were asked if they had any further comments
and also what they thought of the sort tasks and interview. The researcher then transcribed the taped interviews (see appendix IV for an example of a participants’ script).

**Multidimensional scalogram analysis (MSA)**

The MSA programme allowed for the data analysed to demonstrate whether the A/E nurses, in comparison to the CMHT nurses, had different conceptual systems underlying their beliefs and attitudes about DSH clients. Wilson and Hammond (2000) explained that multidimensional analysis (MDA) is used to examine the underlying structure of qualitative data in terms of the relationship between the variables and the themes chosen by participants. The background for MDA comes from Kelly’s (1955) personal construct theory. He stressed that people have personal constructs with meaning unique to themselves thus, it is important for researchers to enable participants to express their ideas in their own terms. MDA is an extension of the repertory grid technique (Kelly, 1955) and the Q-sort technique (Stephenson, 1953). MSA is one specific technique under the heading of “MDA”. In particular, MSA is used to compare the profiles of individuals or groups in terms of their similarities (or differences) in regards to some shared concepts.

MSA plots the data of each individual as points in a geometric space. Thus, elements (i.e. the cards exploring attitudes towards clients who DSH), that are responded too similarly by nurse group members will be represented as points which are closer together on the MSA plot. Elements that are responded to differently by nurse group members will appear further away from each other on the plot. Clusters of elements in different regions are presented on the MSA plot so the investigator can examine the similarities of each cluster and the differences seen in relation to others. The MSA used in this study was invented by Hammond (1990) and comes from the Gutman-Lingoes series. The coefficient of contiguity is automatically set at a criterion of 0.9 for Hammond’s (1990) MSA. This represents the measure of goodness of fit between the similarities of the profiles and their spatial representation. For a detailed account of the MSA procedure see Wilson and Hammond (2000).
The rationale for using the card sort approach for this study was that it offered a highly structured yet flexible way to explore the categories and concepts that the nurses had regarding their “attitude towards target” (ie. their attitude towards clients who DSH).

“Attitude towards target” is one of the additions to Ajzen’s (1987) model, seen in figure 1, which this research sought to explore. Using card sorts also has the benefits of firstly, providing a more interesting task for nurses to participate in, as opposed to a questionnaire. This was viewed as important in regards to recruiting the nurses in this study who are usually inundated with questionnaires. Secondly, card sorts offer a relatively quick method for obtaining qualitative data. This was essential given that due to the nurses busy work schedule they did not have the time for lengthy interviews. Thirdly, given the sensitiveness of this topic the card sort procedure was hoped to provide a relaxed atmosphere for exploring their attitudes towards this client group thus, promoting more open responses. Finally, social desirability may also be less transparent when using card sorts (Brenner, 1985).

Sort one

A free sort offers greater freedom to participants in performing the sort task and so assists the interviewer in learning more about their construct system. Sort one allowed for the exploration of nurses’ beliefs about the causes of DSH. An understanding of nurses’ different beliefs as to the causes may highlight the reasons for why they hold certain attitudes towards client who self-harm. For example, if a nurse holds the belief that a common cause of DSH is due to the client using it for “manipulation” their attitude is likely to be less empathetic than if they believe the common cause is more likely due to the client suffering with “loss” or “depression”.

Sort 2 and 3

Structured sorts were used to allow the researcher to gain more specific data regarding the participants “attitudes towards target”. This assisted in being able to hypothesis about the influence that nurses’ attitudes towards DSH clients may have on their behaviour. Sort 3
was chosen as it was thought that impacting on nurses' attitudes towards clients who self-harm, would be their beliefs about the clients' own attitudes towards their self-harming behaviour.

Analysis of data
The steps used to analyse the data from the sort tasks was as follows:
1) Participants' responses from the sort tasks were recorded on the data collection form.
2) A matrix was constructed in order to analyse data using the MSA programme. This included the elements (as seen in table II) being numbered in columns and the responses of each participant, which were numbered according to the same scoring system as each other, being placed in rows. For sort one, in order to code the participants' responses, the groups made by the participant in the sort were each numbered. Elements that belonged to a particular group could then be given the number of that group and recorded in the row.

3) The MSA programme (Hammond, 1990) then analysed the data. This programme works by partitioning the geometric space so that it corresponds to the constructs of the participants. Analysis included, taking the individuals' sort and dividing the geometric space so that elements in the same category were plotted in the same region. For sort one where participants repeated the sorting procedure a further step was taken. This involved keeping the original regions intact within the geometric space whilst the analysis process was repeated with the second sort. Thus, the final plot has both sorts represented in terms of space. The MSA programme produces an individual plot for each participant and a group plot which is the “average” of all the individuals’ plots put onto an over all plot. Thus, an overall plot was produced for the A/E group and the CMHT group.

4) The closer elements are on the group plot, the more often individuals in that group have put them in the same category. Regions with certain clusters of elements indicate a common response among group members. Lines were then drawn on the plots to divide up the regions that had shared meanings to group members. For sort one, the “headings” that
participants gave to their groups assisted in understanding the meanings of clusters or regions on the plot.

5) The plots were interpreted by examining item clusters and how the different conceptual areas related to each other. For sort one this included content analysis of the “headings” respondents gave to the groups that they made. This was achieved by listing all the headings that each nurse group gave and then categorising them according to common themes. These were then labelled. Table IV and V in the results section presents the content analysis of the most common headings used by CMHT and A/E nurses in sorting elements regarding the possible causes of DSH.

6) Sorts two and three were structured sorts where the researcher specified the construct and the choice of categories. Since categories of “yes”, “no” or “maybe” were specified, content analysis was not needed. As “yes” responses were coded as “2”, “maybe” as “1”, and “no” and “0”, the responses given for each element along the rows could be easily calculated to indicate which elements were given a “yes”, “maybe” or “no” response by group members. If more than 50% of respondents agreed on either a “yes” or “no” response to a particular element then the element was marked to indicate this “yes” or “no” response on the plot. Elements that got a more than 50% “maybe” response and, elements where 50% or less agreement was found to any one response by group members, were marked to indicate a “maybe” response on the plot. Lines were then drawn on the plots to separate regions and these indicated three distinct areas showing clusters of either a “yes” or “no” or “maybe” response.

The steps used to analyse the data from the semi-structured interview were as follows:
1) The semi-structured interview was subject to content analysis in accordance with Krippendorf (1980).
2) Pre-existing categories were taken from the amended version of Ajzen's (1987) model as seen in figure 1, (i.e. subjective norms, attitudes towards behaviour, perceived
behavioural control, past behaviour, attitudes towards target and behavioural intentions) to establish the existence of any of these themes amongst the nurse groups.

3) Key themes, phrases and processes within each of the categories (taken from Ajzen’s model) were explored and listed.

4) Frequency of occurrence of certain themes was counted for each category.

Inter-rater reliability

Before analysis was undertaken one rater (a trainee clinical psychologist) randomly selected data taken from a sample of five participants. They then used the same method for analysis of the data as the researcher for both sort 1 and the interviews. Following this, for sort 1: the categories into which the five participants’ data was placed were then numbered. The amount of agreement between researcher and rater as to the categories into which the participants data was placed was then calculated using Kappa (Kappa is a chance-corrected measure of agreement). The results indicated that \( K = 0.9 \) which indicates a high level of agreement. Secondly, for the interviews: the categories used for the content analysis were numbered and the amount of agreement between researcher and rater as to the category into which the participants themes were placed was then calculated using Kappa. \( K = 0.85 \) which is again a high level of agreement.

Ethical Approval

The proposal for this study was submitted to the Hospital’s Research Ethics Committee and University of Surrey Ethics committee and was approved (see appendix VI).
Results

The sort tasks

Interpretation of sort 1

Sort 1 focused on possible causes of DSH. This was to explore the differences between the two nurse groups beliefs in respect of “causes of DSH” seeking to highlight the reasons why they hold certain attitudes towards clients who DSH. “Attitudes towards target” is stressed by Eagley and Chaiken (1993) as a crucial influence on ones behaviour and was therefore added to Ajzen’s (1987) model and explored by use of this free sort.

Content analysis of the most common headings that both nurse groups made for sort 1 are presented in table IV and V below. If five nurses or more had headings with the same meaning they were included in the tables. The headings below were made up from the most common words used by nurses for their headings.

Table IV: Content analysis of the most common headings generated by CMHT nurses for sort 1

<table>
<thead>
<tr>
<th>Headings</th>
<th>Number of nurses in agreement (and percentage)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Key causes of DSH</td>
<td>8 (80%)</td>
</tr>
<tr>
<td>2. Psychiatric disorders where there is a potential for DSH</td>
<td>6 (60%)</td>
</tr>
<tr>
<td>3. Clients who use DSH due to their inability to deal with emotions</td>
<td>5 (50%)</td>
</tr>
<tr>
<td>4. Persistent personality disorders which are strongly linked to DSH</td>
<td>5 (50%)</td>
</tr>
<tr>
<td>5. Clients who DSH where the cause of it is difficult to treat</td>
<td>5 (50%)</td>
</tr>
<tr>
<td>6. Elements that are not linked to the causes of DSH</td>
<td>5 (50%)</td>
</tr>
</tbody>
</table>
Below are some of the examples of headings given by CMHT nurses for sort 1 that were used to create the headings in Table IV. These are in the same order as the table:

1. a) Key indicators of self-harm. b) Root causes of self-harm.
2. a) Psychiatric disorders prone to self-harm. b) Severe illness - potential to DSH.
3. a) DSH caused by inability to deal with emotions. b) Feelings dealt with by DSH.
4. a) Personality disorders (PD) strongly linked to DSH b) Persistent PD links to DSH.
5. a) DSH clients difficult to treat. b) Causes that make the DSH hard to treat.
6. a) Elements distinct from the causes of DSH. b) Causes not linked to self-harm.

Table V: Content analysis of the most common headings generated by A/E nurses for sort 1

<table>
<thead>
<tr>
<th>Headings</th>
<th>Number of nurses in agreement (and percentage)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Patients who I feel most empathetic towards as there is an understandable reason for their DSH</td>
<td>7 (58%)</td>
</tr>
<tr>
<td>2. Psychiatric disorders where there is a potential for DSH</td>
<td>7 (58%)</td>
</tr>
<tr>
<td>3. Patients who use DSH due to their inability to deal with emotions</td>
<td>6 (50%)</td>
</tr>
<tr>
<td>4. Patients who I feel least sympathetic towards due to their repeated admissions with minor DSH acts and no serious reasons for doing it</td>
<td>6 (50%)</td>
</tr>
<tr>
<td>5. Patients who DSH that are seen most in A/E</td>
<td>6 (50%)</td>
</tr>
<tr>
<td>6. Patients who DSH that are seen least in A/E</td>
<td>6 (50%)</td>
</tr>
</tbody>
</table>

There follows some of the examples of the headings given by A/E nurses for sort 1 that were used to create the headings in Table V. These are in the same order as the table.

1. a) Patients I feel empathy for as they do need help. b) Patients who DSH that I feel empathy for as they have understandable reasons for their DSH.
2 a) Psychiatric disorders which can lead to DSH. b) Mental illnesses leading to DSH.
3 a) DSH due to inability to cope with feelings. b) DSH as a way to cope with feelings.
4 a) Revolving door patients I have least sympathy for due to there being no serious 
    reasons for their minor DSH acts. b) Least sympathy for patients who do not 
    have understandable reasons for their continual returning with non-serious DSH.
5 a) Patients who DSH that I see least in A/E. b) DSH Patients rarely seen in A/E.
6 a) Patients who DSH seen most in A/E. b) DSH Patients most frequently seen.

MSA plot 1
Plot 1a (A/E nurses plot) and 1b (CMHT nurses plot) below show nurses responses to sort
1 which explored “possible causes of DSH”. The plots had regions with certain clusters of 
elements, this indicating a common response among group members. Boxes were drawn 
on the plots to divide the regions where 50% or more respondents shared the same 
meanings. This was done by using the data from the content analysis which indicated 
where 50% or more nurses shared headings with the same meanings (see tables IV and V).
For the analysis, elements had been numbered according to the group (or category) a 
participant had placed them in. The analysis therefore revealed the group to which each 
element belonged on the individual’s plot. By overlapping and comparing each nurses’ 
individual plots, similarities in clusters of elements and their headings could be found.
Where 50% or more nurses have grouped together the same elements and given that group 
a heading with the same meaning these are shown on the plot. Where there is less than 
50% agreement the data is excluded.
Figure 2: MSA plot 1 (a) A/E nurses’ responses to possible causes of DSH.

<table>
<thead>
<tr>
<th>Patients who DSH that are seen least in A/E</th>
<th>Psychiatric disorders where there is a potential for DSH</th>
</tr>
</thead>
<tbody>
<tr>
<td>psychosis</td>
<td>borderline personality disorder</td>
</tr>
<tr>
<td></td>
<td>personality disorder</td>
</tr>
<tr>
<td></td>
<td>rapid mood swings</td>
</tr>
</tbody>
</table>

a) Patients who DSH that are seen most in A/E
b) Patients who I feel least sympathetic towards due to their repeated admissions with minor DSH acts and no serious reasons for doing it
   alcohol
   illegal drugs
   copying
   unexpressed anger
   attention-seeking
   relationship problems
   emotionally needy
   manipulation
   self-punishment
   tension relief
   self expression
   low self-esteem
   rejection
   self disgust

Patients who I feel most empathetic towards as there is an understandable reason for their DSH
   loss
   hopelessness
   depression
   mental abuse
   physical abuse
   rape
   child sexual abuse

Figure 3: MSA plot 1(b) CMHT nurses’ responses to the possible causes of DSH

child sexual abuse
rape
physical abuse

self punishment
mental abuse
tension relief
relationship problems
unexpressed anger
self expression

Key causes of DSH
   loss
   low self-esteem
   rejection
   emotionally needy
   copying

self-disgust
hopelessness

Elements that are not linked to the causes of DSH
   manipulation
   attention-seeking

Persistent personality disorders, which are strongly linked to DSH
   personality disorders
   borderline personality disorder

Psychiatric disorders where there is a potential for DSH
   depression
   rapid mood swings
   psychosis
   illegal drugs
   alcohol
Comparison of plot 1 (a & b) and the headings made by CMHT and A/E nurses

Both groups used headings that, once subjected to content analysis, indicated the two groups shared similar meanings in respect of, "clients (or patients) who use DSH due to their inability to deal with emotions" and, "psychiatric disorders where there is a potential for DSH" (see table IV and V). The latter heading was included on the plots of both nurse groups showing that over 50% of the members of each group agreed on the elements it contained. However, the two nurse groups failed to agree on the elements they chose to place under this heading with the exception of "rapid mood swings". That is, A/E nurses included in this group the elements "personality disorder" (PD) and "borderline personality disorder" (BPD), whilst CMHT nurses included "depression" and "psychosis". CMHT nurses, unlike A/E nurses, grouped PD and BPD together under the heading "persistent personality disorders, which are strongly linked to DSH". PD and BPD are placed closely to "key causes of DSH" on the plot indicating that they are strongly related. A/E nurses, contrary to CMHT nurses, have placed "psychosis" as very distinct on their plot with its own heading (i.e. "patients who DSH that are seen least in A/E").

A main difference between the nurse groups was that whilst CMHT nurses focused on the "key causes of DSH" and appeared to reflect upon treatment difficulties, (as supported by the heading created in content analysis of, "clients who DSH where the cause of it is difficult to treat"), A/E nurses appeared to take into account their feelings of empathy, sympathy and understanding when categorising elements (as seen by the headings that include the terms such as "least sympathetic", "most empathetic towards" and "understandable reasons"). A/E nurses also took into account the seriousness of the DSH, including in their headings the concept of "minor DSH acts" whereas CMHT nurses did not. A/E nurses appear to reflect their medical professional role by focusing on the physical damage, this does not appear in the CMHT nurses themes.

The plots indicated that A/E nurses and CMHT nurses viewed "manipulation" and "attention seeking" very differently. CMHT nurses had a distinct region for these elements
and appeared not to want to include these in the causes of DSH as indicated by the heading, “elements that are not linked to the causes of DSH”. However, A/E nurses clustered these elements within a larger group including, for example, “unexpressed anger”, “copying”, and “emotionally needy”. They also related “manipulation” and “attention-seeking” to two headings which inter-linked these included; "patients who I feel least sympathetic towards due to their repeated admissions with minor DSH acts and no serious reasons for doing it” and, “patients who DSH that are seen most in A/E”. The headings were combined because the nurses evenly distributed the same elements between them.

Five CMHT nurses clustered illegal drugs and alcohol together and these have a close proximity on the plot to elements under the heading “psychiatric disorders where there is a potential for DSH”. In comparison, A/E nurses grouped “alcohol” and “illegal drugs” with elements under the heading ”patients who I feel least sympathetic towards because of their repeated admissions with minor DSH acts and no serious reasons for doing it”.

Different forms of abuse are similarly clustered together by CMHT nurses and A/E nurses. CMHT nurses cluster these with “self-punishment” thus relating this concept with “abuse” where clients who have been abused can go onto abuse themselves. As these elements are clustered together this indicates CMHT nurses had a similar response to them. However, less than 50% of agreement was found on a common heading for this cluster suggesting that there were differences in meanings held by CMHT nurses for these elements. In contrast A/E nurses cluster these different forms of abuse under a heading with terms that include “empathetic” and “understandable reasons for the DSH”. A/E nurses do not include “self-punishment” with these elements placing it in a large cluster under a heading with terms such as “least sympathetic” and “no serious reasons”. A/E nurses have large clusters of elements under the same heading indicating considerable agreement among A/E nurses as to their concepts within the area of “causes of DSH” whereas CMNT nurses do not.
Plots 2 and 3

Plots 2 (a & b) and 3 (a & b) below show nurses responses for the structured sorts. Plot 2 (a & b) are the results from sort two which focused on nurses attitudes towards clients who DSH. Plot 3 (a & b) are the results from sort three which focused on nurses beliefs about the attitudes of clients towards their own DSH behaviour.

If more than 50% of nurse members agreed on either a "yes" or "no" response to a particular element that element was marked to indicate this "yes" or "no" response on the plot. "Yes" responses are marked on the plot by bold type and "no" responses are marked on the plot in capitals and underlined. Elements that were given a more than 50% "maybe" response by a nurse group and elements where 50% or less agreement was found to any one response by nurse members were marked on the plot in italics to indicate a "maybe" response. Once elements were marked on the plot according to a nurse groups "yes", "no" and "maybe" responses, lines were then drawn on the plots to separate regions. These regions were marked on the plots by the headings "yes", "no" and "maybe" which, revealed that each plot had three very distinct areas showing clusters of elements that were given similar responses by nurse members.
Figure 4: MSA plot 2 (a) A/E nurses' attitudes towards DSH clients

Figure 5: MSA plot 2 (b) CMHT nurses' attitudes towards DSH clients
Interpretation of MSA plot 2 (a & b)

Both nurse groups have distinct clusters of elements in separate areas on their plots indicating there is considerable agreement among group members in their categorisations. Furthermore, both groups, although categorised differently, similarly held in their “yes” category the elements of “empathy”, “compassion”, and “responsiveness” which, can be described as “positive” attitudes towards DSH clients.

Plot 2 (b) has a large cluster of elements with a “no” response. This shows the attitudes that more than 50% of CMHT nurses do not hold towards DSH clients. That is, most CMHT nurses did not think DSH clients were “time-wasting”, neither did they feel a sense of “distance” from them or feel “responsibility” for their DSH. Contrary to CMHT nurses more than 50% of A/E nurses held all these attitudes (see plot 2 (a)). A/E nurses also clustered feeling a sense of “responsibility” with “sympathy” and “compassion” indicating a relationship amongst these elements whereas CMHT nurses did not.

Plot 2 (b) shows that more than 50% of CMHT nurses clustered “de-skilled” with “frustration” as attitudes they held towards DSH clients. A/E nurses gave a mixed response to feeling “de-skilled” grouping it with “shock” and “overwhelmed”. More than 50% of A/E nurses, similar to CMHT nurses, felt “frustration”, which was clustered with “anger” and “distance”. CMHT nurses gave a mixed response to “anger” which, was clustered with and hence related to being “overwhelmed”.

Figure 7: MSA plot 3 (b) CMHT nurses' beliefs about what they thought DSH clients felt towards their own DSH.
Interpretation of MSA plot 3 a and b

The CMHT nurses plot (3 b) had very distinct regions of closely clustered elements. The A/E nurses plot had less distinctive regions and fewer close clusters. This indicates that there were clearer agreements amongst CMHT nurses than A/E nurses. A/E nurses had a more varied response to what they thought clients felt towards their own DSH.

More than 50% of nurses from both groups agreed that clients who DSH do not feel “selfish” or “shocked” about their own self-harm behaviour. All A/E nurses agreed that DSH clients felt “angry” about their DSH and this was closely clustered with “lost”, “sad” and “frustrated”. CMHT nurses gave a mixed response to whether DSH clients felt “angry”. Both nurse groups closely clustered the elements “angry” and “powerfulness” indicating a relationship between these. More than 50% of A/E nurses considered DSH clients felt their DSH gave them a sense of “powerfulness” whereas CMHT nurses gave this a mixed response. More than 50% of A/E nurses believed DSH clients were “accepting” of their DSH whereas CMHT nurses gave this a mixed response.

Over 50% of CMHT nurses thought DSH clients felt “responsibility” for their DSH whilst A/E nurses gave a mixed response. This corresponds with plot 2 where over 50% of CMHT nurses did not feel a sense of “responsibility” for clients DSH whereas most A/E nurses did.
Content analysis of the semi-structured interview

The semi-structured interview was designed to explore the behaviours of nurses towards clients who DSH. The interview questions were developed in accordance with Ajzen’s (1987) model and also included Deaux et al’s (1993) addition of “past behaviour”. The sections below discuss the findings from content analysis of the interviews with the two nurse groups. These are in the order of: “subjective norms and compliance”, “past behaviour”, (including behaviours of referring and giving advice, and differences in interaction with DSH clients and non-DSH clients), “attitudes towards behaviour”, “perceived behavioural control”, and “behavioural intentions”.

Subjective norms and compliance

Three key themes were found from content analysis of the interviews that applied to this heading. These themes are discussed under the three sub-headings below:

1) Nurses beliefs about the subjective norms of their team

More A/E nurses (11 out of 12) than CMHT nurses (6 out of 10) stated that their nurse team’s most common behaviour towards DSH clients was “negative”. "Negative" behaviour included those seen as unhelpful towards the DSH client, (eg. Showing frustration or apathy). A/E nurses described a more "extreme" negative behavioural norm in comparison to the CMHT nurses. This included A/E nurses describing behaviours such as being uncaring, dismissive and angry whereas CMHT nurses did not use these words in their descriptions. CMHT nurses more common responses being that the client may unintentionally perceive impatience or frustration. For example, whilst A/E nurses gave common responses such as;

‘Many nurses stand back and try to avoid treating patients who self-harm, letting their anger show’. And,

‘Often staff behave uncaringly, not wanting to understand and being dismissive’.

A common response of CMHT nurses included:
'Sometimes there is a sinking heart feeling, an "oh no not again" response, especially with "repeaters" and this might be picked up by the self-harming client as impatience, apathy or frustration'.

Five CMHT nurses but only one A/E nurse reported that team members vary in the way they behave towards DSH clients. For example, a common reply was:

'Nurses' behaviour is varied; some act with intolerance where the self-harm is viewed as "attention-seeking" or "bloody minded". This is seen in the nurses' body language and most likely interpreted by the client as rejection. Other nurses, after trying everything and finding nothing works, get to "I don't know what to do next". In the main this stems from anxiety at not knowing how to help and their behaviour might seem impatient'.

2) Nurses' beliefs about colleagues expectations of them

Most CMHT nurses (8 out of 10) felt there were few expectations from their nurse colleagues to behave in a certain way, whilst most A/E nurses (9 out of 12) considered there were clear expectations.

Six out of ten CMHT nurses and no A/E nurses, reported that there was an expectation of behaving according to set procedures such as, "risk assessments" and "monitoring treatment". Four CMHT nurses, in contrast to no A/E nurses, observed that, when working in pairs with a DSH client, they have an agreed expectation of each other's behaviour towards the client. For example one nurse said:

'When you are working in two's or three's you have a certain agreed response, you're expected to behave a certain way, such as more firmly or empathetically. As responsibility is shared you tend to feel more motivated and less negative'.

Two CMHT nurses explained that sometimes there was "black humour" amongst CMHT nurses about DSH clients. This was not reported by A/E nurses. CMHT nurses stressed
that; 'it is expected you might become frustrated or impatient towards continually self-harming clients'.

Eight A/E nurses but none of the CMHT nurses, explained that other nurses’ expected them to behave in a specific way depending on the “type” of DSH client. If the DSH client was a repetitive self-harmer, alcoholic, rowdy (i.e. shouts or protests), an “attention-seeker”, young, or a “cutter” (especially with only superficial cuts) then they were expected to make them wait whilst other patients took priority, they spent less time with them, or offered a "pull yourself together" less sympathetic approach. However, if the client was elderly, a “first-timer” (i.e. a patient who had not been admitted before with DSH), bereaved, a “serious overdoser” or compliant (described by the nurses as patients who accept treatment readily and thankfully) they were expected to behave more compassionately. For example two common replies were:

'Reasons why they've done it are important, if they are recently bereaved or divorced then you're expected to be more sympathetic. For "regulars" (i.e. clients who repetitively self-harm) you're expected to ignore them, let them sleep it off'.

And,

'Elderly people often overdose following the death of their partner, everyone's more sympathetic towards them. Other nurses expect you to behave sympathetically towards these cases....but for those who are abusive or drunk "self-harmers" you're expected to keep them quiet and be annoyed if they play up (i.e. if they are not compliant towards treatment and shout or protest when being helped) and behave unemotionally'.

Three A/E nurses but no CMHT nurses explained that because they have a reputation of being empathetic towards DSH clients or were thought to be understanding due to their life experiences, other nurses’ expected them to be more sympathetic. To quote one nurse, 'my colleagues see me as having 'been there' they expect me to identify and be more understanding with self-harming clients'.
Four A/E nurses, no CMHT nurses, stressed that some of the more experienced nurses expected them to “toughen up” and behave in such a way as to “not get too involved to avoid getting manipulated”. For example, one nurse observed:

‘When training, a patient started digging a biro in her arm and the nurse-in-charge told me to ignore her saying she’s manipulating me for attention’.

3) Pressure to comply to nurses’ expectations

All nurses (except one A/E nurse) expressed that they did not feel motivated or pressurised to comply with how they thought other nurses expected them to behave. This included not complying with "negative" behaviours, (eg. behaving angrily or frustrated) either seen as expected of them by other nurses or described as common behaviours. The one A/E nurse that was the exception observed that; ‘I comply to what experienced nurses say about toughening up and have toughened up but it’s probably not a good thing’. Table VI below shows nurses’ responses to whether they felt motivated to comply with behaviour perceived as expected of them by other nurses.

Table VI: The two nurse group's responses regarding the need to comply with the subjective norms of their nurse teams

<table>
<thead>
<tr>
<th>Need To Comply</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>A/E nurses</td>
<td>1</td>
<td>11</td>
</tr>
<tr>
<td>CMHT nurses</td>
<td>0</td>
<td>10</td>
</tr>
</tbody>
</table>
Nurses’ past behaviour

A/E nurses gave a more varied response in respect of their past behaviours towards DSH clients than CMHT nurses. Table VII below shows the different past behaviours stated by A/E and CMHT nurses.

Table VII: Responses of A/E and CMHT nurses regarding past behaviours with DSH clients

<table>
<thead>
<tr>
<th>Type of Past Behaviour</th>
<th>Number of A/E nurses</th>
<th>Number of CMHT nurses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sympathetic</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>Unsympathetic with repetitive DSH clients</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>Non-judgmental / remaining open-minded</td>
<td>3</td>
<td>7</td>
</tr>
<tr>
<td>Supportive</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>Behaving awkwardly</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>Irritated &amp; fearful with aggressive DSH clients</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>Avoidance</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>Frustration</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>Behaving firmly in setting boundaries</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>Empathetic</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>Using communicative skills to build a relationship (ie. listening, building rapport &amp; trust)</td>
<td>3</td>
<td>6</td>
</tr>
</tbody>
</table>

Three A/E nurses admitted that they behaved awkwardly. To quote one nurse, ‘I ask if they want to talk but I don’t push it. I feel I behave awkwardly with them because I haven’t had the training about self-harm and I explain I am not a psychiatric nurse’.
Avoidance also appeared linked with lack of training for two A/E nurses. One nurse stated, 'I tend to avoid clients who self-harm as I'm not trained or experienced. I'm scared of not knowing how to react and worried about them becoming violent'. In comparison, seven CMHT nurses, no A/E nurses, used the term "client centred" to describe their behaviour. They often explained being, "open-minded and responsive to the needs of clients that self-harm".
Past Behaviours of referring and giving advice

Table VIII below shows that CMHT nurses responded consistently whilst A/E nurses gave variable responses with regards to their past behaviours of referring and giving advice to DSH clients.

Table VIII: Responses of A/E and CMHT nurses towards their behaviours of referring and giving advice

<table>
<thead>
<tr>
<th>Behaviour</th>
<th>A/E Nurses</th>
<th>CMHT Nurses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Advised about other services (i.e. social services, crises team, citizens advice bureau, CMHT and substance misuse team)</td>
<td>6</td>
<td>10</td>
</tr>
<tr>
<td>Advised the patient to see their GP</td>
<td>5</td>
<td>0</td>
</tr>
<tr>
<td>Referred to psychiatrist on call</td>
<td>5</td>
<td>0</td>
</tr>
<tr>
<td>Advised younger DSH patients or patients who had self-harmed for the first time more than &quot;repeaters&quot; thought to have received advice in the past.</td>
<td>4</td>
<td>0</td>
</tr>
<tr>
<td>Referred to doctor on duty</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>Referred if appropriate to psychologist or specialist unit</td>
<td>0</td>
<td>8</td>
</tr>
<tr>
<td>Referred if appropriate to a psychiatrist or GP</td>
<td>0</td>
<td>10</td>
</tr>
<tr>
<td>Gave strategies or plans to use instead of self-harming, including telling them about the full range of services</td>
<td>0</td>
<td>10</td>
</tr>
<tr>
<td>Stated no involvement in any of the above behaviours</td>
<td>4</td>
<td>0</td>
</tr>
</tbody>
</table>
Contrast between nurses past behaviour towards DSH clients and “non-DSH” clients

All CMHT nurses stated that they interacted with DSH clients in the same way as with any other client. However, A/E nurses gave a mixed reply. Eight A/E nurses stated it was the same and four that they interacted differently with DSH clients as opposed to “non self-harming” clients. The differences included:

1) Interacting at a "deeper level" to find out what caused the DSH.
2) Interacting at a "more superficial level" to avoid involvement.
3) Giving more privacy to DSH clients so that they are able to discuss their problems.
4) Giving a more frustrated response with DSH client that are demanding or drunk.

Nurses attitudes towards their own behaviour

CMHT nurses viewed their behaviour as more beneficial towards DSH clients than did A/E nurses who gave a varied response. Table IX below shows the differences in the most common benefits to be derived according to the responses of the two nurse groups.
Table IX: A/E and CMHT nurses' attitudes about how beneficial they viewed their behaviour was towards DSH clients

<table>
<thead>
<tr>
<th>Behaviour</th>
<th>A/E nurses attitudes About their behaviour</th>
<th>CMHT nurses attitudes About their behaviour</th>
</tr>
</thead>
<tbody>
<tr>
<td>Beneficial</td>
<td>4 out of 12 nurses</td>
<td>7 out of 10 nurses</td>
</tr>
<tr>
<td></td>
<td>Benefits provided:</td>
<td>Benefits provided:</td>
</tr>
<tr>
<td></td>
<td>Physical care</td>
<td>&quot;Giving clients effective strategies</td>
</tr>
<tr>
<td></td>
<td>Leaving a &quot;first impression of a</td>
<td>to prevent DSH&quot;.</td>
</tr>
<tr>
<td></td>
<td>caring service&quot;.</td>
<td>&quot;Giving clients who DSH a chance to</td>
</tr>
<tr>
<td></td>
<td>&quot;Offering a chance to talk and</td>
<td>cope&quot;.</td>
</tr>
<tr>
<td></td>
<td>be listened too, thus preventing</td>
<td>&quot;Providing the client with long-term</td>
</tr>
<tr>
<td></td>
<td>a more serious DSH act&quot;.</td>
<td>benefits in their recovery.</td>
</tr>
<tr>
<td></td>
<td>&quot;Convincing them to get help&quot;.</td>
<td></td>
</tr>
<tr>
<td>Limited Benefits</td>
<td>6 out of 12 nurses</td>
<td>2 out of 10 nurses</td>
</tr>
<tr>
<td></td>
<td>common replies included:</td>
<td>Both nurses replied similarly:</td>
</tr>
<tr>
<td></td>
<td>&quot;We are not able to follow our care</td>
<td>&quot;How beneficial, is difficult to</td>
</tr>
<tr>
<td></td>
<td>through so do not produce long-term</td>
<td>answer.&quot;</td>
</tr>
<tr>
<td></td>
<td>benefits. I can only give limited help&quot;.</td>
<td>&quot;If you're centred on the DSH then</td>
</tr>
<tr>
<td></td>
<td>&quot;They get medical care but I am aware</td>
<td>you're not going to have an effect. If</td>
</tr>
<tr>
<td></td>
<td>of my limits, I haven't got the answers&quot;.</td>
<td>you work on the underlying issues, I</td>
</tr>
<tr>
<td></td>
<td></td>
<td>think it can have an effect, I'm not</td>
</tr>
<tr>
<td></td>
<td></td>
<td>saying it does, it depends on so much&quot;</td>
</tr>
<tr>
<td>No Benefit</td>
<td>2 out of 12 nurses</td>
<td>1 out of 10 nurses</td>
</tr>
<tr>
<td>------------</td>
<td>-------------------</td>
<td>-------------------</td>
</tr>
<tr>
<td>Both nurses replied similarly:</td>
<td>&quot;Repeater's come back I don't see they benefit at all&quot;.</td>
<td>One CMHT nurse replied: &quot;Interventions do not have a great effect on whether the client self-harms again&quot;</td>
</tr>
<tr>
<td>&quot;For ‘first attempters’ it can make it worse as I have to keep leaving them for other work&quot;.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Five A/E nurses also mentioned lack of feedback. For example, one nurse stated that,

_The lack of feedback makes it hard to know who benefits from your help._

**Nurses perceived behavioural control**

Extreme differences existed with eleven out of twelve A/E nurses feeling not in control and, nine out of ten CMHT nurses feeling in control over the ways in which they wanted to behave towards DSH clients.

A/E nurses' gave many reasons for why they felt not in control. Nine A/E nurses stated that too many interruptions prevented them from establishing a constructive rapport with the patient. A common response was;

_The time factor stops me working how I want to and I feel frustrated. Sometimes with an ‘overdoser’ I’m disturbed to do other things so I have to get up and then come back. When I have to get up and come back several times, it’s no good_.

Six A/E nurses stressed workload prevented them feeling in control over their behaviour, for example on nurse said; _The amount of workload causes tiredness so I’m not at my best and I also get too busy to sit with clients who self-harm_.

Four nurses replied that their role as a nurse took away control, one nurse stated;
'We are told sick people must have priority, and most “self-harmers” don't need much medical treatment'.

The uniform was also seen as a barrier, preventing the patient from “seeing the human underneath”. Three A/E nurses mentioned budget constraints since there was not a special area for psychiatric patients with staff employed especially to treat them. To quote one nurse;

'When there is no private place for the self-harming patient we have to ask them to wait in the waiting room for the psychiatrist and they often walk out'.

Three A/E nurses were frustrated by the lack of training in this area limiting their control over how to behave, as they put it "not knowing how to help them".

Six A/E nurses stated that their control was over-ridden by doctors even if they believed the DSH client was at risk. Three A/E nurses advised that control was lost if police were called, for example, one nurse stressed;

'If the self-harming patient was aggressive but I wanted to continue to work with them I would be over ruled with the police quickly taking the patient away'.

Six A/E nurses stated they had no control over psychiatric services, a common response was;

'Sometimes I want to get a self-harming patient seen quickly but find “back up” is slow'.

Seven CMHT nurses, similarly to A/E nurses, acknowledged time pressures as a problem. However, unlike A/E nurses, they stated that they had freedom over their workload and thus control over how they wanted to behave. Four CMHT nurses explained that they could call on team members to help them if they were busy. To quote one CMHT nurse;

'I think you can have control of that (i.e. time pressures) as you can ask somebody else to maybe see one of your clients if you haven't got the time in the day".'
Only one CMHT nurse believed she had little control and explained that this was due to the team not being “self-cohesive”. She observed, ‘as the team is fragmented different messages are given to the client and this gives you less control with them’.

Behavioural intentions

A/E and CMHT nurse’s similarly “intended” to behave in a caring manner towards DSH clients. Table X compares the behavioural intentions of both nurse groups.

Table X: Comparison of A/E and CMHT nurses’ behavioural intentions towards DSH clients

<table>
<thead>
<tr>
<th>Intention</th>
<th>A/E Nurses</th>
<th>CMHT nurses</th>
</tr>
</thead>
<tbody>
<tr>
<td>To reassure the DSH client</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>To be helpful / caring / respectful</td>
<td>7</td>
<td>6</td>
</tr>
<tr>
<td>To build a relationship with the client</td>
<td>4</td>
<td>6</td>
</tr>
<tr>
<td>Not to build a relationship with the client</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>Consider safety first with DSH clients</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>Explain confidentiality</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>Discuss and explore their problems and issues</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>To make client aware of their responsibility for their DSH and its consequences</td>
<td>0</td>
<td>4</td>
</tr>
</tbody>
</table>

A common response from A/E nurses was:

‘I always intend to be helpful, caring, and professional’.

A/E nurses, contrary to CMHT nurses, gave a varied response about whether or not to build a relationship with the DSH client. The reasons for not building a relationship with DSH clients was that some nurses felt this might make things worse for them by bringing
emotions to the surface that could not be adequately dealt with because of operational constraints. To quote one nurse:

'It's difficult to know how far to go. I don't intend to start a relationship with a patient who self-harms as I don't want to make things worse, it may bring emotions to the surface and due to demands of my job I can't stay with them'.

Two A/E nurses voiced an intention to consider their own safety first for example, one nurse stated:

'My intention is to consider my own safety first and find out how agitated or drunk they (i.e. clients who self-harm) are. I worry about those that are possibly violent and if they are drunk I expect I will behave abruptly towards them'.

Four CMHT nurses intended to make the client aware that they were responsible for their DSH and its consequences. To quote one nurse;

'I intend to always make clear that it is up to them, they are responsible for their DSH behaviour and the consequences of their actions'.

After nurses completed the sort tasks and interview they were asked if they had any further comments they would like to make. Appendix VI offers a detailed account of those comments.
Discussion

The research findings indicated clear differences between A/E and CMHT nurses in their beliefs, attitudes and behavioural intentions, as predicted by Ajzen’s (1987) model. In accordance to Ajzen’s model A/E nurses were less likely than CMHT nurses to behave in line with their intentions towards DSH clients. This was due to their ambivalence as to the benefits of their behaviour and lack of control over how they wished to behave towards this client group. Using Ajzen's (1987) model with the additions of “attitudes towards target” and “past behaviour”, we can understand possible reasons for the differences that were found, and explore solutions to help nurses work more effectively with DSH clients.

The influence of “subjective norms” on nurses’ behavioural intentions

Most A/E and CMHT nurses viewed that common behaviours towards DSH clients were negative, with A/E nurses’ responses indicating more extreme negativity. All nurses (except one A/E nurse) claimed that they did not comply with these negative behaviours or with the behavioural expectations of other nurses. There seemed little or no pressure to comply with these expectations and the nurses wish not to comply with negative behavioural expectations seemed particularly strong. Since most nurses asserted negative behaviours were common and yet all but one nurse stated non-compliance with them, it is possible that either they overestimated the existence of negative behaviour towards DSH clients and/or gave sociably acceptable answers in respect of their own behaviour. These findings indicate that, for both nurse groups, subjective norms (i.e. nurses’ beliefs about how they think other nurses expect them to behave towards DSH clients and motivation to comply) do not play an influential role in their behavioural intentions, and hence behaviour.

The influence of “attitudes towards behaviour” on nurses’ behavioural intentions

More CMHT nurses than A/E nurses viewed their behaviour as beneficial towards DSH clients. Situational factors could provide the reasons for this. Whilst CMHT nurses follow treatment through and are more likely to see the benefits of their work A/E nurses stressed
that they did not get feedback and often saw the same DSH patients repeatedly coming back for treatment. A/E nurses also stressed that they had little time to spend with DSH clients and therefore the effect that they could have on this client group could only be limited. Descriptive statistics indicated that CMHT nurses had more DSH training and experience with DSH clients than A/E nurses. In addition, A/E nurses emphasised their lack of training on DSH. It is therefore likely that CMHT nurses have a greater understanding of what behaviours benefit this group, which could lead to more confidence in believing their behaviour was worthwhile and beneficial to the client. According to Ajzen's model, as CMHT nurses viewed their behaviour as being beneficial they are more likely to behave in the same way again. As A/E nurses were less likely to view their behaviour as beneficial their behaviour towards DSH clients is more difficult to predict.

The influence of “perceived behavioural control” on nurses’ behavioural intentions
Most A/E nurses were of the opinion that they did not have control over the ways they wished to behave, whereas CMHT nurses felt they did or were able to overcome problems preventing them from behaving in the way they thought appropriate. Many situational reasons are given by A/E nurses to explain their feelings of lack of control over their behaviour (e.g. time pressures, lack of resources, and lack of influence over other professionals). In addition, A/E nurses, in contrast to CMHT nurses, emphasised their lack of DSH training as restricting their choices of behaviour towards clients that DSH. Table VIII demonstrated that the CMHT nurses, in comparison to A/E nurses, were more likely to give strategies in an attempt to help the client gain control over their DSH, thus taking the risk that certain strategies may not work leading to a further DSH acts. A/E nurses were more likely than CMHT nurses to quickly want to refer the DSH client on. Work context, training, experience and perhaps also CMHT nurses being, on average, older than A/E nurses, may play a part in the nurses ability to feel comfortable and in control with the risk of further DSH whilst the client learns new strategies to overcome this behaviour. In addition, CMHT nurses appeared more willing to give their clients responsibility and control in respect of their DSH whilst they gave them strategies to try to help prevent
further DSH. According to Ajzen’s model, CMHT nurses were more likely than A/E nurses to behave in accordance with how they choose (or intended to) without feeling restricted in this choice.

CMHT nurses’ behaviour predicted by Ajzen’s model

According to Ajzen’s model the CMHT nurses were more likely to behave in line with their intentions which were described in a positive way, behaving in a caring manner and intending to build a good relationship. This is because CMHT nurses viewed their behaviour as beneficial and felt in control over how they wished to behave. Subjective norms (relating to nurses’ expectations) did not appear to influence intentions, with all CMHT nurses stating that they felt no pressure to conform. All CMHT nurses emphasised that they did not comply with “negative” behaviours either viewed as common or expected of them by other nurses.

The above findings corresponded with CMHT nurses’ responses to the additions to Ajzen’s model of “past behaviour” and “attitudes towards target”. Most CMHT nurses stated that there past behaviour had involved working on building a relationship and on being client-centred. The nurses also shared similar behaviours, always offering advice, giving strategies to prevent DSH, and referring if appropriate. In addition, all CMHT nurses stated that they interacted with DSH clients in the same way as with any other client. Concerning “attitudes towards target”, most CMHT nurses (seen in plot1b) shared a similar understanding of the psychopathology of DSH, distancing elements of “manipulation” and “attention-seeking”. Most CMHT nurses’ believed that clients did not commonly DSH in order to manipulate or attention- seek but instead key causes of DSH were related to “loss” and “rejection”. This belief can be argued as being in line with CMHT nurses having an empathetic attitude towards DSH clients. This may impact on their behaviour causing them to be more understanding and caring. However, other elements believed to be key causes of DSH such as “copying” acts of self-harm or self-harming due to feeling “emotionally needy”, may also influence nurses behaviour in less positive ways. Plot (2b) and (3b) are consistent with the
above findings. For example, plot (2b) showed that CMHT nurses did not hold the attitude that DSH clients were “time-wasting” or felt a sense of “disgust” or “distance” from them but felt “empathy”, “compassion” and had a sense of “responsiveness” towards them. Plot (3b) also revealed that CMHT nurses held the belief that DSH clients mainly viewed their DSH in a negative way such as feeling “ashamed”, “self-disgusted”, “guilty” and a sense of “self-blame” about it. This could be argued as likely to lead to the nurses having a more empathetic attitude viewing that both the client and themselves are working together to overcome this behaviour.

A/E nurses’ behaviour predicted by Ajzen’s model

In comparison with CMHT nurses, A/E nurses gave a mixed response in respect of whether they viewed their behaviour as beneficial. Most nurses also felt a lack of control over the ways in which they would like to behave towards DSH patients. In addition, subjective norms for all A/E nurses, (except one), did not appear to influence intentions with the nurses also stressing non-compliance with “negative” behaviours. Most A/E nurses regarded their behavioural intentions as “positive” towards DSH patients (e.g. Intending to be helpful, caring, respectful, and to listen to the patient). However, in accordance with Ajzen’s model, as there is a sense of a lack of control over their behaviour and ambivalence regarding its benefits these positive intentions may not always be achieved.

The responses concerning their “past behaviour” towards DSH patients were also varied. These ranged from being sympathetic and supportive to behaving awkwardly, acting irritated, fearful and avoiding DSH patients. In addition, behaviours of referring and giving advice varied considerably with some nurses not doing either. A mixed reply was also given to whether nurses interacted with DSH patients in the same way as with other patients.

It was interesting to find that A/E nurses’ responses in relation to “attitudes towards target” (see plot 1a) were not variable but very similar to each other. For most A/E nurses how understandable the reasons were for the DSH appeared to play a role in their
subsequent emotional responses to the DSH patients. Plot (1a) indicated that DSH patients are likely to get varying responses depending on whether they are patients who have had “repeated admissions with minor DSH acts and no serious reasons for these acts” or a patient with an "understandable reason" for their DSH - the latter receiving more empathy. Plot (2a) also revealed that nurses may have varying responses towards DSH patients with most A/E nurses stating for example, that they felt “compassion”, “empathy” and a sense of “responsiveness” but also of “distance”, “anger”, and viewing the client as “time-wasting”. In Plot (3a) we also see that most nurses had varied beliefs about what they thought patients attitudes were towards their DSH for example, A/E nurses believed DSH patients felt “angry”, “lost”, “sad” and “hopeless” about their behaviour but also “accepting” it with the DSH giving the patient a sense of “powerfulness”. In summary, this study found that A/E nurses shared similar beliefs and attitudes, these however covered a wide spectrum indicating that most A/E nurses had a varied opinion towards DSH clients. This finding appears to be reflected in the nurses varied behaviour towards this client group and in the greater difficulty in predicting A/E nurses behaviour as opposed to CMHT nurses.

Possible reasons for the differences in the results between A/E and CMHT nurses

CMHT nurses, similarly to A/E nurses, were in agreement with each other in regards to their beliefs and attitudes and in the case of CMHT nurses this also manifested itself in similarities in behaviour towards DSH clients. It is likely that there are several reasons for this which may include: CMHT nurses, in comparison to A/E nurses, have more similar backgrounds in their training (see table 1), more experience in nursing and specifically with DSH clients, (which perhaps causes a tendency towards the same conclusions about treatment being drawn), group supervision allowing a closer sharing of ideas about treatment, and, shared responsibility when working together with DSH clients. Such similarities and sharing may account for a more cohesive group of like-minded people with a convergence of attitudes, beliefs and behaviours. A/E nurses however, had more diverse training giving rise to different ideas regarding treatment and due to time restraints, they
did not have a nurse support group with an opportunity to talk about DSH clients or to share frustrations and ideas regarding treatment.

Behavioural intentions appeared highly relevant to how the nurses behaved towards DSH clients. This is because the A/E nurses’ intention is to quickly treat the DSH client, get them through the hospital system and be ready to treat the next patient. CMHT nurses’ intention is to engage with the DSH client giving support and developing a relationship, which is going to have a past, present and future aimed at rehabilitation of the client. The nature of these different contacts means that A/E nurses will have a fairly superficial relationship where they may or may not see the client again, thus, it remains mostly impersonal. Despite their behavioural intentions to be caring and understanding the busy and stressful environment in which A/E nurses work seriously hinders the fulfilment of these intentions leading to a degree of displayed frustration towards DSH client. The CMHT nurses role, however, is to develop a relationship where they will see the client over a period of allocated time with a purpose of preventing the DSH. Their behavioural intention is therefore understandably linked to their practice of acting in a caring manner and building a relationship, so that only when all interventions have been exhausted frustration towards the client can manifest itself.

“Manipulation” and “attention-seeking” (as seen on plot (1a/b) were viewed differently by A/E and CMHT nurses. The way these two elements were viewed by A/E nurses as related to DSH clients and by CMHT nurses as not related can be argued as likely to cause a difference between the two nurse groups behaviours towards this client group. Ghodse et al. (1986) found intentions important to A/E nurses with an ambivalent attitude towards those believed to have “manipulative” or “attention-seeking” motives. This study supports Ghodse et al’s findings, with most A/E nurses stating that they were least sympathetic where the cause of the DSH is related to “attention-seeking” or “manipulation”. Reasons for the differences in how A/E and CMHT nurses view “manipulation” and “attention-
seeking” could be the result of A/E nurses having less DSH training thus less understanding of the underlying causes of DSH. Time-limitations are also likely to effect A/E nurses who are not able to enter into an in depth discussion as to the underlying causes such as “loss” or “rejection”.

Plot (2 a and b) revealed that both A/E and CMHT nurses agreed that they felt “frustration” towards DSH clients. However, CMHT nurses linked this with “de-skilled” whereas A/E nurses linked “frustration” with “distance” and “anger”. It appeared that CMHT nurses felt “frustration” when efforts to help did not appear to work. This frustration could therefore be linked to themselves, professionally, with a sense of helplessness at being “de-skilled”. However, “frustration” for A/E nurses appeared related to the extreme work pressures they have, and the need to “distance” themselves from the DSH client with no time for comprehensive discussion about their psychological distress.

A feeling of “frustration” and “anger” is likely, given the extra demands this patient group place on them and this could explain their response of mostly viewing DSH clients as “time-wasting”. This is supported by Suokas and Lonnquivist's (1989) study where 76% of A/E nurses believed DSH clients waste staff time. Frustration could also be due to most A/E nurses, as seen in plot (2a), feeling “responsibility” for the DSH client in contrast to CMHT nurses who gave this back to the client. Not being able to stop patients committing DSH and yet feeling responsible for them, may have an impact on nurses feeling frustrated which, in turn, impacts on their less empathetic behaviour, especially towards clients who repeatedly self-harm. Lack of feedback is likely also to lead to frustration. Suokas and Lonnqvist (1989) stressed that not receiving patient development and prognosis feedback denies A/E staff feelings of satisfaction towards treating this group. In addition, Ghodse et al. (1986) stated that frustration could be due to negative pre-existing attitudes or staff finding it difficult to empathise with a patient that is gambling with life and death. The finding that both CMHT and A/E nurses agreed DSH clients do not feel “selfish” or “shocked” by their behaviour could give rise to feelings of frustration. That is, the nurses may feel that DSH acts can be “selfish” and could feel frustrated at the clients lack of
awareness or refusal to accept the awful impact of their behaviour on relatives, friends or the nurses themselves.

Criticisms of this study include; firstly, because of serious time constraints on the nurses only two were available to input their views for interpretation of results. Naturally, a larger input would have been more beneficial. Secondly, the influence of nurses giving sociably acceptable answers to the questions on subjective norms and compliance was always likely to be problematic. It appeared that nurses were able to discuss norms in general as being “negative” and highlight some expectations from other nurses that could be described as unhelpful practices (such as, ignoring repetitive DSH patients or acting in an annoyed manner towards young, abusive or drunk DSH patients if they were not compliant towards treatment). However, nurses may not have felt able to state that they did, or felt pressure to, comply to other nurses’ “negative” expectations. This study’s findings that subjective norms did not appear to influence intentions could therefore be inaccurate and more research is needed to further explore this area. In addition, more research needs to be done on the influence of subjective norms exploring the effects of other groups of people (such as, the public, relatives, and other professionals) on nurses’ behaviour towards DSH clients.

Possible solutions towards working more effectively with clients that DSH

The finding that most A/E nurses’ intentions were to treat DSH patients with understanding, helpfulness, caring and respect, but that this could be thwarted by the lack of control over the ways in which they wished to behave and the inability to see the benefits of their work, provides useful information towards finding solutions to help A/E nurses work more effectively.

Specialist nurses

A/E nurses stressed that they felt a “lack of control” in several areas, these included: in their work loads, lack of resources, lack of influence over other professionals and lack of training. A/E nurses blamed the interruptions of other work demands for the lack of time
they were able to spend with DSH patients. The need for the provision of specialist nurses employed for this patient group was stressed as essential.

A specific treatment area for DSH patients
The provision of a treatment area specifically for DSH patients would help prevent the problem, highlighted by nurses, of these patients leaving whilst waiting for further treatment after being asked to stay in the waiting room.

Guidelines giving nurses more control over decisions
Meetings of professionals who work with DSH clients that are treated in A/E could be held to draw up guidelines that would give A/E nurses more influence in decision making regarding this client group.

Training
Training on more effective ways of working with DSH patients would help nurses feel less restricted in how they behave towards this client group. Gaining DSH training could also help nurses feel more confident that they have acquired effective behaviours that benefit DSH clients and subsequently they are more likely to keep behaving in this beneficial way. This training would need to address the effects that intentions and severity of the DSH have on A/E nurses. A/E nurses could be trained to look beyond the DSH to the individual’s own psychological pain and future risks, which can be similar, whether a client has taken a severe overdose or made superficial cuts. The literature of DSH clients accounts of their feelings about their DSH and experiences of treatment at A/E can be used in training to help A/E nurses gain a greater understanding of their perspective (Harrison, 1997; Pembroke, 1994; Pembroke and Spandler, 1996).

Feedback
A/E nurses are not often aware of the benefits of their work because they refer DSH patients on to other services and also they frequently see the same DSH patients coming
back for treatment. There is a need for mental health professionals such as psychiatrists, psychologists and CMHT nurses to provide feedback on clients that have been referred from A/E departments. A "feedback loop" within the service to ensure A/E nurses get consistent updates regarding the work that is done and progress that is being made with DSH patients that they are familiar with would assist in A/E nurses being aware of their essential role in this process.

**Supervision**

Supervision groups run by an expert on DSH, could help A/E and CMHT nurses to work more effectively with DSH clients. This would not only help to increase nurses own skills in working with this client group but also offer the supportive environment necessary to express frustration when CMHT nurses feel they have exhausted all channels in trying to help the client and A/E nurses when they are trying to work with DSH clients within the limits of a busy and demanding A/E department. Supervision could also incorporate the need for support from colleagues where, A/E nurses could develop the practice that was highlighted by CMHT nurses regarding, working in pairs which helped nurses share responsibility with DSH clients.

**Support from mental health professionals**

A/E nurses emphasised the need for more support from mental health professionals. To ensure this, a specialist service for DSH clients could be set up with psychiatrists, psychologists, and CMHT nurses who can meet the need for rapid referral for DSH clients, feedback to A/E nurses, the provision of information on DSH and supervision. The service could include a DSH training programme for A/E nurses where those trained could then work in the specialist service for DSH clients offering treatment to DSH patients admitted into casualty, as well as, training and regular supervision for other nursing staff. This would enable the continuous development of special skills and knowledge and lessen A/E nurses feelings of helplessness and frustration when treating DSH clients.
Further research

Further studies need to assess the effects of the provision of such services, as mentioned above, employed to help nurses work more effectively with DSH clients. A pre and post interview could be used to establish which, if any, has the greatest benefits. Such studies may benefit from using Fazio's (1990) mode model as a framework in understanding the variables that influence nurses' behaviour. This is because Fazio's model, by integrating spontaneous and deliberative processes offers a chance to gain a greater understanding of the multiple processes by which nurses' attitudes influence their behaviour. Deliberative processing is effort-full and requires reflective and active retrieval or construction and consideration of attitudes. As a result Fazio argued that although deliberative processing occurs it does so less frequently than spontaneous processing. Spontaneous processing centres on the individuals spontaneous behaviour as it flows from their constructions of the events as it occurs and links attitudes to behaviour via the influence that attitudes have on individuals definitions of events. Such a process is argued as common in our daily lives and therefore important to address. Spontaneous processing is likely to be what enables nurses to function relatively effortlessly and smoothly when working with DSH clients. Given the constantly changing situation on a busy A/E department or the crises demands on CMHT nurses research needs to take into account those situations where the opportunity for reasonable decisions on attitude relevant behaviour are missing and instead highly assessable attitudes automatically guide behaviour.

Counselling psychologists, along with other mental health professionals, as part of hospital teams’ and CMHT’s can play a role in helping their team work cohesively towards developing services such as those suggested above that will facilitate nurses in their practice with DSH clients. For example, counselling psychologists, as with other professionals, can organise meetings to develop new guidelines giving A/E nurses more influence in decision-making, offer to provide DSH training, supervision and consistent feedback, set up a specialist service and develop research projects aimed at evaluating the provision of such services in assisting nurses to work more effectively with DSH clients.
References


HAMMOND, S. (1990) Psychometric analysis package (pap); a programme for the multivariate analysis of psychometric data. Guildford: Department of Psychology, University of Surrey.


Appendix

I  Letter to participants
II  Data collection form
III  Consent form
IV  A participant’s script
V  Ethical approval
VI  Comments of participants
Appendix I

Dear

I am writing to invite you to take part in a research project. The purpose of the project is to explore the beliefs, attitudes and behaviours that accident and emergency nursing staff and community mental health nursing staff have in regards to clients who self harm. This will provide a greater understanding of the reasons and influences underlying nurses' behaviours towards clients who self harm. It is necessary to increase our understanding of this in order to target important areas that need addressing in staff training programmes for this client group. This research could also highlight ways to improve education, treatment and management of clients who self harm. This may involve the provision of services such as, staff support or supervision groups, specialist staff for this client group and more resources to address the possible effects of work demands on nurses' behaviour towards clients who self harm.

What you will be asked to do, if you decide to take part is a) sign a consent form, b) complete a card sort task, grouping together cards with different words about clients who self harm, and c) answer questions about your behaviours towards clients who self harm. The duration of the task will be approximately 25 minutes and will be performed at a time and place suitable to you. The names of individuals, services, and places will be replaced by pseudonyms in the final research. This is to maintain confidentiality ensuring no individuals will be identifiable to others in the research report. This project has been approved by the University of Surrey Ethics Committee and XXX Hospital Clinical Research Ethics Sub Committee.

Yours sincerely
Appendix II

Data Collection
Participant Number ..................................................
A/E or CMHT ..........................................................
Grade.................................................................
How many years of nursing.................................
What nurse training have you had....................
How many years of nursing with DSH clients........
What training have you had about DSH clients.....
Age......................................................................
Gender..................................................................

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1. Groups

Elements

2. Groups

Elements

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Appendix III

Research Consent Form

This research project is being carried out by Sue French as part of the PsychD
Psychotherapeutic and Counselling Psychology Course at the University of Surrey. The
aim of the research is to explore the beliefs, attitudes and behaviours that accident and
emergency nursing staff and community mental health nursing staff have in regards to
clients who deliberately self harm.

You will be asked to 1. Complete a cards sort task, putting the cards with different words
about clients who self harm into groups. And, 2. To take part in an open ended interview
where I will ask you about your behaviours towards clients who self harm. The duration of
the task will be approximately 25 minutes. The interview will be recorded on audio tape so
that, in writing up the research I can cite people's experiences directly. To protect
confidentiality no identifying information such as names or locations will be used in the
research. Your name will be replaced by a number and letter code to ensure that all
responses are anonymous to others.

Please feel free to ask the researcher any questions that you may have about this research
before reading on.

Please read the following paragraph, and if you are in agreement, sign where indicated.

I agree that the purposes of this research and that the nature of my participation in this
research have been clearly explained to me. I therefore consent to be interviewed about my
beliefs, attitudes and behaviours regarding clients who self harm. I also consent to an audio
tape made of this discussion and to all or parts of this recording being transcribed for the
purpose of research. I understand that I will be able to withdraw from the study at any
time.

Participant Signature........................................  Date..........................

I undertake that professional confidentiality will be ensured in regards to any audio tape
made or any information given by the above participant and that this will only be used for
research purposes. The anonymity of the above participant will be protected.

Researchers Signature..............................  Date..........................
Appendix IV

A Participant’s Script:

1. I (Interviewer): What do you think are the standard or most common ways that CPN's behave towards clients who self harms?

R (respondent): I think there is a kind of negative attitude of "oh no! not again". I think it's from past experience of the frustrations and anxieties that they cause. I think there's a general feeling that you do want to help but there is frustration that it is very hard to stop it (i.e. the DSH) and this makes it quite difficult. We are always trying to find newer ways to deal with it. Ways that you've tried before don't always work for everyone and the client gets quite frustrated when you go and see them and you come away.

2. I: Within the sub-culture of CMHT's are there any other ways staff behave towards clients who self harm?

I think different people have different ways. Some are quite positive in wanting to work with them and some are negative, and will say "they are hard work". You don't get a natural consistent approach.

3a) I: What are the ways in which you think other nurses expect you to behave towards clients who self-harm?

I've never got the impression that I have to do what anyone is telling me or how I should work with a person who is self-harming. I have the freedom to do what I think I should do with the client and I've got the support there. If what I'm doing is not working then maybe from their past experience they will tell me what does work but no one says this is how you should work with them. I think in our team we do have a similar way of working which is an individual approach with the clients.

3b) I: How much, if at all, do you feel motivated to comply to these behaviours?

I don't feel I have to comply. I consider the individual's needs and what they want and try to empower the client. I go with what the actual client needs rather than with what people are telling me what I should do.

4. I: How have you behaved towards clients who self-harm?

I've tried to behave with empathy, trying to understand the emotions that they are feeling and reasons why they use their self-harm behaviour. I think I do empathise that it is their way of coping with emotions that they are experiencing. Yeah, I have tried to act in a supportive way.

5. I: How do you intend to interact and behave towards clients who self-harm when you meet them?

Hopefully in a way that they can trust me in that I'm not going to, you know, reject them. I intend never to be derogatory of them because of their self harm behaviour. Um, I want to listen to them and how they are feeling. I just intend to be there to listen to what they are experiencing at that moment.

6. I: How have you dealt with clients who self-harm in regards to referral for further treatment and advice regarding services they can use?

My approach is usually an empowering one. I tell them that it's their choice and their way of coping, they use the self-harming and therefore it's their responsibility. I make sure that
they know all the risks involved in their behaviour and also have a "treatment box" to deal
with their self-harm. That is, when they cut themselves they have a box with sterile wipes
to deal with the behaviour. Um, with other types of behaviour then it's their responsibility
to contact the appropriate agencies and I always give them a list of these with the
telephone numbers. Especially I always make sure they have the crises team number. I also
try to give them coping strategies so that they have other ways of dealing with their
emotions rather than using self harm.

7. I: In regards to your behaviour towards clients who self-harm that you have discussed,
how beneficial do you think these behaviours are?
Um, I think they benefit positively because I've seen it from past experience, working with
clients on the ward. I use my approach and now having used it and seen it work I feel that
I can keep using it with clients.

I: Can you tell me more about that?
My approach is to always be open to discuss things and always let the client know they can
approach me. My behaviour is all about building a good relationship this usually causes the
self-harm to lessen. I feel it helps them because they feel that there is someone there that
can maybe listen to them and understands.

8. I: Taking into account the demands of your work, how much control do you feel you
have over the ways in which you want to behave towards clients who self-harm?
You have to priorities the time you feel the person needs. With some who need more
support you can intensify how often you see them and then basically you need to give them
some time. I actually have the responsibility over my time but its just prioritising who
needs this more intensive daily support or more than weekly or fortnightly support. Being
able to priorities gives me control and I can choose to give the client more or less time
depending on how much they are self-harming. At times that they are self-harming a lot
then you can intensify your support and maybe reinforce your approaches. Um, I think you
can have control also because of the other system that we have. You can ask somebody
else to see one of the clients that you need to see or there is a person who does purely deal
with crisis. So if you do not have the time to see all of your clients you can get another
person to see them. There's other people there, or there's somebody there as duty worker
for crisis who you can say, "can you see this person, this is what I've been doing with them,
can you go and see them".

9. I: You have described your standard interactions with clients who self-harm, is this the
same or different in any ways from other clients who you work with?
No, I don't think so I feel my approach with everyone is the same. I try and communicate
with every one in the same way. My underlying approach is the same.

I: Are there any other comments that you would like to make or thoughts about the sort
tasks and interview?
R: I can't think of anything.
04 April 2000

Ms Sue French
PsychD Psychotherapeutic & Counselling Psychology Trainee
Department of Psychology
University of Surrey

Dear Ms French

An exploration of the differences in beliefs, attitudes and behavioural intentions of two nursing staff groups towards clients who deliberately self harm working within Accident and Emergency Department or Community Health Teams (ACE/2000/2/Psych)

I am writing to inform you that the Advisory Committee on Ethics has considered the above protocol and the subsequent information supplied and has approved it on the understanding that the Ethics Guidelines are observed.

The letter of approval relates only to the study specified in your research protocol (ACE/2000/2/Psych). The Committee should be notified of any changes to the proposal, any adverse reactions and if the study is terminated earlier than expected (with reasons). I enclose a copy of the Ethics Guidelines for your information.

Date of approval by the Advisory Committee on Ethics: 04 April 2000
Date of expiry of Advisory Committee on Ethics approval: 03 April 2005

Please inform me when the research has been completed.

Yours sincerely

Helen Schuyleman (Mrs)
Secretary, University Advisory Committee on Ethics
Registry

cc: Professor L J King, Chairman, ACE
Ms M John, Co-Investigator, Dept of Psychology

Enc
Dear Ms French

Re: Application 2293 - Attributions made by A & E staff and CHMT staff in regard to people who self harm

The Hospital Clinical Research Ethics Sub Committee considered your application at the meeting held on Friday 18 June 1999.

After discussion the members felt that as long as there was no patient involvement in the study only that of members of nursing staff it did not require ethical approval.

However I must emphasise that if this changed and patients were approached in the study ethical approval would be required and you would be required to submit the amended application to the appropriate Ethics Committee.

The members of the Hospital Clinical Research Ethics Sub Committee are as attached.

Yours sincerely

Chairman - Hospital Clinical Research Ethics Sub Committee
Appendix VI

Comments

7 out of 12 A/E nurses gave comments mostly about lack of support. Only one CPN commented, stating the need for, "proper and effective supervision from an expert on DSH".

Seven A/E nurses strongly stated psychiatric services do not give enough support leading to frustration. They stressed the need for;

1. a "direct line" to a CPN or psychologist for back up when they were too busy to talk with DSH patients.
2. more emergency services, awareness of what was available and explanations about the work of the crisis team with leaflets providing help-line numbers.
3. easier access to psychiatrists.
4. specialist trained nurses in DSH.
5. training on DSH about ways of talking with DSH clients.
6. a nurse support group or debriefing to cope with the stresses of working with DSH clients.
7. the need for feedback from psychiatric services about the progress of DSH clients.
An Evaluation of the Usefulness of the CORE in a
Cognitive Behavioural Therapy Group for Depression
An Evaluation of the Usefulness of the CORE in a Cognitive Behavioural Therapy Group for Depression

Abstract

This research evaluated the usefulness of the CORE (Clinical Outcomes in Routine Evaluation) in monitoring change in clients in a cognitive behavioural therapy (CBT) group for depression. Fifty-six participants completed the CORE and BDI-II before, during and after the CBT group. Convergent validity between the CORE and the BDI-II was then evaluated. As well as this the compatibility of the CORE with the 3-Phase model was explored. According to its developers (The CORE systems group, 1998) the CORE is compatible with the 3-Phase model (Howard et al., 1993). This model predicts that clients will change in the order of subjective well-being first, then symptoms and finally functioning. However, there has been no research to establish whether or not the CORE does map such a sequence of clients’ improvements.

This study found good convergent validity between the CORE and the BDI-II, although for the CORE’s domain of risk/harm this was low. These findings generally supported those of the CORE systems group (1998) and provided evidence of the validity of the CORE in assessing clients suffering from depression within a therapy group setting. In addition, the research found some evidence for the compatibility of the CORE with the 3-Phase model. A sequential pattern of improvement in the order of well-being first, followed by symptoms and then functioning was generally found. However, the results did not clearly show that improvement in one domain was "a necessary probabilistic condition" for improvement in another according to Howard et al's. (1993) predictions. The usefulness of the CORE in improving the evaluation and treatment of clients suffering from depression is discussed.
An Evaluation of the Usefulness of the CORE in a Cognitive Behavioural Therapy Group for Depression

Introduction

The development of the CORE

The CORE battery (Clinical Outcomes in Routine Evaluation) was developed following increasing pressure throughout the 1990s from the Department of Health (DoH) for outcome measures that would assist evidence-based practice, clinical audit, and feedback to health authorities and GP fund-holders (DoH, 1996). The CORE systems group (which comprises a multi-disciplinary team of researchers and clinicians representing, psychology, psychotherapy, counselling and psychiatry) developed this outcome battery to provide mental health services with a single standardised routine outcome measure applicable to all clients in psychotherapy regardless of the clinical setting, mode of therapy, or clinical problem.

The CORE was produced following an extensive development project that began by reviewing previous attempts to create outcome battery measures. A survey of purchasers and providers of mental health services was then undertaken to determine what its uses would be. A set of items was developed and these items were then evaluated for inclusion in the CORE by means of psychometric testing and clinicians'/non-clinicians' ratings of an item's quality and foci. A thirty four item self-report measure was finally developed with the total score indicating an individual's global level of distress. Each item consists of a statement such as “I have felt like crying” and is measured on a five-point scale. The items
cover four domains: 1) Subjective well-being, 2) Symptoms, 3) Life and social functioning, and 4) Risk/harm.

**Psychometric properties of the CORE**

The CORE systems group (1998) evaluated the psychometric properties of their battery on a clinical and non-clinical population of over two thousand respondents. 45% were clients in counselling and psychotherapy and 55% were lay respondents, students and a large sample of convenience. The results demonstrated high internal reliability with results showing alphas between 0.75 and 0.95 for all domains. Good test-retest stability was also found with stabilities from 0.87 to 0.91 on all scores apart from the risk score. A paired comparison of scores taken before and after individual therapy from brief student counselling, counselling in primary care and from a variety of NHS provider units all showed large and statistically significant group improvements. The rates of reliable and clinically significant change were found to be good and the results also identified a few clients who appeared not to change and a very few that significantly deteriorated. This evidence suggested that the CORE was able to measure individual differences on entry into therapy and was found to be adequately sensitive to change. In addition, no significant differences were found in internal consistency across all thirty four items or specific domains between overseas students (or for those to whom English was a second language) and a sample for whom English was their first language. Small gender differences were found.

Although the CORE is designed to tap a common core of problematic states across its four domains, the CORE systems group hoped that the scores would show some convergent validity against more specific measures. They reported that the CORE showed good
convergent validity against eleven widely used measures, (such as, Beck’s Depression Inventory-II, Beck’s Anxiety Inventory, The General Health Questionnaire A (for anxiety) and D (for depression), and the Brief Symptom Inventory), with high correlations found with item measures conceptually closer to its domains. However, in regards to the BDI-II (1996) a sample of only twenty nine clients in individual therapy was used to test the convergent validity. Hence, the CORE systems group warned against attaching too much confidence to the observed values found (these are reported in Table 1 in the results section). In addition, they found a low correlation between the BDI-II and risk domain (\((N = 29), \text{rho} = .32, p < .05\)).

The reliability and validity of the BDI-II has been well demonstrated by Dozois et al. (1998), Osman et al. (1997), Steer and Clark (1997) and Whisman et al. (2000). However, the reliability and validity of the CORE has only been evaluated by its developers. Further research is needed to establish the relationship between the CORE and BDI-II.

**Comparison between the CORE and the BDI-II**

The CORE and the BDI-II share some similar concepts. For example, they both measure sadness/unhappiness (CORE question 27, BDI-II question 1), crying (CORE 14, BDI-II 10), and self blame (CORE 30, BDI-II 8). However, there are also some differences in concepts. For example, only the CORE measures isolation (1), support (3), coping ability (7) and feeling affection (19) and only the BDI-II measures appetite change (18), feelings of being punished (6), and loss of interest in sex (21). Most importantly the BDI-II focuses only on symptoms of depression whereas the CORE although it includes this, also considers "symptoms" in a more general way within its four different domains.
The BDI-II has been widely used in research. In particular, several studies have found the BDI-II an effective outcome measure for evaluating client change in cognitive behavioural therapy (CBT) groups for depression (Ball et al., 2000; Bristow and Bright, 1995; Free, 1999; Scott and Stradling, 1998; Shapiro et al., 1994). In contrast, there are only two published studies of the CORE. These include Evans et al. (2000) on the development and utility of the CORE, and Whewell and Bonanno (2000) who assessed the validity of the CORE risk sub-scale for clients with borderline personality disorders. The lack of studies is unfortunate since it is increasingly being used in the NHS. In addition, the CORE has not been evaluated in regards to group therapy, even though psychotherapy groups are increasingly being used within the NHS. The increase in this form of psychological intervention has been supported by research finding that CBT groups for depression provide a cost-effective treatment with long-term benefits (Ball et al., 2000; Free, 1999; Scott and Stradling, 1998). The usefulness of the CORE in evaluating client change in CBT groups for depression needs to be assessed. One way that this can be done is by establishing whether or not the CORE shows good convergent validity with the BDI-II within such a group setting overtime. This research will also add to the existing findings on the convergent validity between the CORE and the BDI-II.

Compatibility of the CORE's results with the 3-Phase model

The CORE systems group (1998) stated that, "the domains of subjective well-being, symptoms and functioning should be compatible with the 3-Phase model" (p. 5 section E). Howard et al. (1993) tested their 3-Phase model by evaluating the progress of five hundred and twenty nine patients in individual therapy (by using a method of causal analysis (Blalock, 1964)). They concluded that there was a sequential impact where improvement of well-being was seen first, progressing to a reduction in symptoms in the second place,
and then finally leading to an enhancement of functioning. According to Howard et al. (1993) the model also predicted that improvement in well-being was a "probabilistic necessary condition" for reduction in symptoms, and symptom improvement was a "probabilistic necessary condition" for improvement in functioning. Howard et al's term "probabilistic necessary condition" means that it is necessary and likely that for example, an enhancement in well-being is seen before symptoms begin to remit. However, there has been no research to establish whether or not the CORE does map a sequence of clients' improvements comparable to that mapped by the 3-Phase model and whether this sequence follows probabilistic necessary conditions.

The 3-Phase model

Howard et al. (1993) described the three phases that occur in treatment as follows:

1) "Remoralization" (ie. improvement in well-being) - This refers to a change from demoralisation prior to therapy, leaving the client with feelings of hopelessness, powerlessness and a sense of distress about the persistence of their symptoms, to a sense of hope that therapy will be beneficial to them. The notion that hope must be experienced at the beginning of therapy has received wide support (Goldstein, 1962; Peake and Ball, 1987; Wilkins, 1985). This phase occurs early on, often beginning with the setting of the first appointment and completed when a good working alliance is established. Howard et al. (1993) found a significant improvement in well-being by the second session.

2) "Remediation" (ie. improvement in symptoms) - This involves a resolution of clients' symptoms and/or life problems. Some clients may begin therapy in this stage having sought help before demoralisation. This entails facilitating mobilisation of clients' coping skills
and/or encouragement of more effective coping strategies. Howard et al. (1993) found a significant improvement in symptoms by the fourth session.

3) "Rehabilitation" (ie. improvement in functioning) - This is focused on the unlearning of maladaptive patterns and the establishment of new ways of dealing with various aspects of life and oneself. Some clients may enter therapy at this stage. This phase takes the longest time with gradual improvement where the goal is to help the client towards a better mode of functioning. Howard et al. (1993) found clients improved in functioning by the seventeenth session. However, this study only measured change at sessions two, four and seventeen where any change occurring from the assessment to session two and between the fourth and seventeenth session is unknown.

As CBT groups involve group dynamics and this is missing from individual therapy one would expect that this might have an influence on the questionnaire results. In particular, Yalom (1995), Ohlsen et al. (1988) and Beck et al. (1979) have highlighted how a group context can have a greater impact on interpersonal relationships and social functioning. Working in groups provides the possibility of eliciting and dealing with a variety of negative inferences that may not come to light during individual therapy. For example, groups increase the likelihood that negative self-comparisons will be triggered. If identified and explored it provides opportunity for change that might never arise in individual therapy. Ohlsen et al. (1988) stated that clients tend to learn in groups quicker than in individual therapy. Reasons for this include, people with depression apply rules to themselves quite different from those they apply to others. Their greater objectivity and flexibility in recognising and re-evaluating others cognitive distortions appears to quickly facilitate the recognition and re-evaluation of their own. Confrontation and feedback from
other group members has also been found to be harder to ignore and more likely to be accepted than if coming from just the therapist, this helping to facilitate change. Group members can provide a larger base of validation, encouragement, support and acceptance. Clients become recognised for their contributions in the group which increases their sense of self worth. Beck et al. (1979) stated that clients who help each other in a group setting are more likely to learn social skills, helping skills, assertiveness behaviour and other social abilities than clients in individual therapy. They can learn how to gain satisfaction from helping others, empathise, share their successes whilst also celebrating those of others in the group and develop more satisfying relationships. Yalom (1995) stated that the group evolves into a social microcosm a miniturized representation of the clients' social universe. Through feedback and self-observation they become aware of their interpersonal behaviour and its impact on others' feelings and opinions of them. In the security of the group they can learn new ways of being with others. Behaviours learned in the group eventually are practiced outside the group and impact on their relationships. As the clients' ability to form rewarding interpersonal relationships is increased, their self esteem rises and the need for self concealment decreases thus feelings of isolation also decrease.

Aims of the study

The main aim of this study is to evaluate the usefulness of the CORE in monitoring change in fifty six primary care clients over time in a CBT group for depression. More specifically "usefulness" was assessed in accordance to the following questions: Firstly, does the CORE show some convergent validity with the well established BDI-II in the context of a CBT group for depression? And secondly, are the CORE's results compatible with the 3-phase model?
This research is important for counselling psychologists and other mental health professionals since any outcome measure should be tested in different contexts and its usefulness in practice assessed. If the findings show that the CORE results follow a predicted sequence in the order of well-being, symptoms and functioning this would provide clinicians with useful information to help clients change according to which of the three "phases" they are in. That is, the CORE results could establish the phase that the client is having difficulty improving in and the clinician could then tailor their treatment accordingly. This measure could also highlight the importance of clients staying in therapy until improvement has occurred in all three domains. In addition, it could evaluate which therapy sessions produce most change in certain aspects of the clients' lives, and also predict which clients need more help than others in group therapy. For example, the CORE results may be able to reveal the clients who have made little or no improvement in their well-being in relation to other clients.

The CORE, in contrast to the BDI-II, can be used by many professionals without the need for specific training. The CORE is therefore important to evaluate since it could prove to be a valuable tool for different mental health professionals to compare findings and learn from each other about how to improve overall therapeutic benefits of individual and group treatments for clients. This study will also address current concerns about the use of battery self report measures as an evolving method of evaluation of therapy where its limitations will be discussed.
Method

Participants

The participants were fifty six primary care clients, referred for psychotherapy by a GP, Community psychiatric nurse or psychiatrist. All met the criteria for a major depressive episode as specified by DSM-IV (Frances et al., 1995). They received the diagnosis of major depression either by their GP, psychiatrist or a psychologist. Clients receiving individual therapy as well as clients with psychosis, severe suicidal ideation, substance misuse, or cognitive impairment were excluded. Participants were chosen from the psychology department's waiting list on the basis of their likelihood of meeting the above requirements. They were then sent a letter inviting them to come to an assessment for the CBT group (see appendix I). All participants completed a ten-week CBT programme for depression run by two counselling psychologists (which hereafter will be named "group leaders"). The groups consisted of nine to ten members with the study including participants from six groups.

There were three participants that dropped out within the first four sessions of a group (this was due to personal problems or career demands) and these have been omitted from this study. Age means were similar across the groups with the mean age of all participants being 45.4 years (SD 9.24 years and range 30 years (28-58)). The male to female ratio was 2:3. Participants ranged from having moderate to severe depression as indicated by their scores on the BDI-II and CORE at assessment (the mean score on the BDI-II was 28, (SD 8.78) and CORE 1.86 (SD 0.41)). All participants were from a lower to middle class and had secondary school qualifications. 60% of participants had some further educational training.
Instruments

Instruments include two self-report measures:

1) CORE. This has 34 items. Each item is measured on a five-point scale from 0 to 4.

These cover four domains as indicated below:

1. Subjective well-being (4 items).
2. Symptoms/problems (12 items).
3. Functioning (12 items).
4. Risk/Harm (6 items).

The measure includes high and low intensity items to increase sensitivity and 25% of the items are "positively" framed. The CORE is scored by adding together the response values (ranging from 0 to 4) on each of the 34 items and then dividing this score by 34. A client's total score will therefore range from 0 to 4. The measure is problem-scored so that the higher the score the more problems and/or distress the individual has. The CORE systems group (1998) specified that the male and female cut-off scores between clinical and non-clinical populations is 1.19 for males and 1.29 for females. (see appendix II for a copy of the CORE).

2) BDI-II. This has 21 items each item being measured on a four-point scale from 0 to 3. The score range is from 0 - 63, the total score gives the severity of cognitive-affective and somatic symptoms of depression as indicated below:

0-13 minimal depression
14-19 mild
20-28 moderate
29-63 severe

(see appendix III for a copy of the BDI-II).
Procedure

Following the letter inviting them to come to an assessment, participants were seen by a group leader for an hour where information was gained about their background history, depression and goals of treatment. The participants were then asked to complete the CORE and BDI-II. This was done without help from the group leaders. Participants were then asked at intervals throughout the group and at a follow-up session to complete the CORE and BDI-II. Group leaders gave the measures out to each participant before group sessions. They completed the measures within the room used for the CBT group and after completion gave them back to the group leaders. Order effect was avoided by participants completing the measures in different orders. The intervals in which the CORE and BDI-II were given included:

Time 1: Assessment (pre-group)
Time 2: Wk 1
Time 3: Wk 4
Time 4: Wk 7
Time 5: Wk 10 (Post-group)
Time 6: Follow-up at 8 weeks.

There were five participants from different groups that missed a session when the CORE and BDI-II were being completed. These participants therefore completed the measures a week later before the session.

(For overview of course content see Appendix IV).
Analysis of Data

Convergent validity: Pearson's r was used to evaluate the convergent validity of the CORE with the BDI-II. Participants' mean scores on the BDI-II and CORE including its domains were correlated over the six measurement times. As the BDI-II specifically measures symptoms of depression this was also correlated with the CORE items specifically measuring "symptoms of depression". Given the number of correlations undertaken a p value of .001 was used as a measure of significance.

An ANOVA and MANOVA was used to provide a comparison of the changes in participants' scores over time on the BDI-II and CORE respectively.

Evaluation of the compatibility of the CORE's results with the 3-Phase model

To compare the progressive order of change of participants' results on the well-being, symptoms and functioning domains over time this study used the same method of causal analysis as Howard et al. (1993). This causal analysis was carried out as follows:

First, a value of "1" was given if an improvement was found in a participant's overall mean score on a domain (improvement was measured by the participant moving, within the domain, at least one point down on the Likert scale from one time of measurement to the next). A value of "0" was given if no improvement was found in a participant's overall mean score on a domain (non-improvement was measured by the participant remaining constant or having a higher score on the Likert scale from one time of measurement to the next). For example, change in well-being was measured by improvement or non-improvement made from assessment to session 1, session 1 to session 4, session 4 to session 7, session 7 to session 10, and session 10 to follow-up for each participant. This was repeated for symptoms and functioning.
Second, cross-tabulation was used to compare the causal relationship between the three domains. 2x2 tables were generated to show the number of participants who had improved or not improved in well-being compared to symptoms and symptoms compared to functioning. To evaluate whether clients followed a sequential pattern in the order of well-being, symptoms and functioning, the number of participants who had improved in a domain at any one time of measurement could be counted in the table's cells. Therefore participants' results of improvement in one domain could be compared to the improvement in another. The significance of the causal relationship between the two domains could then be determined by Chi square tests. This method is particularly concerned with a comparison of the relative frequency of the number of participants that have improved or not improved in one domain in relation to the other. This allows for the exploration of the causal relationship between variables. Howard et al's. (1993) further prediction that these improvements follow "probabilistic necessary conditions" can also be assessed in this way.

Ten cross-tabulation tables were generated, five tables for the five comparisons between well-being and symptoms over time and, five tables for the five comparisons between symptoms and functioning over time. A Bonferroni adjustment was therefore used to decrease the likelihood of a type 1 error. This resulted in the significance level being .005. Pearson's Chi-square tests were used to measure significance unless tables had 25% or more cells with expected frequencies less than five. Fisher's exact test was used when this was the case.
Ethical Considerations

This study used data that had already been collected during therapy. To protect confidentiality no identifying information such as participants’ names, group leaders’ names or location of the group sessions is reported in this research. Names of participants have been removed from the CORE and BDI-II to ensure that they are anonymous to the researcher. The group leaders stressed that since the participants had left the service, to contact them for this research may cause undue distress. Given that the research is interested in audit-based questions of the CORE’s validity and compatibility with a theoretical model, they felt that it would not be in the participants’ best interests to contact them. The NHS Trusts ethics committee gave approval for the study only on the basis that the researcher did not have access to clients’ names and they were not contacted. Ethical approval was also given by the University of Surrey ethics committee on the same basis (See appendix V). The Data Protection Act (1998, IV.33) states that personal data which is processed for research purposes is exempt from needing ethical approval if the results of the research or any statistics are not made available in a form that identifies any of the data subjects.

However, there are ethical considerations that are important to address in that participants were not given information that their data was being used. Therefore they did not have the option to deny access to their information or to be informed of the findings. From discussion with the group leaders about these issues it was believed that this research would be helpful in improving the treatment programme and the benefits that this could bring for future sufferers of depression was viewed as an important reason to precede with this research.
Results

Convergent validity between the CORE and the BDI-II

The results in Table I present the findings of the correlations between the CORE and the BDI-II over the six times measured. The table shows the total scores on the BDI-II compared to the total scores on the CORE and the domains of well-being, symptoms (including the items addressing symptoms of depression), functioning and risk/harm. The means of the six measures for each domain and the total CORE score are presented in bold figures. The CORE systems group's (1998) findings of the correlations between the CORE and BDI-II on twenty nine clients are presented in the shaded boxes.
Table I: Results of the Pearson's r between the BDI-II and CORE

<table>
<thead>
<tr>
<th>BDI-II</th>
<th>Wellbeing</th>
<th>Symptoms</th>
<th>Depression</th>
<th>Functioning</th>
<th>Risk</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>.78 **</td>
<td>.22</td>
<td>.42 **</td>
<td>.71 **</td>
<td>.45 **</td>
<td>.70 **</td>
</tr>
<tr>
<td>2</td>
<td>.36 *</td>
<td>.44 **</td>
<td>.54 **</td>
<td>.58 **</td>
<td>.42 **</td>
<td>.59 **</td>
</tr>
<tr>
<td>3</td>
<td>.55 **</td>
<td>.59 **</td>
<td>.64 **</td>
<td>.79 **</td>
<td>.42 **</td>
<td>.74 **</td>
</tr>
<tr>
<td>4</td>
<td>.72 **</td>
<td>.61 **</td>
<td>.63 **</td>
<td>.81 **</td>
<td>.48 **</td>
<td>.67 **</td>
</tr>
<tr>
<td>5</td>
<td>.78 **</td>
<td>.63 **</td>
<td>.73 **</td>
<td>.74 **</td>
<td>.51 **</td>
<td>.78 **</td>
</tr>
<tr>
<td>6</td>
<td>.73 **</td>
<td>.27 *</td>
<td>.42 **</td>
<td>.62 **</td>
<td>.33 *</td>
<td>.68 **</td>
</tr>
<tr>
<td>Means Across Times</td>
<td>.65</td>
<td>.46</td>
<td>.56</td>
<td>.71</td>
<td>.44</td>
<td>.69</td>
</tr>
<tr>
<td>Results Of the CORE Group</td>
<td>.79*</td>
<td>.74*</td>
<td>No result Given</td>
<td>.78*</td>
<td>.32*</td>
<td>.81*</td>
</tr>
</tbody>
</table>

LEGEND: Significance level of p ≤ .05 is indicated with one asterisk. Two asterisks indicate p < .001.
Well-being: The mean correlation between the BDI-II and the well-being domain was .65. All individual correlations over the six times measured, as presented in table I, were significant at $p < .001$, except at time 2 (the first session) which was $p = .006$.

Symptoms: The mean correlation between the BDI-II and the symptoms domain was .46. The correlations over the six times measured varied in significance. At time 2, 3, 4 and 5 the results were significant at $p < .001$. The results at time 1 and 6 were not significant at $p = .10$ and $p = .04$ respectively.

Depression: The mean correlation between the BDI-II and the items addressing symptoms of depression was .56. All correlations over the six times measured were significant at $p < .001$.

Functioning: The mean correlation between the BDI-II and the functioning domain was .71. All correlations over the six times measured were significant at $p < .001$.

Risk/harm: The mean correlation between the BDI-II and the risk/harm domain was .44. All correlations over the six times measured were significant at $p < .001$ except at time 6 (follow-up) which was $p = .01$.

Total CORE score: The mean correlation between the BDI-II and the total CORE score was .69. All correlations over the six times measured were significant at $p < .001$. 
ANOVA and MANOVA results

The ANOVA and MANOVA results on the BDI-II and CORE respectively can be compared in figure 1 below. In order that changes in participants’ scores over time on the BDI-II and CORE can be compared the BDI-II scale has been mathematically adjusted to be compatible with the CORE scale. This adjustment includes BDI-II readings being multiplied by 4/63.

Figure 1: Participants’ scores on the CORE and BDI-II over the six times measured

The MANOVA results on the CORE were \( F(51, 5) = 53.1; \ p < 0.001 \)

The ANOVA results on the BDI-II were \( F(51, 5) = 50.8; \ p < 0.001 \).

A comparison of the BDI-II and the CORE results in figure 1 shows that participants’ scores followed similar patterns. Participants’ scores reduced slightly more on the BDI-II than the CORE from time 2 to 3. Both measures then remained more constant from time 3 to 4 before reducing again between times 4 to 6.
Changes in participants' scores over time on the BDI-II and CORE's domains including the depression items can be compared in figure 2 below. This presents the ANOVA and MANOVA results on the BDI-II and CORE respectively.

Figure 2: Participants' scores on the CORE's domains and the depression items in comparison to the BDI-II over the six times

Tests of within subjects contrasts indicated that participant change over the six times measured on the total CORE score and the domains was significant at $p < 0.001$, for well-being ($F = 88.5$), symptoms ($F = 174$), functioning ($F = 138$), risk/harm ($F = 24.2$), depression items ($F = 222$) and for the CORE total score ($F = 201$).
An analysis of significant changes in participant’s scores on the BDI-II compared to the CORE

In order to examine the agreement between the BDI-II and CORE in terms of which each participant was judged to have clinically significantly changed, the cut off scores between having a clinical or non-clinical problem on the CORE and the score “bands” showing the four levels of severity of depression on the BDI-II were used (see page 227). If participants move across the cut off criteria on the CORE or move to a different level on the BDI-II this shows a clinical significant change. Table II below shows participant’s scores at assessment in regards to the CORE’s cut off criteria and the BDI-II’s levels of depression.

Table II: Participant’s scores on the CORE and BDI-II at assessment

<table>
<thead>
<tr>
<th>Participant’s scores on the CORE</th>
<th>Participant’s scores on the BDI-II</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-clinical criteria</td>
<td>Minimal depression</td>
</tr>
<tr>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Mild depression</td>
</tr>
<tr>
<td></td>
<td>2</td>
</tr>
<tr>
<td>Clinical criteria</td>
<td>Moderate depression</td>
</tr>
<tr>
<td>54</td>
<td>29</td>
</tr>
<tr>
<td></td>
<td>Severe depression</td>
</tr>
<tr>
<td></td>
<td>25</td>
</tr>
</tbody>
</table>

The two participants in the mild depression level on the BDI-II were also in the non-clinical criteria on the CORE showing agreement between these measures.

Table III below compares the significant changes of participant’s scores on the CORE and BDI-II from assessment to session 10.
Table III: A comparison of changes on the CORE and the BDI-II from assessment to session 10

<table>
<thead>
<tr>
<th>Changes on the BDI-II</th>
<th>Change</th>
<th>No change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Change on the CORE</td>
<td>38</td>
<td>0</td>
</tr>
<tr>
<td>No change on the CORE</td>
<td>16</td>
<td>2</td>
</tr>
</tbody>
</table>

The results on the CORE correspond to the BDI-II showing that 38 participants who changed criteria on the CORE also changed levels on the BDI-II. Most participants changed on the BDI-II from the moderate to minimal level whilst also changing on the CORE from the clinical to non-clinical criteria. In addition, 2 participants who did not change from the severe level of depression on the BDI-II also did not change on the CORE from the clinical criteria with their scores becoming higher on both measures.

Examples of significant changes on the BDI-II which did not correspond to those on the CORE included: 1) 6 participants who changed on the BDI-II from the moderate to mild level of depression and 1 participant who changed from the severe to mild level. These participants remained in the clinical criteria on the CORE. Their CORE scores did however reduce showing agreement with their scores on the BDI-II. 2) 2 participants who changed on the BDI-II from the moderate to severe level remained on the CORE in the clinical criteria. However, their CORE scores did increase showing agreement with their BDI-II scores. 3) 2 participants who changed on the BDI-II from the mild to minimal level remained on the CORE in the non-clinical criteria.

Table IV below compares the significant changes of participant’s scores from session 10 to follow-up.
Table IV: A comparison of changes on the CORE and the BDI-II from assessment to follow-up

<table>
<thead>
<tr>
<th>Change on the CORE</th>
<th>Changes on the BDI-II</th>
<th>No Change</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>16</td>
<td>3</td>
</tr>
<tr>
<td>No Change on the CORE</td>
<td>2</td>
<td>35</td>
</tr>
</tbody>
</table>

The results on the CORE corresponded with the BDI-II showing 35 participants who did not significantly change on the CORE or the BDI-II. Most of these participants had maintained improvement in the minimal level of depression on the BDI-II and the non-clinical criteria on the CORE. 14 out of the 16 participants that changed on the BDI-II and CORE improved from the mild to the minimal level on the BDI-II and the clinical to non-clinical criteria on the CORE.

Examples of significant changes where agreement was not found between the CORE and BDI-II included. 1) 2 participants who changed on the BDI-II from the severe to moderate level at session 10 and then back to the severe level at follow-up. No change is seen on the CORE for these participants who remained in the clinical criteria. 2) 3 participants who did not change on the BDI-II remaining in the minimal level of depression changed on the CORE from the clinical to non-clinical criteria where their scores had reduced enough at follow-up to cross this boundary.

In summary the above results reveal that the CORE shows considerable agreement with the BDI-II in regards to significant changes made by participants. However, as the CORE only has two criteria “clinical” and “non-clinical” as opposed to the BDI-II that has four, it appears not to be as sensitive in showing individual’s significant changes. This is particularly seen in these results between assessment and session 10.
An evaluation of the compatibility of the CORE’s results with the 3-Phase model

This section presents the findings from the causal analysis. Table V presents the results from the cross-tabulations between well-being and symptoms over the six times participants were measured.

<table>
<thead>
<tr>
<th>Occurrence of wellbeing improvement in indicated session</th>
<th>Occurrence of symptom improvement</th>
</tr>
</thead>
<tbody>
<tr>
<td>(assessment to) Session 1</td>
<td>NO</td>
</tr>
<tr>
<td>NO</td>
<td>35</td>
</tr>
<tr>
<td>YES</td>
<td>13</td>
</tr>
<tr>
<td>Session 4 NO</td>
<td>36</td>
</tr>
<tr>
<td>YES</td>
<td>4</td>
</tr>
<tr>
<td>Session 7 NO</td>
<td>39</td>
</tr>
<tr>
<td>YES</td>
<td>1</td>
</tr>
<tr>
<td>Session 10 NO</td>
<td>32</td>
</tr>
<tr>
<td>YES</td>
<td>12</td>
</tr>
<tr>
<td>8 week Follow up NO</td>
<td>34</td>
</tr>
<tr>
<td>YES</td>
<td>5</td>
</tr>
</tbody>
</table>
Figure 3 below presents the improvements made in well-being and symptoms. The grey bars show improvement in well-being and white bars improvement in symptoms. The black part of the bars presents the number of participants that improved in both well-being and symptoms. The reader is reminded of the predictions of the 3-Phase model that an improvement in well-being precedes an improvement in symptoms. Figure 3 can aid the assessment of this prediction as the reader can see the pattern of improvements made in well-being compared to symptoms.

**Figure 3: Well-being and symptom improvement from time 1 to 6**

Session 1: The results of the relationship between symptoms and well-being at session 1 were significant (Fisher’s exact test (N 56), p < 0.002). Figure 3 shows well-being improved before symptoms. Symptoms improved with well-being for all participants except one.
Session 4: The results were significant (Fisher’s exact test (N 56), p < 0.001). Figure 3 shows well-being and symptoms improved at similar rates. Most participants (11) who improved in well-being also improved in symptoms. Five participants improved in symptoms only. The increase in symptom improvement follows a large improvement in well-being in session 1.

Session 7: The results were significant (Fisher’s exact test (N 56), p < 0.004). Figure 3 shows a large improvement in symptoms. Ten participants improved in symptoms only. The increase in symptom improvement follows a large improvement in well-being in sessions 1 and 4.

Session 10: The results were significant (Fisher’s exact test (N 56), p < 0.001). Figure 3 shows a large improvement in well-being. Symptoms improved with well-being for all participants except one. Many participants, as in session 1, improve in well-being only.

Follow up: The results were significant ($\chi^2$ (1, N = 56) p < 0.003). Figure 3 shows most participants (9) improved in well-being and symptoms together. The increase in symptom improvement follows a large improvement in well-being in session 10.
Table VI presents the results of the cross-tabulations between symptoms and functioning over the six times participants were measured.

**Table VI: Symptom and functioning improvement from time 1 (assessment) to time 6 (follow up)**

<table>
<thead>
<tr>
<th>Occurrence of symptom improvement in indicated session</th>
<th>Occurrence of functioning improvement</th>
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</thead>
<tbody>
<tr>
<td>(assessment to)</td>
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<td>NO</td>
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<td>4</td>
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<td>39</td>
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<td>YES</td>
<td>6</td>
</tr>
<tr>
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<td>NO</td>
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<tr>
<td>YES</td>
<td>5</td>
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<td>8 week follow up</td>
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<td>NO</td>
<td>34</td>
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<tr>
<td>YES</td>
<td>7</td>
</tr>
</tbody>
</table>

243
Figure 4 below presents the improvements made in symptoms and functioning. The white bars show improvement in symptoms and the grey bars show improvement in functioning. The black part of the bars presents the number of participants that improved in both symptoms and functioning. The reader is reminded of the predictions of the 3-Phase model that an improvement in symptoms precedes an improvement in functioning. Figure 4 can aid the assessment of this prediction as the reader can see the pattern of improvements made in symptoms compared to functioning.

Figure 4 shows symptoms and functioning improvement from time 1 to 6

Session 1: The results of the relationship between symptoms and functioning at session 1 were significant (Fisher’s exact test (N 56), p < 0.003). Figure 4 shows symptoms improved before functioning. Functioning improved with symptoms for four participants. Two participants improved in functioning only.
Session 4: The results were significant (Fisher's exact test (N 56), $p < 0.001$). Figure 4 shows a large improvement in symptoms alone. Functioning improved with symptoms for nine participants. Two participants improved in functioning only.

Session 7: The results were significant (Fisher's exact test (N 56) $p < 0.001$). The findings were similar to those found previously in session 4. Functioning improved with symptoms for nine participants. Two participants improved in functioning only.

Session 10: The results were not significant ($\chi^2 (1, N = 56) p < 0.17$). Figure 4 shows functioning improved for twenty-three participants with sixteen improving in this alone. The large increase in functioning improvement is preceded by a large increase in symptom improvement in sessions 4 and 7.

Follow up: The results were significant ($\chi^2 (1, N = 56) p < 0.001$). The findings showed that most participants (10) improved in symptoms and functioning together.
Discussion

Convergent validity results

Convergent validity was supported by significant correlations between the CORE and the BDI-II in the context of a CBT group for depression. Significant correlations were found between the BDI-II and the total CORE score over the six times measured (the mean correlation over the six times measured as shown in Table I was $r = .69$). Significant correlations were found for the well-being ($r = .65$) and functioning ($r = .71$) domains over time. Correlations between the BDI-II and symptoms domain were found to be lower than those above ($r = .46$) over time. This result was significant at $p < .001$, (except when measured at time 1 ($p=.10$) and 6 ($p=.04$)). In regards to the symptoms domain a significant and higher correlation between the BDI-II and the CORE's items measuring "symptoms of depression" was found ($r = .56$). This indicated that the CORE has admissible convergent validity with the specific area of "symptoms of depression" as measured by the BDI-II. The lowest correlation was found between the BDI-II and the risk/harm domain ($r = .44$) over time.

The results from this study generally supported those of the CORE systems group (1998) adding evidence for the good convergent validity between the CORE and the BDI-II. However, there were some differences. The CORE systems group reported even higher correlations for the well-being and functioning domains than were found in this study (see Table I), although, both studies similarly found that the well-being and functioning domains were the most highly correlated with the BDI-II. Another difference between the two studies was that the CORE systems group found a much higher correlation between the BDI-II and symptoms domain than was found in this study. More confidence can be placed
in the results of this study which had fifty six participants as opposed to the CORE systems group which only had twenty nine. The results of this study were highly significant since all correlations for the domains over time had a \( p < .001 \) (except four, of which three had \( p < .05 \)). The CORE systems group only used a significance value of \( p < .05 \) which means a type one error is more likely to be found for their results than this study’s results. Given this study’s findings it can be argued that the high correlations reported by the CORE systems group for the above domains may not always be found when tested. Finally, a similarity between the studies was that both found the risk/harm domain to have the lowest correlation with the BDI-II.

The ANOVA and MANOVA results on the BDI-II and CORE found that participants’ change over the six times measured was very clear and significant. Figure 1 shows that both measures followed a similar pattern of change in participants’ scores over the six times measured. This supports the correlation results which found good convergent validity. The CORE and the BDI-II both showed participants’ scores remaining more constant between time three (session four) to time four (session seven). This was also supported by the MANOVA results on the functioning domain where participants’ scores were more constant. Well-being scores can be seen as raised. For the symptoms domain, in contrast to the BDI-II, participants’ scores continued to improve between time three to four. The CORE items measuring symptoms of depression followed a similar pattern of change in participants’ scores as the BDI-II and this supports the higher correlation found in comparison to the symptoms domain. Finally, a different pattern of change was found between the BDI-II and risk/harm domain which supports the low correlation results found between these.
A comparison of the questions on the CORE and BDI-II can help explain why higher correlations were found for the well-being and functioning domains than the symptoms and risk/harm domains. Three of the four questions (75%) in the well-being domain are similar to those in the BDI-II. These relate to: self-esteem (CORE 4, BDI-II 7, 14), crying (CORE 14, BDI-II 10), and optimism/pessimism (CORE 31, BDI-II 2). This helps explain the good convergent validity found for this domain.

Six of the twelve questions (50%) in the symptoms domain are similar to those in the BDI-II. These relate to: tension/anxiety (CORE 2, BDI-II 11), sleeplessness (CORE 18, BDI-II 16) energy (CORE 5, BDI-II 15), hopelessness (CORE 23, BDI-II 2), sadness (CORE 27, BDI-II 1) and, self-blame (CORE 30, BDI-II 8). The latter four comprise the symptoms of depression items which would account for the higher correlations found for them. The symptoms domain, in contrast to the BDI-II, includes items on physical pain, panic, and trauma which would account for the lower correlations found.

Only one of twelve questions (8%) in the functioning domain is similar to that in the BDI-II. This is related to irritability (CORE 29, BDI-II 17). The lack of similarity in the items between the BDI-II and functioning domain appears in contrast to the good convergent validity found. However, many questions are related, although less directly, to those on the BDI-II (e.g. "I have been happy with the things I have done" (CORE 12) is related to (BDI-II 4, 12, and 14) focused on loss of pleasure, interest and self-worth. "Feeling criticised by other people" (CORE 25) is related to self-criticism (BDI-II 8), and "feeling humiliated and shamed by other people" (CORE 33) may be related to self-guilt, self-dislike, feelings of failure and low self-worth (BDI-II 5, 7, 3 and 14) ). This relationship
between concepts on the BDI-II and the functioning domain may account for the good convergent validity found.

One of the six questions (17%) in the risk/harm domain is similar to that in the BDI-II. This related to suicidal thoughts (CORE 24, BDI-II 9). The risk domain also includes questions on suicidal plans (16), deliberate self-harm (9, 34) and harm to others (6, 22). Since the BDI-II only includes one question on risk/harm it is understandable that a low correlation was found.

Results on the compatibility of the CORE with the 3-phase model.

This study found some support for the compatibility of the CORE with the 3-Phase model. A sequential pattern of improvement in well-being first, followed by an improvement in symptoms and then in functioning was generally found. A large improvement in well-being is found from the assessment to session one. From session one to session four there is a large improvement in symptoms and from session seven to session ten there is a large improvement in functioning. However, in contrast to Howard et al's (1993) findings, the results did not clearly show that an improvement in any one domain was "a probabilistic necessary condition" for improvement in another. Many participants appeared to improve in symptoms alone and functioning alone. For example, in session seven (Fig. 3) the results showed that many participants improved in symptoms alone with only few participants improving in both symptoms and well-being together and, in session ten (Fig. 4) most participants improved in functioning alone with few improving in both functioning and symptoms together. Accounting for this could be that an increased improvement in well-being preceded an increased improvement in symptoms when next measured. For example, well-being improvement increased at session one and four (Fig. 3) followed by an
increased improvement in symptoms in session seven. In addition, well-being improvement increased in session ten followed by a increased improvement in symptoms in the follow-up. Also an increased improvement in symptoms preceded an increased improvement in functioning when next measured. For example, symptom improvement increased in sessions four and seven (Fig. 4) followed by an increased improvement in functioning in session ten.

However, it must be stressed that the above is only a tentative hypothesis of how one domain may be impacting on another. There are contradictions and exceptions to this sequential pattern and it is important not only to look at the impact that well-being improvement may have on symptoms improvement or the impact that symptoms improvement may have on functioning improvement but to also look at this relationship the other way round. For example improvement in symptoms in session four and seven (Fig. 3) could be argued as preceding an improvement in well-being in session ten and, improvement in functioning in session ten (Fig. 4) could be argued as preceding an improvement in symptoms in the follow-up.

Possible reasons for the differences between the findings of this study and Howard et al's (1993) are as follows. Howard et al's measures were very different to the CORE. Well-being was measured by two multiple choice items which were, "how well do you feel emotionally and psychologically", and "how upset or distressed have you been feeling" (1993, p. 680). A correlation of .79 was reported between these two items and Dupuy's (1977) General Well-being Scale (GWS). Verma et al. (1983) reported satisfactory reliability and validity for the GWS although it was not validated against their measure. Edwards (1978) stated that the GWS was not adequate to allow for reliable assessment of
individual change over time and it has never been validated against another measure of well-being (Fazio, 1977; Pimley, 1990). Symptoms were assessed by using forty seven items selected from the Symptom Distress Check List (SCL-90-R (Derogatis, 1977)). The reliability and validity of the SCL-90-R has been widely supported (Buckelew et al., 1988; Davison et al., 1997; Derogatis and Savitz, 1999; Franke and Staecker, 1995). Finally, functioning was assessed by the development of a twenty three item inventory. The reliability and validity of this inventory was not assessed. The above suggests that the well-being and functioning measures used by Howard et al. (1993) may not have been robust enough to test the hypothesis regarding the 3-Phase model.

This study measured participants at mostly similar intervals whereas Howard et al. (1993) measured participants at three unequal intervals (i.e. session two, four and seventeen). The large gap between session four and seventeen does not allow for a consistent pattern to be seen in the sequence of changes made in the domains from session to session. This lack of consistency of findings prevents any clear conclusions to be drawn about the 3-Phase model.

Only three participants dropped out of this study whereas many participants were eliminated or dropped-out of Howard et al's (1993) study. Participants who scored near the ceiling on a particular measure were eliminated from that measure. Participants who were also at the extreme ends of a measure with either a very high or low score were thought to be highly unlikely to change and were eliminated from the analysis on that measure. This resulted in 24% of participants being eliminated from the analysis on a particular measure. Eliminating participants at the start of analysis to maximise the amount of improvement that can be made is likely to have had a large impact on the differences
found in the two studies. In addition, a further drop-out rate of one hundred and forty eight to fifty four in the Chi-square tests for well-being and symptoms and one hundred and forty one to fifty in the Chi-square tests for symptoms and functioning is reported. Howard et al. (1993) do not account for this. Many of these participants may have dropped out because they were not changing with Howard et al's results not reporting this.

The participants differed between the two studies with Howard et al. (1993) including voluntary participants with 52% aged between twenty five to thirty five years treated for a variety of psychological disorders from mild to moderate. 90% had further educational training. The participants paid to receive private treatment from one of eighty six psychotherapists where the treatment varied from CBT to a more psychodynamic approach. The length of treatment was also not limited to ten sessions as with this study. The intervals between sessions is not reported by Howard et al and may not have been weekly. The differences in participants used may account for why the two studies differ in their findings. For example, Howard et al's much younger sample with a range of mild to moderate problems, in comparison to this study's participants with moderate to severe depression, may have accounted for their findings of quicker improvements and more clear cut changes in domains. That is, many of Howard et al's participants may have had more short-term and less entrenched problems such as anxiety which usually follows a clearer recovery process than depression.

The criterion for improvement from one time of measurement to the next also differed between the two studies. Howard et al. (1993) measured improvement by the client increasing, within a domain, 0.5 of a standard deviation or more - relative to the client population that they had in their study. However, they do not justify why an improvement
of 0.5 of a standard deviation was used as a measure of clinical improvement. Given that the measure and population used in this study was very different to Howard et al's, a straight comparison of number of improvements was not possible and not necessary since this study's aim was to explore the sequential pattern of improvements made and not purely the number of improvements. Therefore, this study chose a more absolute approach than Howard et al, which was concerned with measuring clinically significant improvement. Each movement on the Likert scale of one point within a domain, according to the CORE systems group (1998), represents a significant clinical change. Therefore a movement of one point down on an item within a domain indicates that a significant improvement has been made within that domain. This criterion for improvement is also much easier for clinicians to use in their practice.

The following is an example from this study of how the CORE produced useful information that could not be obtained from the BDI-II. ANOVA results on the BDI-II between session four to seven found clients' scores remaining more constant, indicating little improvement in symptoms of depression. However, MANOVA results on the CORE gave more information revealing that symptoms were still improving but improvement in well-being had declined along with only a small improvement in functioning. The large improvement in well-being at session one, which could be associated with increased hope at starting treatment (as explained in the remoralization phase), appeared to decrease by the middle of the group. With this information the clinician can review their programme to understand what may be causing this and ensure that improvement in well-being is maintained. For example, the clinician could question if the assignments were becoming too hard or if the morale in the group had fallen. The programme in this study showed that between session four to seven there was intensive work towards cognitive re-structuring.
Perhaps the participants’ experience of changing their way of thinking may have caused them to feel unsettled. This may account for a decline in their sense of well-being as well as a lack of improvement in their functioning while coping with these changes. A rapid rise in well-being is made at session ten which could be due to session nine having focused on participants’ achievements and positive changes.

As this study did not find a clear pattern of improvement from well-being to symptoms and then functioning, treatment can not confidently be based upon these findings. Further research is needed to examine if the CORE could be used in order to tailor treatment to the particular stage of change of most group members at a given time and if their treatment is improved by doing this. This study’s results indicated that the CBT group treatment was effective with clients’ scores reducing throughout the group. Improvement in all domains also continued after the end of the sessions. This appears in line with some studies on CBT groups such as Ball et al. (2000) but not with others such as Free (1999). More research could explore the differences between these groups to discover what facilitates a continued improvement. Given Yalom’s (1995), Ohlsen et al’s (1988) and Beck et al’s (1979) belief that group dynamics are likely to increase improvement in interpersonal relationships and social functioning it may be that the improvements in scores on the functioning domain in this study were due to the clients being in group therapy as opposed to individual therapy. A greater improvement in functioning was not found in relation to the other domains. As Howard et al. (1993) focused on individual therapy and not group therapy this is likely to have caused differences in the results of the two studies. One difference that was seen was in the functioning scores. This study in comparison to Howard et al’s (1993) found functioning improved more quickly. As there were many differences between the two studies other variables may have impacted on this. More research is therefore needed to
establish if clients' improvement in functioning does increase at a greater rate and/or more quickly for individuals in group therapy as opposed to individual therapy. Yalom (1995) hypothesised that symptoms eminated from disturbed interpersonal relationships. He therefore believed that developing a variety of distortion free, gratifying interpersonal relationships with group members would have a large impact in the reduction of symptoms. This is an area that could also be explored.

**Criticisms of this study**

A standard way of evaluating the convergent validity between the CORE and the BDI-II where the researcher would normally only measure a group of participants at one time only was not used in this study. Participants were measured over six times because this allowed for an evaluation of whether similar correlations were likely to be found between the CORE and BDI-II at different testing times. Important information was gained from doing this. For example, had the participants been measured at time one (the assessment) only the correlation results between the BDI-II and symptoms domain would reveal \((56), r = .22, p = .10\). However very different results are found when comparing this with the findings at time five \((56), r = .63, p < .001\) and with the means across the six times of measurement which found \(r = .46\). Being able to compare the results of six measurements over time on the domains also allowed for a more confident argument to be made concerning whether the high correlations found by the CORE systems group are typical results that one would find. Another criticism is that although the sample used in this study is considerably larger than that of the CORE systems group (1998) it still could be argued as being too small to place enough confidence in the results on convergent validity.
Causal analysis is concerned with establishing quantitative measures of causal connection between variables. It does not prove that one variable causes another. When a theoretical model is shown to have a "good fit" with the data, any acceptance of that causal relationship must be tentative (Birnbaum, 1981). This is because there is no guarantee that the relation will be supported by further experience. There are many dangers of inferring causality. For example, there can be a failure to pay attention to potential unmeasured causes and the many variables not accounted for, bias in order to support a theory, and a failure to entertain the possibility of alternative models for the same data. Causality is still a controversial topic in psychology causing much debate because of the epistemological differences that exist (For an in-depth discussion of this debate see James et al., 1983).

This study used the same method of causal analysis as Howard et al. (1993) in order that comparisons of the sequential relationships between well-being and symptoms, and symptoms and functioning could be made. However, this method did not take into account the relationship between well-being and functioning which may have revealed important information. The criteria for improvement did not take into account that some participants may have improved greatly (i.e. improved their score from 0 to 4) whereas others may have only moved one place (0 to 1). Further analysis regarding this may have revealed useful information about the types of improvements made on the domains. Measuring change from time one to two, two to three and so on does not take into account the change that has occurred previously. Therefore this research has only tentatively been able to suggest that previous improvement in a domain may be impacting on later improvement on another domain. Variables, other than treatment, could be impacting on the sequential pattern found. For example, a participant may have had a change at work, in a close relationship or in their medication. However, the causal analysis only considered the impact that one domain had on another as the cause of change. Results may also have been
effected by clients being given the same measures repeatedly and at relatively short intervals, for example practice and fatigue effects are likely by time six.

Howard et al. (1993) stated that clients may enter therapy at different phases. Participants in the second or third phases, related to symptoms and functioning, may have confounded results by showing changes according to these phases and not in well-being. This could be argued as the reason for the results not showing a much clearer sequence of changes as predicted in the 3-Phase model. A ceiling effect on any domain may confound results since participants who begin with the maximum score can show no further change. No participants were eliminated from this study due to ceiling scores because the study aimed to assess the "usefulness" of the CORE for clinicians in their everyday practice. The findings that the CORE produced are therefore likely to be similar to those found by clinicians running standard CBT therapy groups for depression. Participants entered the group suffering with moderate to severe depression with the data from nearly all the assessments showing Likert scores on the domains as being very low. A ceiling effect was also not evident in the data since participants' scores showed a consistent improvement over the six times measured with occasional large peaks in improvement in a domain throughout the group.

A further criticism is that this study used data that had already been collected. The researcher had no opportunity to put into place standardised procedures for all participants in order to eliminate confounding variables. However, it is important to stress that the group leaders followed the same assessment schedule with all participants and gave them the questionnaires in different orders with the same basic instruction to "complete them". The five participants who missed a group and therefore completed the questionnaires a
week later may have also confounded results given the different time factors and that they missed a session.

No control group was used for comparison with the experimental group. This could have given useful information about changes that may occur in well-being, symptoms and functioning with participants not in therapy. Another criticism is that the sample was too small to place enough confidence in the results on the compatibility of the CORE with the 3-phase model especially given the high rate of participants that did not improve at any one time of measurement to the next. Given the small number of participants and the fact that they were from one psychology department it is likely that they were not fully representative of the general population. However, they are still likely to be a typical sample of clients suffering with depression that is found within this regional service which covers several towns. There is a need to evaluate the compatibility of the CORE with the 3-phase model on different client groups where further research should take into account the above limitations and issues raised from this study.

Criticisms of the CORE as a single battery measure

The requirements of clinical governance for evidence-based practice led to the quest for a single measure and hence the CORE (CORE group, 1998; DoH, 1996; NHSE, 1996). However, there has been a growing awareness of the limitations of such measures which will be briefly addressed. One criticism is that participants may give socially acceptable answers or answers that they feel will please the therapist. This may have been a problem confounding this study. Young and Heller (2000) stated that the reduction of symptoms is often viewed as a necessary requirement for a "cure". They argued that self-report measures are likely to be seriously distorted if both the therapist and client have a vested
interest in demonstrating that symptoms have been reduced and improvement has been made: the therapist perhaps under pressure to demonstrate their clinical effectiveness due to the requirements of clinical governance and the client perhaps for transferential reasons. Grayson (1997) also argued that single battery measures do not take into account individual differences. He stated that single measures wrongly present an ideal reality where every client can fit into the same heading of "mental illness" and therefore be easily and quickly measured in the same way. Pimley (1990) stated that the main criticism of single measures is that they are too broad and therefore much of the detail and complexity of clients' specific mental health problems is lost. Shapiro (1964) stressed that battery measures do not help to facilitate a rapport with the client and many items on a battery measure do not apply to the individual; this can possibly make them feel alienated and believe that their specific problem is not understood. It can also be argued that the CORE is not sensitive enough to measure the more subtle changes in a client that mental health professionals such as counselling psychologists have helped them to work upon. For example the CORE cannot measure the establishment of a strong therapeutic relationship essential for future personal development and growth or subtle changes in personality.

Advantages of the CORE as a single battery measures

One reason why the CORE was developed was due to the staggering number of separate measures on the market (some without any reported reliability and validity) causing fragmented differences across the NHS service in treatment evaluation (Froyd et al., 1996). The aim of the CORE was to provide one standardised measure which was current and accessible to all professionals. This meant that it could allow for inter-service discussions where comparisons regarding different treatments for a client group could be made, leading to an increase in their effectiveness. Evans et al. (2000) stressed that, congruent
with clinical governance, "Practice Research Networks" are an ideal setting for such discussions. These could include meetings for professionals running CBT groups for depression who could use CORE data as a tool to provide feedback from their different programmes which can be subject to peer review. In this way practice based evidence can be used and developed.

The CORE offers GPs easy, understandable data to check that the therapeutic work psychologists are doing is effective. This is crucial given the importance of primary care groups (PCGs) where GPs with significant funds will require feedback on the effectiveness of psychological services. The CORE's use in providing data on evidence based practice can be seen as offering psychologists an advantage since it meets the demand for transparency and accountability as well as offering a way to harness resources for research activity, and for access to dissemination to promote psychological services and de-mystify the process and outcomes of psychotherapy to service users, GPs and other health professionals (Reynolds, 2000). The CORE also allows for flexibility with Evans et al. (2000) stating that it has been designed to be a "core" to be supplemented with other measures as appropriate to the service. Therapists can therefore have both the CORE's benefits of allowing cross communication among mental health services and other professionals such as GPs as well as flexibility where other measures can be used that offer more specific information that they may need within their practice.

Further development of the CORE

Pimley (1990) suggested how psychiatric measures, such as the CORE, could be improved to provide more in-depth information on the individual and take into account the complexity of mental illness. He explained that such measures assign an equal weight to
each symptom but this is misleading since symptoms vary greatly in the degree to which they are experienced in the population. From analysis of clients' scores on screening scales, he discovered that items most rarely reported were among the most severe, frightening and painful. These were described as symptoms of chronic depression. Items most commonly reported were those most people experience from time to time and were thought of as "stress" or having a "bad day". He argued that assigning all items equal weight does not take into account that they are distributed differently and have different meanings to the sufferer. Two people may score the same total score but one person may have several severe symptoms and the other several common symptoms and this information is lost. This becomes more of an issue on scales such as the CORE that have a cut-off point to categorise people as suffering from psychological distress or not, particularly for those that fall close to the border.

One option requiring further research would be to devise a system of weights for each item on the CORE where symptoms which are more extreme would receive a greater weight, while less extreme symptoms would receive a lower weight. This would also make maximum use of all data available for the clinician. This research would benefit from involving psychologists and other mental health professionals who could give their viewpoint as to a system of weights for the items. This would be useful given the wide opportunity that they have had to see how particular symptoms or problems within the domains affect the quality of individual's lives. This kind of approach is supported by work done in the 1960s using conditional probability models (Haese and Meile, 1967; Overall and Gorham, 1963; Smith, 1966) which gave weights to symptoms based on the likelihood that they were experienced by patients.
Conclusion

Good convergent validity was found between the CORE and the BDI-II within the context of a CBT group for depression. This adds support to the findings of the CORE systems group (1998). Both studies also found the correlations between the BDI-II and risk/harm domain were low. This is understandable given that the CORE has six questions addressing harm to self and others, whereas the BDI-II only has one question addressing suicide. This study found a much lower correlation between the BDI-II and symptoms domain than the CORE systems group. More confidence can be placed in the results of this study as a larger sample was used with a much stronger significance found of p < .001. A higher correlation was found between the BDI-II and the CORE's items on symptoms of depression than between the BDI-II and symptoms domain, which is important given that the BDI-II specifically measures this. ANOVA and MANOVA results found that both measures showed a similar pattern of change in participants’ scores. These results appeared to be compatible with the correlation results found between the BDI-II and the CORE’s domains. A comparison of questions on the BDI-II and CORE showed that the domains found to be more compatible with the BDI-II also shared similar concepts.

This study offers some support for the CORE systems group’s (1998) belief about the compatibility of the CORE with the 3-Phase model. A sequence of improvement in well-being first, followed by symptoms and then functioning was generally found. However, this study, in contrast to Howard et al's (1996) findings, did not support that an improvement in one domain was a "necessary probabilistic condition" for improvement in another. Any inferences made about the causal relationship between the domains must be tentative and treated with caution. Further research still needs to be done to establish the compatibility
of the CORE with the 3-Phase model. This study has aimed to show that the CORE can be a useful tool for assessment of clients within a group context. Clinicians could potentially use it to improve their treatment programmes and detect clients who may need specific help to change in a particular domain. Finally, one way of improving the CORE so that it can provide more in-depth information on an individual's specific problem is by devising a system of weights for each item. In order to do this the role of psychologists and other mental health professionals in its development and evaluation would be crucial.
References


Appendix

I Letter to respondents

II CORE measure

III BDI-II measure

IV Overview of course content

V Ethical approval
June 2000

Appendix I

Dear

We have received a referral on your behalf from your GP, Dr , from which it appears that cognitive therapy might be the most appropriate form of help for you. We will be running a Cognitive Therapy Group at from and if you would like to discuss this I can offer you an assessment appointment on in the Psychology Department at . I enclose some details about the course. The alternative would be to remain on the waiting list for individual therapy for which there may be a wait of several months.

In order to gather some background information that could help me understand your difficulties, I enclose a questionnaire. If you are willing to answer all or some of the questions please do so and bring it with you to your appointment.

Please confirm if you wish to attend this appointment by . You can telephone the Psychology Secretary on ext between the hours of 9.00 am and 5.00 pm on weekdays or leave a message on our ansaphone at anytime.

Yours sincerely

Counselling Psychologist

cc
Appendix IV

Overview of course content

Session 1  (Repeat tests, BDI-II & CORE), introductions, name game, getting to know each other, hopes & fears, ground rules, the cognitive model (with examples), activity scheduling, establishing diaries.

Session 2  Check names, go over ground rules, review of assignments (make behaviour-feelings links), theories of depression & approaches to treatment, own experiences of depression, naming of feelings, diary monitoring of situation & mood.

Session 3  Review of assignments, linking thoughts to feelings & behaviour, identifying automatic thoughts, forms of twisted thinking, diary monitoring of automatic thoughts.

Session 4  (Repeat tests, BDI-II & CORE), review of assignments, challenging automatic thoughts (cognitive re-structuring / ways of untwisting thinking), support networks & activity scheduling.

Session 5  Review of assignments, chains of association to core beliefs, vertical arrow technique to elicit core beliefs, guided visualisation.

Session 6  Review of assignments, continuing vertical arrow technique, organising beliefs through cognitive maps, perceptual shifting.

Session 7  (Repeat tests, BDI-II & CORE), review of assignments, beliefs can be changed, identifying unhelpful (maladaptive) beliefs, testing through experiment.

Session 8  Review of assignments, further testing of unhelpful beliefs. Development of counters.


Session 10 (Repeat tests, BDI-II & CORE), follow-up arrangements, review of personal achievements & future goals, dealing with setbacks, reflections on course, ending.
Dear Ms French

An evaluation of the usefulness of the CORE outcome battery, in comparison to the BDI-II, for monitoring improvement of clients in a cognitive behavioural therapy (CBT) group for depression (ACE/2001/02/Psych)

I am writing to inform you that the Advisory Committee on Ethics has considered the above protocol and the subsequent information supplied, and has approved it on the understanding that the Ethics Guidelines are observed.

The letter of approval relates only to the study specified in your research protocol (ACE/2001/02/Psych). The Committee should be notified of any changes to the proposal, any adverse reactions and if the study is terminated earlier than expected (with reasons). I enclose a copy of the Ethics Guidelines for your information.

Date of approval by the Advisory Committee on Ethics: 01 March 2001
Date of expiry of the Advisory Committee on Ethics approval: 28 February 2006

Please inform me when the research has been completed.

Yours sincerely

Catherine Ashbee (Mrs)
Secretary, University Advisory Committee on Ethics

cc: Professor L J King, Chairman, ACE
    Mr R Draghi-Lorenz, Supervisor, Dept of Psychology
Dear Ms Huggett

Thank you for the copy of your letter of 24.10.00. If your study simply involves anonymised data collected for audit purposes and you are not having access to patient names or contacting patients at all there is no need for ethical approval.

Yours sincerely,

Chairman - Research Ethics Committee