PORTFOLIO SUBMITTED AS THE REQUIREMENT
FOR THE DEGREE OF PSYCH.D,
UNIVERSITY OF SURREY 1995

Patricia d'Ardenne BA, MSc, C.Psychol, AFBPsS
ACKNOWLEDGEMENTS

This portfolio was prepared with the support and encouragement of the Mental Health Directorate at the City and Hackney NHS Community Trust. The cooperation of the Ward Manager and his staff were indispensable for the completion of the research project; nurses gave time out of a very busy schedule, and throughout a very difficult period of transition and change in East London. A big thank you to Neil Telfer and Dr Jay Smith.

I am grateful for the support and helpful suggestions from Mr Simon Jakes, Dr Graham Powell and Mr Paul Devonshire, my supervisors, as well as Ms Rebecca Cheatle and Mr John Rowe for their assistance in data collection for the research project. My departmental colleagues have provided me with time and space to study by picking up some of my duties within the department of clinical psychology.

Mrs Tracy Wells has provided unflagging secretarial support, good humour and coffee for the duration, and I am indebted to her for the care and patience she took over this manuscript, although I own all errors of form and content.

Last but not least, my husband, sons and daughters have tolerated a very busy and pressured time, and have offered the loving support and understanding needed to keep the preparation of this portfolio as an achievable and important goal for this year.
PSYCH.D PORTFOLIO

CONTENTS

A. PERSONAL STUDY PROGRAMME ......................................................... 4
   1. Proposal .......................................................................................... 5
   2. Supporting Letters ........................................................................... 13
   3. Professional Development .............................................................. 15

B. ACADEMIC AUDIT
   1. Psychoeducation and its impact on the relatives of patients
      with schizophrenia ........................................................................ 16
   2. Culturally appropriate Mental Health Services for the
      long-term mentally ill ..................................................................... 55
   3. Some characteristics of nurse victims of assault in
      psychiatric hospital settings ......................................................... 91

C. CLINICAL AUDIT

   Developing psychology for a multiracial community
   in inner London .............................................................................. 117

D. RESEARCH AUDIT

   Changing the culture of a locked rehabilitation ward
   in East London - Another stressor for Nurses? ............................ 192

E. MSc, UNIVERSITY OF LEEDS, 1972

   MSc Course Syllabus ....................................................................... 266
   Dissertation - An investigation into the permanence
   of intellectual deterioration in chronic alcoholics
   as measured by the WAIS .............................................................. 268
PERSONAL STUDY PROGRAMME PROPOSAL

Name: PATRICIA D'ARDENN
Date of Registration: 4/10/94
Registration number: 3406806

1. Overall aims and objectives

2. Academic
   2.1 Aims
   2.2 Objectives
   2.3 Rationale
   2.4 Plan

3. Clinical
   3.1 Aims
   3.2 Objectives
   3.3 Rationale
   3.4 Plan

4. Research
   4.1 Aims
   4.2 Objectives
   4.3 Rationale
   4.4 Plan

Signed............................Participant

Signed...........................Head of clinical department (if appropriate)

Signed...........................Course Director

Submitted as part requirement for the Degree of Psych.D, University of Surrey
PROPOSAL

1. OVERALL AIMS AND OBJECTIVES

Prime aim:
To attain greater professional competence in order to enhance the contribution of clinical psychology to health care in the City & East London.

Prime objective:
To produce a portfolio of study, practice and research that will demonstrate increased competence in each of these three areas. A central tenet of competence will be psychological skill for a multiracial community.

2. ACADEMIC

2.1 Aims
To enhance academic competence in three specialist areas of clinical psychology so as to develop the services offered both within the department and across City and Hackney Community Services NHS Trust.

To demonstrate that psychological need can be informed by academic skills.

To encourage new staff to maintain, develop and market their own academic competencies.

To increase knowledge in areas where current information is lacking or is unreliable.

2.2 Objectives
To complete three academic reviews, one for each of the following specialist areas:
* The impact of educational support groups on the relatives of people with schizophrenia.
* Culturally appropriate mental health services for people with long-term illness.
* Some characteristics of nurse victims of assault in locked psychiatric hospital settings.
* To attend continuing professional development training workshops presented by the CPSPDC or by the University of Surrey.
2.3 Rationale

My service and department may not be academically up to date in all contracted areas of work. In my current clinical work, I am challenged by patients with serious and long-standing mental disorder whose needs I currently address through the ward staff, the Locality Mental Health Teams and through their families. We have recently established a relatives' support group on two of the rehabilitation wards; many of the relatives are themselves very isolated and reveal in the groups lack of understanding about serious mental disorder. They have specifically requested educational materials. An academic review will inform our choice of educational content and process and what outcomes we might reasonably expect from such actions.

In the wider area of rehabilitation, patients, Health Purchasers and many local organisations involved in mental health care have asked us to provide more culturally appropriate services for patients from black and ethnic communities. An academic review will help to ascertain which cultural dimensions of healthcare are effective and achievable. Whilst consideration will be given to the needs of diverse ethnic communities in urban settings, the wider meaning of 'cultural' will be addressed.

Lastly, I need academically to inform myself and my service in the area of risk assessment in psychological rehabilitation. The ward staff are regularly exposed to dangerous incidents with their clientele, both in secure and unlocked settings. Of particular relevance is the literature on staff's vulnerability to assault and what inputs might realistically reduce this.

These reviews will provide an authoritative base for the clinical and consultative work of clinical psychology in mental health rehabilitation. It will hopefully identify service needs as described in ELCHA's Public Health documents, in City and Hackney's Mental Health Quality Plan, in Hackney's Community Care Plan, in Hackney MIND's Annual Report, and in our Section 117 Mental Health Act Protocol.

The academic reviews will in part inform us about:

1. How education affects relatives' perceptions of mental illness. A critical review of the literature will examine different models of education, particularly didactic vs
participatory, and what evidence effect on relatives’ understanding and positive attitude towards serious mental illness.

2. The psychological requirements for culturally appropriate mental health care. A critical review will examine both the broad and narrow meanings of ‘cultural’ and investigate any evidence that shows that such attention to care is more or less likely to produce better outcome in psychological and psychiatric rehabilitation.

3. The vulnerability of nursing staff working in locked psychiatric settings. A critical review will address in particular the difference between what maintains and what reduces risk.

2.4 Plan
A review of how education affects relatives’ attitude towards mental illness to be completed by December 1994.
A review of user’s requirements for culturally appropriate mental health services by Easter 1995.
A review of psychiatric nurse victims of assault in a secure inpatient setting by July 1995.
Attendance at CPCPC workshops on Transcultural Psychiatry UK Workshop, October 1994.
Attendance at University of Surrey Workshops. Topics to be decided.
TAPS July 1995, Conference.
Special Interest Group in Rehabilitation Conference, November 1994.
Submission of Reviews for publication.

3. CLINICAL

3.1 Aims
To increase personal professional competence and to develop the services offered by clinical psychology in Hackney.

To present the development and implementation of a strategic plan for better servicing the needs of a multiracial society in Hackney, based on established good practice and expressed need.
3.2 Objectives

To examine the literature for successful and appropriate models of psychological care in a multiracial setting.

To present an account of how a plan for a clinical psychology service was developed historically with written accounts of unmet psychological needs in Hackney.

To describe how a template was devised on the basis of national requirements and post Tomlinson Strategy for health care in inner London, how this was implemented, and how progress has been achieved.

To provide the results of service audit and devise future measures that would meet Purchasers', Users' and postholders' requirements.

To make recommendations for clinical psychologists' training and continuing professional development to the British Psychological Society, based on our findings.

3.3 Rationale

There have been historical difficulties in recruiting and developing psychological services in City & Hackney. Dr John Hall from the Department of Health was approached by this Health Authority in 1991 to redefine service need and recommend a way forward. Applicants were recruited for a new post of Head of Service and were asked to prepare a 'Vision of Psychology for the Barts NHS Group'. This vision served as a blueprint for defining the way in which clinical psychology services could be prioritised, and how recruitment to posts could be achieved. Service developments have been achieved through London Implementation Zone monies, through reprovision monies, through Inner City Partnership and from joint funding with Hackney Social Services. New bids and job descriptions focused on appropriate and accessible services and applicants were specifically recruited with good local knowledge, and explicit skills for working with diverse communities. All of these documents will be included within the portfolio.
3.4 Plan

The service plan for City & Hackney Community Services NHS Trust and Psychology Services has been drafted and the results of our local audits are being assessed and will be included within the portfolio.

All of these developments will be presented at the DCP Third Annual Conference at Warwick, April 1995, as part of a paper entitled, 'The Provision of Clinical Psychology Services within a Multiracial Community'. Specific attention will be paid to the core competencies required for clinicians working with diverse communities, and recommendations made for future training purposes.

4. RESEARCH

4.1 Aims

To increase research based knowledge of the needs of the long-term mentally ill and how they impact on the wellbeing of those who nurse them.

To demonstrate a survey method that is appropriate to those who nurse people with serious mental health problems.

To audit nurses’ occupational stressors as part of a wider clinical audit on a long-stay psychiatric ward.

To ascertain which activities nurses perceive as continuing to or reducing stress. To undertake a qualitative analysis of each subject’s response with particular emphasis on the use of resources within the team and within the Trust.

4.2 Objectives

To select a group of 25 psychiatric nurses employed within an East London Health Trust, currently responsible for the care of 15 patients with serious and enduring mental illness in a locked psychiatric ward. Nurses must have been working on the ward for at least 2 months.
To use this population as their own control and measure personal and occupational stress before and after specific interventions introduced on the ward to make it a more therapeutic culture.

To ascertain whether changing such a culture was itself another stressor for nurses.

### 4.3 Rationale

This study is being carried out as part of an audit of the ward prior to any direct intervention with the ward atmosphere.

The Intervention:

After the initial assessment, a range of independent variables will be introduced to the ward. These will include:

- An audit of patients' mental state, their satisfaction with the ward, their social networks, their quality of life, their levels of and types of medication and the degree of support they get from relatives and friends.

This audit will also take into account environmental factors on the ward and other staff indices and will continue as part of an ongoing programme of upgrading the ward.

The introduction of new staff including the appointment of a permanent consultant psychiatrist and a more stable multidisciplinary team.

A multidisciplinary education programme for all ward staff provided on a rolling basis for all grades of people working on the ward.

The introduction of a weekly staff support group attended by all members of the multidisciplinary clinical team.

The introduction of daily community meetings for both patients and staff of at least 45 minutes' duration.
The introduction of a leisure project aimed at enabling patients within a locked ward setting to be taken out and provided with access to a range of non-occupational activities within the Borough.

All of these independent variables will be introduced as part of a comprehensive attempt to change the culture of the ward, which has an overall purpose in improving the mental state and quality of life of patients within it. The specific outcome measures of this study include the following:

* Nurse sickness levels
* Nurse absence levels
* Absolute number of violent incidents on the ward
* Staff turnover
* Nurse stress as measured by the Nurse Stress Index (Harris, Hindley & Cooper 1988)
* Occupational stress, occupational health and coping mechanisms as measured by the Occupational Stress Indicator (Cooper, Sloan & Williams 1988)
* Ward Atmosphere (Moos 1990)
* Semi-structured Interview (including a ten point optimism/pessimism scale)

Measure, Reliability and Validity
The first three independent variables will be absolute figures and which are recorded within the ward as part of routine nursing policy. Any reduction in these indices will provide a broad indication as to the improvement of ward culture and have a face validity inasmuch as they are generally recognised by nursing management as being indicators of low morale and stress.

The Nurse Stress Index is a well validated and widely used measure of nursing stress and employs a standard five point Likert-type scale. It has been factor analysed and yields six major factors which can be summarised as managing the work load, managing resources, organisational support and involvement, dealing with patients and relatives, home and work conflict, and confidence and competence in professional role. The Occupational Stress Indicator provides a wider measure of distress within the work situation and also examines coping mechanisms for this.
It has been standardised on a very large number of occupational groups including health authority workers in the UK, North and South, primary health care workers, nurses working with people who have learning disabilities and nurses.

It locates sources of stress intrinsic to the job, in managerial role, in relationships with other people, in career and achievement, in organisation structure and in home/work interface. It looks at general behaviour - attitude to living, style of behaviour and ambition. It looks at events around the subject, at total locus of control, at coping with stress, at job satisfaction and current state of mental and physical health. It is measured by a broader and more detailed picture of overall perceived stress and response to it.

Both the Nurse Stress Index and the Occupational Stress Indicator have proved acceptable to the nursing staff in pilot (with the exception of the biographical questionnaire that proceeded the OSI). This is therefore being omitted and has slightly reduced the validity of our information since major personal variables have been excluded from the ward profile.

The Ward Atmosphere Scale is a well standardised tool used in a large number of psychiatric settings including long-stay rehabilitation wards and it is particularly flexible inasmuch as both patients and staff have been able to use it previously on this ward. The real/actual discrepancy score has been used to provide the study with a possible source of distress to the nursing staff.

Finally, the Semi-structured Interview was carried out by the author because she was known to the nursing staff, having been on the ward for the previous 24 months. The reliability of the study depends on reducing the 'Hawthorn' effect of bringing in new staff to provide measures and promote a sense of 'something being done' that was not previously measured.

4.4 Plan
Consultation with the Multidisciplinary team, October 1994.
Submission to ELCHA Ethics Committee, end of November 1994.
Submission to University of Surrey for approval, November 1994.
Additional literature searches and training in questionnaire administration and scoring,

Re-submission to Surrey for approval, February 1995.

Find field tutor and consult about design, February 1995.

Data collection, 2nd and 3rd weeks of March and 2nd and 3rd weeks of July 1995.

Statistical analyses to be completed by 1st week of August 1995.

Send results to City and East London Public Health Research Library.

Seek publication in appropriate refereed journal, early 1996.
University of Surrey, 
Guildford, 
Surrey, 
GU2 5XH 

22nd November 1994

TO WHOM IT MAY CONCERN

Dear Sir/Madam,

Re: Ms. Patricia d’Ardenne - Psych D Conversion Programme

I am writing in support of the above's application.

The academic, clinical and research content of the course represents an important stage in the applicant's professional development and will be of direct relevance and value to the clinical work that she pursues with the City & Hackney Health Authority.

Yours faithfully,

Peter Allen 
Head of Psychology Service (CELFACS0
Mrs P. d’Ardenne,
Head of Clinical Psychology
Hackney Hospital

16th March 1994

Dear Pat,

Re: Practitioner Doctorate in Clinical Psychology (PsychD)

Thank you for your letter of 14th March 1994 about which we have had a number of discussions.

I am delighted to confirm my support and encouragement for you to further your professional development in this way.

We have discussed both the very real additional time pressures which this course will undoubtedly put you under and the advisability for you to anticipate this adequately. I am pleased to note that you have identified a number of current commitments which you can delegate for the period involved.

I have no doubt that the practice based academic stimulus which this course will prove to you will be of enduring value both to yourself and to the service which you head up.

I have already discussed with Anne Bruton and agreed the principle that service contribute 75% of the course fee with you contributing the other 25%. She will be able to confirm to you which budget code this should be drawn from.

I wish you well on this endeavour.

With kind regards

Yours sincerely

Dr Niall Moore
Divisional Director
Division of Psychiatry

CITY and EAST LONDON
Family and Community Health Services
Hackney Hospital
PROFESSIONAL DEVELOPMENT

1995-1995

Joint workshop provision, 'Towards Better Clinical Psychology Practice in a Multiracial Britain', WHO Conference on Mental Health, Race and Culture in Europe, University of Bristol, April 1994

BPS Special Interest Group in Rehabilitation, day conference, London, October 1994

BAC Annual Conference, gave workshop on racism in counselling, Goldsmiths College, October 1994

Attendance at all Transcultural Psychiatry Society events, 1994/5

Attendance at several continuing Professional Development workshops, University of Surrey, 1194/5

BPS Annual Conference, presentation of Clinical Project, Warwick, March 1995

Attendance at TAPS Conference London, July 1995

Invitation to give six workshops on Psychology for a Post-Apartheid Society, University of Cape Town, and University of Western Cape, South Africa, November 1995

In addition to the above, I have continued as Editor in Chief of Sexual & Marital Therapy, an international multidisciplinary Journal for clinicians, and continue to review psychology texts for a number of refereed Journals, including Behaviour Research and Therapy, and The British Journal of Psychiatry
ACADEMIC REVIEW

Psychoeducation and its impact
on the Relatives of Patients
with Schizophrenia

Submitted as part requirement for the Degree of Psych.D, University of Surrey
CONTENTS

1. The Role of Family in Schizophrenia ................................................. 18
2. The Reluctance of Professional .......................................................... 19
3. Models of Education ........................................................................ 21
4. Psychoeducation ................................................................................ 24
5. Goals of Psychoeducation .................................................................. 25
6. Expressed Emotion ............................................................................ 26
7. Assessing Relatives’ Knowledge Prior to Education ......................... 28
9. Education with Therapy .................................................................... 35
10. Education without Therapy ............................................................... 38
11. Conclusions ....................................................................................... 43
12. References ......................................................................................... 47
Any group of people with enduring psychiatric disability requires not only specific therapeutic interventions but an integrated and coordinated network of services. (Bridges et al 1994). Those patients entering a psychiatric rehabilitation service have come from families who have profoundly influenced their past, and will continue to influence their future, in many instances in an immediate and intimate way (Birley & Hudson 1993). Notwithstanding, the family has in the past been scapegoated as a major contributor to the pathogenesis of schizophrenia, even though the exact nature of this relationship remains essentially unresolved (Bennun and Lucas, 1990). There has been a long association between observed disturbances in family relationships in which one member has been diagnosed as having schizophrenia, and an assumption that these disturbances preceded the illness and contributed to it. It is outside the scope of this review to examine the literature about this, except to remark that there is no adequate evidence to support a causal link. It is, however, true that firstly, discordant family communication is very common in families with schizophrenic members, as it is for all patients with serious and chronic disease, (Farina and Holzberg, 1968; Caputo, 1963) and that secondly, the stress generated within these families because of poor communication and problem-solving aggravates and sustains schizophrenia, (Falloon et al., 1984). It is perhaps small wonder that families still regard their role as stigmatic and have inherited a burden of guilt which remains difficult to shift.

The author is aware of the pros and cons of diagnosing schizophrenia (see Wing, Boyle 1990; Wing 1978a, 1978b, 1991) but uses it to refer to a large central group of conditions, of biological origin, precipitated by stress and shaped by social, cultural and environmental factors.
2. The Reluctance of Professionals

Mental health professionals have often avoided detailed discussions with relatives about the diagnosis, symptoms and prognosis of schizophrenia, (Brown et al., 1966). The most commonly cited reasons given are the lack of diagnostic clarity, the perceived effects of stigmatisation on patient and family, the clinician’s own discomfort with imparting such information, the notion of implicating the family in the illness, the issues around patient confidentiality, and the patient’s disorganised mental status, (Falloon et al., 1984; Woof et al., 1988) make a similar observation and have noted that in the North West Regional Health Authority, that although social workers saw over one third of the patients, they saw just under one fifth of relatives, contact with relatives did not appear to be standard practice. Furthermore, these are records purely of contact, without any analysis of the nature of the contact. The recent changes in social policy in the UK have required families to take increasing responsibility for their relatives, and professionals have moved to ensuring that families be given more information prior to discharge as part of each patient’s individualised care plan (Birchwood and Tarrier, 1994; Tarrier et al., 1988). Much can be achieved even where the patient is in hospital or even where his family have become estranged, or before discharge, (O’Brien and Azrin, 1973; Hollingsworth and Sokol, 1978). Lastly, there has been in the last ten years a general rise in public interest in health, and a greater consumer responsiveness required from health professionals, (Fry, 1984; Tarrier and Barrowclough, 1986).
Barrowclough and Tarrier, (1984), remind us that the current debate concerning the relatives of schizophrenics, is focused on how to use them as a resource, capable of maintaining the patient out of hospital, and that families need to be supported in seeing themselves in this more positive light, rather than as a pathogenic agent.

The common concerns of families need firstly to be addressed, (Bennun and Lucas, 1990) viz the burden of post-discharge care; the witnessing of their relative’s deterioration; the continuous seeking of explanation; the desire to return to the way things used to be; the feelings of anger and betrayal; and last but not least, the relative ignorance about the nature of the illness itself. Abramawitz and Coursey, (1989) also suggest the responsibility relatives have for the patient’s finances, employment (or unemployment), social life and social care, the overall lack of resources for their care of their relative, and of course, lack of information about the illness itself. Newton, (1988), mentions the distressing effect on relatives of not understanding about the side effects of medication, or about the financial assistance that may be available to them, and above all help with their own daily experiences of guilt, anger and stress in caring for an afflicted family member.

All of these authors are keen to stress that the family has needs, including educational support and training, and that if professionals can assume a didactic, supportive and consultative role, that the family can assist in relapse prevention, if not a cure.
3. Models of Education

Before examining the effects of education upon the relatives of those suffering from schizophrenia, it might be useful briefly to examine the more classical models, and ask to what extent our theoretical and practical knowledge about effective education have been applied to this area of clinical concern.

Educational models may be represented along two bipolar dimensions; firstly, those based on objectives or skills acquisition (Skilbeck, 1977) vs those based on processes, including experiential ones, (Stenhouse, 1975); and secondly, those based on task analysis (Skinner, 1971; Gagné, 1977) i.e. a 'bottom-up' approach vs those based on 'top-down', cognitive approaches, (Bruner, 1977).

In summary, the skills acquisition model views education as a means towards an end, where the objectives of education are to be formulated a priori by the educators themselves - a good example of this is the development of a National Curriculum for Schools. The proponents of this model emphasise that objectives are derived as a result of a consideration of the learners themselves, contemporary life outside, the nature of the subject being learnt, the psychology of learning, and a set of values within which education occurs (Skilbeck, 1977). The objectives model is frequently associated with prescribed, measurable, specific items, such as facts, concepts, skills, and is well suited to most of the experimental work described in this review. Much of what relatives have been taught has been driven by what clinicians e.g. Leff, (1981; 1982) or Falloon, (1985) have seen as essential for the safer care of relatives with schizophrenia.
A curricular structure, and measures of it, are described by Berkovitz et al., (1981) and Birchwood et al., (1986), which implicitly states that the clinicians are the experts, and that they set the curriculum.

By comparison, the process model of education, specifies the contexts, conditions, criteria and activities within learning - and is viewed by educational theorists as stemming from a very different political and philosophical framework. Its proponents argue that important, and long-term learning expresses itself within certain contingencies, not necessarily by testing, e.g. on the Knowledge about Schizophrenia Interview (Barrowclough et al., 1987). Furthermore, educators themselves will miss opportunities for learning if they themselves are driven by their own objectives, unaware of the actual learning that is taking place. Process theorists see education as comprising *training*, (acquisition of skills and capacity to perform); *instruction*, (acquisition of information leading to retention); *initiation* (familiarisation with social values that leads to a capacity to interpret the social environment and to anticipate the reaction to one’s own actions) and *induction* (the understanding as evidenced by the capacity to grasp and to make for oneself relationships and judgements).

The failure of many of the educational programmes in schizophrenia to achieve even the retention of knowledge beyond a few months suggests that more regard must be paid to the processes relatives themselves use to learn. Glick et al., (1984) and MacCarthy et al., (1984) demonstrate that relatives are very keen to learn, but that their agenda is driven by the need for meaning in their day to day experience of schizophrenia.
The 'top-down' educational model expounded by Bruner, (1977), and Ausubel, (1978), says that the meaningful acquisition of new material, must be related to existing knowledge, but also differentiated from it. An 'advance organiser' is proposed as a psychological device which provides the concept definitions first, followed by examples of instances and non-instances. In educating relatives about schizophrenia, one might introduce the idea of a biological illness, that is stress induced and is characterised by unusual and distressing symptoms. Relatives could then be presented with examples of these, and their 'advance organiser' would confirm or not whether these fitted their construct of schizophrenia, (see Helman, 1981). The 'top-down' model is less useful with a learner's lack of knowledge of relevant word meanings, or lack of abstract cognitive capacities, which may lead to misconstruals that can be difficult to detect and even harder to remedy, (Helman, 1981).

Gagné's, (1978), 'bottom-up' approach stresses that complex skills are made up of sub-processes, and that their learning should be correspondingly logical and hierarchical, proceeding from specific details, identified through task analysis, through to complex coordinations. He originally used the behaviourist paradigm, (Skinner, 1971), to show how the basic simple processes of classical and instrumental conditioning could be combined to account for complex conceptual skill learning. Thus, for families learning about the reduction of stress with their identified relative suffering from schizophrenia, it might be an important pre-requisite that they understood something about the nature of expressed emotion (EE); that they can generalise from one instance to a universal recognition of stressors, and that they have certain verbal and communication skills, before they can undertake an educational programme successfully, (Berkovitz et al., 1990).
Another educational model refers to the *methods* by which people learn successfully viz whether they can learn spontaneously on an experiential basis, without any guidance from the educator, (Ausubel et al., 1978). A good example of this might be the manner in which relatives come to understand something of their circumstances in a relatives' support group, for example, where learning is unstructured and informal, (MacCarthy et al., 1989).

It is worth noting that Barrowclough and Tarrier's, (1984), success lies not so much in the ability of relatives to learn spontaneously, but on the *meaningfulness* of the material that they were learning, based necessarily on their understanding of schizophrenia as an illness to be experienced, rather than a disease to be defined and analysed.

4. Psychoeducation

Psychoeducation needs to be distinguished from training, counselling, consultation or therapy. This review will consider education alone and combined with other types of intervention. One useful definition of psychoeducation might be "a method of care that provides attention to the family system without sacrificing the potential contributions of biological, psychological, and vocational systems... with the aim to develop a good therapeutic alliance which will sustain patients in the community and minimise relapse without undue stress on family members themselves" (Walford & Hayes, 1991).

Barter, (1984), has suggested, "the use of educational techniques, methods and approaches to aid in the recovery from the disabling effects of mental illness," or "as an adjunct to the treatment of the mentally ill, usually within the framework of another ongoing treatment,
Interestingly, both of these definitions have inbuilt aims which are directed primarily towards the needs of the schizophrenic member, and not necessarily for those of the people receiving the education. There is evidence (Tarrier and Barrowclough, 1986; McCreadie et al., 1991) that relatives seek and want education, and a belief held by them, perhaps not wholly unjustified, that their own suffering would be assuaged if professional people took the trouble to explain something to them about this severe and perplexing illness.

5. **Goals of Psychoeducation**

In a major review of family educational intervention studies, Lam, (1991) listed a range of aims, that included: a gain in knowledge; a change in the belief systems of the family; changing negative attitudes towards the schizophrenic member; reducing relatives’ self-blame; reducing relatives’ distress, sense of burden, fear and anxiety; fulfilling a moral requirement to inform mental health service users; engaging families as a precursor to therapy; changing patients’ behaviour, preventing patient relapse.

In a earlier study, Anderson et al., (1980), incorporate some more family orientated goals, including: a reduction in family stress; an increased understanding of the illness by the family; the enhancement of social networks by the family; the diminution of longterm issues contributing to family stress; survival skills training; de-isolation, de-sensitisation and normalisation about the subject of mental illness.
Falloon, (1981, 1983a and 1984) asserts that the actual goal of education is not the imparting of information, but rather to enhance the patient's compliance with medication, and to provide a rationale for family-based stress management. He concludes that the information sharing with relatives and the patients is useful as a means of facilitating discussion and engaging families in the process of working with the therapist.

Curran, Faraone and Graves, (1989), provide us with some slightly variant goals for psychoeducation: a resolution of family guilt; ensuring adherence to neuroleptic medication; the identification of stressors within family life; the management of disruptive behaviour; and lastly, keeping the family healthy!

There is, therefore, plenty of expressed optimism by clinical researchers that educating families might be good for them in teaching them to be less stressful, less stressed, more helpful in increasing treatment compliance, but it is not clear what relatives themselves say they want from education?

6. Expressed Emotion

The work of Brown et al., (1966), Brown et al., (1972), Vaughan and Leff, (1976a), Leff et al., (1982), Leff and Vaughan, (1981), identified a quantifiable measure of environmental stress that was demonstrably associated with the relapse of schizophrenic patients. It was observed that when patients returned to live with a relative rated as high expressed emotion, (EE), that relapse was significantly greater than those who returned to live with a low-EE relative (Leff and Vaughan, 1981).
It was also demonstrated that this effect could be reduced if maintenance medication were offered to the patient, and if face-to-face contact (i.e. within the same room) could be reduced to less than 35 hours a week.

There followed a substantial series of intervention studies, which focused on alleviating stress in the home environment, with the aim of reducing or even preventing relapse. These studies did demonstrate that with appropriate intervention, EE could be reduced with favourable clinical outcome, but these studies were expensive and methodologically flawed. Not least of these was that many variables were being considered simultaneously, eg. neuroleptic medication, or increased contact of families with the existing psychiatric services, and lastly, there was insufficient follow-up, (see Tarrier and Barrowclough, 1986; McCreadie et al, 1991).

In a controlled trial of behavioural intervention with families to reduce relapse, Tarrier et al., (1988), families with at least one high EE relative were randomly allocated to one of four intervention groups; Behavioural Intervention Enactive, Behavioural Intervention Symbolic, Education only and routine psychiatric treatment.

Patients from low EE families were randomly allocated to two groups; education only, or routine psychiatric treatment. The education condition consisted of a standardised two session educational programme, designed to give the patient and relatives extensive individualised information about schizophrenia and how to manage it in the home environment; (cf. Barrowclough et al., 1987).
Relapse rates over nine months after discharge were significantly lower for patients in the two behavioural groups compared with education only or routine treatment. Education alone, as an intervention with relatives, had no effect on relapse in high EE patients.

The behavioural groups had significantly fewer critical comments than the education and routine treatment group at nine months. The authors, however, concluded that education alone had the effect of preventing low EE relatives from becoming high EE, and make the observation that low EE relatives are not necessarily stable or requiring intervention. Education here is a less costly but useful intervention when behavioural training may not be required.

7. Assessing Relatives' Knowledge Prior to Education

(Berkovitz R, et al., 1981) devised a Knowledge Interview (KI) which is an open-ended questionnaire consisting of 21 questions that were linked closely to the content of the educational programme that the authors were providing for two groups of relatives; those with high EE and those with low EE. The questionnaire was designed not just to assess knowledge, but to provide the researchers with an opportunity to ask relatives whether or not they would like to know more about the illness, and then to introduce the education programme to them, or even more ie. provide them with a behavioural intervention. It is perhaps worth mentioning that in this study, there were no significant differences in relatives' knowledge between high and low EE relatives, except that "low EE relatives believed more often that the patient was his normal self between episodes. "All other differences between the two groups began to emerge once the psychoeducation programme had begun, and the
authors readily admit that attitude towards schizophrenia is just as important as information or misinformation about it". Significant attitudes included positive perceptions on a character attribution scale; the degree to which they rejected their afflicted relative; their overall attitude towards mental illness as a preventable or treatable phenomenon; the level to which they felt themselves supported or rejected by care staff, and lastly, their sense of hopefulness about the future.

Barrowclough et al., (1987) developed a Knowledge about Schizophrenia Interview, (KASI) which places a different value on acquired information, as such, and instead emphasised the functional value of the reported knowledge, not on recall of information. They argue that relatives bring with them to psychoeducation a well-developed and systematised knowledge of their own, which may require substantial change. The authors reveal that the longer a relative has suffered from schizophrenia, and the more separated from psychiatric care, the more idiosyncratic the relatives’ knowledge, and the less susceptible to change.

In an earlier study, (Birchwood, Tarrier et al., 1986), provided relatives with the assessments done on the patient to help provide a more personalised account for the relatives about the patient’s history of psychopathology. They also offer the KASI as an instrument for identifying early the relatives whose beliefs and attitudes may be detrimental to patients’ wellbeing, and who may require more support and advice.

The KASI has the following objectives:

* items should not just assess the presence or absence of information about
schizophrenia, but the effects of that information on the relative's behaviour;

* the items should be phrased simply, and the absence of technical knowledge not penalised;

* administration and scoring of the interview should be relatively quick and require the minimum of training.

Knowledge areas of schizophrenia which were assessed included, diagnosis; symptomatology; aetiology; medication; course and prognosis, and management. Barrowclough et al., (1987), bore in mind the following questions; What information might have a beneficial effect on the relative's behaviour in relation to the patient?, and, What attitudes and reported behaviour might have undesirable effects? In assessing relatives' knowledge, they found that relatives who were rated 'low on criticism' had significantly higher test scores both before and after education, as were relatives of those recently ill. The number of hospital admissions, the pattern of remissions, and the relative's familiar relationship with the patient had no bearing either on relatives' initial assessed knowledge, nor after receiving psychoeducation.

8. Models of Education, and Presentational Issues

Falloon, (1981; 1983) has opted for the vulnerability-stress model of schizophrenia, and therefore educates families by first of all providing what he calls, "guilt reducers". These include being told about the genetic and biochemical origins of schizophrenia; that expressed emotion affects but does not cause the illness, and an explanation of the importance of
medication. Above all, relatives are educated about the reduction of stress. It is explained that low stress does not mean permissiveness, and that relatives must set limits for unacceptable behaviour, even being prepared to calling the police if necessary, whilst at the same time avoiding confrontation with their relative whenever possible. Another way of lowering the intensity of familial relationships is for the rest of the family to resume its own life and other supports. In this way, the author elicits an individual response from each family that best suits the personal requirements of that family.

Tarrier and Barrowclough, (1986), note that the effectiveness of different modes of presentation needs further investigation, but that the accessibility of the information given to the recipient must be assured and not assumed. They propose two major outcomes of information giving; it will alleviate an undesirable state (eg anxiety, distress or confusion), or it will encourage desirable behaviour (eg lowering EE or promoting compliance with medicine. They offer two models - a deficit model or an interactional one, to explain the outcomes.

The deficit model implies if relatives, for example, express hostility and criticism to their schizophrenic relative because they wrongly attribute negative symptoms to laziness. The provision of information will address this deficit and a change in attitude and conduct might be anticipated, (cf. Berkowitz et al., 1984). In a similar vein McGill et al., (1983) hypothesised that high levels of EE may be due to a deficit in knowledge about this illness, and that they would benefit from information giving.
The more complex, interactive model predicts that patients and their relatives have a subjective experience of schizophrenia - which the authors call a lay model of sickness. This perception of the illness and its consequences is influenced by individual, familial, environmental, social and cultural variables, and is therefore idiosyncratic to each family. Helman, (1981) observes that though these models may be based on false scientific premise, they have an internal consistency and meaning. The clinician, by contrast, uses the term schizophrenia to refer to an "objective pathology", (Tarrier and Barrowclough, 1992).

Lam (1991) reviewed six family intervention studies involving psychoeducation, all of which had different methodology. The frequency of educational programmes varied from two to six sessions, and the duration from a three hour session to two hours every two weeks. He examined:

1. Didactic teaching with the patient present for a single family;
2. A didactic method without the patient for a single family;
3. Interactive learning with the patient and a single family;
4. An oral presentation with audiovisual aids, booklets and homework for a multifamily programme;
5. A didactic method for a multifamily programme with the patient absent.
6. A didactic method with the patient absent, but with some sharing of that experience between the family and the patient.

In examining the effects of such programmes, Lam concluded that a gain in knowledge by relatives could be achieved, and what is more, sustained at six months follow-up. However, there was very little change achieved in the belief systems of families about the nature of the illness, and the nature of negative symptoms in particular. There was a demonstrable improvement in families in their optimism about their own role in the provision of treatment to the patient, and a reduction in self-blame, but this was not sustained at six month follow-up. Not one of the studies revealed any impact on relatives' negative attitudes towards the patient, nor did any of the education programmes prevent or reduce relapse.

As far as the best education model is concerned, Lam concluded that didactic and interactive modes both have their uses. Relatives do seem to learn more in a face-to-face semi-structured seminar, and the inclusion or not of the relative in part reflected how ready the family and the patient were to work in this way. In two of the studies, members of the family requested an opportunity to express their guilt and hostility about their relative in a safe way, without the patient being present, but did wish to take this up with the schizophrenic member at a later stage of intervention, when they themselves felt more confident.

In conclusion, this author (Lam, 1991) emphasised that the education programmes reviewed had all been brief, but that some general points could be made. Firstly, all of them fulfilled a current requirement all clinicians have to communicate more with consumers of the services
that they provide. Secondly, all of these programmes seemed to provide a good grounding for later interventions including family therapy. Thirdly, families perceived the programmes as friendly and non-threatening and there were some non-specific effects including the reduction of distress and fear in relatives. Fourthly, families expressed an increased sense of being supported by clinicians, and this needed to be built on and linked to therapeutic intervention. Fifthly, there was no relationship between an increase of knowledge about schizophrenia and a change in beliefs about the illness or attitudes towards the sufferers.

Birchwood et al., (1986) and Birchwood et al., (1992) reviewed educational methods and found that videos and booklets were as effective as therapists in the long run in imparting information, but that relatives prefer having a therapist to teach them. They recommend indirect teaching where relatives might not otherwise attend, or where material needs to be translated. After assessment of patients and relatives is carried out, the authors recommend that patients be included in the educational programme as soon as is practical, and that information be presented in a simple, culturally appropriate format. They refer to Ley's (1979) finding that patients and their families are able to absorb only a few items at a time in a clinical setting, and that each family had a different rate of assimilation. Presentation of material must therefore accommodate these differences, and suggest a reading analysis (Flesch 1948) be applied to materials to ensure they are readable. Falloon (1989) responds to this by reminding readers that the word 'schizophrenia' is rare and artificially raises the reading age requirement for their materials, but cannot suggest a simpler phrase!
Andrews (1987) makes an interesting point about the use of terms 'positive' and 'negative' symptoms in schizophrenia. ('Positive' symptoms refer to hallucinations, delusions, bizarre beliefs, and thought disorder. 'Negative' symptoms refer to loss of function, apathy, poverty of speech, blunted affects, self neglect and withdrawal). Andrews, (1987), suggests that one of the reasons relatives and others may have greater difficulty in dealing with 'negative' symptoms is that the words themselves are value laden, and that lay people are more concrete in their thinking. They might tend to see positive symptoms as real and negative ones as less so, and she recommends alternatives such as 'florid-deficit'; 'active-passive' or 'psychotic-loss of function'. Lewiner (1987) responds to this by asserting that it is the role of the clinician to explain the term negative, and that clinicians must distinguish between a scientific term and a layperson's interpretation. He also argues that it may just as well be the behaviour rather than the term negative symptom which is ambiguous and demoralising, and that that is where relatives need help in education.

9. Education with Therapy

In California, Goldstein and Doane (1982), were the first to assign randomly the study of family therapy used in aftercare and relapse. It is worth noting a cultural difference from the UK in as much as the mean period of hospitalisation was merely 14 days, but that the authors were facing a situation where 31% of readmissions occurred within four weeks of discharge, patients having been unable to comply with medication or use the supportive services of the outpatient department.
Goldstein and Doane, (1982), offered brief, very concrete education, aimed at helping the family understand the events around the psychosis, and to improve their future coping strategies. The patients attended these with their families. They got results. After six weeks of moderate drugs usage, and short-term education, there were significant reductions in relapse and social withdrawal for up to six months. At three to six year follow-up, however, all effects were lost.

Leff et al., (1982), applied a different formula. Due to the very limited resources that were available to them, family groups were offered direct education given at home without the presence of the patient, and consisted of those with high and with low expressed emotion. It was hoped that the high EE relatives would learn some of the interpersonal skills manifested by the low EE relatives. This intervention consisted of four short lectures covering the causes, symptoms, likely course, and treatments of schizophrenia. Questions were then invited from the families and informal discussions followed. As with Goldstein et al., (1982), the style of education was concrete, limited in information and aimed at destigmatising the illness, (n.b. the term 'schizophrenia' was used throughout both programmes).

Falloon, (1985), used yet another combination of ingredients; he kept medication to a minimum, using only oral, which was flexible according to need. He included the patient in his education programme, who was made a 'symptom expert', and allowed the clinician to play a much more back-seat role. Education was carried out at home, rather than in a relatives' group in a clinical setting.
All of these studies demonstrated that the educational component leads to a lowering of guilt in relatives, an increase sense of relatives being in control of their own lives, an increased compliance with treatment for the schizophrenic member, and a reduction in vagueness about the illness, and a reduction in distress. These studies also show that although increasing compliance was achieved with all experimental groups, that this alone was not enough to prevent relapse.

Anderson et al., (1980), offered a day long educational workshop to families early on in a programme designed to teach them survival skills with their schizophrenic member. They provided clear didactic information about the illness, followed by descriptions of the experiences of patients, where relatives were provided with information about patients’ difficulties with processing and responding to complicated or excessive stimuli. Questions about causes, prognosis, treatment and management were then encouraged and used on an interactional basis. Patients were not present for the education section, but joined their families for the skills programme, which dealt with limit setting for unreasonable behaviour; avoiding direct confrontation; provision of psychological space for the patient; attending to the needs of family members; modification of expectations by the family of performance of the patient, eg. sleep, withdrawal; reality testing; reinforcement of family boundaries, dealing with problem behaviours with the patient and with the family.

In two sister articles, (McCarthy et al., 1989, and Kuipers et al., 1989) a controlled trial was carried out to ascertain whether the provision of an education and counselling group would have greater benefit to relatives more than those who were supported by the existing outpatient psychiatric service.
The authors put an argument that the relatives of those with long term illness, have exceptional emotional demands made of them, and that clinicians in the past have either blamed them or exploited them throughout their many years of contact with psychiatric services. Their results showed that relatives who were provided with education and counselling had a greater sense of optimism about mental illness, and were more able to instigate problem solving than those who were merely supported.

10. Education Without Therapy

Smith and Birchwood (1987), argue that education alone will meet the needs of families in some part, and that it needs to be considered as a significant and cost effective intervention in its own right. They examined the specific (knowledge acquisition) and non-specific (stress reduction and attitude change) effects of education on families. There were two experimental groups; the first was through four weekly group seminars, conducted in a semi-structured seminar format involving oral presentation and audiovisual material; the second was a postal intervention where families received similar information in a typed booklet format, with an accompanying letter and asked to complete accompanying homework attached. All subjects were given education in four separate areas covering: concepts, epidemiology and aetiology of schizophrenia; symptoms of schizophrenia; treatments and outcomes; hospital and community resources, and limited management advice.

Both subject groups were assessed before and immediately after education and at 6 months follow-up on knowledge acquisition; beliefs about schizophrenia and its treatment; worry and fear; behavioural disturbance; stress; and family distress.
Group relatives recalled more significantly more information about schizophrenia than postal relatives and were more optimistic about the family's role in exerting control. At six month follow-up, only knowledge gains had been maintained across all participants, with the group subjects still better informed and more optimistic, all non-specific effects having disappeared. No correlation was found between the amount of knowledge acquired through either method and the reduction in perceived burden.

The authors make a number of observations; the context of education enhances acquisition, although the information content was crucial. Relatives educated together in a seminar with a range of social contacts, and materials learnt more positive attitudes than the postal group - though their curricular knowledge remained the same. The biggest gain made for both groups was that of understanding the role of medication in the treatment of schizophrenia. Families were educated without their relative for this programme, though the authors recommended that the educational needs of patients be addressed separately.

Smith and Birchwood, (1987), conclude that although education did not correlate with non-specific effects, that it is more than academic. They argue that families achieve some 'cognitive mastery' over their situation, that leads them to want to change their own behaviour and approach. Many subjects specifically requested training in management techniques, confirming Falloon's (1983, 1985) and Goldstein's (1982) findings that education is a precursor to family intervention.
In a later study, (Birchwood et al., 1992), refined their method to examine educational delivery mode in more detail. Relatives receiving education in a group acquired more information than the relatives receiving information by post or video, but these differences were not maintained at six month follow-up.

Very recently, Glick et al., (1994); demonstrated that psychoeducation of patient and family was associated with better outcome because working with members of the family 'empowers’ them to interact and join in a more collaborative, rather than adversarial way with the patient to achieve medication and therapy compliance. The authors further suggest that the mediating variable may be the actual delivery of the psychoeducation, rather than the achievement of the psychoeducational goals ie. the new knowledge that the family can reiterate at follow up may be less important than being engaged with mental health professionals in the first place and starting empowerment.

Bennun and Lucas, (1991), looked at the impact of providing information alone to six single cases with schizophrenia, with their spouse/partner, and found that it was enough to improve the couples’ perception of their ability to cope with presenting problems. It did not, however, have any effect on either positive or negative symptoms, nor on relapse, either immediately or at 24 month follow-up.

Cozolini et al., (1988) assessed an educational programme for families without patients of three hour’s duration presented in four parts, to groups of 6-10 in a semi-formal setting around a table. This was followed by an informal chat with staff over coffee and doughnuts, followed by a less formal educational session from staff on a one-to-one basis.
The authors assessed outcome on no fewer than twelve measures, and found that after two months there was no recall of specific information about schizophrenia, but that there were increased feelings of support, understanding of the importance of medication. In understanding the loss of information, the authors conclude that information was too complex, (cf. Tarrier and Barrowclough, 1986); too intense, in one hour there were no booklets to take and no audiovisuals (cf. Smith and Birchwood, 1989) non-interactive (cf. Tarrier and et al., 1988); too generic; and provided at an acute phase of some of the patients' illnesses.

We know that the imparting of facts alone does not change relatives' fundamental beliefs (Berkovitz R, et al., 1981; 1990), and the counselling sessions were in fact to provide relatives with a safe and facilitating place to make their attitudes explicit, providing the basis for future discussion with relatives. Relatives in the experimental group were assessed in their own homes, the results used as a basis for education and discussion, and finally as a means for introducing relatives to a counselling group, which was held monthly for an hour and a half at the local day hospital. The control group of relatives for these studies, both received routine daycare throughout.

The authors defined the aims of the group as: to facilitate social interaction; to counteract social isolation and stigma; to repeat and reinforce acquisition of information about individual diagnoses and expectations; to help with problem solving; to help relatives hold more realistic expectations about the future.
The strategies of the group included: reducing EE; group counselling; behavioural skills training.

The leadership style in the group was defined as: positive, non-judgemental, but directive and focused; engaging relatives - done at home during the assessment, because of the high degree of motivation required; problem-solving, using assets, themes of grief, changing expectations due to the vulnerability of patients and exploitation by others, worry about the long term future, lack of confidence in community care.

Results showed that: the experimental group had a greater number of subjects who moved from high EE to low EE scores; the experimental group abandoned more maladaptive coping styles and adopted more positive strategies, e.g. taking up other activities, or having calm discussions with patients.

Relatives who had been educated and counselled became less critical and reported improvements in their relationships with patients. Even more significantly, along with an increase in the relatives' self-confidence, there was a concomitant improvement in the patients' clinical status, and their ability to perform independently a range of domestic and self-help skills.

Falloon, (1985), has noted that families with the fewest conceptions, or misconceptions about schizophrenia, were those who responded best to psychoeducation. His style of intervention begins by being didactic, ie. authoritative and addressing a deficit in information or knowledge.
This review has considered the main issue about whether or not educating relatives of patients with schizophrenia has any demonstrable effect, either on the relatives, or the patients. There is no doubt that there has been a demand from relatives themselves who have been to some extent marginalised and even blamed for causing the patient’s illness. Their needs have centred on understanding the course of the illness, and its outcome, as well as managing challenging behaviour at home. In addition they have suffered themselves from the enormous emotional challenge of acute episodes, from the grief of lost expectations of their relative, and from social isolation, prejudice and stigma. As a recent 'MIND’ advertisement aptly said, "You don’t have to have schizophrenia to suffer from mental illness".

In addition there has been a cultural and political change in health service provision that now views users of services, including relatives and carers as consumers, as entitled to be given a much more detailed account of treatment.

Inviting relatives to meet together to be given information about the nature of the illness has the immediate effect of increasing their knowledge, but also their self confidence and optimism about the future. The enduring effects of the information giving, however, is not maintained, as most studies show no permanent gains after six months. Not only this, relatives did not benefit by changing any of their attitudes, beliefs or perceptions about their relatives, and the benefits for patients, therefore, from giving information to relatives about schizophrenia are limited.
An examination of educational models indicates that many of the programmes have focused on didactic forms where the curriculum has been directed by clinicians themselves. Little consideration has been given to the informal ways in which relatives continue to make meaning of their experience of schizophrenia, nor has much attention been given to what relatives themselves say they want to learn.

The one substantial exception to this has been in educating relatives about the importance of treatment compliance, and of enlisting their partnership in ensuring medication is taken at home, with an effective impact upon relapse reduction.

The studies of expressed emotion (EE) have revealed that certain behaviours and attitudes held by relatives can influence the rate of relapse of schizophrenic patients. Educating people about the avoidance or reduction of stress, (including face to face contact), criticism, and explicitly critical messages has helped to change the outcome of patients, and to make more relatives feel in control and hopeful about the future. The EE studies, however, provided relatives with more than information giving; relatives were given detailed and structured interventions, that were tailored to their individual circumstances; information given was limited to what was needed to alleviate that family’s distress. The clinicians had a full and supportive engagement with these families, and with few exceptions, the involvement of relatives in achieving any change at all, has an empowering effect on them.

Most recently, researchers have shown that the deficit model of education cannot account for the change that is possible. Didactic methods have assumed that relatives’ ignorance about schizophrenia as a disease could in large part be addressed through giving formal packages
of information to them. Published studies reveal a much more active role by relatives who have their own constructs about schizophrenia, and require above all an interactive model of education. Such a process acknowledges and works with their model of schizophrenia as an experience of illness that can have devastating consequences for other members of the family over many years. No academic account of negative symptoms of the disease known as schizophrenia will impact upon a mother who sees a once lively and affectionate child become an unwashed and 'lazy' adolescent who refuses to get out of bed in the morning. Educators have to acknowledge that daily experience, and work with mother and patient in that context, if mother is ever going to change her perception of the illness, and her own attitudes and behaviour as a consequence.

The mode of education delivery affects outcome only inasmuch as relatives derive additional support from meeting each other. The information gains from written, audiovisual or postal material do not significantly vary, but may provide a more cost-effective and accessible intervention to relatives who cannot come to the psychiatric services, or who do not speak the majority language.

The culture of education seems critical in engaging relatives, especially if they are eventually to undertake family therapy. We have seen the importance of acknowledging their 'misinformation' and building from it. Relatives also need hopefulness and a sense of collaboration with care staff in fighting the long term effects of schizophrenia.

This is done best by professional staff being willing to assess where relatives are in their understanding, and providing the structure and opportunity to formulate questions appropriate
to their circumstances. As with patients, relatives need a consistent and appropriate approach, and one built on respect and support, rather than criticism and guilt. The papers on education as part of a wider counselling package for relatives through a group process demonstrate what can be achieved here.

Last but by no means least, groups of relatives educate each other, and there is evidence in the literature for enhanced learning and attitude change within a group setting, with or without the patient. Educational models suggest that as well as a curricular approach to schizophrenia, clinicians need to consider experiential and cognitive processes with which relatives are engaged in all their learning about this illness. Working with patients present helps to educate relatives about the nature of the symptoms and provides some insight into the illness if relatives are given the patient's assessments and history by clinicians. If nothing else, relatives learn that they are not alone, and that if patients do not necessarily become cured, they can recover function substantially.

Ends

3 February 1995
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ACADEMIC REVIEW

Culturally Appropriate Mental Health Services

for the Long-Term Mentally Ill

Submitted as part requirement for the Psych.D, University of Surrey
## CONTENTS

1. Introduction ......................................................... 57

2. Race - a cautionary note ........................................ 58

3. Mental Health of black and ethnic populations - the past and present .... 59
   3a. Mental Health Needs of Women ....................... 62

4. Racism in Psychiatry .............................................. 63

5. Some lessons from Africa ....................................... 64

6. Community Mental Health Services ....................... 67

7. Good Practice and Recommendations .................... 69
   7a. Cultural and Racial Training ......................... 72
   7b. Challenging Assumptions ............................... 73
   7c. Inner City Projects ....................................... 73

8. Social Psychological Theory; Some Applications ........ 75

9. Conclusions ......................................................... 77

10. Bibliography ..................................................... 79

11. Acknowledgements ............................................. 90
1. INTRODUCTION

Mental Health Services for people with severe psychiatric illness have undergone huge changes in the last few years, with much emphasis on community care. Less thought seems to be given to the nature of what constitutes mental health itself, and to its place within Britain as a multiracial society. As Fernando (1991) puts it, "concepts of mental health are derived largely from the medical model of illness (derived largely from the medical model of illness developed in psychiatry), and ideas about community care (based on assumptions about personal autonomy etc., prevalent in European cultures) are grounded in white, middle-class, ideologies that are likely to be too Eurocentric to be of much meaning to other communities..."

Only seven years ago, a question for the Membership to the Royal College of Psychiatrists was listed thus:

Question; 'What are the major psychiatric disorders in immigrants to the UK?

Answer; Schizophrenia; common in Africans, especially with paranoid delusions, religious ideas and hypochondriasis. First rank symptoms (FRS) in 33%. For Asians, FRS in 38%. West Indians have FRS in 48% with paranoid delusions, religious beliefs and disturbed behaviour common. A typical psychosis, particularly common in this group, with confusion, paranoid ideas, short durability of illness, good prognosis and negative family history "(Burns et al. 1988).

It has been popular in the transcultural psychiatric literature to berate the dearth of systematic studies evaluating good practice and the elimination of racism in current mental health services (Littlewood & Lipsedge 1988; 1989; Littlewood 1992; Cochrane et al. 1983; Smaje 1995; Ahmed 1994). Ramon (1994) specifically cites the instance of continuing care with ethnic communities as working, but that it is an arena that is still being much neglected by the new NHS Trusts and GP Fundholders. He argues that jointly funded programmes assessing efficacy will still need to be funded in the new market-driven health culture.

This study sets out to establish what the current state of the art is, with particular reference
to people from black and minority populations with long-term psychiatric needs, and what empirical evidence there is that particular approaches or models ensure greater access and equity. No study would be complete, however, without reference to transcultural psychiatry, to the current inequalities in healthcare, and some analysis of the social and political context within which all of these issues are being examined.

2. **RACE; A CAUTIONARY NOTE**

The National Health Service has become much more sensitive to the needs of minority ethnic groups in the UK, resulting in a huge volume of literature about better and more accessible health provision (Aanchawan 1995; Fernando 1988; Triandis 1990).

Nevertheless, the language of race and culture in the field of transcultural psychiatry is itself culturally laden and reflects assumptions of the authors and clinicians alike (Littlewood & Lipsedge 1987; d'Ardenne & Mahtani 1989; Fernando 1989; Nasser 1994). These assumptions are not based on any scientific principle whatever. 'Race' as a term in health literature is widely used, but has no meaning to biologists or anthropologists (Littlewood 1990; d'Ardenne & Fernando 1992). Ethnic groups are not defined by unique inherited physical characteristics, and 'race' here is a social and political construction. 'Ethnicity' now replaces 'race' in the literature and incorporates self-defined characteristics, of shared culture, history and beliefs. The census data, and NHS minimum data set require people to categorize themselves according to a selection of pre-defined racial and/or ethnic groups, or 'other' (CRE 1991). In the census, people who did not categorise themselves, were officially counted as 'white British' (whatever that may mean), which led to an under-representation of certain groups of people, notably young, African Caribbean males (Jacobson 1994).

The term 'black' or 'black populations' is similarly fraught, but will be used in this review to describe people from racial or other minorities in this country who may 'be disadvantaged because of their racial background' (Aanchawan 1995).

Terms such as 'culture' require consideration also. Implicit in this term is the idea that white British is a homogeneous culture, and that anything else is 'ethnic'. Brady (1964) asks whether it would not be more useful to define culture as merely a pattern of shared behaviour
characteristics within a given society. Triandis (1980; 1990) similarly points out that 'Asian' culture in the UK means that of the Indian subcontinent, whereas in the US, this may mean that of China or South East Asia. All the literature reminds us that culture is never static, and that there is now a growth of a universal culture, and language, made possible through global access to mass media and information superhighways (Aanchawan 1995). For the purpose of this study, therefore, cultures will be differentiated wherever possible, and 'black' will be used in the political sense, i.e. to describe people who themselves experience racism in a predominantly 'white' culture.

3. MENTAL HEALTH OF BLACK AND ETHNIC POPULATIONS - THE PAST AND PRESENT

Lipsedge (1993) has established over a number of years that the problems of people from African, Caribbean and Asian communities who have severe mental health problems, can be categorised into: the implementation of the 1983 Mental Health Act, racist and ethnic stereotypes, and the pathologising of culture.

Hospital records have for some time shown that there are disproportionately high numbers of people detained under the Mental Health Act from the Caribbean and from West Africa, between two and three times that of white, UK born patients, and that they are more likely to be referred after contact with the police or Social Services, and less likely to be referred by their GP (Owens et al. 1991).

African Caribbean men are especially likely to be detained under Section 136 which permits compulsory detention for up to 36 hours, and are more likely than their white counterparts to receive a diagnosis of schizophrenia (Rogers & Faulkner 1989).

Chen, Harrison & Standen (1991) established that African Caribbean patients were more likely than their white controls to be given Depot medication, were judged to be more disturbed than their white controls, and were discharged earlier in the treatment process. Lipsedge (1993) highlights that there have been explanations for this that focus on the black patient as 'different', more antisocial and co-operative; explanations of the communities that see severe mental illness as more stigmatising and therefore delay the seeking of medical help
at the onset of symptoms, and; explanations that emphasise the role of the psychiatrist and the GP who collude with the social worker in the practice of overt and covert racism in their initial handling and judgement of the black patient (cf. Bolton 1984; Littlewood 1992; Rogers & Faulkner 1987).

It is also clear that young African-Caribbean people are less likely to seek help early on in predominantly white mental health services, and would also be reluctant to disclose any previous mental illness, thus inflating the number of 'first admissions' to a service for black people (Smaje 1995; Glover 1991; Burke 1989; Harrison et al. 1989).

There are many possible explanations for high rates of schizophrenia. Misclassification by mental health workers who do not understand the presentation of psychological distress is one (Flaherty & Hoskinson 1989); another is that there may be biological differences (Eagles 1991); social and economic factors are certainly known to be causative in contributing to disproportionately high incidences of schizophrenia, which themselves correlate with poor antenatal and perinatal care and infection (Eagles 1991; McGovern & Cope 1987).

Just as importantly, overt prejudice, high levels of unemployment, poor accommodation, and social marginalisation and isolation all contribute to or aggravate alienation and the maintenance of serious mental illness (Ramon 1994; Lavender & Holloway 1988). Cochrane & Fisher (1983) found in his study that Irish patients were more likely to be hospitalised with a diagnosis of schizophrenia, but that it was young African or Caribbean males who were more likely to be detained, and brought in by the police. Similarly, Dunn & Fahy (1990) obtained some startling results when they examined police admissions to a psychiatric hospital in Lambeth, South London. They found that 33% of them were African-Caribbean, more of whom were on neuroleptics, more of whom were diagnosed as schizophrenics, and more who were compulsorily detained.

Gupta (1991) compared 86 patients of Indian, Pakistani or Bangladeshi origin to 86 English white patients with long-term mental illness and found that the Asian groups spent less time in hospital, had fewer in patient re-admissions, had lower relapse rates, and overall better prognostic outcome. He did, however, observe, that as a group, more were married, more
were likely to have been misdiagnosed in the first instance, and that they actively avoided hospital as it was more likely to be seen in Asian culture as stigmatic. These conclusions are anecdotal, however, and his evidence for less stigma in English populations needs substantiating.

Lokare (1992) points out that the "process of learning in this multi-cultural multi-racial worlds can create unforeseen complications and misunderstandings ...., and that the risk of this happening is greater when a geographically confined area minority live under the influence of the majority group who have their own different cultures. " He describes the present situation in Britain, the States and many other Western countries as "a transitional stage in the midst of a cross-current of cultures", where the majority group fails to identify the real needs of the minority because it uses its own values and norms for comparisons. There is however, no evidence that the present situation in Britain is 'transitional.' Data (OPCS 1992) suggests that there is a continuing number of UK residents who classify themselves as minority ethnic, and that this trend is continuing. The implications for mental health care are therefore ongoing. Lokare recognises that there has been a growing awareness of the importance of socio-cultural factors in problems of mental health, that much has to be achieved, both at the individual, and multidisciplinary level, and at the way we educate and train mental health professionals.

Laungani (1992) in considering the difference between mental health services in Indian and the West, points out that a psychiatrist in India, for example, may be one of many experts consulted about mental illness - and by no means be the head of a queue. He clarifies this in his description of four interrelated core values - bipolar constructs - in mental health which distinguish Western from Eastern approaches in dealing with mental illness: materialism vs spiritualism; individualism vs communalism; free-will vs determinism; cognitivism vs emotionalism. Though these constructs are interesting, the author offers no empirical evidence to support these distinctions, and such broad brush descriptions of 'Western' or 'Eastern' approach, as though they were unitary ideas, may be less useful than originally supposed.

Laungani (1992) develops his thesis that mental health services for Indian people must in
some respect acknowledge mental illness, but provide a flexible approach that includes notions such as the law of *Karma*, which states that happiness or sorrow (nb there is no Hindi word for depression) is the "predetermined effort of action committed by him sometimes either in his present life or in one of his numerous past lives". It is worth noting that in such a philosophy, where the *locus of control* is beyond that of the individual, there may be less stigma in suffering from psychosis, and less despair, but that equally, there may be resignation and inertia in accepting one's *Karma*.

**Mental Health Needs of Women**
Lipsedge (1993) and Smaje (1995) have highlighted another main area of serious psychiatric casualties amongst ethnic communities in the UK, viz the increased incidence of parasuicide among young Indian, Bangladeshi and Pakistani women in a wide range of settings. Webb-Johnson (1991; 1993) and her colleagues have both researched need and prepared a training pack which challenges many of the stereotypes maintained by white professionals and allows other approaches to be tried and evaluated. Their approach might be described as good practice in any mental health setting: their primary concern is that current services do not appear to address need.

Christies & Blunder (1991) make an urgent plea for more women-only services that will deal with racism and parity, and which offer a holistic approach including complementary therapies. They also urge an increasing awareness of mental health needs of women with general practitioners. For these authors, increasing *access* and *appropriateness* of a service for black women represents improvement. 'Dealing' with racism begins with acknowledging its presence in the experience of these women, both in everyday life and in the structures and practices of mental health services.

Francis (1994) in Bradford & Marchant (1994) working in Wolverhampton, both highlight locally based projects, which are homely, intervene early, and which target women and depression. They also dispel the white myths that Asian families look after their own, that they have no mental health problems, that they somatise their problems, and that Asian men will not accept such services for their female relatives. Mahtani & Huq (1993) offered extensive anxiety management with Bangladeshi women in Tower Hamlets, comprising
education, skills training and social support in a mental illness preventative context. All of
these studies are descriptive without long-term follow-up. Their value lies in the contact
made with women, some of whom had never been in contact with any mental health agency,
but who expressed satisfaction with these projects and were seen to use them to handle
psychological distress but not major psychiatric disorders.

All of these studies indicated that patients from ethnic communities were even less likely to
be offered any type of talking therapy than their white controls, and more likely to be offered
physical treatments. Even more interesting is that white mental health workers are likely to
perceive their black or ethnic clients as being more somatic than white counterparts
(Littlewood 1986; Littlewood & Lipsedge 1987; Khan 1991). There is no evidence to
support such a perception. d’Ardenne and Mahtani (1989) reported that Bangladeshi patients
in a psychiatric setting had a wide range of emotional concerns. They focused on somatic
symptoms because first, they were asked about them, second, they believed it gave them a
'ticket of admission' to the service and third, language and cultural differences made
discussions of psychological concerns more difficult.

All of the womens’ studies need careful evaluation and follow-up. Consumer surveys in part,
inform practitioners about whether services are becoming more accessible and appropriate.
Good practice has to be demonstrably achieving mental health gains for all communities
however, and would need to be measured by a range of criteria that extends beyond patient
satisfaction.

4. RACISM IN PSYCHIATRY
Comas-Diaz (1992) makes the interesting observation that in the United States, a quarter of
all Americans are black or ethnic, and that by the year 2000, white people will be the
minority, with far-reaching implications for the social and cultural constructions within
psychotherapy and mental health.

Racism in the care of schizophrenia and other mental disorders in the UK has received great
attention from members of Transcultural Psychiatry UK, whose founder, Fernando (1975;
1985; 1986) has written extensively about the impact of racism in psychiatric diagnosis and
treatment and who has campaigned with this organisation, but see also Burke (1989) and Christies & Blunder (1991). Racism "is woven into the very fabric of Western medicine" (Littlewood & Lipsedge 1989 cf. Fernando 1988; Littlewood 1990; Lipsedge 1993). The diagnosis of schizophrenia is perhaps the most politically and socially charged, eg. the diagnosis given to Soviet Dissidents sent to secure hospitals (Fernando 1988). Burke (1989) argues that social and economic deprivation and racism combined, substantially contribute to the mental ill health of black and ethnic populations, and that these factors are never given any weight in epidemiological interpretations. Not only this, but, "the reinforcement of stigma, the increased social distance of doctor to patient, and the poor after-care of black patients reflect lower trust in and access to the services" (Burke 1989).

Fernando (1986) argues with plenty of evidence that white psychiatrists repeatedly ascribe incorrect diagnoses when confronted with a symptom beyond their own cultural experience. Since a hallmark of psychosis is a presumed lack of contact with reality, the psychiatrist (or other mental health professional) has to judge what is normal or abnormal for the individual, and one which may in the case of black or ethnic patients, reflect racist stereotypes. Mental State Examinations, a fundamental part of the psychiatric assessment procedure, are themselves ethnocentric, and the DSM-IV (Fauman 1994) makes no allowances whatever for cultural or racial differences, ensuring that a global (ie. Western) model prevails.

5. SOME LESSONS FROM AFRICA

The needs of people with severe mental illness in Africa have been described in the literature recently (Ilechukwu 1989; Olpaku 1991; Swartz 1985; 1986; 1987; 1991; Swartz, Ben Arie & Teggin 1985) and may provide some insights into more appropriate services for UK sufferers of psychosis, who are themselves of African origin. This is because in many sub Saharan African cities, urbanisation, multi-ethnicity and industrialisation have placed unprecedented demands on mental health services, and where traditional healers have acknowledged that they are out of their depth. (Ilechukwu 1989; Fannon 1967).

Services required include established models of psychotherapy, particularly in the early stages of mental illness; the need to secure training at least at doctoral level to secure identity; learning English and at least one major tribal language; learning from patients in an honest
and non-condescending way; being comfortable in ambiguous situations, ie. in transcultural settings; providing an explicit link between the world of traditional healers and the modern world, and lastly, being willing to combine Western and African models in practice.

Olpaku (1991) in comparing American to African models of long-term psychiatric care, observes that African professionals are not accustomed to lobbying for better care, and in fact associate lobbying with individual corruption.

Stressors in many African cultures produce briefer, more accessible psychoses that require local knowledge and approaches; eg. 'brain-fag' is a common presentation in rural West and East African communities, where children are very stressed by the expectation to perform combined with minimum parental or grandparental support, anxiety about fees, and poor nutrition. It would not be difficult to compare Third World urban-rural divides with those in the West and ascertain if the former is greater and leads to greater stress and the prevalence of 'brain-fag' is as a direct result of this. Such a study remains to be done to make meaningful comparisons of psychosis between cultures. Various authors (Littlewood 1991; 1991a; 199b; Christies & Blunder 1991; Cresswell 1995; Fahy & Dunn 1990) have, however, observed that the WHO Pilot Study of Schizophrenia (1979) included too many transient syndromes like this, which may have artificially inflated the global picture.

Swift and Asuni (1975) remind us that schizophrenia is still the most common and crippling of psychiatric diseases in Africa, but that there has been a dramatic move to management outside hospital, with hospitalisation being used only for the most acute episodes of the illness. The authors stress the need for educating relatives about the non-contagious nature of the illness, and the need to see it as stress related. Families can thus be encouraged to accept the patient with affection and without fear, and to tolerate symptoms rather than remonstrate about them. Many of their recommendations are comparable with the psychoeducation programmes on Expressed Emotion (EE) carried out by Leff & Vaughan (1981) and others in the West. Intercultural epidemiological studies would allow clinicians to establish commonalities in very differing settings which aggravated or ameliorated the incidence and prevalence of severe psychiatric disorders.
The picture in a racially mixed community dominated by white mental health practices informs our practice even better. Swartz (1991b) and Drennon et al. (1992) in discussing racism in South African psychiatric services, observes that mental health services have both the promise of personal and collective liberation, while at the same time, guaranteeing social reproduction. What they mean by this is that the institutional practices will override individual liberalism or even non-racist and antiracist practices. Schwartz (1991b) examines the false distinction between relativism and universalism in psychiatry, and uses a derogatory term, first used by Kleinman (1977) of 'vetinary psychiatry' in South Africa. Such a model embraces the notion of universal mental illness, but deals with cultural relativism through the construction of patients’ explanatory models’ without ever having asked black patients what they actually believe. Diagnostic and treatment procedures are applied to these non-compliant and/or non-verbal patients which minimalise the actual engagement needed with the patient’s own realities, eg. Mental State Examination; Psychotropic medication; ECT. Kleinman (1980) makes the distinction between disease - the malfunctioning of biological and/or psychological processes, and illness - the psychosocial experience and meaning of perceived disease. Illness thus becomes the shaping of a disease into behaviour and experience, is a cultural adaptive activity, is part of healing itself, and inevitably takes place within the context of family and social network.

The argument here is that in a chronic illness like schizophrenia, there may be difficulty in distinguishing disease from illness, as the relationship may be reciprocal, with the illness manifesting itself as the disease is in remission, and vice versa.

Both Kleinman (1980) and Swartz (1986) also refer to the hierarchies of resort - ie. the health ideologies that guide the health seeking process, and the cultural rules that govern individual and group decisions, independent of specific episodes of sickness, which begins with the values embedded in generic illness labels. (cf Foucault 1965; Gussow & Tracy 1970). These ideologies must in part determine presentation and outcome, but there is no overall theoretical framework beyond the political that allows researchers to establish how valid these rules are, and how useful is the idea of a 'resort hierarchy'.
6. COMMUNITY MENTAL HEALTH SERVICES

Community Care as a concept in care for the long-term mentally ill is here to stay, with the closure of long-term mental hospitals, and the introduction of the Community Care Plan (HMSO 1989; Mental Health Foundation 1994).

The Mental Health Foundation, when reporting into Community Care for People with Severe Mental Illness (Mental Health Foundation 1994; Department of Health 1994; Herzberg 1987; HMSO 1994) specifically recommended research and development work in the needs of, and provision for, people from black and minority ethnic groups. It reiterated that good community care for such groups, as for all members of the community must address needs for:

* an appropriate place to live
* an adequate income
* a varied social life
* employment and other day activity
* help and support
* respect and trust
* choice and consultation

Great emphasis is placed upon the requirement of service providers to listen to the needs of people with severe mental illness and their families, rather than doing what is most convenient to them. What is not indicated is how this might be achieved, or indeed which questions would even need to be asked to begin this process. In a poignant submission to the North East Thames and South East Thames Regional Chairman, a friend of Christopher Clunis, a black patient suffering from schizophrenia, who killed a white friend, as a result of poor community supervision, writes:

"He was a tall, muscular man and at the time not at all obese. He was over six feet tall but not, as depicted, awkward. He was then most unlike the overweight violent schizophrenic portrayed on the Dispatches programme .... I would question a society that took a vibrant, brilliantly gifted young musician and creates a schizophrenic capable of taking another's life" (HMSO 1994).
Harris (1994) tries to answer this by asserting the existence of personal and institutional racism in the treatment of Christopher Clunis. He refers to factors common to many black people with serious mental illness, including; denial of access to psychotherapy; excess use of drugs; reluctance to admit to catchment area hospitals; fear of black males; failure to involve the patient’s family in diagnosis and aftercare, lack of cooperation between agencies, and the need for a bill of rights for black patients and their advocates. There are of course substantial difficulties in moving from a particular case to the general. It should be noted however, that the government at the time rapidly introduced Psychiatric Supervision Registers as a result of this one case, rather than examining the evidence for psychiatric patients frequently killing members of the public - an extremely rare event.

Roach (1992) reviewed such services for black and ethnic communities in one London Borough with a high ethnic population and found that facilities for the rehabilitation and resettlement of the recovering mentally ill into the community were very limited and fell far short of official recommendations and that very little consideration was given to meeting the needs of other communities. He analysed data from Social Services, Health, and Voluntary Agencies, as well as 120 black and ethnic users and non-users, and concluded that minority communities believed they had little or no say in decisions about services, and thus felt excluded. The author drew a sharp distinction between users and providers’ perception of how well community mental health addressed the needs of black and ethnic populations. Roach (1992), concludes that communities incorporate "normative needs, perceived needs, expressed needs and relative needs", and emphasised the complexity of the task, (cf. Jaffee 1982; Moroney 1977; Ramon 1994).

In an earlier work, Ramon (1991) cited the significance of integration, empowerment and normalisation in the rehabilitation of those with serious mental ill health. His model is that of Social Role Valorisation - SRV (Wolfensberger, 1983) which proposes that each society has rules, settings, behaviours and emotions which it values or not, and that positive or negative social sanctions are attached to these. SRV accepts the necessity to cater for culturally different definitions of what is and what is not socially valued. Within this model, it is necessary to ask whether people are being rehabilitated within the community according to age, gender or ethnicity, and whether or not mental health services are truly multiracial and
multicultural. Ramon (1991) is quick to point out, however, that 'colour blind' policies and services in integrated services may serve only the need of the cultural majority, and opts for models of separate service development for black and ethnic mental health services in the community. Sue & Sue (1990) and Triandis (1990) make similar points. To be culturally 'colour-blind', ie. neutral, is to discount a huge dimension of black and ethnic users' experience, and will lead to these communities abandoning such services, however well-intentioned.

In the same text as Ramon, Warner (1991) observes that recovery rates from schizophrenia have always been higher in the early nineteenth-century America, and in the developing world than in the UK or the US today (cf. Lo & Lo 1977; Kulhara and Wig 1978; WHO 1979). He offers the following explanation; that the labour settings of the former two were or are favourable for the rehabilitation and social integration of marginally functional people. In early America an extreme labour shortage encouraged the employment of the disabled and in the Third World villages the subsistence economy allows the employment of many who would be excluded from a wage-labour force burdened with significant levels of unemployment. There was a time when such structural problems would have been beyond the scope of health and social services projects, however, can ensure that some local structures can be changed. The implications for community in the UK and such jointly funded programmes to help those with serious mental illness and their carers, remains to fund innovative approaches with housing and work related activity (Ramon 1994).

7. GOOD PRACTICE
Murphy (1990) & Hoggett (1993) both argue that the current mental health legislation will have to be replaced by more therapeutic, appropriate services within the community which lead users at less risk of being overlooked, mistreated or posing a threat to others. They relate three key principles:
1) institutional care and treatment should be provided under conditions of no greater control, segregation or security than is justified by the degree of danger presented to the people concerned or to others;
2) there should be a comprehensive, multidisciplinary approach to providing care and treatment in the community; and
3) there should be proper consideration for the views of families and carers.

Many authors (Smaje 1995; Benzeval, Judge & Whitehouse 1995; Benzeval, Judge & Solomon 1992) have referred to the need for looking at all neglected groups in mental health, e.g., women, older people, and those with disability, and the need to gain a clear comparative perspective with all evaluation studies. All refer to the need to upgrade staff training and development in cross-cultural skills, and in placing racism and anti-racist practices firmly on the agenda. All speak of the need to involve different communities in the planning, monitoring, evaluating and delivery of a mental health service, and attention to housing and advocacy is of particular importance with patients who have enduring mental health problems.

Corrin (1990) describes the meanings that psychiatric patients give to being deinstitutionalised, by reminding us that it is Western values that emphasise individuality, anonymity, independence and isolation, and that patients from a range of cultures will still need to use 'mediating spaces' within and outside their own social field when discharged. She cites some interesting examples; supermarkets; drop-in centres; street cafés; public libraries; and sports centres, where patients are able to regulate their own cultural and social distance with flexibility and variety.

Roach (1992) makes specific recommendations:

1) The need for accessible information about the service.
2) The need for leaflets in minority languages, disseminated by the black and ethnic minority agencies.
3) The need for health providers to develop facilities jointly with Social Services on an innovative basis with the user involved early in the decision-making process.
4) The need to develop the communication (including linguistic skills) of mental health providers.

None of these represents a controversial or avant garde approach, but many UK services are a long way from achieving these standards. Fernando (1988) in dealing with the 'over representation' (i.e. significantly higher) of schizophrenia among black and ethnic minorities...
(cf. Harrison et al. 1984) suggests that schizophrenia should only be offered as a diagnosis if the clinician has given full weight during assessment, to the effects of racism in society and to the cultural background of the patient. He does not, however, indicate how this might be evaluated. He also recommends:

* That compulsory detention not be offered on the basis of the diagnosis alone.
* That the assessment of dangerousness is equally separated from the diagnosis of schizophrenia.
* That British psychiatry should dissociate itself from racist, pro-apartheid psychiatry, like that found in South African Apartheid.
* That Equal Opportunity Policies be implemented in all NHS structures, including medical colleges, and the Royal College of Psychiatrists.
* That ethnic monitoring be implemented in all local mental health services to establish firstly, if the service is equable and accessible to all communities, and secondly, that those compulsorily detained in hospital are not there as a result of local racist practices.

Once again Fernando does not suggest in specific terms how this could be established this purpose, in part, is to raise awareness rather than to provide method. Morice (1985) suggests that problem-posing research in mental health care is an appropriate model for psychosocial issues in a transcultural setting. He argues that instead of seeing problems within communities as intractable, that we should perhaps question our own methods of giving advice and intervention.

In his study with an Australian Aboriginal community in the Nullabor Plain, to help a very high incidence of adolescent boys being incarcerated for alcoholism, and petrol sniffing, he highlighted the following good practices:

* Using aboriginal field workers at all times.
* Making it explicit that they were working only with that black community.
* Carefully collecting data from the families themselves about their concerns and their targets for remedy.
* Feeding back to the relevant groups the findings of the survey.
* Feedback presented in verbal, diagrammatic and video format.
* No solutions offered! This was for each community to evolve in its own time and cultural format.

7a Cultural and Racial Training

NAFSIYAT (1989), a specialised Intercultural Therapy Centre in North London, argues that professional training for doctors, social workers and psychotherapists on antiracism and intercultural approaches is an essential part of good practice. In their first five year report they noted a significantly higher proportion of black and ethnic people with serious mental illness had been referred to their centre. They have argued for compulsory training for all mental health staff, and have also highlighted the need for:

* a confidential helpline for carers needing anonymity
* more focused information on mental health and racial issues
* dealing with language and cultural ignorance among ward staff
* the need of the voluntary sector to start working with statutory agencies

Intercultural therapy centres appear to work best as centres for training, supervision, research and development. Triandis (1990) makes the point that specialist therapy centres absolve mainstream services of their obligation to provide for all their users, thus marginalising black and ethnic users further. The debate continues: black and ethnic clients use alternative centres because they feel poorly served. It is for white clinicians and policy makers to change that balance.

Burke (1986) recommends that the best way of ensuring good future care for black people with serious mental ill health, is to improve all psychiatric and psychological training. He argues that this should not be by learning the cultural parameters of 150 language groups in the UK, but rather by taking a general approach to culture and race and by protecting patients rights by introducing a code of practice on race, which would allow a patient exposed to possible discrimination or insult to have an opinion or therapy from someone of a similar background. This is an interesting proposal that has yet to be adopted by the Royal College of Psychiatrists, the British Psychological Society, or any of the current Health Trusts.
Nadirshaw & d’Ardenne (1994) and d’Ardenne & Mahtani (1989) have made a similar plea for the training of clinical psychologists. The argument again is not about specific knowledge, but rather a range of cross cultural competencies, and an awareness of power imbalances within mental health services, especially through racism.

7b Challenging Assumptions
The Confederation of Indian Organisations (Webb-Johnson 1991) has published a number of articles advocating good practice in mental health care of Asian communities in the UK. In its handbook it advocates that common assumptions made by non Asian professionals be challenged ie.: 
* that Asian culture is homogeneous
* that Asian culture is stifling and denies individual freedom
* that Asian women play a submissive role within their communities
* that Asians are obsessed with religion
* that Asians are not psychologically minded and somatise symptoms
* that Asians look after their own
* that Asians want to be told what to do
* that Asians have arranged marriages which are not happy

The difficulty about such a list is that it implies white culture (whatever that is) is also homogeneous, and that workers are all at the same stage of learning about Indian cultures. In addition to challenging the assumptions held by mental health workers about their black and ethnic clients, the authors assert that the competencies of therapists need to incorporate:
* the therapists’s sensitivity to the cultural variations and the cultural bias of her own approach
* the therapist’s increasing understanding of the cultural background of the client
* the therapist’s ability to respond to the greater complexity of working across cultures, (d’Ardenne & Mahtani 1989)

7c Inner City Projects
Various inner city projects have tried to ensure good access and maintenance of mental health services for black and ethnic patients with serious mental illness, eg. Bristol Inner City
Mental Health Project, Kings Fund 1990; The Newham Black and Ethnic Community Care Forum 1992; White City Project; Holland 1991; The Hackney African/Caribbean Crisis Sanctuary Project (CPRU 1995). Lewisham and Guy's Mental Health Trust (Strong 1994) has launched an innovative approach; aimed at cutting through white peoples' perceptions of the needs of the mental health needs of black people.

All these inner city projects have campaigning and surveying high in their agenda. Although each project has been responsive to individual need, they do have some common attributes:

* They begin by auditing the take-up of mental health services for minority ethnic groups, and provide an accurate profile of black users and potential black users.
* They put race firmly on the agenda of any mental health forum.
* They select sympathetic consultants and survey them to start.
* They review services and criteria for referral.
* They support all victims of racial harassment.
* They employ trained professional interpreters.
* They target people with long-term mental ill health, who are seeking specialist intervention, to help resolve psychological distress, and to help deal with their relatives' mental ill health.
* Some projects provide a residential service, offering short-term place of respite and sanctuary for individuals of families with young children.
* They advocate compulsory ethnic monitoring throughout healthcare.
* They publish their results!

These projects are primarily concerned with what is perceived to be a more politically just system where access to, and acceptability of the services is the primary criterion for success. Strict empirical assessments of the efficacy of such projects is yet to feature on the agenda, but is not yet a high priority for fieldworkers.

The Kings Fund has taken a number of initiatives nationwide to promote improved mental services for black populations (Aanchawan 1995) which includes putting race on the agenda, and by working with professionals in the field, and people in the community over several years. The intention of the mental health partnership, for example, as developed by the
Prince of Wales Advisory Group on Disability and the NHS-ME Mental Health Task Force, is to set up regional meetings in cities where there are large black communities and local initiatives already taking place, especially those done by black workers. Within this initiative, it is planned to deliver better and more appropriate services, with careful auditing of outcome.

8. SOCIAL PSYCHOLOGICAL THEORY - SOME APPLICATIONS

The reason for the dearth of empirical studies on cross-cultural mental illness lies in part because of few theoretical models that would provide a structure to research method. Social psychology and the psychology of intercultural contact, in particular, provide some interesting ideas (Furnham 1983c; Bochner 1982; Lonner & Sondberg 1985). The substantive areas of research into 'culture shock' have included international education, aid, business, migration, tourism, cross-cultural and antiracist training, from which certain findings have emerged.

* there is consensus that cross-cultural contact is inherently stressful
* there is no consensus about the nature and determinants of such stress
* those who suffer 'culture shock' (cross cultural stress) are more usefully seen as needing new social skills training than a more medicalised psychotherapeutic or counselling approach
* 'culture learning', a term that social psychologists use to describe the new learning required of the outsider, can be compared to learning a new language with new grammatical rules. It does nor require adjustment, assimilation or a forgetting of ones 'first language'
* 'culture learning' requires extensive preparation, social support, orientation and highly specific skills training about the host or majority cultures

Furnham & Bochner (1986) have widely used the culture learning model to explain why and how people in unfamiliar environments cope or do not cope. Their model would suggest for the purposes of mental health that the smaller the cultural distance between the therapist and the client, the less new learning would be required, but it does not necessarily predicate better longterm outcome. Their theory depends on the correct identification of new skills to be learnt. They assert that the acquisition of the majority language is the single most
important aspect of integration into the majority culture. Inability to do this leads to reduced social mobility, increased ghetto living and increased disruption between parents and children.

Such a proposal has not been systematically assessed. d'Ardenne & Mahtani (1989) observe that language, for example, is a necessary but not sufficient condition for increasing social change. Members of minority communities may be linguistically fluent, but still 'kept in their place' by increasingly subtle cues and attitudes held by those in power.

Furnham & Bochner (1986) are not unaware of the effects of external attitudes; they describe the structural aspects of societies during cross-cultural contact, which include:

* the extent on internal cultural homogeneity influences the nature and quality of the contact experience
* the extent to which ethnic identification matters and is responded to within a majority culture affects the quality of cross cultural contact
* the greater the psychological 'distance' between cultures, the greater the difficulties encountered in accommodation to the majority culture

Furnham (1983c) refers to the psychological variables that make up to contact experience.

* the territory where interaction occurs
* the timespan of that interaction
* the purpose of that interaction
* the type of involvement of both parties
* the degree of intimacy
* the relative status of the parties involved
* the numerical balance - (though it should be noted that the term 'ethnic minority' is less about numbers than status
* the distinguishing characteristics of the participants
* the expectations and dispensations of the stranger or visitor
* the in-group/out-group differentiation and the discrimination in favour of those within the in-group
Cross-cultural contacts, according to Furnham & Bochner (1986) have four different outcomes:

- genocide; assimilation; segregation or integration, of which only the last is judged to lead to the acquisition of multicultural skills for all parties.

Within the context of mental health, migrants and travellers are perceived as being exposed to more physical and psychological stressors, and to subsequent poor health. The distinction between selective migration and migration stressors has been examined as far back as 1936 (Malzberg 1936) looking at the higher rates of schizophrenia for first generation migrants of New York State. Cultural Learning Theory can provide research with a bewildering choice of factors but one which could lead to a more systematic analysis of what places individuals outside the majority culture at risk of psychiatric disorder, what helps prevent this, and what ameliorates it if it occurs. It would also provide a less emotive account of racism that allowed psychiatric epidemiologists to identify the greater threats to mental good health.

9. CONCLUSIONS

In conclusion, much needs to be done to improve the quality of services to black and ethnic people with serious and long-term mental illness, who may be triply disadvantaged, economically, socially and psychiatrically. This study has endeavoured to show that there is a need to recognise that current services are often judged to be inappropriate and insensitive to the needs of ethnic communities, and there is evidence to show that these communities do not take up the use of statutory services. It appears that services are based on assumptions of normality which are held within the white English-born population, and which exhibit an overdependence on Western medical models (Webb-Johnson 1991). There is, however, another trend showing a significantly higher number of African-Caribbean males with a diagnosis of schizophrenia in the UK, and who are detained under various sections of the 1983 Mental Health Act. The reason for this is still being debated between those who offer racism in psychiatry as a specific cause; those who argue that racism in society stresses black people and causes schizophrenia, and those who argue that such persons have constitutional differences, physical and psychological, that make them more vulnerable to mental disorders.

Transcultural psychiatry has shifted in emphasis from rendering black and ethnic communities
Transcultural psychiatry has shifted in emphasis from rendering black and ethnic communities as exotic, to a more focused examination of how individual and organisational racism contribute to serious mental illness. Despite this, black people continue to experience harsher forms of psychiatric intervention (Littlewood & Lipsedge 1989) with very little implementation and assessment of good practice. This review has found little empirical evidence that systematically appraises outcome from current projects. Many of the initiatives coming from community groups and funded by the Kings Fund are politically correct and have a strong ethical base. At face value, they appear to challenge ethnocentric assumptions (Webb-Johnson 1991). Good practice must recognise social, political, economic and historical factors which impact and prevail upon the individual. Nevertheless, there remains much evaluative work to be done to place such good intentions on a stronger scientific footing. Social Psychology offers some models that would allow researchers to ascertain which skills contribute positively to integration at an individual level, but do not provide answers to the wider issues of prejudice and xenophobia within the majority culture.

Transcultural models acknowledge dislocation and alienation experienced by black and ethnic communities, but must now demonstrate that good practice will ultimately treat and prevent relapse of serious mental illness for all members of a multiracial society.
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10. ACKNOWLEDGEMENTS

The author would like to thank the following people for help in the preparation of this manuscript:

Tracy Wells for secretarial support, at the Hackney Hospital,
Staff at Kings Fund Library, Albert Street, London, NW1,
Staff at Institute of Psychiatry Library, De Crespigny Park, London, SE5
ACADEMIC REVIEW

Some Characteristics of Nurse Victims of Assault in Psychiatric Hospital Settings

Submitted as part requirement for the Degree of Psych.D, University of Surrey
CONTENTS

1. Introduction ................................................................. 93
2. A Clarification of Terms ................................................. 94
3. Violence - The Current Risks to Psychiatric Nursing Staff ....................... 96
4. Blaming the Victim ....................................................... 99
5. Nurses Under Reporting of Assaults .................................. 100
6. Victims and Non Victims .............................................. 102
7. Nurses’ Own Perception of Violence ................................ 103
8. Recommendations for Change ....................................... 107
9. Conclusions ............................................................... 109
10. Bibliography ............................................................. 111
11. Acknowledgements .................................................... 116
1. INTRODUCTION

The subject for this review arose in the preparation of a longer research proposal on stress among nursing staff in a locked psychiatric ward in Inner London. It was noted that there were high levels of subjective stress and distress reported by these staff as well as high numbers of violent incidents recorded on the ward (d’Ardenne 1995). Although there is a statutory requirement to report all incidences of violence on wards, actual numbers may have been even higher. That there are organisational as well as individual reasons for possible under reporting (Turnbull et al. 1990; Swanson et al. 1990; DHSS 1988).

There is no shortage of interest in aggression in psychiatric hospitals (Larkin et al. 1988; Carmel & Hunter 1989) the patient characteristics in aggression (Noble & Roger 1989; Blomhoff et al. 1990; Convit et al. 1990) and the factors influencing aggressive behaviour (Blair 1991; James et al. 1990). There is less about the effect of aggression on nurses (Lanza 1988; Whittington & Wykes 1989) or about nurses’ perception of aggression, and about how this influences and is influenced by their own experience of aggression (Blair 1991; Morrison 1993; Finnema et al. 1994).

This review will concern itself with characteristics of psychiatric nurses associated with physical and verbal aggression from their patients, and will include the nurses’ own perceptions and experience of aggression and violence. It will hopefully cast some light on how perceptions of aggression are modified by experience, by education, and by the quality of the setting in which aggression occurs. It will also seek to establish some individual and organisational recommendations for change that would reduce risk in future (Turnbull et al. 1990; Breakwell 1989; HMSO 1987).

It seems reasonable to predict that, with the advent of community care since the ’eighties, with increased alternatives to hospitalisation, and with increased use of psychotropic medication, that the remaining inpatient population will be proportionately younger, more acutely ill, and more challenging (Lanza et al. 1991; McCarrick et al. 1985; Pepper & Rygiewicz 1981). The implications for hospital nursing practice will be considered briefly.
2. A CLARIFICATION OF TERMS

There has been much press speculation about increased violence in mental health settings, as though violence and assault were terms which are universally understood and agreed upon. In fact, Greenland (1985) (cf. in Webster et al. 1985) observes that violence is often promoted rather than condemned in society, and must be defined and assessed within a socio-political context, before it can be judged within clinical or psychiatric criteria.

In this section, the terms 'violence', and 'aggression' will be defined within the meaning of occupational assault, rather than by the strictly legal definitions, which are imprecise.

Convit et al. (1990) asserts that there are discrepancies in the reported rates of violence within different institutions, and in the demographic descriptions of the patients responsible for that violence. This is in part because of the absence of a single accepted definition of violent or assaultive behaviour. He cites authors who include verbal abuse (eg. Hafke et al. 1983; Lion et al. 1981) through to those who only define it when it requires medical attention (Depp 1983). Morrison (1990; 1991) examined 34 psychiatric nurses and 35 student nurses' perceptions regarding violent behaviour to self, others, and property, and the seriousness of such violence, and found large disagreements within and between the groups about the seriousness of such behaviours, and the implications for predicting risk. She does not, however, offer any theoretical framework for how such behaviours might be assessed in a clinical setting, nor indeed does she measure the relationship between the perception of dangerousness and predictability - a point she acknowledges in a later paper on a similar theme (Morrison 1990; Tardiff & Sweillam 1982) define assault as any violent physical contact directed against another person.

The American Safety and Health Administration definition is standard in many studies, (Carmel et al. 1989; Morrison 1991; Morrison 1994). An assault is, 'injuries that resulted in death or in lost workdays, loss of consciousness, restriction of work or motion, termination of employment, transfer to another job, or medical treatment (other than first aid)'.

In the areas of concern for the Department of Health and Social Security (DHSS 1988)
'violence' means:

1. 'the application of force, severe threat or serious abuse, by members of the public towards people arising out of the course of their work whether or not they are on duty',

and it includes

2. 'severe verbal abuse or threat where this is judged likely to turn into actual violence; serious or persistent harassment (including racial or sexual harassment); threat with a weapon; major or minor injury; fatalities. The DHSS does recognise that violent language is harder to gauge. It recognises that extremely rude gestures or swear words may be offensive or threatening to some, but that these may be the normal language of some members of the public, and that this is how they wish to communicate. Staff are asked to use their 'common sense' and 'to retain a sense of proportion' in distinguishing between annoyance and harassment or distress when reporting violence (DHSS 1988').

'Aggression' as a term has received even more attempts at definition. Rothenburg (1971) provides a positive perspective of aggression by describing it as 'a forceful, inappropriate non-adaptive verbal or physical action designed to pursue personal interests'. Rothenburg (1971) also argues that dangerous offenders can be categorised as:

- **chronic antisocial** - who have habitually aggressive psychotic episodes - where violence is associated with an acute episode marked by loss of contact with reality, and build-up of tension (cf. McKnight et al. 1966)

- **episodic and situationally violent** - associated with manic-depressive psychosis; organic brain dysfunction & alcoholism

- **extensively suicidal** - mainly women who have killed for altruistic reasons - often depressed with help-seeking and warning behaviour.

Rothenberg's categories are phenomenological, and are defined only by loose associations - eg. a diagnosis or a behavioural description. They are less helpful in helping the clinician in a working definition of aggression, which is generalisable and predictive.

Finnema et al. (1994) noted that nurses are not in agreement about how they perceive or describe aggression. A working definition of aggression is therefore impossible to obtain
from them. For example, individual nurses work to the (mostly) unwritten rules of the ward and are influenced by whether the ward is open or locked. The authors describe nurses as having a less critical view of aggression than the general public because of their situational exposure to violence rather than any training.

Breakwell (1989) has provided some useful working definitions for practitioners; 'Aggression is typically defined by psychologists as any form of behaviour intended to harm or injure someone else against his or her wishes. This means that intentionally harming someone else is not aggression if the injured party wanted it to happen. Aggression entails any form of injury - psychological or emotional included. So, belittling, cursing, shaming, frightening or threatening can all constitute aggression. Violence comprises those acts in which there is a deliberate attempt to inflict physical harm. Thus accidental harm does not comprise violence. For example, damage, which is a by-product of anger but is not intended does not comprise violence. It may feel the same to the victim but it cannot be explained in the same way as deliberate attempts to harm. The distinction between accidental outcomes is made in our everyday lives and in the legal system. We make it in deciding how we react to the individual causing the damage. We need to bear it in mind in explaining and predicting violence'. (Breakwell 1989, p 89).

Lanza et al. (1991) provide a conceptual framework for studying 'assault', which is seen not just as the patient's intrapsychic characteristics, but resulting from the interaction of these with environmental stressors and components within the care-givers. Similarly, Monahan (1981) sums this up by considering 'violence' on at least three general types of predictor variables: the potentially violent person; others involved; and situational factors. Utility of such models lies in their consideration of violence as an interactive process, where the characteristic of the victim must also be understood in predicting the likelihood of a violent incident occurring. This is not the same as saying that victims are responsible for the assault, but that nurses, for example, may be more in control of reducing the risk of assault if they are aware of all risk factors.

3. VIOLENCE: THE CURRENT RISK TO PSYCHIATRIC NURSING STAFF
The most comprehensive analysis of violence in the NHS was conducted as long ago as 1986
by the Health and Safety Commission, where 5000 health workers were surveyed, of whom 60% responded (HMSO 1987). This survey showed that although the most vulnerable staff of all are student nurses and ambulance drivers, that most types of serious incidents in the Health Service occur most frequently in psychiatric settings. Not only this, but one in four respondents had suffered minor injury after such attacks, a finding replicated in the US by Morrison (1994) and in Australia by Baxter et al. (1992).

Noble et al. (1982) analysed violent incidents in inpatient settings, and found that violence was often repetitive; that the most common victims were psychiatric nurses, and then other patients; that violent patients were more likely to be schizophrenic, deluded and hallucinated, and to have been recently admitted. The violent and the non-violent controls had similar backgrounds, and both groups had high levels of social isolation and unemployment. Violence was repetitive, and violent patients were more usually identifiable from previous aggressive and disturbed behaviour. There was a high proportion of African-Caribbean patients who tended to be younger, more psychotic, and more seriously violent. African-Caribbeans were particularly likely to be detained compulsorily and treated in a locked ward. The authors did not, however, offer an explanation for such results, psychological or social, nor indeed discuss the implications for race relations or racial awareness training in psychiatric settings in the light of such findings.

Larkin et al. (1988) examined 1144 incidents in a special hospital, and found, not surprisingly, that incidents occurred more frequently, and were of a more serious nature, than in a general psychiatric context. Only a small number of patients were involved, but comprised 75% women, who were only 25% of the special hospital population. Nursing staff were three times as likely to be assaulted as other patients. The gender imbalance may in some part have contributed to the high rate of violence, although the authors did not pick up this point nor make reference to the gender divide of the client group. It is worth noting in this study that 85% of the incidents appeared to arise spontaneously, and had not been predicted by staff in any way - a figure uncannily like the American figure of 77% (Dietz & Rada 1982).

In another British study, James et al. (1990) looked at an acute psychiatric ward over a period of fifteen months and examined the number of reported violent incidents in psychiatric
nursing incident book. They found that an increase in violent incidents was associated with the increase of temporary nursing staff ($r=0.63$) despite the maintenance of a constant nursing complement, i.e. 39% of the variance in violent incidents was associated with changes in staff. Staff were twice as likely to be attacked as patients. The small number of subjects ($N=14$) did not allow any other statistically significant trends to occur, except under-reporting, but it does replicate the findings of Lion et al. (1981) who did the first major study of this phenomenon in psychiatric nursing practice. The authors offer the most obvious explanations that temporary nurses are less familiar with patients, have less sustained relationships and trust established with them, may be less knowledgable and certainly less well-rehearsed in ward safety policies and procedures, and may themselves operate from different motivations than those of permanent staff. What they do not explore is why being a temporary nurse should prove to be so explosive in psychiatric settings. Many non-psychiatric NHS wards are staffed by temporary staff; there is no corresponding literature to suggest that assaults increase directly as a result. James et al.'s study had no control groups, eg. a non-psychiatric ward with the same number of temporary staff. This might have cast some light on whether there was any causal connection between being a temporary nurse and being more vulnerable to assault.

Pearson et al. (1986) found that in their survey of 283 violent incidents recorded in a range of psychiatric ward settings, that patients (114 incidents) were more likely than staff (92), to be the victims of aggression, and that they the attacks on patients were more severe. They attribute this to the fact that staffing levels were very low, and that violent patients simply had more access to their fellow patients. Fottrell (1980), on the other hand, found that nurses were more likely to be assaulted when the ratio of nurses to patients was higher, and suggests that by comparison, the mere availability of nurses made them more vulnerable to assault. None of these studies indicates how an ideal staff level might be gauged; nor do they postulate how the quantity of nurses interacts with the quality of nurses to increase the probability of attack. There is overall an absence of empirical literature that has followed up any of these observations. A better approach might examine wards with different numbers of staff caring for similar clients matched for dangerousness.

Fairlie and Brown (1994) examined accidents and incidents involving patients in a mental
health service and found that they were most likely to occur between 1600 hours and 2200 hours, and explained this in part, because of the build-up of frustrations throughout the day, because of nursing shift changes, because of the end of other therapies, eg. occupational therapy, and also because nurses were less interactive with patients than in the morning with washing, dressing etc. The authors suggest ways of changing nurse practice to reduce risk, such as talking to patients and providing additional quality one to one time at the end of the day. In comparison, Pearson et al. (1986) found no such relationship, except a slight increase at meal times, although there is again no clear attempt to examine timing of assaults in a controlled and systematic study.

Baxter et al. (1992) in a survey of 425 nurses, found that the mean annual rate of assault per nurse was 2.0, with student psychiatric nurses (X 6.7), significantly more at risk than any other group. They suggest that student nurses are less skilled at predicting early signs of violence, and yet are often exposed maximally to patients in a ward setting. The implications for supervision and training of students in reducing risk are not referred to, nor are these results replicated in the literature. Winger et al. (1987) in fact examined aggressive behaviour in long-term psychiatric care, and found no specific staff ratio, skill mix or time correlates for assaults. Instead they found that where nurses gave patients more control over their physical activities of daily living, that this improved patients' morale, and that the numbers of assaults for all nursing staffs could be reduced.

4. BLAMING THE VICTIM
Professional carers who are victims of assault are occasionally blamed for having caused the assault. Not only this, but the victims may also blame themselves and accept common stereotypes of incompetence and inexperience (Rowett and Breakwell 1989). The authors also suggest that nurses, social workers and teachers additionally describe such victims as being inflexible, demanding and unable to detect the early signs of violence in a given situation. It is not clear why such stereotypes develop, nor indeed why victims themselves so frequently concur with them. Breakwell (1989) suggests two models. The first is a bias concerning 'actor-observer' differences in attribution. If you do something yourself and are asked to explain it, you are more likely to explain it in terms of situational constraints and circumstances. On the other hand, if you watch someone do something, you are more likely
to explain why he did it in terms of personal characteristics.

The second model is the 'just-world' hypothesis, where people only get what is coming to them. If something bad happens, you must have deserved it. Rapes, muggings and other violent crimes are often thus defined.

Such stereotypes which blame the victim are purposeful; they locate the control of violence in the practitioner. As long as you are not inadequate as a nurse, you may then assume you are safe. These stereotypes may also explain the under-reporting of violent incidents in psychiatric practice, and the difficulties mental health managers have in supporting staff after the event. What this means is that victims of assault will not report an incident in case they are judged to be incompetent.

5. NURSES' UNDER-REPORTING OF ASSAULTS

All studies involved in identifying assaults on nurses are affected by the under reporting of assaults, and the inaccuracy and unreliability of subsequent information. Britzer (1988) showed that assaults defined as low hostility were rarely recorded. Lion & Reid (1983) estimated that as many as 80% of assaults were unreported, but do not indicate how they came to such a figure. Lanza (1983; 1988) questioned nurse victims over three months and concluded that up to half of them admitted to one unreported assault in the previous year.

Larkin et al. (1988) carried out a prospective study of assaults on nurses, aimed at eliciting a high rate of return, but there was only a 60% recording on the female ward, and 80% on the male ward, because staff saw these as performance failures, i.e. an inability to retain control of the ward (see Lion et al. 1981). The prospective study did not indicate in its method how it would reduce the unreliability of such records nor indeed what was the basis for estimating 'real' figures for assaults on the ward.

Under reporting, has been analysed by the DHSS (1989) and reasons offered include,

* just part of the job - this is especially true for psychiatric nurses
* pressure of work, with little time for so much paperwork
* guilt and embarrassment
perceived lack of sympathy or help from managers or peers
lack of awareness of existing support structures available
fear of reprisals
misunderstanding or ignorance of the need and value in reporting
reluctance to report incidents between clients where staff have tried to act as mediator.

Lanza and Campbell (1991) in the US, similarly included,

the variable definition of assault
differential attributions made to the patient about the degree of intent to commit harm
staff inurement to assaults
assault is to be expected; its part of the job
peer pressure not to report
gender bias in reporting
fear of blame
excessive paperwork
invalid reports lacking information or firsthand witnesses

In their study Lanza and Campbell (1991) included two additional categories of assaultive behaviour - agitated behaviour such as pacing and yelling, and combative or threatening verbal and physical behaviour - which were not reported on the incident forms, but which were included on the daily ward reports. The authors urge more comprehensive definitions of assault.

Convit et al. (1990) demonstrated that biases occur in reporting with recidivists, who are responsible for over half of the assaults in inpatient psychiatric settings. They suggest that nurses become acclimatised to such conduct, and become less inclined to fill out an incident form in which that patient has been involved. Conversely, violent acts committed by an infrequent assailant would merit more attention from nurses than that of a recidivist. Little work has been done on nursing bias in reporting incidents.

Baxter et al. (1992) reported that 23% of the respondents did not report a recent assault, even though 93% said that however minor the assault, that it should be reported! However,
of the 77% who did report the incident, only 34% said that they had had a helpful response. There is therefore a discrepancy between attitude and practice, and an organisational tolerance of it.

6. VICTIMS AND NON-VICTIMS

The prediction of violence among psychiatric patients has proven elusive. Blomhoff et al. (1990) & Convit et al. (1988) have suggested that previous violence, aggression on admission, and a diagnosis of schizophrenia are the only patient predictors, and that consideration could be given to the ward and the conduct of nursing staff (Monahan 1981). In this context, the conduct of nursing staff is not specified, other than what tautologically becomes described as 'provocative' ie. eliciting violence.

Morrison (1994) found in three studies which examine aggression and violence in psychiatric settings, that it was possible to identify both nursing and patient variables, and proposed a theoretical structure which would predict assault. This included nurses' discrepant interpretation of the therapeutic rules, and inconsistent enforcement of the therapeutic rules (as measured by the Personal Therapeutic Rule Scale, the General Therapeutic Rule Scale, the Social Rule Scale, and the Social Behaviour Scale, Morrison 1994), both of which interacted with patients' inability to adhere to therapeutic rules, or to social rules. She found that if these factors were combined with a history of violence and shorter hospital stay, that 55% of attacks could be predicted. What her study does not indicate is what proportion of assaults could be predicted by looking at nurse variables alone, since presumably these are more accessible to change, than those of the patient population. Nor does she take into account the environmental and institutional reasons that contribute to nurses' inconsistency; measures were by questionnaire only.

Lanza et al. (1991) questioned the assumption that there is something special about the victims of patient assault, and that they possess certain characteristics or behave in a different way from those staff who are not assaulted. This they did by firstly characterising staff victims and comparing them to non-assaulted staff, and secondly by documenting outcomes on staff who were assaulted. Their design included a prospective and retrospective phase. Nursing staff on two acute and four long-term psychiatric units were asked sociodemographic
and job-related information at the beginning of the study. The frequency with which each staff member was assaulted was recorded. At the end of 1 year, staff who had been assaulted were compared with staff who had not been assaulted. Any staff members who were assaulted were interviewed to assess physical and emotional effects.

Among Lanza's findings were that there were no differences between assaulted and non-assaulted staff in terms of body size, age, length of work as a nurse, length of time in mental health, number of children, times previously assaulted, or seniority within the nursing hierarchy. There were, however, differences in marital status - married being significantly less often assaulted; the authors speculate that this may reflect maturity and greater interpersonal skills, rather than anything specific to the professional nursing role. Indeed this one curious result may reflect the fact that the authors had not placed any weight at all on interpersonal style in their original profiling. Their methodology looked at 'professional' and demographical details that proved unrelated to the status of victim. Yet there already exists a substantial literature in the field of school bullying (Gillham 1981; O'Leary & O'Leary 1972) that indicates victim's interpersonal competencies may be critical in eliciting violence from potential assailants.

7. **NURSES' OWN PERCEPTIONS**

Finnema at al. (1994) carried out a major qualitative study of nurses' perception, and addressed the following three questions;

1. How do nurses working in a psychiatric hospital describe aggressive behaviour?

They made records of twenty-four nurses in both locked and unlocked wards, and were able to categorize statements including:

- definitions containing a value statement on aggression
- definitions describing a form of aggressive behaviour
- definitions describing a function of aggression
- definitions describing the consequences of aggression.

Interestingly, nurses were able to acknowledge positive aspects of aggression, including:

- as a way to express feelings
- as a way to send out feelings
- as the start of a more positive relationship
as an easy way to get things done which would otherwise not have been done.

2. What causes of aggressive behaviour by patients are distinguished by the nurses?
The nurses’ perception of the causes of aggression included mental illness; interactional and environmental factors; patients’ lack of privacy; patients being forced to comply with ward rules; absence of a clear aggression policy; inadequate staff attitude and the lack of influence of the patient on his or her own treatment plan, inadequate listening, failing to keep appointments, provoking, restricting, neglecting, asking too much of nursing staff, and interrupting patients.

3. What interventions are used by nurses working on psychiatric wards to prevent and stop patients’ aggressive behaviour?
Prevention and stopping aggression often involved similar strategies, ie. the nurses did not themselves see that the two tasks were essentially different. They included talking to the patient; distracting the patient; comforting the patient; giving unexpected reactions; extra medication; locked seclusion. Interventions appeared to depend on different factors such as the structure and culture of the ward and the individual nurse’s assessment of the situation, with subjects reporting that they often acted intuitively at the moment of aggression. The implications for nurse training here are evident. After, if there were doubts, support from colleagues affirming the handling would be solicited, along with a chance for discussion. Many of the interventions involved nurse-patient teaching, and were more common than restrictive measures, though both could be used at the moment of aggression.

The authors recommend that more research be carried out to investigate whether the different definitions of aggression in this study are generally accepted or considered important by nurses in psychiatric practice, and what factors are crucial in causing situations involving aggressive behaviour.

Ryan and Poster (1993a) surveyed 61 assaulted nurses in psychiatric settings, and found that the predominant emotional response was anger. Six weeks after the assault, the most commonly reported response was anxiety, helplessness, irritability, soreness, hyperalertness, sadness, depression, shock, disbelief that the attack had occurred, feeling sorry for the
patient who had committed the assault, and a feeling that the victim should have done
something to have prevented the assault from occurring. This reflects the findings of Lanza
(1981) and Poster & Ryan (1989) where the victim assumes responsibility for having become
the victim. Although most nurses had no symptoms six weeks after being assaulted, a small
number continued to report moderate to severe reactions at six months and one year
following the assault, even in the absence of severe injury.

Poster & Ryan (1989) also argue that while the number of psychiatric staff on duty is
important, that the critical factors are whether they are regular nurses, full-time,
knowledgable about their clients, and skilled and experienced. Nurse managers could have
a key role in promoting the view that patient violence is unacceptable, and that staff are
somehow to blame. They could also develop programmes to help staff cope with and prevent
violence, as well as challenge the idea that nurses are there to expect violence, and that they
should be tough enough to cope with it on an everyday basis. Nurses have emotional needs
too, and will end up suffering cumulative trauma if neglected, as with any other professional

Ryan & Poster (1993) reported on a survey of 554 nurses of whom 32% worked in
psychiatry on their experience of violence. Nurses' attitudes to and expectations of being
physically assaulted can have a crucial influence on staff recruitment and retention. They
found that 66% of psychiatric nurses said they agreed that nurses could expect to be
assaulted. This compares with 38% for paediatric nurses, 1% of nurses in general medical
wards, and 70% of those nurses working with learning disability. On the subject of whether
patients admitted to a ward were likely to exhibit assaultive behaviour, 16% of medical
nurses agreed; 27% of nurses working with children agreed; 57% of psychiatric nurses
agreed, and 64% of those working with learning disability agreed.

Turnbull et al. (1990) in preparing a training pack for nurses' management of aggression,
found that nurses subjectively expected that in the ward, they should:

* know what they are supposed to do
* be fully in control at all times
* cope with an incident with minimum fuss
* act in accordance with guidelines at all times, complete the paperwork, and
* not involve senior management if at all possible.

The reality was very different for the course participants as they reported:
* not knowing what to do and 'freezing' on the spot
* feeling afraid
* looking to others for help
* muddling through the incident

The authors discuss both individual and organisational implications for such a disparity.

Colson et al. (1986) factor-analysed the emotional ratings of different mental health professions to 127 difficult psychiatric patients in terms of 'counter-transference' - term loosely defined as "the hospital staff's emotional reactions to patients". They measured these factors against four dimensions of patient behaviour that contributed to staff expectations of treatment difficulty - viz. withdrawn psychoticism; severe character pathology; suicidal - depressive behaviour; and violence and agitation. Factors for nurses included - angry; positive; fearful and protective; for activity therapists - angry; protective and positive; for social workers - angry; positive; helpless and fearful; and for psychiatrists - helpless; angry and positive. They found some interesting differences between professional groups in response to patient violence. All professions manifested some anger in response to violence, but typically, nurses and OT's showed marked degrees of helplessness and fearfulness as well. The authors suggest that while doctors and social workers see patients in an office setting, that nurses and OT's have a greater role in the immediate daily management of patients' behaviour, which makes these emotions more likely.

Baxter et al. (1992) used a questionnaire to look at the experience and attitudes of psychiatric hospital nurses to assault from patients. The authors showed that psychiatric nurses can expect to be physically assaulted on average almost twice a year, higher if a student nurse, and highest of all in psychogeriatric nursing. The implications for recruitment and retention were discussed. Perhaps more alarmingly, the authors found that nurses had a willingness to tolerate physical assaults, almost as a prerequisite for training as a hospital based psychiatric nurse. Nevertheless, subjects reported that it took up to six months to recover psychologically from such assaults.
Nurses assumed, that they would be assaulted; that they should be able to predict assaults; that nurses invited assaults (70%), although 44% believed that nurses were unfairly blamed for provoking assaults; that hospital administration does most of the blaming, rather than peers; that administration does not do enough to protect from assault, nor to support staff after the event. The reliability of such studies is difficult to ascertain. If on the one hand, nurses expect to be assaulted and under-report such assault, why are the authors confident that they have elicited a comprehensive and accurate account of what is happening to the nurses through interview?

Aggression management workshops did not reduce risk, though nurses viewed them very favourably. Views about managing assault differed widely, especially in the use of seclusion for violent patients, and in the willingness of nurses to prosecute after assault. This lack of consensus is, in the minds of the authors, a major hindrance to the development of optimal strategies to deal with the core problem.

Morrison (1990) compared perceptions of aggression and violence by doctoral students in nursing with psychiatric nurses currently working in an inpatient psychiatric setting. She used Thurstones's method of paired comparisons and judgements regarding the seriousness of each type of violent behaviour for the categories of doing grievous harm to self, others or property. The most noteworthy difference between the groups was the extent of disagreement within the psychiatric nurse group regarding the seriousness of violent behaviour towards them. The author notes that the students were educated to a homogenous standard, and that this was associated with a low tolerance of aggression. Clinical nurses, however, had very different levels of education and clinical experience, all of which served to influence their perception of dangerousness and risk. The implications for ward management are discussed. As long as these differences in subjective perception of risk remain, the problem of defining and reducing risk will be compounded.

8. RECOMMENDATIONS FOR CHANGE
A recent survey showed that the guidelines being set out by the National Association for Staff Support are not being implemented across the UK, (National Association for Staff Support, 1992).
The law about safety at work seems clear enough. The Health and Safety at Work Act, 1974 (DHSS 1989), Section 2 (2) (c), requires an employer to provide 'such information, instruction and training and supervision as is necessary to ensure, so far as is reasonably practicable, the health and safety at work of his employees'. Section 7 (a) of the Act says that 'it shall be the duty of every employee to take reasonable care for the health and safety of himself and other people who may be affected by his act or omissions at work'. Within the spirit of the Act, the above conditions impose a duty on staff to advise those who need to know of the potential risk of injury from a violent person.

Breakwell (1989) quotes Strathclyde Regional Council in the importance of managing violence at a managerial, as well as at a personal level, and includes:

1. Setting up guidelines for practice in the areas of risk assessment; speed of alerting senior staff; type and back-up services; long-term reviews of violent clients; short-term handling; decisions about police prosecution; counselling of witnesses of the attack; logging of staff movements; clients' complaints procedures; proposals for easy, accessible and speedy reporting that make liaison with interested parties easier.

2. Supporting staff after an assault; automatic debriefing; counselling offered as routine, with an awareness of possibly delayed reactions; facilitation of the team in supporting the assaulted colleague, with options on handling the assailant in the future; paid time off for the duration; advice about police reporting and compensation from the Criminal Injuries Compensation Board; staff insurance and legal costs covered for prosecution etc.

3. Structuring training to deal with violence and its aftermath. Nurses can be offered many options; management can suggest both conventional schemes and less conventional eg. job exchanges; social skills and theatre work for dealing with a wider number of violent scenarios; training in predicting and avoiding violence; joint training with other professional groups, which is effective, less costly, and promotes good interagency liaison in the aftermath of violence.

4. Providing technological, organisational and environmental safeguards against assaults. Technological aids in the form of personal alarms, mobile telephones are bought by management, often after a violent attack in response to staff demands. Their efficacy however, is unproven. Organisational changes in nursing practice are perhaps harder
to achieve, but may in the long-term prove more effective, eg. reviewing staffing establishment to ensure that sickness, training and holiday leave is properly covered; better supervisory arrangements; environmental changes include space, furniture, room layout, lighting, door locks etc, where nursing management can considerably influence the risk factors to all nurses.

Turnbull (1993) has long argued that organisations should have clear policies and guidelines to help staff deal with violence in the workplace. He argues that our knowledge of violence is considerable, but that our understanding of it is not. This is particularly the case when violence is perceived as a reflection of professional, rather than organisational, failure. He cites the need to redesign incident forms, that would cast light on the antecedents and immediate consequences of violence on the ward, and would establish the skill-mix on the ward at the time of the incident. Forms typically have to be filled in immediately, although there is no evidence that victims recall events well when still traumatised; furthermore, they allow no description of psychological damage, only physical sequelae.

There is pressure on staff to return to work too soon, and not to be seen 'letting down' the side, (cf. Lanza 1983; Baxter et al. 1992). More pragmatically, Turnbull et al. (1993) have produced a training programme which appears to provide nursing staff with an understanding of the nature of violence and a repertoire of skills that would allow them to feel more confident in their abilities to cope with violent incidents for their own safety and ultimately, for the safety of their patients.

9. CONCLUSIONS

The picture emerges of psychiatric nurses who are second only to those in learning disability as expecting violent patients, expecting to be assaulted, and expecting this to be a normal feature of professional life. Not only this, there is evidence that these expectations are learnt when nurses begin their training and that these beliefs are sustained within nursing hierarchies and organisations, as well as individually. There may well be a culture in psychiatric nursing which tolerates both physical and psychological violence that is not apparent in other nursing settings. This review has shown that psychiatric nurses are indeed more likely to be assaulted by their patients in hospital settings, although there is no evidence
that nurse grade, (with the exception of student nurses) gender, background or experience either increases or decreases the probability of assault. Several studies have shown that interpersonal skills and the adherence to therapeutic rules on the ward can reduce risk. There may be other processes that can also reduce the chance of assault. A nursing culture that expects or tolerates violence is itself likely to be a contributor to the problem.

This is particularly well demonstrated in the under reporting of less serious incidents, and may explain why nurses do not see the point in completing incident forms. Furthermore, there are some findings to show that being assaulted is seen as a sign of professional incompetence - a finding that had been replicated in social work and teaching, though not in medicine or other mental health professions. Nurses as a professional group are less likely to see violence as an institutional failure, and less likely to see that organisational changes may have a greater impact on their safety than individual training in specific competencies.

There are, however, attitude and competencies in nurses that could be changed to reduce risk. The research shows that nursing management must play a high profile in achieving a change in culture and expectations as individual change may be a necessary but not sufficient condition for greater safety in psychiatric wards.
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11. ACKNOWLEDGEMENTS

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CLINICAL PROJECT

Developing Psychology for a Multiracial Community in Inner London

Submitted as part requirement for the Degree of Psych.D, University of Surrey
This paper sets out to define the processes and mechanisms deployed in reforming a clinical psychology service appropriate to the needs of one of the most socio-economically deprived districts in the country. Attention is given to how Public Health, Purchasers and the local community have defined physical and mental health needs and how a blueprint for psychological services was derived from these. The actions involving the funding, developing, recruiting and retaining psychologists with good local knowledge and cultural and racial awareness are described as are the examples of good practice and action research. This paper also considers how far NHS psychologists have responded to the needs of black and ethnic populations and tackles the wider aspects of training and clinical practice and how they could be improved locally, regionally, and nationally, within the BPS's own equal opportunities policy.
CONTENTS

Introduction - The Post Tomlinson Reforms ................................................................. 120
Health Guidelines - The Larger Picture ........................................................................ 120
Equity ............................................................................................................................... 121
The Local Picture ............................................................................................................ 122
Implications for Purchasers and Local Services in Hackney ...................................... 124
The Development of Clinical Psychology in Hackney .................................................. 126
A Vision of Clinical Psychology ...................................................................................... 127
Local Consultations, Funding and Developing Clinical Psychology ............................ 128
Recruiting and Training .................................................................................................. 132
Results and Recommended Guidelines ......................................................................... 134
Examples of Good Practice ............................................................................................ 135
Models of Good Practice ............................................................................................... 138
Good Practice Conclusions ........................................................................................... 139
Clinical Psychology, Race and Culture Special Interest Group .................................... 140
Clinical Psychology Provision ....................................................................................... 141
Access to The Profession for Black and Ethnic People ................................................ 142
Clinical Psychology and Racism .................................................................................... 145
The Response of the British Psychological Society ....................................................... 147
Conclusions and Recommendations ............................................................................. 149
Bibliography ................................................................................................................... 150
Appendix 1 ..................................................................................................................... 157
Appendix 2 ..................................................................................................................... 167
Appendix 3 ..................................................................................................................... 174
Appendix 4 ..................................................................................................................... 191
Introduction: the Post Tomlinson Reforms

No discussion about healthcare in London in the 'nineties would be complete without reference to the commissioned work of Sir Bernard Tomlinson and his colleagues by the Departments of Health and Education in 1992, to re-organise the National Health Service and medical education and research in London (Tomlinson 1992). Its immediate recommendations were that hospital based services in the metropolis be cut, and that resources be allocated outside the City, as well as into primary and community services in London. The redistribution of resources was assigned to the London Implementation Group, (LIG) a body charged with ensuring that primary-secondary interface in health service was continuous, accessible and equatable. Thus were priorities within health services altered and an opportunity provided for the redevelopment of psychological services more attuned to the needs of the local population.

Health Guidelines: The Larger Picture

The Patient's Charter (1991) advises us that "every citizen has the right to receive health care on the basis of clinical need regardless of ability to pay". That is not to say that there are no limits to costs, but that these cannot and should not be born by the individual patient. A report by the Kings Fund (1994) reiterated that care could not be allocated on the basis of class, race, sex income, clinicians' interests or preferences, but that criteria had to be on the basis of need, effectiveness and cost (taken together). Furthermore, the Charter advises that "the NHS will be aiming to provide for you: respect for privacy, dignity, and religious and cultural beliefs; and arrangements to ensure everyone, including people with special needs, can use the services".

Despite this, and the targets set for all citizens in the Health of the Nation (Tomlinson 1992), there is clear evidence of substantial differences in health standards and access to services amongst many people from ethnic groups in the UK today (Balarajan 1991; 1992; 1991; Census; OPCS 1992).

Against this background of healthcare reforms in London and the surrounding areas, and in medical teaching and research, there has been another shift in culture in the NHS. The present Government's reforms have split health authorities into purchasers and providers of
healthcare, who now construe the patient, his GP and his relatives as consumers of services, who need to be delighted by quality as well as cured of ailment. Not only this, but the establishment of NHS trusts as self-governing businesses essentially competing with each other for income through service contracts, has increased awareness of The Equal Opportunities Task Force (Kings Fund 1990), which recommended that agreed standards and targets for movements towards equal opportunities in employment should be negotiated by purchasing authorities provider units and trusts, included in contracts, and performance monitored.

**Equity**

If the Patient's Charter promises every citizen the right to receive health care on the basis of clinical need regardless of ability to pay, how do we set limits on care? A summary statement of criteria for eligibility for care which are not acceptable include, class, race, sex, income, clinician preference or interest, acceptable need, effectiveness and cost (taken together). Arguable criteria include age, lifestyle, time waiting, extent of others' dependency and treatment compliance. Ethnic monitoring (Kings Fund 1989) is recommended and essential for:

- an account of the extent of racial discrimination
- understanding that discrimination occurs not only directly, but indirectly and unconsciously through existing personnel practices
- examples of racial inequality in the health service
- identifying and remedying the causes of inequality
- guidance provided by statutory and other organisations
- examples of employers who have already adopted ethnic monitoring systems
- need to comply with code of practice
- monitoring actually does lead to enhanced equality of opportunity

The Kings Fund (1989) recommended that Health Authorities should:

- assess whether equal opportunity for all ethnic groups is being achieved;
- to see whether equal opportunity initiatives are producing positive results;
- to identify where remedial measures may be required;
- to develop the Equal Opportunities, programme appropriately;
- justify positive actions that may be required;
In another paper looking at racial inequality in the nursing profession, the Kings Fund (1990) concludes:

"Racial inequality in the nursing profession is wide ranging and deep seated. Not only this, but it has been entrenched for a long time and will be difficult to remedy. There are no easy answers, but says the Kings Fund, failure to recruit and retain black and ethnic minority nurses will severely limit the ability of the profession to deliver adequate and appropriate health care to Britain’s multiracial, multicultural population. The perspectives, skills, and knowledge which black and ethnic nurses bring to the profession must be seen to be recognised and positively valued. Staff levels are also critical".

This paper also refers to midwives and health visitors and it describes some good practices and on introduction of anti-racist practice at work. However, there appears to be no overall effort by the profession as a whole to tackle racial equality issues, and the Kings Fund concludes that this has to change.

The Local Picture

Hackney poses a challenge to a policy of equal health access. Some demographical data might illustrate this. The population of Hackney is young, mobile, ethnically diverse, with a disproportionately higher number of refugees than in the neighbouring Boroughs of Islington, Newham and the City (OPCS 1992). To understand why this is, a brief history of ethnic minority settlement in the Borough might help.

The Jewish community was the first ethnic community to settle in Hackney in large numbers, starting from the eighteenth century, and greatly accelerated by the advent of fascism and anti-semitism in Europe. The Hackney community was greatly swollen by Holocaust survivors, who settled mainly in the Stamford Hill area. Jewish people who had moved out to wealthier suburbs were replaced by a new Caribbean community who settled in the '60's, when, due to a labour shortage, black people were actively recruited and encouraged to settle in Briton by public and private sectors. Today Caribbeans account for approximately 26.8% of the local population, the largest ethnic group in Hackney.
The number of Asians residing in the Borough is 9.4%, including people from Uganda, Kenya, Pakistan, Bangladesh, and above all, India.

The most rapidly growing ethnic community in Hackney in the 1970's was the Cypriot, both Turkish and Greek. The Turkish invasion of Cyprus in 1974 led to substantial migration to Britain, and significant numbers (over 8000) are now established within the Borough. Other significant ethnic groups include Nigerian, Ghanian, Ugandan, Irish and Chinese.

The refugee population has reached a peak in the last five years, where Hackney has been perceived as a natural and safe destination for those refugees whose communities were already established here. Estimates at present are 23,700 persons.

Since 1975, and the end of the Vietnam war, it is estimated that 2,200 Vietnamese refugees reside in Hackney, despite, the Home Office's official policy of dispersing these people very thinly around the UK. In the last six years, the numbers of Turkish Kurds in Hackney has increased form 1,500 to 8000, following persecution in Kurdistan.


Hackney also has high levels of unskilled and semi-skilled workers, higher unemployment rates than the rest of inner London (21% compared to 16%), low home ownership levels, at 37% compared with 70% nationally, up to 18,000 homeless people, not including its refugees. Hackney has the highest number of single parent families, and along with its neighbour Tower Hamlets, is one of the most economically deprived in the country (OPCS 1991).

The Mental Health Focus Group Report (Jacobson (1994); Hackney Community Care Plan 1994) lists Hackney as having, not just economic privation, but social isolation and disequilibrium. It derives this from the mobility, the ethnic composition, and the high rates
of homelessness in the Borough. Consequent to this, Hackney has demonstrably high psychiatric admission rates, high incidence of schizophrenia, a higher than national rate of suicide, and a higher than national rate of deliberate self harm (OPCS 1992).

The Jarman indices (Jarman 1992) predict high rates of psychological distress and morbidity in such an area, but local services have undertaken a very careful analysis of users' needs and attempted to define a useful model for such a deprived area (Bowling & Parkham 1992). Amongst their findings were that within the acute psychiatric population examined, 40% of subjects were black Caribbeans, black UK, and black Africans. In addition, black people were significantly more likely to have been admitted via the law courts or prisons, although no more likely than whites to have been admitted by the police.

Black Africans, Caribbeans and black British were more likely to have a diagnosis of schizophrenia (country of birth was not significant). Of particular relevance to psychological services was that, in interviews carried out with ward staff, patients and GP's, that the most frequent reasons for the admission of seriously mentally ill people was (in descending order of magnitude) relationship difficulties, accommodation problems, family discord, violent or dangerous behaviour, social isolation and anti-social behaviour. What many interviewees listed as unmet need included life and social skills training (33%), behaviour modification needs (21%), counselling and support for carers (16%), and psychotherapy (10%). These findings are similar to those in other urban areas (Littlewood & Lipsedge 1989; Melzer 1991; Public Health Report 1990; Thornicroft et al. 1993).

Implications for Purchasers and Local Services in Hackney

Health in the East End (Public Health 1994) has addressed the enormous demands of Health of the nation by taking a controversial stance. It asserts that adopting unrealistic and unachievable national targets in such a deprived Borough would be wrong and that a local considerations would be to:

* assess need and the ability to benefit from intervention
* place great emphasis on prevention rather than cure
* target vulnerable groups

Public Health in City and Hackney (Jacobson 1994) has indicated that any health strategy
must address:
* higher levels of ill health due directly to poverty
* making services accessible to people with little transport, who change address frequently, and whose first language is not English
* overcoming the "inverse prevention law", ie. the healthiest and the wealthiest tend to respond to preventive programmes

Their mental health strategy includes:
* a range of supported housing
* better services for ethnic minorities
* evaluation of newly established community mental health teams. What they did not specify was what exactly what they meant by better services for ethnic minorities.

Consultation in the voluntary sector (MIND 1994a) has provided some useful insights in the field of mental health in Hackney. MIND (The National Association for Mental Health) has innovated an advocacy project, aimed at supporting the rights of users of mental health services, including an African-Caribbean advocate, following its finding (MIND 1994b) that African-Caribbean patients were: over-represented as sectioned patients at the Hackney Hospital; under-represented in the pilot survey due to their declining to be interviewed; more suspicious than white users about the care received; less likely to see a consultant than white users in their first day of care; less likely than white users to get written information about their section; less able to elicit a willing response from staff to answer questions; less likely to have their treatment discussed with them; and less positive about their careplan. The survey was not without its methodological flaws, but it provided a focus for understanding some of the needs expressed by service users in Hackney of mental health services, who were black.

The Joint Planning process between the Health Authority and the Local Authority in the City and Hackney has revealed that the needs of a multi-racial society are far-reaching, complex, but not unachievable (Hackney Community Care Plan 1994/1995; The First Hackney Children's Plan 1994/1995). The City and Hackney Joint Planning Structure uses the Black and Ethnic Minority Working Group to represent these needs. They have highlighted the need for counselling, for information, for translation and interpreting services, for culturally
appropriate services to different ethnic groups e.g. the orthodox Jewish community, for
advocacy, and for more informal and accessible services provided across the Borough,
including the homeless and refugees. Health and Social Services in Hackney made their
recommendations for all care groups, including the Elderly and Children, and committed
substantial funds, including LIG (London Implementation Group) monies to achieve access.
The specific role of clinical psychology in these two plans will be discussed below.

In conclusion, there has certainly been a recognition that the health needs of a multiracial
society in Hackney have not been adequately addressed within existing structures. Public
Health, the voluntary sector, and the users themselves, have highlighted specific service
needs that would need to be met for the service to meet even the minimum standards of
equity and quality required by the Patient's Charter. The next section will deal with the
origins of the current department of clinical psychology, and the efforts it has made to
countenance this shortfall in service provision, and the models and skills it has brought to
bear to achieve this.

The Development of Clinical Psychology in Hackney
Overall, by the beginning of the 'nineties, it was clear that the psychological needs of many
members of the community were recognised, but not necessarily being met. At that time the
Department of Clinical Psychology was substantially underdeveloped, and consisted of 5.0
wte's, two working in specialities, one in learning disability, one in mental health, and one
person (HH) undertaking project work with the department of Child Health on populations
known to be at risk.

The Divisional Directorate of Psychiatry within Barts NHS Group approached Dr John Hall,
Consultant Advisor in Clinical Psychology to the Department of Health, to carry out a major
review of the existing clinical psychology services in the City and Hackney, and to highlight
and prioritise the objectives for what he called, "a classic inner city environment" (Hall
1992). He translated the need to establish or fill posts in the areas of:
- mental health generally, but particularly related to the needs of ethnic minorities, and
to those with long-term mental health needs;
- substance abuse generally, and alcohol abuse in particular;
services for older people;
work with children, noting the implications of the 1989 Children Act;
people with learning disabilities, noting the proposed posts in challenging behaviour;
community care and health promotion/illness prevention, working closely with the FHSA and GP’s;
support for community and voluntary agencies working with travel and multi-need groups, including the homeless;
sexual disorders and sexually transmitted diseases generally.

Hall (1992) indicated that a new Head of Service with a developmental role should be appointed and charged with the task of establishing a vision for all psychological services within the Trust, as well as planning creating and implementing a team to achieve this.

A Vision of Clinical Psychology

The author applied for the nationally advertised post, and after a formal presentation of a vision to the Trust managers and lead consultants, was appointed at the start of 1993.

The Vision of Clinical Psychology contained five basic tenets, which were:

1. to be a major provider for City and Hackney people and to achieve identifiable improvements in their psychological wellbeing, according to national and local guidelines
2. to offer a comprehensive and competitive range of services of high quality and value, in response to purchasers’ requirements and users’ needs
3. to inform, involve and work with patients according to the Patient’s Charter
4. to provide locally-based, accessible services within hospital and community, which are appropriate to the diverse needs of an inner-city multi-ethnic population
5. to develop a high academic profile within the Trust in collaboration with University College London and University of East London training courses, and in keeping with Working Paper 10

The Actions for each of these objectives are enclosed in Appendix 1; those required for the creation of more accessible and appropriate services, included the promotion of cultural and racial awareness; the establishment of this awareness as a quality factor with user groups,
and giving positive weighting to black and ethnic psychologists, and to provide recruitment and retention measures for candidates with good local knowledge.

**Local Consultations, Funding and Developing Clinical Psychology**

The City and East London Health Authority was approached for how it would support the development of such a service, and it responded by asking that the service should submit bids under LIG funding, that provided good interface between primary and secondary services. It supported a bid for the development of a Primary Care psychology service, whose brief would be to establish a service to GP's with seamless access to locally based mental health services. Three posts were created, two of them joint appointments with the Locality teams, requiring close liaison between generalist and specialist services within the community. In addition, the team had a specific brief to work with communities not currently accessing healthcare, and to assist in supporting and developing counselling services in the voluntary sector.

The Health Authority also funded additional posts in the Localities, requiring emphasis on psychological care of people with long-term mental health problems, working with a multidisciplinary team aiming to provide integrated social and health care. These were originally also LIG funded.

The Division of Psychiatry was consulted and responded by the creation of two new posts in psychological therapies. Emphasis here was placed on ensuring that psychological support on the acute ward would prevent rapid relapse and re-admission - a problem highlighted in the Needs Assessment Survey (Parkham and Bowling 1992). As part of this, the postholders would be required to provide extensive outpatient follow-up, with specialised therapeutic interventions as required (Tarrier et al. 1988). One of the post-holders was commissioned to establish with two consultant psychiatrists a multidisciplinary department of psychological therapies, that would have a Borough-wide focus, and would support the ongoing services within the localities.

Two posts in mental health rehabilitation were identified, and funded out of reprovision monies from patients being returned to the Borough for resettlement, under the requirements of the Community Care Act. Their specific brief was to assist the multidisciplinary teams
in the assessment of and interventions with people with long-term mental disorder, and in the preparation of Individualised Care Plans for clients, who would then be placed under the care of the Locality Teams. One of the posts was combined with a Locality post, to ensure liaison and smooth transition (Bennett 1980).

Great sensitivity and diplomacy was required for all of these posts; the reputation of the Hackney Hospital, both locally (MIND 1994) and nationally, (Littlewood & Lipsedge 1989) was one of high levels of sectioned patients (under the 1986 Mental Health Act) and a substantial over-representation of African-Caribbean patients, with heavy emphasis on medication, containment and restraint. The course of these posts will be discussed later; suffice it to say that psychiatry, although open to psychological models of care, was facing a situation of 130% occupancy of its beds, i.e. with patients on home leave losing their beds to new admissions. Psychiatry also had concerns about dangerousness, and the release of psychiatric patients without adequate supervision and support, e.g. the stabbing to death of Steven Zito by a schizophrenic patient in Hackney (NETRHA 1994).

Additionally, the Division of Psychiatry supported the development of two more posts in Old Age Psychiatry, with a brief to develop work with families, as well as working with the more general range of organic and functional disorders. Again, the issues of culturally appropriate and accessible services were placed on the agenda (Hackney Community Care Plan 1994/1995) with the objectives of empowerment, being in control and equity. Even in the age group 65-74 years, 16% of the population are from black or ethnic communities (OPCS 1992) which is an under-representation. For example, the strictly Orthodox Jewish community, long established in Hackney, was not separately identified on the Census; neither were other minorities, including Greek, Turkish, Kurdish and Cypriot elders.

The Community Directorate of City and Hackney had already commissioned a Community Child Health Clinical Psychology service, aimed at project based interventions with populations known to be at risk. The service was required to ascertain the needs of families with young children for psychological support; to work with parents and children as appropriate, in a variety of settings, including health centres; to provide services for ethnically and culturally diverse people in Hackney, and to ensure that assessments were
sensitive to the needs of black and ethnic children and their families. The original postholder had singlehandedly piloted, evaluated and written the outcomes of early interventions, and established close working relationships with a wide range of health professionals involved with the families of the under-fives in Hackney.

The Child Health Directorate made it clear that it would continue to support this style of psychological work in the future, and agreed to fund three additional posts in Community Child Health for this work to be carried out on the four geographical localities in Hackney. During this consultation period, the Social Services Directorate at the London Borough of Hackney agreed to fund these posts with the Health Authority through the joint planning process. They also agreed to fund and help clinical psychology develop a Hackney Schools and Community Service, aimed at, according to its protocol, "developing and supporting school based projects in Hackney, designed to promote psychological wellbeing, prevent psychological distress in pupils and staff, intervene early and appropriately, and make the best use of individual and organisational strengths and resources".

The Community Psychiatric Research Unit (CPRU) was consulted early in the development of this service. It had secured Inner City Partnership funding for the establishment of a Challenging Needs Team, to complement the work of the Learning Disability Services in Health, Social Services and voluntary sector, and to address the needs of users who were currently being excluded from resources within the Borough because of their challenging needs. (At the time of writing, over 150 people out of a total of 918 on the Learning Disability register were placed away from Hackney, sometimes over a hundred miles away).

A steering group convened by the CPRU recommended that a clinical psychologist manager be recruited and appointed to lead and direct a multidisciplinary specialist service, sensitive to the diverse needs of its users. The Community Care Plan for Hackney (1994/1995) had specifically recommended advocacy for users, that the Challenging Needs Team should involve users and their families as much as possible, and that access to psychological, physical and occupational therapy services specifically be made more accessible to them.

The FHSA and the Hackney GP forum were consulted about what they wanted from a
redeveloped Clinical Psychology Service, having supported the principle of a Primary Care Psychology Service. The GP’s were divided between those who wanted a generic walk in service for all forms of psychological distress, and those who favoured a more specialised service, offering clinics for particularly challenging problems, and providing easy access to the Locality mental health teams. Two national assessors, approved by the Department of Health for the selection and appointment of higher grade posts, were consulted. Mary Burd and Halina Brunning, assisted the Head of Service in developing a slow-growth model, aimed at reducing stigma, assisting agencies providing advocacy and counselling to ethnic minorities, and ensuring that early intervention work complemented the work of the Community Team on the one hand, and the Locality Mental Health psychologists on the other (Brunning & Burd 1993).

The FHSA and Public Health recommended that psychology should commence with establishing itself with group practices already sympathetic and open to psychological approaches, rather than on the neediest of single handed practices (there are 139 GP’s in Hackney, of whom only two are Fundholders). They also commissioned the Department of Clinical Psychology to provide some team building for the primary Health teams being set up to integrate care at the first point of contact with the NHS.

The Directorate of Immunology in the then Barts NHS group had already developed a clinical psychology post for HIV/AIDS services, but consultation revealed their commitment to develop a second post focused on community care and prevention. A third post has since been developed for work with sexual and GU disorders. In the North-East Thames region, Hackney has the largest number of people living with AIDS after Camden and Islington. Many people, known to be sufferers from black and ethnic communities have not made contact with health or social services (Hackney Community Care Plan 1994/1995; East London and the City Annual Public Health Report 1994/1995). New postholders were sought in clinical psychology who could address this issue in an effective and demonstrable way. The first objective for this care group in joint planning, was that all people living with HIV/AIDS be made aware of where they can obtain information, advice and counselling, and have easy access to these services. The second was that people living with HIV/AIDS have "added years to life". One way of achieving this objective has been improving the interface
between hospital and community care, specifically by improving hospital discharge policy.

Psychologists have a well defined clinical role in giving direct clinical care to AIDS in the City and Hackney, as well as an organisational, supervisory and training function. Recent discussions with East London Purchasers have enabled this service to take a lead role in extending and generating an East London wide clinical psychology service with this care group, since there is evidence (Public Health Report 1994/1995) that an urban at risk population like this is transitional and migratory across East London, and that specialist and scarce care skills need to be more effectively harnessed.

**Recruiting and Training**

The last two years in this department have seen unparalleled change and growth. The Barts NHS Trust application collapsed, and reformed as the Barts NHS Group, where it waged a vigorous campaign to save Barts Hospital - with a million and a half local signatures, and the support of the City of London - to no avail. In December 1993, the Department of Health decided to close Barts, and amalgamate it with The Royal London at Whitechapel, to form an Acute NHS Trust, The Royal Hospitals Trust. The remaining priority services in the City and Hackney were then advised of an ambitious bid to form a Pan-East London provider service, by combining with Tower Hamlets and Newham. The process was managed by a transitional body, the City and East London Family and Community Health Service (CELFACS) to prepare a Trust application. It failed. The Secretary of State decided on December 15th, 1994, that the three East London Boroughs should form separate Community Trusts, with a strong local focus, and close collaboration with the Local Authorities for effective community care. The fate of clinical psychology has yet to be decided by the Purchasers in the midst of all this upheaval, and the current indications are that it will be managed on a Pan-East London basis. Thus, the present shape of a local health service can be determined by regional and even national political considerations, with clinical psychology playing a very small but visible role.

Emphasis was placed on firstly the recruitment of clinicians sensitive to and knowledgable about the local community and secondly finding people who already lived and worked locally. We were particularly interested in individuals who could identify positively and
enthusiastically with the needs of the Borough. The two local training courses (UEL and UCL) were appraised of the situation, and national advertisements went out through the BPS Appointments Memorandum, the Guardian, and the Hackney Gazette. Where grading for the post was flexible, the advertisement indicated that points could be negotiated, and that career development was possible with appropriate professional development. Flexible working hours, jobshares, combined posts, and honorary academic titles were deployed in a determined bid to fill new posts with good quality candidates as soon as possible.

As important as specific academic and clinical skills, were candidates' experience of working in an inner city environment, a proactive stance towards equal opportunities in general and racism in particular, and additional community and cross cultural skills, e.g. a community language or working experience with an ethnic community. We were looking for candidates who recognised that psychology could oppress as well as liberate, and could bring a multicultural model of intervention, rather than the more traditional Eurocentric models still prevailing in many training courses (Alladin 1992; Kareem & Littlewood 1992; d'Ardenne & Mahtani 1989; Goodwin 1985).

The Equal Opportunities Policy of the Health Authority did not allow us to recruit exclusively black or ethnic minority clinical psychologists, but we put a positive value on candidates who were black and could provide a unique personal perspective to their own clinical and professional role (Nadirshaw 1993). Furthermore, several of the personal specifications for new posts (appendix no. 2) required knowledge of the impact of socio-economic deprivation, racism and sexism on psychological wellbeing, and relevant command of early intervention and prevention strategies. Above all, we valued innovative, rigorous and courageous methods of tackling the myriad problems faced by the potential users of our services, and help them to achieve significant health gains.

In no way was the challenge of working in this new environment minimised or trivialised. Rather it was 'sold' as a unique feature of the post, that working in an inner city environment with the level of need already described, would bring its own rewards and results.

Urgency was added to this process for a variety of reasons. First, there was a demonstrable
appropriate, meaningful and necessary to other cultures, and that they develop new
techniques and standardise norms relevant to all communities within the health district.

Within the provision of services, Nadirshaw & d’Ardenne (1994) have recommended that:
* Psychologists work within the religious and cultural context of the client
* Psychologists use tests that are appropriate, meaningful and necessary to the client from another culture
* The psychologists develop new techniques and standardised norms relevant to all communities within the UK
* That relevant socio-political factors - number of years in the community; fluency in English; extent of community support etc be fully documented as part of good professional practice

A full audit of the department has not yet been completed, although certain quality standards have been achieved, users' and referrers' questionnaires distributed, and the beginnings of service level agreements completed with the purchasers. Nevertheless, several parts of the service have worked very well to their brief of ensuring that psychology is accessible to all members of the community, and these examples of good practice are offered for consideration and debate.

Examples of Good Practice
Examples of good practice include:

1. The translation of basic information about clinical psychology in Primary Care into the four major community languages of Hackney; Turkish; Kurdish; Greek and Bengali. This was financed by a successful bid via London Implementation Group (LIG). Funding to improve the visibility and accessibility of clinical psychology to potential users in primary care. Hall (1995), in reporting on inequality of health care, points out that "health messages have not been assimilated by Britain ethnic minorities. Unexpectedly high numbers of people do not speak English sufficiently well to benefit from information, and the health of minority groups is being significantly damaged by cultural barriers and illiteracy, as well as by economic disadvantage..."
2. The supervision and professional management of the Turkish Health Advocacy Project. The postholder was appointed in January 1993, to provide a culturally sensitive, psychodynamic counselling service to Kurdish, Turkish, and Cypriot Turkish peoples in Hackney. Psychological supervision has been shared between the Community and Primary Care Psychology services, and the first year report to the Purchasers has already been submitted indicating the need for continued funding.

3. Psychological Support Services for Families with Under Fives in Hackney; a project aimed at promoting young children's wellbeing and counteract the disabling social environment in a deprived, multiracial setting.

4. The New Lives project - an Action Research project based on a cohort of 300 new mothers who received an information pack just after their baby was born - with particular focus on mothers from ethnic communities. The aim was to elicit the support needs of these new mothers and interests established, and screen for postnatal depression.

5. Homestart Project where volunteers are trained to befriend families under stress, and who come from many of the communities. A group of Turkish women has been set up by the project where women gain social support and have classes to learn English. The Community Psychology Service has piloted, supervised and evaluated the outcome of this work.

6. Women working with Women : Two community psychologists and two health promotion officers ran 6 training workshops for women’s health and community workers who wanted to set up support groups for women in their own communities. The first two workshops were on self-esteem and confidence and the remaining four on groupwork skills. Three new groups evolved, including one run by the Asian Womens’ Centre in Hackney, which networks and supports similar initiatives.

7. The new psychologists in the Community Child Health services, jointly funded by Social Services, are specifically required under their job descriptions, to train and support the ethnic health advocates in the prevention of stress and the promotion of self-esteem.

8. The Challenging Needs Team has recruited fieldworkers from the ethnic community groups in Hackney to work with families of those with challenging needs within the Borough, who are not fully engaged with the Learning Disability Service, for
whatever reason.

9. Relatives’ Groups: The Mental Health Psychology service is currently establishing and evaluating the impact of relative’s education and support groups on the wellbeing of patients about to be discharged from the Hackney Hospital. Particular emphasis has been placed on making these groups user friendly, and in assisting relatives tackle their own experience of racism, both in general and in their dealings with the mental health services. In a recent audit (appendix no.4) relatives reported that mutual support and sharing of problems was of greater value than any specific information received, either about the wards, or about metal illness (Yalom 1975).

10. Locality Teams ethnic monitoring: clinical psychology has taken a lead role in the design and development of assessment forms and ethnic monitoring of users of the new Locality Mental Health Teams. The results of this are not yet known, but the efficacy of these teams is being carefully monitored by the Joint Planners and Purchasers who initiated them.

11. Training counsellors at Offcentre, a Drop-In Service for young people in Hackney, in transcultural counselling - this was a specific request made by the Director to the Head of Psychology for the workers at the centre, who brought their own casework and used it for their professional development.

12. Supervision of other minority counselling groups. The Orthodox Jewish community and Hackney Jewish Liaison Officer have held a series of Public Meetings about the mental health needs of the Orthodox Jewish community. Clinical psychologists in Primary Care, Locality and Mental Health Rehabilitation Services have been involved with these, and are now offering support and supervision of those counsellors, who have requested it, and have advised about quality and audit of the service for the purposes of ensuring future funding.

13. Serving on the management committee of counselling groups; four members of the Department of Clinical Psychology actively serve on the committees of ethnic counselling services in Hackney, and provide not just professional advice and support, but also a link with the statutory health services, either in mental health or family and community services.

14. Teaching transcultural skills: three Heads of Service are involved with raising awareness about racism and multicultural models of care within the statutory services.
These are not meant to replace racism awareness training, but rather to give a positive focus on the transcultural skills healthworkers already possess, and to build on them.

15. Development of a Life Story Project with Refugee Turkish Women; with the aims firstly, of evaluating the effectiveness of oral history method to enable refugees to express their current experiences and needs in ways that can enhance social support and self esteem - proven protective factors against depression (Brown & Harris 1978) and secondly to develop educational resource material to inform primary care and community health staff about the needs of women from Turkey in Hackney so as to meet their health needs in a more sensitive and appropriate way (Awiah 1992).

16. Development of Psychotherapy Services for ethnic minorities within the Department of Psychological Therapy. This work has been commissioned by the Directorate of Psychiatry, in response to Public Health (1994, 1995) and MIND (1994) recommendations. The Head of Psychology will be consulting with all relevant community groups, with Public Health, and with specialist multicultural therapy organisations like NAFSYIAT (Acharyya 1989; Kareem & Littlewood 1992) to establish existing training and development models appropriate to the needs of Hackney.

17. The Head of Service is assisting the Directorate of Psychiatry in the preparation of an ethnic monitoring Good Practice Paper for the proposed Trust.

Models of Good Practice

Approaches to Supporting Women Who Do Not Speak English - Linkworkers' Scheme. The Asian Mother and Baby Campaign was sponsored by the Department of Health and Social Security (DHSS 1992) and Save the Children and was in 16 Health Districts, between 1984 and 1987. They pioneered the development of link workers, employed to make links between Asian women whose languages they spoke, and those delivering maternity services (Winkler 1986).

Their success depended on individual women, health workers and nursing managers working alongside linkworkers within a service. Linkworkers were solely engaged with women in the maternity services. They were less effective in changing racist practice, and providing
a more equitable service and their role was inevitably limited.

Far more successful had been the deployment of autonomous advocates in Tower Hamlets (d'Ardenne & Mahtani 1989; Mahtani & Huq 1993; Maternity Services Liaison Scheme 1984; d'Ardenne 1993) and in Hackney, with the Multi-ethnic Women's Health Project, which started at the Mothers' Hospital in Hackney, and still thrives. This project was commissioned by the CHC, Hackney Council for Racial Equality and the City and Hackney Health Authority (Parsons et al. 1993; Parsons & Day 1992; Hunt 1992). The project was established to test the hypothesis that health advocacy could improve obstetric outcomes in non-English speaking women. The study found significant differences between the groups in their length of antenatal stay, induction rates and method of delivery, in particular, Caesarian rates reduced. The results show that advocacy targeted at populations of women at greatest risk may improve outcomes.

One of the key differences between linkworkers and advocates is that the latter are independent of health professionals, and they are now managed by the CHC, and supported, trained and supervised by the Department of Clinical Psychology, and still able to maintain its autonomy. The Maternity Services Liaison Scheme (MSLS 1984; d'Ardenne 1992) in contrast was supervised and trained by clinical psychology, but was not able to retain independent funding, and eventually collapsed.

**Good Practice: Conclusions**

There are some common themes to all these examples of good practice. They are, however, about indirect research, evaluation, support, education, training, supervision, and advocacy for existing groups already working with black and ethnic groups within the Borough. The reason for this is that psychology is a scarce but articulate resource, and one able to promote antiracist practice in a wide range of forums within the Authority. As several of our new recruits to the department are black, they themselves provide important role models to clients and to other health workers. Our biggest potential contribution has to be in ensuring that the impact of racism and cultural prejudice on mental health and wellbeing is addressed at every level, including within the profession. The members of our new department want to offer a service based on need, and to be able to provide different cultural approaches to distress,
as well as more appropriate settings in the community.

The department would like to offer assessment and therapy in the language of choice, as well as in information about psychology in written, oral or video format in community language. Our psychologists would like to offer directly that language of choice personally, or through professionally trained advocates and interpreters. We recognise that using interpreters is itself a transcultural skill that needs to be acquired by members, and that the highest standards of care need to be deployed for it to be as effective as working in the client's own language directly (d'Ardenne & Mahtani 1989; Shackman 1985).

Our new recruits include assistant and qualified staff with relevant community languages (Turkish and Bengali) but we have yet to undertake language training or specific training in the use of interpreters.

Clinical Psychology, Race & Culture Special Interest Group
Many of the above practices have already been discussed at the BPS Special Interest Group on Race and culture, which has allowed clinical psychologists working in sister Boroughs to present their innovations (Mahtani & Huq 1993; Webb Johnson & Nadirshaw 1993; de Silva 1993). The SIG was established four years ago as a local interest group for East London Clinical Psychologists, many of whom had been members of Transcultural Psychiatry UK and who wanted a separate forum for psychology issues. The SIG has now become an authoritative voice in the BPS in addressing the need to understand cultural and ethnic issues and in providing more appropriate psychological services to the whole community. It has defined its aims thus:

"1. To ensure that clinical services are relevant and accessible to people of all ethnic backgrounds.
2. To improve communication between clinical psychologists on issues of race and culture.
3. To alert clinical psychologists to examples of good practice in service delivery.
4. To sensitise individual clinicians to examples of good practice in service delivery.
5. To combat racism in professional practice.
6. To encourage awareness that the accessibility of services to people from different
ethnic backgrounds is indivisible from the representation of people from these backgrounds in the profession and its knowledge based.

7. To promote the view that training in clinical psychology should reflect the needs of people from different ethnic backgrounds in addition to those of the indigenous population.

8. To promote research on issues relevant to the psychological health of people from different ethnic backgrounds.

9. To disseminate psychological information and knowledge about issues of race and culture" (BPS 1990).

The Special Interest Group consists of both black and white members and has done much to achieve its goals in placing racism in clinical practice firmly on the agenda of the profession. It might, however, be helpful to look at racism within individual departments, within postgraduate training course and at the national level of the BPS.

Clinical Psychology Provision

The lower utilisation of psychology services by black and ethnic people has received scrutiny. Goodwin (1985) conducted a survey of 192 psychology departments in England to ascertain current provision of services for ethnic minorities and the opinions of psychologists on how such services might be developed. Responses to what psychologists believed were the main difficulties in providing a service fell into the following categories:

1. Language and communication difficulties.

2. Culture - in particular psychologists lacking knowledge of ethnic minorities and services themselves being culturally biassed.

3. Access - these issues included a lack of knowledge on the part of ethnic minority cultures about the existence of available psychology services and how to gain access to them, with people form these communities also being less likely to be referred by other agencies.

4. Attitudes and Expectations - people from ethnic minorities were perceived by psychologists as having lower expectations and less likely therefore to approach the service. Lack of familiarity with psychological models and a tendency to be somatic were suggested, along with a preference for medical models of care. Others in the
survey referred to stigma and reluctance to admit to psychological problems, preferring family resources to outside help. Also mentioned were distrust and suspicion of services, and beliefs by clients that services were inappropriate to their needs.

It has been argued that it is exactly because of these assumptions that black people are more likely to be prescribed medication than psychological interventions (Webb-Johnson & Nadirshaw 1993; Littlewood & Lipsedge 1989). Furthermore, the literature supports the view that the lowered expectation and attitude of the clinician is critical, not that of the client (Thomas & Sillen 1972; Katz 1978; Sue 1990; Alladin 1992; d'Ardenne 1993).

The respondents in Goodwin’s study did, however, make the following suggestions for improvement:

1. Training for all clinical psychologists in cultural awareness.
2. Recruitment of more psychologists from minority groups.
3. Language training for psychologists and the use of interpreters.
4. More community-based work to improve access.
5. Research to assess needs.
6. Having psychologists specialise in this field in orders to be in a position to share knowledge and advise others.
7. Liaising with voluntary groups, social workers working with minority groups and community relations officers.

Access to the Profession for Black and Ethnic People

Numerous authors (Goodwin 1985; Bender & Richardson 1990; Boyle et al. 1993; Roth & Leiper 1995; CTCP 1991) have expressed concern about the small numbers of black and ethnic candidates for the profession, although there has been until now, no overall strategy for monitoring selection, progress, and outcome of such candidates. There is a strong case for the BPS, under its new Equal Opportunities Initiatives, as well as the National Clinical Training Group to undertake such a task, and to challenge the inevitable perception of black graduates that the profession is structurally racist.
Boyle et al. (1993) conducted a survey on their 1991 intake at the University of East London course (the first for which they have ethnic monitoring) to ascertain whether there were firstly, very few ethnic applicants; and whether these applicants were of a lower quality than their white counterparts, or they were of good quality, but were treated unfairly. Three independent assessors rated 23 application forms from applicants who had defined themselves as being of "non-UK/Irish background" - Ethnic Minority (EM) to the UEL Clinical Programme, and compared them with 23 candidates not identified as ethnic minority, on a sample of variables used in selection, as well as some others that may have influenced selection.

On analysis, there was no evidence that applicants from ethnic minority groups were treated unfavourably, though there were some significant differences between the groups. Ethnic language and interest, unsurprisingly, was one, as was being over the age of thirty. None of these qualities conferred any advantage to the EM candidates. By comparison, EM candidates were judged to have a less well structured form, less likely to have had it typed, less likely to have had a post as an assistant psychologist, less likely to have already obtained a degree, and less likely to have an exceptional clinical reference. Lastly, the authors identified through Clearing House and PCAS data, that the low number of ethnic candidates is in part attributable to their low numbers on undergraduate courses.

Boyle et al. (1993) draw four major conclusions; first, there is a need for more constructive information to be given to students about making their applications for clinical psychology; second, a close and more systematic look at the process of gaining relevant experience may be required - to include fluency in ethnic languages or experience the ethnic communities; third, courses may need to justify their selection criteria, and whether or not some of them might not indeed disadvantage some groups of applicants; and fourth, courses can only act individually, and should approach the BPS, under its new Equal Opportunities Initiatives, to develop a overall strategy for monitoring selection, progress and outcome.

Roth and Leiper (1995) have examined the criteria for selection for clinical training on all twenty four courses in the Clearing House system. They reported that fourteen courses had an Equal Opportunities Policy, and of the remainder, some reported that they routinely
discuss "the issues" or "like to think they do it implicitly" and provided some interesting findings about Equal Opportunities. For example, few courses reported any formal monitoring of Equal Opportunities, unexpected given the number who report having explicit policies on the issue. This is even more surprising, in view of the BPS Equal Opportunities Statement and Policy (1993) which states in connection to academic and professional training, (section 1.3), that "courses should monitor applicants with respect to ethnic origin, gender and disability".

The authors conclude that the good intentions which courses have in this area need to be translated into practice if the profession is to reflect the balance of minority groups in society. They also remind the profession that it is within the domain of psychology to use its discipline in selecting its future members, which must include "a respect for the experience of the candidates and their legitimate needs".

Bender and Richardson (1990) reveal a profile of trainees within the profession. Asian and black psychologists are beginning to apply in larger numbers, but there is still a remarkable dearth of candidates from African-Caribbean background, and the reasons for this are not apparent. Is it the case that clinical psychology is seen by black people as so much part of the establishment that oppresses them? Or is it the case that young black graduates themselves face huge barriers even as late as the selection stage of clinical training? One thing remains clear; a greater portion of black and ethnic candidates for training in clinical psychology fail to complete that training; no specific positive values are placed on candidates from black and ethnic backgrounds. Training courses and employers continue to adopt a 'colour-blind' approach, as indeed do many white therapists when seeing their black clients. But as Alladin points out, a psychologist who denies individual differences, and says that colour, race or ethnicity, does not make 'a blind bit of difference', is in effect turning a blind eye to one of the most important dimensions of that person's life. Howitt (1991) takes this one step further, and suggests, "that to deny racism in structures, we treat everyone the same, is to ensure its continuity. Psychology is neither impersonal nor apolitical, and its orthodoxy and pseudo scientific objectivity have merely provided a safe place for racism and ethnocentrism to thrive". Racism is alive and kicking in the NHS, (Littlewood 1991; Wing 1991; Kings Fund 1990; McNaught 1985; Turner 1994; Burke 1986).
Clinical Psychology and Racism

Thomas and Sillen (1972) pose an interesting question to clinicians; if the idea of white supremacy forms part of the fabric of Western (including the UK) societies, what makes the dealings in a consulting room between a white therapist and a black client any different? Furthermore, what are the processes that the therapist needs to go through in order to disentangle themselves from the personal and structural racism of the society in which they live and where they were raised?

He then defines the harm of racism to the black client, and the enormous difficulty white therapists will have in raising their own awareness, and facing the power issues in all therapy. He is, of course, at pains to point out that racism is too often equated with hatred and conscious beliefs in the inferiority of black people, or that it is about violence. As with sexism, racism that is covert and polite can be very damaging. White clinicians have to re-work and re-examine their own attitudes and assumptions because they are members of a society that has its own pervasive, negative views about black people, and will have difficulty in separating out the black individual from his or her race. Littlewood (1991) provides us with a familiar example of a black client referred to the white psychiatrist.

"There is usually some supercilious comment that I will surely find this cultural problem of interest. Such patients frequently turn out to have quite intractable personal circumstances, several personality disorders, or to be just rather difficult people - individuals in other words. The 'difficult' becomes transformed into the 'culture', the personal into the public, the psychological into the political... this compounds a more general picture in which perception of a minority group as 'having' a problem insidiously turns to perceiving them as 'being' the problem. Thus their culture is held to be good for 'them', bad for 'us'".

A clinical psychologist (MacCarthy 1988) reiterates this theme when discussing white therapists working with black clients in mental health. "Psychologists treating individuals, families or groups from ethnic minorities have to work with unfamiliar symbolic systems, and different world views, expectations and values. In all settings both therapists and their patients have to deal with the consequences of implicit or explicit racist beliefs - categorical assumptions which may interfere with the perception of others as individuals".
Two clinical psychologists, one white, one black, working in Tower Hamlets with many ethnic communities, recognised that some of these tasks could be achieved, both at the individual and organisational level, and set an agenda for both black and white psychologists, (d’Ardenne & Mahtani 1989). Both of them acknowledged that nothing in their professional role or development had prepared them for transcultural work; only their personal experiences in trying to assist their clients from a very practical level, they suggested that clinicians might consider:

- how your cultural or racial background affects your attitude to your client;
- whether or not you see the client’s culture or race as a cause of the present problem;
- whether or not you see the client’s culture or race as part of the solution to the present problem;
- whether or not you can accept, acknowledge and understand your client’s culture;
- whether or not your expectations about the client’s culture affects the outcome of therapy;
- whether or not your prejudice has a bearing on the therapeutic relationship;
- whether or not any cultural prejudice or racism experienced by you affects the therapeutic relationship (p 36).

Alladin (1992) takes a more radical view of racism, and asserts that it will take more than personal effort from individual clinicians to change the world. He argues that theory, practice and research in clinical psychology need to be examined and changed if they are to have any relevant voice in tackling individual and institutional racism, and challenges clinical psychologists who, as scientist-practitioners, see themselves as divorced from their socio-political context, and therefore scientifically neutral. He quotes Howitt (1991), "the other major factor delineating psychology as Eurocentric is its assumption that the minds of individuals are the central focus of psychological understanding".

Alladin (1992) also suggests that instead of a Eurocentric psychology, (i.e.a white psychology) or a black psychology, that we need to develop a multicultural or pluralistic psychology, applicable and accessible to all. A multicultural model will not suffice in challenging racism alone; racism must be acknowledged explicitly (MacCarthy’s categorical assumptions’ 1988). The position of the BPS is also challenged by him. The BPS wished
to be seen as a political body, concerned with scientific and professional affairs only. Yet it proclaims itself as anti-sexist, adopts an equal opportunities policy, and sponsors MP’s - all political activities. Where it fails in being truly antiracist, argues Alladin, is in its failure to address structural racist practice. It has instead, encouraged individual black psychologists to form a special interest group; clinicians are sent on individual racial awareness training workshops; and ultimately, organisations that perpetuate racism through their very structures, are absolved of any responsibility to change.

The Response of the British Psychological Society

It has to be asked eventually whether or not clinical psychology is now in any better position to serve the diverse populations of a multiracial society (Nadirshaw 1993; Nadirshaw & d’Ardenne 1994). People who were trained in the last three decades will have had no professional guidelines or formal training and may or may not have developed on an individual basis. This situation is rapidly changing, and it remains for the profession to decide whether it is now more aware and more able to decide whether it offers the public an equitable and accessible service.

The BPS produced a major report in 1988, 'The Future of Psychological Sciences', in which it at least recognised the multi-ethnic, multiracial composition of the population, though Alladin (1992) observes, "not one single black psychologist was invited to make a presentation or serve the working party that produced the report. Consequently, recommendations are inevitably from a Eurocentric perspective". He compares it to an all-male working party making suggestions for women!

Nevertheless, the BPS then convened the presidential Task Force for the Promotion of Equal Opportunities (1991) which elicited six key areas for Equal Opportunities Practice within the profession:
* Society practices which affect individual members
* Management policy in relation to employees of the Society
* Recommendations in relation to honorary appointments, committee membership and honours
* Proactive public comment on Equal Opportunities and discriminatory practices
* Training and education
* Provision of expert advice both for members and external bodies

The most recent statement on Equal Opportunities (BPS 1994) has now established policy for:
* Council, committees and sub-systems
* Individual members
* Academic and professional training in psychology
* Honours and awards
* Monitoring
* Review of policies and procedures
* Raising and responding to public awareness of equal opportunities issues
* Implementation

Both of these documents are characterised by a much more powerful and proactive stance in promoting Equal Opportunities, although, perhaps disappointingly the word 'racism' does not appear once in either document. Nevertheless, the BPS has commissioned several members of the Special Interest Group to devise standard setting and the preparation of a 'Competency Directory' (Nadirshaw & d'Ardenne, in press) based in part on the excellent Guidelines for Providers of Psychological Services for Ethnic Linguistic and Culturally Diverse Populations (APA 1993).

This Directory is still being refined, and the authors have consulted with a wide range of groups within the BPS to ensure its validity and its practicality within a UK context. From the training standpoint, it is recommended that teaching departments at both undergraduate and postgraduate levels review their curricular and teaching practices and placements. This would include working with at least one other ethnic population in training and as part of continuing professional development.

Post qualification training should include linguistic and interpreting skills as part of the race and culture module; curricular cover of sexism, racism and elitism endemic in all professional practice, including within the supervisory relationship.
The move towards better training and practice has come from practitioners themselves, black or white, who have recognised both personal and institutionalised racism within the profession as preventing access to all. The BPS’s own role has until recently been reactive and minimalist but there are now signs of rapid change.

Conclusions and Recommendations

The provision of psychological services for a multiracial society is no longer the province of a Special Interest Group. Members of the profession have brought pressure to bear on the majority of practitioners (somewhat belatedly) to strive for a standard that genuinely recognises the personal and institutional forces that prevent equitable services for all members of the population. The City and Hackney Psychology Service is still a long way from achieving the standards proposed by Nadirshaw & d’Ardenne (1994). Our audits, however, are showing that the psychologist as a trainer, as supervisor and consultant may be as useful as a clinician when working with diverse urban populations. The profession is very small, and without a dedicated recruitment programme starting in schools, it is unlikely that we can obtain clinical psychologists from all the communities resident in the Borough. What matters more is that all psychologists have good transcultural skills within their own professional portfolio.

The agenda that lies ahead concerns all psychologists, predominantly white, and middle-class. This paper has attempted to show that psychological skills for a multiracial society are neither specialised nor ‘exotic’, but rather they represent a consolidation of good professional practice to be owned by all practitioners.

Change has to start at the personal level. This paper has also endeavoured to demonstrate that psychology is neither politically nor culturally neutral. An awareness of our status as clinicians (already engaged as therapists, educators, assessors, and researchers) needs to be seen in the context of empowering others. Our personal awareness of power imbalances between ourselves and our clients works equally with gender, disability, social class, culture or race.
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APPENDICES

Appendix 1  Vision of Psychology

Appendix 2  Personal Specifications

Appendix 3  Annual Report and Organisational Diagram

Appendix 4  Relatives' Questionnaire

Ends
Vision of Clinical Psychology

in

Barts NHS Trust

Patricia d'Ardenne
BA MSc CPsychol AFBPsS

© Patricia d'Ardenne 1992
Vision of Clinical Psychology

1. to be major provider for City and Hackney people with psychological dysfunction or difficulty and to achieve identifiable improvements in their psychological well-being, according to national and local guidelines

2. to offer a comprehensive and competitive range of services of high quality and value, in response to purchasers' requirements and users' needs

3. to inform, involve and work with patients according to the Patients' Charter

4. to provide locally-based, accessible services within hospital and community, which are appropriate to the diverse needs of an inner-city multi-ethnic population

5. to develop a high academic profile within the Trust in collaboration with UCL and UEL training courses, and in keeping with Working Paper 10

© Patricia d'Ardenne 1992
1. To be a major provider...

The current situation

Haringey
19.0 wte

Bloomsbury
and
Islington
33.0 wte

City and
Hackney
7.0 wte

Tower
Hamlets
18.0 wte

Source: NETHRA Directory of Clinical Psychologists, 1991

© Patricia d'Ardenne 1992
1. To be a major provider...

Actions

• identify additional purchasers for:
  mental health
  general practice
  children's services
  AIDs care
  neurology and general medicine

• determine levels of staff and skill mix required for services

• devise full recruitment, training and operational policies for the Trust's requirements

• identify the educational role of clinical psychology in training and supervising non-psychologists involved with specific interventions,
  eg brief psychotherapy
  behaviour therapy

• assist relevant Clinical Directors in contracting services through a Business Plan and fully costed business cases

• ensure outcome measures and agreed targets achieved through quality specifications and clinical review

© Patricia d'Ardenne 1992
2. To offer a comprehensive range of services...

Actions

• create and lead a team of psychologists towards a shared vision and strategy for growth

• support and develop existing specialisms in Child Health, Adult Mental Health, Forensic Psychology, Addiction, Learning Difficulties and Neurology

• establish clear service proposals with East London FHSA for Primary care. Services will have a strong community focus - ideally practice-based

• provide secondary care through multidisciplinary healthcare in psychiatric, children's services and medicine, both in hospital and within the community

• extend tertiary care in specialist areas eg. forensic and neurology

• ensure all levels of intervention are seamless

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2. To offer services...of high quality...

Actions

• require all clinicians to be chartered

• train them in quality management

• introduce IPR to all psychologists by 1993

• establish a Personal Development Plan within each IPR and incorporate with training strategy

• reconvene District meetings, provide peer supervision, professional support and clinical seminars

• ensure clinical audit of all psychological work in conjunction with relevant Directorates

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3. Patients' Charter...

Actions

- ensure all psychologists are trained in Access to Records Act, and that privacy and confidentiality are maintained

- provide clear verbal and written information about clinical psychology to patients and referers - in English and relevant community languages

- give waiting times to patients and GPs with alternatives, in accordance with national and local requirements

- make consent to psychological treatment explicit

- explain complaints' procedure to all users

- ensure patient's care plans and progress are reviewed and shared

- provide regular, prompt and succinct reports to referers

© Patricia d'Ardenne 1992
4. To provide...accessible and appropriate...services...

Actions

• extend local clinics at St Leonards, Penrose House, Maitland Place and GP surgeries

• develop domiciliary services where appropriate, eg mental health rehabilitation and learning difficulties

• promote cultural and racial awareness

• establish this as a quality factor with consumer groups

• give positive weighting to black and ethnic psychologists, particularly trainees from UCL and UEL, and provide retention incentives

• establish more specialist services outside hospital, eg family therapy, sexual disorders, eating disorders

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5. To develop a high academic profile...

Actions

• promote research into clinical needs of purchasers, both with the Trust and the Region

• foster existing academic links within the Trust, eg Barts, RNRU, as well as the Royal London, UCL, UEL and Institute of Psychiatry

• convene District-wide teaching seminars and journal clubs to promote academic excellence within and beyond the profession

• train medical staff and students and others in psychological approaches

• provide scientific and editorial advice to colleagues wishing to publish

• devise teaching and research specifications for all new psychology job descriptions

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THE CITY AND HACKNEY HEALTH AUTHORITY
PERSON SPECIFICATION FORM

POST Clinical Psychologist, Challenging Needs Team
GRADE A
DEPARTMENT/UNIT Clinical Psychology
DATE Sept 1993

<table>
<thead>
<tr>
<th>EDUCATION/QUALIFICATIONS</th>
<th>ESSENTIAL</th>
<th>DESIRABLE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Professional qualification as clinical psychologist (B.P.S. approved)</td>
<td>Post professional training e.g training in behavioural analysis</td>
<td></td>
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<table>
<thead>
<tr>
<th>SKILLS/ABILITIES</th>
<th>ESSENTIAL</th>
<th>DESIRABLE</th>
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</thead>
<tbody>
<tr>
<td>Integrative therapeutic skills. Training and teaching.</td>
<td>Transcultural skills, gentle teaching.</td>
<td></td>
</tr>
</tbody>
</table>

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<tr>
<th>EXPERIENCE</th>
<th>ESSENTIAL</th>
<th>DESIRABLE</th>
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</thead>
<tbody>
<tr>
<td>3 years w.t.e. post training clinical psychology experience, ideally in learning difficulties/challenging needs service in NHS or social service settings</td>
<td>Development of staff training &amp; support. Team work within a Community setting, ideally with field workers and families.</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>KNOWLEDGE</th>
<th>ESSENTIAL</th>
<th>DESIRABLE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Factors affecting challenging needs and stressors for carers.</td>
<td>Familiarity with a culture &amp;/or language of major ethnic group. Good local knowledge of inner city life.</td>
<td></td>
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</table>

<table>
<thead>
<tr>
<th>DISPOSITION</th>
<th>ESSENTIAL</th>
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</thead>
<tbody>
<tr>
<td>Holistic, assertive, enthusiastic, flexible, creative.</td>
<td></td>
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<table>
<thead>
<tr>
<th>OTHER REQUIREMENTS</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Able to travel between sites within the District. No disabled access at Maitland House</td>
<td></td>
</tr>
</tbody>
</table>

SIGNED: PATRICIA d'ARDENNE
POSITION: DISTRICT CLINICAL PSYCHOLOGIST
<table>
<thead>
<tr>
<th>ESSENTIAL</th>
<th>DESIRABLE</th>
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</thead>
<tbody>
<tr>
<td>EDUCATION/QUALIFICATIONS</td>
<td>Professional qualification as chartered clinical psychologist (B.P.S. approved)</td>
</tr>
<tr>
<td>SKILLS/ABILITIES</td>
<td>Proven ability to manage others. Integrative therapeutic skills. Training and teaching.</td>
</tr>
<tr>
<td>EXPERIENCE</td>
<td>7 years w.t.e. post training clinical psychology experience. Responsibility for providing a mental health service</td>
</tr>
<tr>
<td>KNOWLEDGE</td>
<td>Good working knowledge of community care, case management and psychological models of aging</td>
</tr>
<tr>
<td>DISPOSITION</td>
<td>Enthusiastic, flexible, creative, team orientated</td>
</tr>
<tr>
<td>OTHER REQUIREMENTS</td>
<td>Able to travel between sites within the District.</td>
</tr>
<tr>
<td><strong>POST</strong></td>
<td>Adult Mental Health</td>
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<tr>
<td><strong>DEPARTMENT/UNIT</strong></td>
<td>Clinical Psychology</td>
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<tr>
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</thead>
<tbody>
<tr>
<td></td>
<td>Professional qualification as chartered clinical psychologist (B.P.S. approved)</td>
<td>Post professional training in cognitive behaviour therapy</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>SKILLS/ABILITIES</strong></th>
<th><strong>ESSENTIAL</strong></th>
<th><strong>DESIRABLE</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Proven ability to manage others. Integrative therapeutic skills. Training and teaching.</td>
<td>Management of challenging behaviour; and dangerousness.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>EXPERIENCE</strong></th>
<th><strong>ESSENTIAL</strong></th>
<th><strong>DESIRABLE</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>7 years w.t.e. post training clinical psychology experience. Responsibility for providing a mental health service</td>
<td>Provision of largely autonomous &amp; systematic service provision within ward based psychiatric service</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>KNOWLEDGE</strong></th>
<th><strong>ESSENTIAL</strong></th>
<th><strong>DESIRABLE</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Good working knowledge of community care, case management and psychological management of aggression</td>
<td>Familiarity with a culture &amp;/or language of major ethnic group. Good local knowledge of inner city life.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
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<tbody>
<tr>
<td>Able to travel between sites within the District.</td>
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</table>

**SIGNED:** PATRICIA D’ARDENNE  
**POSITION:** HEAD OF CLINICAL PSYCHOLOGY  
**DATE:** 7 JUNE 1993
## PERSON SPECIFICATION FORM

**POST** Assistant in Elderly Mental Health  
**GRADE** A  
**DEPARTMENT/UNIT** Clinical Psychology  
**DATE** June 1993

<table>
<thead>
<tr>
<th></th>
<th>ESSENTIAL</th>
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</thead>
<tbody>
<tr>
<td><strong>EDUCATION/QUALIFICATIONS</strong></td>
<td>Honours Degree in Psychology</td>
<td>Relevant Post Graduate Qualification</td>
</tr>
<tr>
<td><strong>SKILLS/ABILITIES</strong></td>
<td>Proven ability to work with others in a clinical setting</td>
<td>Computing; the assessment of memory disorders</td>
</tr>
<tr>
<td><strong>EXPERIENCE</strong></td>
<td>2 years w.t.e. experience with the elderly</td>
<td>Experience in mental health setting, ideally with the elderly</td>
</tr>
<tr>
<td><strong>KNOWLEDGE</strong></td>
<td>Basic psychological models of aging and memory dysfunction</td>
<td>Familiarity with a culture &amp;/or language of major ethnic group. Good local knowledge of inner city life.</td>
</tr>
<tr>
<td><strong>DISPOSITION</strong></td>
<td>Enthusiastic, flexible, creative, team orientated</td>
<td></td>
</tr>
<tr>
<td><strong>OTHER REQUIREMENTS</strong></td>
<td>Able to travel between sites within the District.</td>
<td></td>
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</tbody>
</table>

**SIGNED:** PATRICIA d’ARDENNE  
**POSITION:** HEAD OF CLINICAL PSYCHOLOGY  
**7 JUNE 1993**
## POST
Trainee Clinical Psychologist in Adult Mental Health

## GRADE
A

## DEPARTMENT/UNIT
Clinical Psychology

## DATE
June 1993

<table>
<thead>
<tr>
<th>EDUCATION/QUALIFICATIONS</th>
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<th>DESIRABLE</th>
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</thead>
<tbody>
<tr>
<td>Honours Degree in Psychology; working towards clinical registration</td>
<td>Relevant Post Graduate Qualification</td>
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</table>

<table>
<thead>
<tr>
<th>SKILLS/ABILITIES</th>
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<th>DESIRABLE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Proven ability to work with others in a clinical setting</td>
<td>Able to assess clients within limited time constraints using psychometry</td>
<td></td>
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</table>

<table>
<thead>
<tr>
<th>EXPERIENCE</th>
<th>ESSENTIAL</th>
<th>DESIRABLE</th>
</tr>
</thead>
<tbody>
<tr>
<td>2 years w.t.e. experience with any client group</td>
<td>Some relevant experience working in Hackney</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>KNOWLEDGE</th>
<th>ESSENTIAL</th>
<th>DESIRABLE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Basic psychological models of learning</td>
<td>Familiarity with a culture &amp;/or language of major ethnic group. Good local knowledge of inner city life.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>DISPOSITION</th>
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<tbody>
<tr>
<td>Able to travel between sites within the District.</td>
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</tbody>
</table>

**SIGNED:** PATRICIA d'ARDENNE  
**POSITION:** HEAD OF CLINICAL PSYCHOLOGY  
**DATE:** 7 JUNE 1993
### Person Specification Form

**POST** Assistant Psychologist in Rehabilitation  
**GRADE** A  
**DEPARTMENT/UNIT** Clinical Psychology  
**DATE** June 1993

<table>
<thead>
<tr>
<th></th>
<th>ESSENTIAL</th>
<th>DESIRABLE</th>
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<tbody>
<tr>
<td><strong>EDUCATION/QUALIFICATIONS</strong></td>
<td>Honours Degree in Psychology; working towards clinical registration</td>
<td></td>
</tr>
<tr>
<td><strong>SKILLS/ABILITIES</strong></td>
<td>Ability to work with others in a clinical setting</td>
<td>Able to assess clients within a mental health setting</td>
</tr>
<tr>
<td><strong>EXPERIENCE</strong></td>
<td>Some experience as a carer with relevant client group</td>
<td>Some relevant experience working in inner City</td>
</tr>
<tr>
<td><strong>KNOWLEDGE</strong></td>
<td>Basic psychological models of learning</td>
<td>Familiarity with a culture &amp;/or language of major ethnic group. Good local knowledge of inner city life.</td>
</tr>
<tr>
<td><strong>DISPOSITION</strong></td>
<td>Enthusiastic, flexible, creative, team orientated</td>
<td></td>
</tr>
<tr>
<td><strong>OTHER REQUIREMENTS</strong></td>
<td>Able to travel between sites within the District.</td>
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</table>

**SIGNED:** PATRICIA D’ARDENNE  
**POSITION:** HEAD OF CLINICAL PSYCHOLOGY  
**7 JUNE 1993**
THE CITY AND HACKNEY HEALTH AUTHORITY
PERSON SPECIFICATION FORM

POST Trainee Clinical Psychologist in Learning Difficulties

GRADE A
DEPARTMENT/UNIT Clinical Psychology
DATE June 1993

<table>
<thead>
<tr>
<th></th>
<th>ESSENTIAL</th>
<th>DESIRABLE</th>
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</thead>
<tbody>
<tr>
<td>EDUCATION/QUALIFICATIONS</td>
<td>Honours Degree in Psychology; working towards clinical registration</td>
<td>Post Graduate qualification with relevant client group</td>
</tr>
<tr>
<td>SKILLS/ABILITIES</td>
<td>Ability to work with others in a clinical setting</td>
<td>Able to assess clients psychometrically both within institutional and home settings</td>
</tr>
<tr>
<td>EXPERIENCE</td>
<td>2 years w.t.e. experience with any relevant client group</td>
<td>Psychometric experience with clients</td>
</tr>
<tr>
<td>KNOWLEDGE</td>
<td>Basic psychological models of learning</td>
<td>Familiarity with a culture &amp;/or language of major ethnic group. Good local knowledge of inner city life.</td>
</tr>
<tr>
<td>DISPOSITION</td>
<td>Enthusiastic, flexible, creative, team orientated</td>
<td></td>
</tr>
<tr>
<td>OTHER REQUIREMENTS</td>
<td>Able to travel between sites within the District.</td>
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</table>

SIGNED: PATRICIA d’ARDENNE
POSITION: HEAD OF CLINICAL PSYCHOLOGY
7 JUNE 1993
CITY & HACKNEY COMMUNITY SERVICES NHS TRUST
CLINICAL PSYCHOLOGY SERVICE

1995

Patricia d'Ardenne

Jim Drinkwater
  Catherine Haw
  Angela Richards
  Dr Carol Valinejad

Simon Jakes

Afreeen Huq
  John Rhodes
  Vacant

Michael Mottram

Christine Richards
  Dr Carol Valinejad
  A. Novakovic

Heather Hunt/ Mary Spence
  Lin Phillips
  G. Moody
  N. Yurtoğlu
  Fiona Norman
  Yasmin Ajmal

Carol Hart
  Dr Maureen Fitzpatrick
  Maxine Sacks

Maire Sharkie
  Anne-Marie
  Neilson
  Rita Dalton
  Vacant
  Vacant

Vacant
CELFACS
City and Hackney - Clinical Psychology Service
1994

- Head of Service
  0.6/Rehab 0.4

- Children A&H 3.6 wte
- Acute Mental Health/Barts 1.0
- Acute Mental Health/Hackney 1.0
- Elderly 0.6
- Challenging Needs 1.0
- DDU 0.5/Manager 0.5
- Forensic 1.0
- Community Child Health 0.8
- Primary Care 1.0
- HIV/AIDS/GUM 1.0

- Locality Teams 2.0
- Hackney Hospital 1.0
- Asst 0.6
- Health Team 1.0
- Challenging Needs 1.0
- Rehab 0.5
- Forensic 4.0
- Community Child Health 4.0
- Primary Care 2.0
- HIV 2.0

- Hmong 1.5
1995 has been a continued period of growth of our new department. We have established a Primary Care Team at the beginning of the year, which has expanded from 2.4 to 3.5 wte's.

The Challenging Needs Team is now recruited a commitment to permanent fund has been made by Purchasers to enable it to fulfil its brief of addressing client need whenever possible within the Borough.

The Community Psychology Service (Child Health) has finally received funding for its two other localities, as well as innovate a Schools Project, jointly funded with education, all currently being recruited.

The Locality Mental Health Teams are now fully recruited (.5 wte per locality) and working with the Department of Psychological Therapies to ensure a high level of professional input to each of the teams.

The Forensic Service has just secured funding for a major development (5.0 wte's) in its new unit, and recruitment is about to begin early in 1995.

The Elderly Service has made a bid to provide input to the new Stroke Unit at the Homerton (.5 wte) and we are awaiting confirmation of funding from the Purchasers.

Our current service bids include upgrading of several posts; a new 'A' Grade post for the Elderly Services, permanent funding for the Adult Mental Health Posts and an extension of Primary Care into the provision of counselling.

We have made a strong bid to remain within the proposed City & Hackney Community Trust. All our staff are clinicians, working mainly within multidisciplinary teams. We wish to retain a clear local focus and ensure measurable health gains for the people of City & Hackney.
PRIMARY CARE PSYCHOLOGY SERVICE

THE TEAM

Carol Hart BA (Hons), MSc, C.Psychol, AFBPsS - Head of Service (1.00 wte)
Maureen T Fitzpatrick BSc (Hons), D.Clin.Psych - (1.00 wte)
Maxine Sacks BSc (Hons), MSc, C.Psychol - (0.3 wte from October)
Aleksandra Novakovic BA (Hons), MSc Psychotherapy, Member IAGP - (1.00 wte)
Kathy Barry - Secretary (0.8 wte)

The Primary Care Psychology and Counselling Service delivers a rapid response to referrals and is an easily accessible, local and non-stigmatising service to patients with a wide range of presenting problems. We utilise level three skills, drawing on a multiple theoretical base, in applying psychological knowledge and expertise to the alleviation and prevention of emotional and physical health problems. "This includes the flexibility to adapt and combine approaches coming from a broad, thorough and sophisticated understanding of various psychological theories". (MAS Report, 1989).

We act as a resource to General Practice in two ways: the provision of direct and indirect services. On-site clinics are held at the Athena Medical Centre, Barton House Health Centre, Cranwich Road, London Fields Practice, Lower Clapton Health Centre and the Nightingale Practice. Referrals for a range of individual and group therapies are taken from all single-handed GP’s in City and Hackney and these patients are seen at St Leonard’s. Every GP in City and Hackney can refer to our group treatments.

We also provide Consultancy, Team Building and teaching and training. Stress management and staff support together with advice on patient management are also available.

DEVELOPMENTS

* Aleksandra Novakovic took up post with the team in June 1995. She sees patients for individual and group therapies and has a remit to provide Team Building. She has also developed a group for Refugees from former Yugoslavia and is currently taking referrals to this group.

* A split post (0.5 wte Primary Care and 0.5 wte South East LMHT) is being recruited and we expect this post to become operational in September 1995.

* We have obtained MISG funding which will allow us to advertise a Counselling Coordinator post and we will begin recruiting to this in the near future.
A series of eight self-help leaflets are being translated into 11 community languages and these will be distributed through GP Practices, Health Centres and Community Centres. Audio cassette versions of the leaflets will also be available to allow people who are not literate in their own language to access the service. Relaxation tapes in the 11 languages will also be available.

We have begun to provide Team Building to General Practice.

From September there will be an increase in the provision of on-site clinics with a particular emphasis on delivering this service to single-handed and small practices.

There will be a Consultancy and Supervision service available to professionals working in Primary Care who are engaged in group work.

ADDITIONAL TRAINING

Carol Hart Supervision; Cognitive Therapy of Depression; Cognitive Therapy of Anxiety Hypnosis (Introductory, Intermediate and Advanced levels)

Maureen Fitzpatrick Present State Examination (PSE) Training

Maxine Sacks D58 Course (Seminars in Psychotherapy) Tavistock (ongoing); Introductory course - Institute for Group Analysis

Aleksandra Novakovic Integrative Gestalt Therapy; ongoing postgraduate Psychoanalytical Observational Studies, Training in Group Analysis
FHSA
LIZ FUNDING

CITY AND HACKNEY COMMUNITY NHS TRUST

PRIORITY SERVICES DIRECTORATE

DEPARTMENT OF CLINICAL PSYCHOLOGY
PATRICIA d'ARDENNE - HEAD OF DEPARTMENT

PRIMARY CARE PSYCHOLOGY AND COUNSELLING SERVICE
CAROL HART - HEAD OF SERVICE

MAUREEN FITZPATRICK
(1.00 WTE)

MAXINE SACKS
(0.3 WTE)

FUNDED POST
(1.0 WTE)

FUNDED POST
(0.5 WTE)

ALEXSANDRA NOVAKOVIC
(1.00 WTE)

KATHY BARRY
SECRETARY
(0.8 WTE)

PROFESSIONAL SUPERVISION/MANAGEMENT OF TURKISH COUNSELLORS
(1.00 WTE + 0.5 WTE FUNDED + 0.5 WTE FUNDED)
MENTAL HEALTH REHABILITATION

Head of Service: Patricia d'Ardenne BA (Hons), MSc, C.Psychol, AFBPsS, Honorary Senior Lecturer in Clinical Psychology, Barts Medical College. (.5 wte)

Carol Valinejad BSc, MSc, D.Clin.Psych (.5 wte)

Rebecca Cheatle BA, Assistant Psychologist

The Rehabilitation Psychologists provide a comprehensive service to people with longterm and serious mental illness, their carers and relatives. We provide supervision, training and support of staff; assessments and interventions with clients and their relatives and actively participate in the planning and development of the service, eg. opening of 15 Homerton Row.

Developments

* We have upgraded the second post in mental health rehabilitation from an assistant to an 'A' Grade, and have recruited the current postholder in November 1994. As a result of this, the work has been divided between Joshua ward and 15 Homerton Row - and the new postholder has undertaken some service for the Outreach Team at the CPRU. The other half of her post is with the SE Locality Mental health Team.

* The Head of Service has begun her Psych.D as part of continuing professional development; the subject of her dissertation being the cultural and educational factors preventing relapse in schizophrenia. Her research is being carried out collaboratively with the nursing and medical staff on Joshua, and will be audited and published in late 1995.

* We have just appointed Rebecca Cheatle as an assistant psychologist for one year to help the two clinical staff in auditing the psychological work of the Rehabilitation Service, and to assist in intensive one to one work with clients.

* We have submitted a service development for another 1.0 wte 'A' Grade to work with the community team and this is being considered in the current round of contracting.

Publications and Presentations:

Patricia d'Ardenne

Sexual and Marital Therapy, Volume 9, Nos. 1, 2 and 3 (Editorials only)

Whom Should You Refer for Psychotherapy? The Practitioner, Feb 1994, Volume 238, page 87-90

The Right to be Understood: Experiences of Racism in Counselling, Paper presented to the Association for Student Counselling, University of Nottingham, April 1994, in Press
Towards Better Clinical Psychology Practice, Workshop presentation with Zenobia Nadirshaw, April 1994, for WHO Mental Health Race and Culture Conference in Europe, University of Bristol


Developing Clinical Psychology for a Multiracial Community in London: BPS Annual Conference submission, Warwick University, April 1995

Carol Valinejad

Users Perceptions of Care at a Mental Health Service for Black people

Courses Attended: Patricia d’Ardenne

University of Surrey: Psych.D Research Workshops, September and October 1994

BPS Special Interest Group in Rehabilitation, London, November 1994

TAPS London Conference, July 1995

Courses Attended: Carol Valinejad

BPS Special Interest Group in Rehabilitation, London, November 1994

TAPS London Conference, July 1995
COMMUNITY PSYCHOLOGY SERVICES (CHILD HEALTH)

Head of Service: Mary Spence, Consultant Clinical Psychologist

Heather Hunt BSc (Hons), MSc, Chartered Educational and Clinical Psychologist, National Assessor for Primary Care Psychology Services, 'B' Grade (.8 wte)

Lin Phillips BSc (Hons), BPS Diploma Clinical Psychology (Distinction), 'A' Grade (1.0 wte)

Nesrin Yurtoglu BSc (Hons), MSc Social Psychology, Research Assistant (.5 wte)

Gabriella Moody BSc (Hons), Psychology, Research Assistant (.5 wte)

Fiona Norman, Community Psychologist

Yasmin Ajmal, Community Psychologist

SERVICE DESCRIPTION

The Community Psychology Service is part of the City & Hackney Child Health Services. It develops and evaluates psychological support services for families with young children with the emphasis on prevention of psychological difficulties which meet the needs and aspirations of the multi-cultural communities.

We work with community health staff with specific projects on a patch basis, eg. Child Development Groups, "New Lives" Action Research Project.

We offer training, consultancy and support to community health, local authority and community groups (eg. Homestart, Newpin in Hackney, Child Health ethnic advocates, Hackney Children and Family Refugee Project, "Women Surviving Together").

We use approaches which enhance self esteem, social support and competencies of parents and carers and maximise community resources, (eg. workshops for community, local authority and community health women workers enabling them to set up support groups for women in their own community).

DEVELOPMENT

Close working with the Local Authority has led to funding for 2 new posts, which will enable:

1. A basic service to be offered to the 4 patches working closely with the preventative, family support teams to be established as part of the Children’s Plan.
2. A psychology lead to starting multi-agency preventative projects with selected schools in Hackney.

**FORMAL PRESENTATIONS**

**Heather Hunt:**


2. British Council sponsored teaching and study tour, Chile, November 1994, including presentation at "Semaínaro Familia, Mujer y Pobreza", Santiago, and "Salud mental Reflexions Psycho-social", Concepcion, Chile.


4. Seminar "Psychological support for families under stress", Child Health Surveillance Course.

5. Training Day to NE London Clinical Psychology trainees "Power and inequality in Clinical Psychology".

**Lin Phillips**

1. "Working with common pre-school problems". Seminar to Regional GP training programme.

2. "Behavioural theory and practise". Seminar to child psychotherapists, Tavistock Clinic.

3. "Psychological support services for families", Child Health Surveillance course, Hackney.


**COURSES ATTENDED**

**Heather Hunt:** Consultation for Groups and Organisations, Tavistock Clinic.

**Lin Phillips:** 2nd year of Phd, joint Tavistock Clinic and Birbeck College.
CLINICAL PSYCHOLOGY SERVICE TO PEOPLE
WHO HAVE LEARNING DISABILITIES

Head of Service : Michael Mottram, BA (Hons), M.Phil, MSC
Erasmo Tacconelli, BSc (Hons)

1 vacancy - to be filled early September 1995

The service offer a range of therapy, assessment and consultation to service users, carers and agencies within Hackney.

The Head of Service is also Head of the Challenging Needs Team for people with learning difficulties. The funding of this Team remains uncertain.

DEVELOPMENTS

Late last year the Learning Difficulties Service became separate from Mental Health and responsible for its own management. This enabled a better focus of resources upon shared service objectives.

Activities during the year have concentrated on establishing psychology as part of two multidisciplinary teams and ensuring that strong links are maintained with the Local Authority services.

Requests for assistance to reduce the need for out-of-Borough placements have meant a reappraisal of service priorities and a focus for the Team’s efforts on a smaller number of clients who have complex needs.

CURRENT RESEARCH INTERESTS

Intensive Interaction
Self Monitoring in Anger Management for People with Learning Difficulties
Needs of School Leavers
Model of Preventative Work
Use of Hackney Hospital in-patient facilities for people who have learning disabilities
ADULT MENTAL HEALTH PSYCHOLOGY SERVICE

Head of Service: Simon Jakes, MA (Oxon), M.Phil, C.Psychol, AFBPS
John Rhodes, BA, MA, PGCE, MSc, C.Psychol
Catherine Haw, BSc (Hon), MSc, Ph.D, C.Psychol (1.0 wte)
Carol Valinejad, BSc, MSc, D.Clin.Psych (.5 wte)
Angela Richards, Assistant Psychologist

Psychology Services are provided to clients through input to the Psychological Therapies Department and by collaboration with the inpatient wards, the Rainbow Project and the Junction. Each Locality Mental Health Team is staffed by a .5 wte Clinical Psychologist providing a major input to this exciting development in the provision of mental health care.

DEVELOPMENTS

* Evaluation of psychological therapy for sufferers from psychotic illness is being planned in collaboration with Dr Trevor Turner.

* Clinical Psychologists have been recruited into the Locality Teams and peer supervision is being developed for these psychologists.

* Bids for further psychologists to work with the wards and the Psychological Therapies Department are being prepared.

PUBLICATIONS

CLINICAL PSYCHOLOGY SERVICES FOR OLDER PEOPLE

Head of Service: Afreen Husain Huq, BSc, MSc, M.Phil, Chartered Clinical Psychologist. One year training in Group Analysis (IGA). Six months training in Family Therapy (Tavistock). Contribution to the Psychologists Special Interest Group for Elderly. Six sessions per week.

Maire Sharkey, Assistant Psychologist

Clinical Psychologists in Training:

Pauline Riley-Hunte
Caitlin Phillips

THE SERVICE

The Psychology Service aims to help users of the service minimise difficulties arising out of a wide range of mental health problems in later life. We are able to see people in the hospital, day hospitals and at home. We are part of the multidisciplinary team: MENTAL HEALTH FOR OLDER PEOPLE IN CITY & HACKNEY.

ACTIVITIES

Activities during the year has included direct and indirect work, teaching sessions for Junior Doctors, regular training sessions for nursing teams on managing challenging behaviour, working with carers/relatives, setting up carers support group, seasonal presentations to the multidisciplinary team forums, regular consultation sessions at the Maitland Day Hospital. Psychology input covers all mental health facilities for older people in Hackney Hospital, in addition to advising care staff in Residential Homes on request and some input for the Stroke Unit at Homerton Hospital.

DEVELOPMENTS

1. A bid has been made to create a Psychology post for the new Stroke Unit at Homerton Hospital.

2. A cognitive-behaviour therapy group for depression is due to start mid February 95 at the Kingsland Day Hospital.


4. A proposal is to be made for a qualified 'A' Grade psychology post for developing new services such as more specialised therapy (individual and group) and supporting existing services such as providing supervision and training.
The Forensic Clinical Psychology Department provides a service to inpatients in the Interim Secure Unit and to outpatients referred from East London. An additional one and a half sessions per week have been provided by Maxine Sacks from March to September. This has meant there is no longer a waiting list for outpatient appointments. During 1994/5 activity was focused on establishing permanent posts to meet the needs of the expanded service which will take place with the opening of the 43 bedded purpose built unit in the Autumn of 1995, and on policy making and service planning. Ann-Marie Nielsen has been appointed at A Grade and has taken up her post on 1 August 1995. Rita Dalton has been appointed at A Grade from 1st October 1995. Two further Assistant Psychologists will be appointed to start in October 1995.

FURTHER PROFESSIONAL TRAINING - CHRISTINE RICHARDS

BPMS Diploma in Forensic Psychotherapy in association with the Portman Clinic (completed July 1995, result awaited).

CONFERENCES ATTENDED

The Portman Clinic Forensic Psychotherapy alumni day, 7 July 1995.

PRESENTATIONS

NEUROPSYCHOLOGY AND MENTAL HEALTH PSYCHOLOGY SERVICE

Head of Service: James Edward Drinkwater BSc., Dip.Psych., C.Psychol., AFBPsS

Zoe Claire Graham BSc - trainee Clinical Psychologist (UEL)

Assessment, therapy and consultation services to psychiatry and general medical and surgical in-patients and out-patients.

Formal presentations: Statistics for MRC.Psych candidates.

Current research interests: Gender Differences in memory for Faces.

Conferences

Capacity to give informed consent and to make legal decisions - organised by the Law and Behavioural Sciences Group

Symposium on Intelligence - organised by the GALTOM Institute (2 day symposium)
It would help us to improve the quality of this service if you could answer the questions below. We have had this group for ten months and need feedback. All answers will be treated confidentially.

1. For how long have you had a relative/friend on Joshua Ward?
2. Have you been offered a Carers' Group on this ward before?
3. How did you hear about this Group?
4. How many have you attended this year?
5. In which of the following ways has this Group been of use to you? Please rate 1 - 5.

<table>
<thead>
<tr>
<th>Not very useful 1</th>
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<th>Very useful 5</th>
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<tr>
<td>Understanding your rights and those of your relatives</td>
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<td>Information about Joshua</td>
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<td>Update about your relative</td>
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<td>Practical ideas for care</td>
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<tr>
<td>Talking to others who understand your experiences</td>
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</tbody>
</table>

6. Are the meetings held at the right time?
7. Are the meetings held often enough?
8. Are the meetings in the right place?
9. Any other comments please.

The meetings are held on the last Wednesday of the month from 7.00pm to 8.30pm in the Psychiatric Boardroom.
RESEARCH PROJECT

Changing the Culture of a Locked Rehabilitation Ward

in East London - Another Stressor for Nurses?

Submitted as part requirement for the Degree of Psych.D, University of Surrey
Summary

This brief intervention study was aimed at establishing whether it was possible to obtain a reliable and valid measure of stress, both qualitative and quantitative, among psychiatric nursing staff on a locked ward in East London. It was hypothesised that the implementation of changes on the ward would reduce stress. It was further hypothesised that the audit of such changes would influence reported indices and levels of stress.

Measures comprised the Nurse Stress Index, the Occupational Stress Indicator, The Ward Atmosphere Scale Real - Ideal discrepancy; Incidents; sickness and turnover; level of optimism; and a semi-structured interview. Results showed some trends in improving stress levels on the ward, although the only measure reaching significance was social support as a coping mechanism. The results are discussed both within the terms of the ward milieu, and with an impending reprovision for the whole ward that took place shortly after the intervention.
Table of Contents

INTRODUCTION AND LITERATURE ...................................................... 196
- nurses and stress ................................................................. 196
- models of stress ................................................................. 197
- stress and burnout ............................................................... 199
- stress and absenteeism ....................................................... 200
- stress and mental and physical health ................................. 201

BACKGROUND TO THIS STUDY ..................................................... 202
- the physical milieu ............................................................. 202
- a brief history ................................................................. 203
- aims of the study ............................................................. 203

EXPERIMENTAL HYPOTHESES ...................................................... 204

METHOD ......................................................................................... 205
- the subjects ......................................................................... 205
- the experimenters ............................................................. 205
- independent variables ........................................................ 206
- dependent variables .......................................................... 207
- data collection ................................................................. 216
- ethical clearance ............................................................... 216
- experimental design .......................................................... 217

RESULTS ......................................................................................... 217
- descriptive analyses and tables of means ......................... 217
- exploratory data analyses ................................................... 217
- t-tests ................................................................................. 218
- qualitative analyses ............................................................ 218
- Nurse Stress Index ............................................................. 218
- Occupational Stress Indicator .......................................... 220
- Ward Atmosphere Scale .................................................... 234
- incidents ............................................................................. 244
- sickness ............................................................................. 244
- optimism - pessimism ....................................................... 244
- semi-structured interviews ................................................. 244
INTRODUCTION
NURSE STRESS
There is a substantial literature documenting the many environmental and internal stressors for health workers, within the work setting. Health workers and nurses in particular, have been found to experience significantly more occupational stress than their counterparts in industry, to have lower levels of job satisfaction, poorer mental and physical health, and a higher proportion of psychological problems (Cooper & Baglioni 1988; Palmer 1989; Payne and Firth-Cozens 1987; Rees & Cooper 1990).

Furthermore, psychiatric nurses are reported as having some of the highest scores of expressed occupational stress, third in rank to nurses working with the elderly, and those working with learning disability (Harris 1989). Major stressors reported are: incomplete time to perform nursing tasks, lack of involvement in decision making, lack of communication and support from nurse management, and inadequate preparation for professional role (Hingley & Cooper 1986; Hingley Cooper & Harris 1986; Harris 1989).

Rees & Smith (1991) in looking at a wide number of health professionals in a Community NHS Trust, on the 'Occupational Stress Indicator' (Cooper et al. 1985) produced a 'League Table of Stress' showing CPN's and Speech Therapists at the top, followed in third place by psychiatric nurses (clinical psychologists ranked 11th out of 17). They compared nurses with Occupational Therapists, and found that nurses were more stressed because of career and achievement issues, problems arising from the professional organisation and lack of support given to nurses within their own profession.

Rees & Cooper (1992) found that one in twelve health workers had stress symptoms of equal magnitude to patients attending clinical psychology outpatient clinics. Whereas general managers reported the lowest levels of pressure, nurses reported the highest levels of stress - a finding that was not affected by grade or by type of nursing background. The authors did not distinguish to what extent nurses self-select in terms of their pre-disposition to stress.

Stress is not just a problem in 'developed' societies. Oyefeso & Osinowo (1992) looked at nurses in third world settings and found them significantly more stressed than their Western
counterparts, by the lack of adequate equipment, drugs, even water and electricity, as well as all the internal and organisational stressors mentioned in the Western literature.

Sickness, staff turnover, expressed discontent, alcoholism, smoking, home-work conflict, and overall physical and psychological ill-health have traditionally been associated with unhealthily high levels of stress in what is deemed to be a profession that makes exceptionally high demands of its members in terms of a wide range of activities, with unexpected outcomes (Bishop 1981; Bailey & Clarke 1989).

MODELS OF STRESS

'Stress' is a very general concept, often used to explain a wide range of human experience and behaviour. It is in danger of becoming meaningless if not used precisely and consistently (Boore 1978). It can, for example denote positive as well as negative experience in nursing; as Hall (1981) puts it, "Stress, emotional and personal, is an important part of both initial and adjustment to many fields of nursing, and in continuing adaptation during the course of a nursing career".

It can be used to describe an external stimulus that impinges on the individual - eg. excessive noise, or the threat of unemployment. This is a stimulus - based model (MacPherson 1974) and explains stress as something that happens to the individual and treats stress as an independent variable for study. Such a model is limited when considering nurses because 1) it does not consider the individual and his or her attitudes to the stimulus; 2) it does not take the individual’s coping mechanisms into consideration; 3) it does not address the effects of habituation or new learning (Lazarus 1981).

The response model of stress focuses on the individual’s response to that environment, and consider this to be 'stress' psychological and physical (Selye 1975) and the outside stimulus the 'stressor'. Much has been made of this model in considering the genesis of all illness, where the illness is viewed as a continuum according to the role played by the stress response. Selye (1981) has postulated a 'General Adaptation Syndrome' (GAS) model which suggests that different stressors can produce the same physiological mechanisms in individuals. Selye's work as an endocrinologist led him to the conclusion that all organisms
struggle to maintain homeostasis, i.e. a stable internal environment, and that all stressors trigger a response from the individual which over time, is phased as a) alarm b) resistance, and c) exhaustion, leading to illness and ultimately, death. This model is non-specific inasmuch as it does not attribute specific stress outcomes to specific stressors, and it also presents the individual as essentially passive, reacting to a hostile environment, and coping through GAS.

The psychological research literature provides a number of models of human distress which postulate that cognitive appraisal of opportunities for gaining personal control of troublesome circumstances mediates self-regulation of positive outcomes (Thomson 1992). The most significant of these are Lazarus’ stress and coping paradigm (1966; 1984) and Bandura’s reciprocal determinist model (1983; 1989). Thompson (1992) however, is critical of both in their neglect of personal dispositional factors in explaining differing stress responses between individuals.

Perhaps the most useful model of stress and coping is a cognitive-transactional paradigm, (Lazarus 1981) which has meaning and practicality in a clinical setting. His model suggested that stress should be considered as fitting in a broad rubric of related problems, rather than a single narrow concept. His 'cognitive-phenomenological-transactional' (CPT) view of stress and coping emphasises the interactional nature of stress, and the importance of the stressed person’s self-appraisal about their ability to cope with that stress, as well as the severity of the stressor. The model is cognitive because it assumes that thinking, memory and the meaning or significance of events to the individual are central in determining stress and coping. The model is phenomenological because it is the individual’s personal appraisal of a stressor which is critical in the response; a new hospital could be seen by one nurse as a threat and by another as a major improvement in work conditions. Lastly, the model is transactional because it emphasises the interaction between the individual’s appraisal and the environment in which that person works. Lazarus (1966) describes stress dynamically, with appraisal, (when the individual assesses the challenge) secondary appraisal (when the individual estimates the ability to cope); and lastly, reappraisal (when the individual can check on the relative effectiveness of any coping to reduce threat).
This model is useful because it gives an account of the relative and ever-changing nature of stress, psychological and physiological. It also allows for the psychological distinction between stress as a challenge and a pleasure, and stress as a threat. It is particularly useful for this study because it provides an interactive paradigm that describes how an individual or group of individuals might be helped to appraise and re-appraise an ever-present external stress - eg. a challenging patient - in such a way as to reduce or change that experience of stress for the better.

**BURNOUT**

*Stress* and *burn-out* are used in a causally related sense in many studies, and in some instances, synonymously (Bailey & Clarke 1989). Definitions vary, but Charnis (1980) observes that the features are the same; burn-out is apparent when the caring professions begin to fail, wear out, or become exhausted by making excessive demands on their energy, strength or resources. In addition, ineffectual coping increases the vulnerability of the nurse to burn-out.

Thompson & Page (1992) found burn-out positively related to pessimism, negative affect and limited self-focus, (ie. "the capacity of individuals to self-regulate their distress at discrepancies perceived in their progress towards valued goals"). Their study was based on 74 psychiatric Australian nurses observed in a semi-secure setting.

Thompson & Cooper (1993) also looked at *burn-out* in psychiatric nurses, and concluded that accomplishment and reduced stress were highly correlated with 'positive affectivity', high self-control, low anxiety and 'private self-focus'. The generalisability of these results, and their meaning are, however, limited. Their results suggested that nurses with good stress coping mechanisms remained less stressed, and those with poorer mechanisms, more stressed. In the words of the authors, the self-control model can be summarised. "When you’re up, you’re up; and when you’re down, you’re down!".

Kandolin (1993) has shown that another significant contributor to occupational burn-out in psychiatric nursing is the shift system. She found that male nurses similar levels of burn-out whether they were working two shifts (day time only) or three shifts (days and nights in a psychiatric ward setting. Female nurses, however, reported more stress symptoms and had ceased to enjoy their work more often if they were working three shifts than only two. Maslach & Jackson (1981) were the first to use this term in a systematic fashion and devised a Burn-out inventory to measure emotional exhaustion in care staffs.
STRESS AND ABSENTEEISM

Rees & Cooper (1991) looked at 1042 NHS employees, including 524 nurses, in the North West of England, and found that there were highly significant high positive correlations between mental and physical ill-health and self reported sickness absence, and a highly significant inverse correlation between job satisfaction and sickness absence. They found that job satisfaction was as great for health workers as for blue collar workers and management consultants, but that mental and physical ill-health were significantly poorer for health workers including psychiatric nurses.

The authors have yet to establish whether nurses with similar levels of stress to other occupational groups have similar reported levels of sickness absence.

Rees & Cooper (1992) found a slightly different pattern. Nurses had the highest reported stress, but not the highest rates of absenteeism. In contrast, ancillary health workers reported lower stress, but also lower job satisfaction, and high absenteeism. They also found that absence from work could be both a cause of stress and a result of it. Colleagues of absentees resent the additional workload and are critical of the absent person, resulting in the absentee taking even more time away from the occupational setting.

Furnham & Walsh (1991) looked at absenteeism, frustration and stress in 46 psychiatric nurses in Surrey. They found positive correlations between Person-Environment variables of congruence, consistency, differentiation and absenteeism. Furthermore, they found no relation between frustration and absenteeism. In explaining these unusual results, the authors considered Goffman's (1968) explanation of absenteeism as a way of avoiding surveillance and gaining more control over one’s time, rather than as an index of stress. They also raise methodological problems within their own work, such as the psychometric properties of their stress measures, (Job Frustration Questionnaire; Spector 1975) the size and stratification of the sample and the reliability of the absenteeism figures.
Nurses have other ways of withdrawing from stress while still remaining on the ward. For example, Handy (1991) examined the ways in which psychiatric nurses developed coping strategies for stress. He found these strategies eventually become embedded in the routines of the institution, intensifying the very problems they were originally intended to solve. For example, nurses who became very involved with their patients, and frustrated by ward practices which limited individual care, would be subtly reinforced by more senior (and more cynical) nurses to withdraw from the patient, not 'become over-involved' (a phrase laden with pejorative meaning), and to preserve the status quo. In this way, the discrepancy between ideal and actual care was constantly being negotiated and a source of limitless and unresolved stress to ward staff. The implicit conflict of interests between different ward staff had to be addressed before stress-reducing work patterns could be evolved at all.

**Stress and Mental and Physical Ill-Health**

Seyle's (1980) prototypical model of human stress suggested that the impact of chronic stress involves an escalation in biological activity that can result in debilitating, long-term mental and physical dysfunction. In a review of the applied psychology literature Pines et al. (1981) and Maslach & Jackson (1981) were among the first to demonstrate that nurses' repeated social contact with others at work on an unpredictable basis, depleted mental and physical resources and led to a range of psychosomatic and psychological disorders. Typically, nurses would report stress, followed by fatigue, followed by defensive changes in attitudes towards their patients and lastly to symptoms.

Rees & Cooper (1991) found health workers had significantly worse mental health than white-collar workers but that the two occupational groups were similar on physical ill-health measures. Health workers generally, if compared to their patients for stress, had a 3.5% overlap with them on the basis of mental ill-health, and a 7.6% overlap on physical ill-health. Nurses reported a slightly poorer physical health than general managers although this did not reach statistical significance. Unsurprisingly, they also found a high relationship between ill-health symptoms and self reported sickness, cf. Kahn & Cooper (1991).

In summary, nursing, and psychiatric nursing in particular, represent professions where there are a large number of external stressors, coupled with a large range of responses to them
from individuals, with inevitably differing outcomes. Stress was seen by nurses as providing a reason for their job, as well as causing their dissatisfaction with it; stress also provided reasons for fatigue, for occupational burnout, for physical and psychological ill-health, and for quitting the job. Any model of stress in nurses needs to look at why it is that two nurses on the same ward with the same environment experience stress differently, and cope differently. This study will concern itself with the stress expressed by nurses in one locked psychiatric ward, and will endeavour to obtain quantitative and qualitative measures of stress in the occupational setting, and establish whether it is possible to modify them by changing the ward environment, as well as providing nurses with structures for reappraisal.

BACKGROUND TO THIS SURVEY
The Physical Milieu
The ward is a locked rehabilitation ward within a traditional psychiatric hospital, once a Victorian workhouse in one of the most socio-economically deprived areas of East London. The hospital is due for demolition within the next five months, and the ward to be re-provided on a low-rise purpose-built hospital a third of a mile away on a District General Hospital site. The ward is in a very poor physical state of repair. There are three single bedrooms, the remainder of beds located in one male and one female dormitory. There is a large area with tables and sofas and a partitioned-off television area. The service profile for the ward indicated that most of the patients at the time of this study exhibited challenging behaviour, and all were detained under various sections of the Mental Health Act. Most of the patients on the ward have a diagnosis of schizophrenia, with at least a two year history, and some also have a forensic history. At the time of the study, there were nine men and six women living on the ward between the ages of 27 and 48, nine of whom came from an ethnic minority group.

The ward had a reputation as being problematic, with recruitment and retention difficulties for all disciplines. Low morale, a high level of violent incidents, and locum senior medical staff compounded the picture, though this was remedied by the appointment of a new, permanent, full-time consultant at the end of 1994.
A Brief History

In 1994, concern had been expressed by the Mental Health Act Managers of the Hospital, and by the local branch of MIND in City and Hackney, about the environment on the ward. Complaints focused in three main areas:

The physical environment; including, the shabbiness of the building; the lack of privacy in the dormitories; the lack of personal possessions; and the lack of access to food and drink outside meal-times.

Medical care; including, the high levels of medication; the poor physical health of the patients; and the low level of knowledge about treatment within the MDT.

The treatment milieu; including, lack of ward activity; low level of involvement by patients in the running of the ward; violence among patients; and high staff turnover.

Additional concerns from the new consultant centred on the lack of cohesive teamwork; covert conflict among the nursing staff and no clear, unified 'culture' of rehabilitation.

There were other signs that all was not well. In a pilot study of the ward (Clarke 1994), the Ward Atmosphere Scale (Moos et al. 1985) was administered to a group of nurses comparing their 'real' to their 'ideal' ward profiles. Results suggested a large discrepancy between these, and significant dissatisfaction with the ward as a therapeutic environment. The most marked discrepancies, in descending order, were in Support, Program Clarity, Involvement, Practical Orientation, and Order and Organisation, (see measures). Nurses subjectively reported at that time that such a discrepancy served as an occupational stressor. It was, therefore, decided to institute a major review of many aspects of the ward’s functioning.

Aims of the Study

These were to establish whether staff stress could be reduced while at the same time undertaking a wider audit of the ward which would:

* quantify areas of deficiency of care, management or administration on the ward
* provide a rational baseline for planning a series of systematic changes in the policies and practices on the ward
collect data which would allow monitoring the effects of such changes in the working environment

It was decided that staff measures should include the following; coping with the work load; confidence in professional role; job satisfaction, locus of control; an index of mental and physical health; absence rates; sickness levels and staff turnover. There was included the absolute numbers of untoward events on the ward. Staff had reported a lack of clarity in the programmes on the ward, and poor organisational support, all deemed to be stressors. Two major measures of stress therefore, the Nurse Stress Index (Harris, Hingley & Cooper 1988) and the Occupational Stress Indicator (Cooper, Sloan & Williams 1988) were selected after a brief pilot on the ward, as to their suitability and acceptability.

It was also agreed to do a repeat measure of the Ward Atmosphere Scale (real), with the staff, after the initial three month intervention, to establish whether the discrepancy between real and ideal had in any measure been reduced.

Limited time and resources did not allow any other staff measures to be taken. Nursing staff did agree to make themselves available for semi-structured interviews, but most of the observed measures of the ward concerned the patients and the therapeutic milieu, and nursing time also had to be deployed for this as well. The ward audit was part of a wider study that will not yield results until the middle of 1996.

EXPERIMENTAL HYPOTHESES

1. That overall levels of stress in the subjects will be reduced in the post-intervention condition, following the introduction of a more therapeutic regime on the ward.

2. That subjects of this study will improve their reported levels of confidence and competence in their role, and their perception of organisational support and involvement - as measured by the Nurse Stress Index, and subjectively by semi-structured interview.

3. That staff will report higher levels of job satisfaction, better physical and mental health indices, and a use of better coping mechanisms to reduce stress.

4. That the discrepancy between subjects’ perception of the ward and as it should ideally
be, will be smaller after the intervention than before.

5. That other indices of staff distress including sickness and staff turnover, and numbers of violent incidents will be reduced post-intervention, or at least maintained from further deterioration.

METHOD

The Subjects

The subjects for this study consisted of 21 psychiatric nurses currently employed in an East London Health Trust, and responsible for the care of fifteen patients, hospitalised within a locked, low secure, rehabilitation ward.

The ratio of men to women was 2:1, and included a range from unqualified 'A' grades, to a 'G' grade. Students and agency staff were not included; neither were nurses who had been on the ward for two months or less. Night staff were included, as they were on rotation, as were part-time nursing staff. Nurses were of a variety of ethnic backgrounds, of differing ages, and total clinical experience.

Participants had between 5 and 36 months experience, ($X = 20.05; SD = 15.02$). Subjects were approached through the consultant and the ward manager, and requested to complete a range of stress measures before and after a number of interventions were introduced to the ward, as part of the clinical audit being undertaken.

100% of the population were contacted but four of the pre-intervention group were not included as they were not employed on the ward in the post intervention period.

This is a brief intervention study, using subjects as their own control, in a repeated measures design before and after. No other controls were deployed at this stage of the study; there is another locked ward within the hospital, but the patient population is different, as is the ratio of nurses to patients.

The Experimenters

All questionnaires were collected by the author in the pre-intervention stage, and by her
assistant, unknown to staff, post-intervention. The Ward Atmosphere Scale questionnaires were administered by a clinical psychologist in training, and by the psychology assistant, neither of them a member of the ward staff.

Semi-structured interviews were carried out by the author, not herself part of the nursing hierarchy, but familiar to staff, and acceptable to them. Limited resources did not allow the allocation of an independent interviewer, and the design of the study will be modified in this respect next year. Ideally, experimenters should have carried out test/retest trials for both reliability and validity in using measures, but again the time constraints did not permit this to occur this year.

**Independent Variables (inputs)**

The independent variables in this study introduced in April 1995 comprised the following:

1. A weekly support group for all nurses and members of the multidisciplinary ward team was provided by an outside facilitator. Attendance was encouraged, but not obligatory, and was held in a room outside the ward just after the week-end, which many nurses had judged to be a particular stressful time on the ward. The group was informal, confidential and focused on the relationship between professional and personal life on the ward. Participants were encouraged 1) to discuss tensions within their profession and beyond it, 2) to identify accurately the source of misunderstandings and conflict, 3) to devise clearer coping strategies where emphasis was on team collaboration and communication. (Hypotheses 2 and 3).

2. All nurses were allocated a named supervisor within the ward and encouraged to arrange time within the working week to attend supervision. The supervisor was of a higher nursing grade than the supervisee, and management and personal issues were the business of these sessions. The ward manager was offered supervision off the ward. The purpose of supervision was to provide support, information and guidance in professional matters. It was also intended to help define more clearly each nurses' professional role. (Hypotheses 2, 3 and 5).

3. A weekly teaching seminar was introduced on the ward by members of the multidisciplinary team, aimed at increasing competence in a professional rehabilitative role. The seminars focused on practical problem-solving, the topics having been
selected by the nurses themselves. Nurses were encouraged to bring and discuss their own clinical material. (Hypotheses 1, 2 and 4).

4. A weekly business meeting was convened by the ward manager to provide all staff with information about new policies, procedures and staff changes, and to discuss how to change the ward to become a more therapeutic community. The nurse manager provides the interface between the most senior clinicians on the ward and higher management in the Trust. The business meetings were also aimed to improve nurses’ team work and confidence. (Hypotheses 2, 4 and 5).

5. Daily community meetings were instigated for both patients and staff, aimed at creating a forum where the whole ward community could express its concerns, make decisions, plan and begin to implement therapeutic changes on the ward. (Hypotheses 1, 4 and 5).

All of these inputs were introduced shortly after the pre-intervention measures were taken, although none of the nurse support measures were compulsory. No attendance records were kept, so it is not possible to ascertain if all subjects were equally exposed to the changes introduced to the ward. The daily community meetings, however, were compulsory for staff, and involved nurses of all grades. The short period of time of this intervention was due to there being a move to a new hospital, the effects of which would certainly have further influenced the reported levels of nursing stress. These variables were aimed at providing nurses with clearer professional guidelines about their role in rehabilitation, and were part of a wider programme aimed at creating a more therapeutic community. (Hypothesis 4).

**Dependent Variables (Outputs)**

1. **The Nurse Stress Index**

The Nurse Stress Index (Harris, Hingley & Cooper 1988) known as the NSI, was designed and has been used extensively in research into stress among UK nurses, with reliability and validity data readily available, and the tool has been factor-analysed (Hingley & Cooper 1987; Cooper, Manning & Poteet 1988; Cooper, Rout & Faragher 1989).

It consists of 30 items, with accompanying five-point Likert-type rating scales, divided into subscales assessing five major sources of job stress amongst nurses:
1. **Managing the Workload** (MW1 and MW2) - these two scales measure pressure due to 'feelings of insufficient time and resources to complete tasks and meet deadlines'.

2. **Organizational support and involvement** (OSI) - this scale assesses the pressures perceived due to lack of involvement in planning and decision-making at work, and issues concerning inadequate feedback.

3. **Dealing with patients and relatives** (DPR) - this scale is concerned with the patient's relationship with the nurse, and the nurse's feelings about death and dying.

4. **Home-work conflict** (HWC) - this scale measures the stresses due to the conflicting demands of work and home.

5. **Confidence and Competence in role** (CCR) - this scale measures the difficulties experienced by nurses with the role they are required to fill, including coping with change and responsibility.

The NSI also includes five items (with five-point Likert-type scales), which form a job description scale (JD), which gives some indication of the individual's feelings about going to work, being at work, and attitude towards the job.

2. **The Occupational Stress Indicator**

The Occupational Stress Indicator (OSI), a self-completion questionnaire, devised by Cooper, Sloan & Williams (1988) is a major instrument used to investigate and measure stress. The OSI provides measures of the respondents' job satisfaction, ratings of current health (both physical and mental), scores on type A personality dimensions, perceived control over working environment, identification of sources of stress and the subject's use of various coping strategies. Although the questionnaire was originally devised for white collar and professional workers, it has been successfully applied to health care professionals, (Rees & Cooper 1990; Cooper et al. 1989). The OSI consists of six scales, (each of which provides a number of sub-scale scores) and a total of 167 items using Likert-type rating scales. Reliability and validity data are widely available and are of a high standard, and all scales have been factor-analysed (Cooper et al. 1988; Robertson & Cooper 1990).

The Sources of Pressure

This scale consists of six subscales which measure a variety of job stressors:

1. **Factors intrinsic to the job**, looks at workload, variety of tasks, and rates of pay.
2. *Management Role* is concerned with how individuals perceive the expectations others have of them and includes role ambiguity and role conflict.

3. *Relationships with others*, looks at pressures that arise from personal contacts at work including 'ward politics' and asks about possible lack of support from superiors.

4. *Career and Achievement*, is concerned with respondents’ perception of their career development, their promotion prospects and perceived threats of redundancy.

5. *Organisational structure and climate*, looks at problems that may arise from bureaucracy, communication problems and morale within the organisation.

6. *Home and work*, is concerned with the *interface* between home and work. It asks about whether home problems are brought to work and whether work has an impact on home life.

Individual Differences

Type A behaviour pattern

This scale produces three subscales which are summated to produce a total type A score:

1. *Attitude to living* measures attitudinal aspects of Type A, such as confidence, commitment to work and how much of a priority the job is.

2. *Style of behaviour* assesses the behavioral aspects of Type A including time pressure and abruptness of behaviour.

3. *Ambition* measures aspects of achievement needs.

Perceived Locus of Control

This scale produces three subscale scores which are summated to produce an overall LOC score. The items in this scale ask about an individual’s control or autonomy over a number of work situations:

1. *Organisational forces* measures the extent to which respondents perceive their control over the 'invisible' influences and constraints within the organisation.

2. *Management processes* looks at how subjects’ performance is appraised, how they get promoted or progress, and their influence over these.

3. *Individual influence* looks at a more general ability to have influence within the workplace.
Coping with Stress

This scale asks respondents to rate the frequency of use of six kinds of stress-coping strategies:

1. **Social support** looks at subjects' use of various means of informal and formal personal support networks.
2. **Task strategies** looks at how individuals organise their work into manageable chunks and forward planning.
3. **Logic** addresses respondents' adoption of an unemotional and rational approach to situations.
4. **Home and work relationships** is concerned with the use of non-working time to dissipate stress.
5. **Time management** measures aspects of work organization in terms of priority setting and use of delegation.
6. **Involvement** is concerned with individuals' job commitment and acceptance of the situation in which they work.

The OSI provides two kinds of criterion measure; *current state of health* and *job satisfaction*. Both were included in the present study because of the extensive research evidence indicating their relationship with individual turnover, absenteeism and job performance (Griffin & Bateman 1986).

**Current State of Health**

This is in two parts, mental and physical ill-health. These two aspects of wellbeing are measured using six-point Likert-type scales of symptom frequency:

1. **Mental ill-health** taps a range of cognitive aspects of strain.
2. **Physical ill-health** looks at the somatic symptoms of anxiety and depression.

**Job Satisfaction**

This scale produces five subscale scores which are summated to provide an overall job satisfaction score:

1. **Achievement, value and growth** looks at respondents’ perceived opportunities for advancement, how valued they feel and whether their job is rewarding.
2. *Job itself* measures satisfaction with the type of work undertaken.

3. *Organizational processes* looks at perceptions of whether the organisation facilitates or hinders getting things done.

5. *Personal relationships* examines views about the quality of personal relationships at work.
A schematic representation of the OSI structure (Rees & Cooper 1992) may assist in understanding its functions:

<table>
<thead>
<tr>
<th>STRESS ELEMENTS</th>
<th>INDIVIDUAL DIFFERENCES</th>
<th>STRAIN EFFECTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Source of Pressure</td>
<td>Type A Behaviour Pattern</td>
<td>Current State of Health</td>
</tr>
<tr>
<td>intrinsic to the job</td>
<td>attitude to living</td>
<td>mental ill-health</td>
</tr>
<tr>
<td>management role</td>
<td>style of behaviour</td>
<td>physical ill-health</td>
</tr>
<tr>
<td>relationships with others</td>
<td>ambition</td>
<td></td>
</tr>
<tr>
<td>career and achievement</td>
<td></td>
<td></td>
</tr>
<tr>
<td>organisational structure and climate</td>
<td></td>
<td></td>
</tr>
<tr>
<td>home/work interface</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Perceived Locus of Control</td>
<td></td>
</tr>
<tr>
<td></td>
<td>organisational forces</td>
<td></td>
</tr>
<tr>
<td></td>
<td>management process</td>
<td></td>
</tr>
<tr>
<td></td>
<td>individual influence</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Coping with Stress</td>
<td></td>
</tr>
<tr>
<td></td>
<td>social support</td>
<td></td>
</tr>
<tr>
<td></td>
<td>task strategies</td>
<td></td>
</tr>
<tr>
<td></td>
<td>logic</td>
<td></td>
</tr>
<tr>
<td></td>
<td>home/work relations</td>
<td></td>
</tr>
<tr>
<td></td>
<td>time management</td>
<td></td>
</tr>
<tr>
<td></td>
<td>involvement</td>
<td></td>
</tr>
</tbody>
</table>
Kahn & Cooper (1991) were interested in establishing the reliability and validity of the OSI as a stress measure with psychiatric nurses. They found that the Mental Health and Coping scales were both very reliable measures. The Mental Health scale is also significantly correlated with the Crown Crisp Experiential Index, and it has a statistically significant relationship with the job dissatisfaction and introversion scale. There was also an inverse relationship between coping and both mental health measures.

3. The Ward Atmosphere Scale
The Ward Atmosphere Scale - WAS - (Moos 1974b) was developed to measure the social climates of psychiatric treatment programmes as perceived either by patients or staff. It comprises 100 items with statements referring to various aspects of the ward atmosphere. Subjects are asked to respond whether they think the statement is true or false of their particular ward.

There are ten subscales
The first three are relationship dimensions
1. **Involvement**: how active and involved patients are in the day to day social functioning of the ward.
2. **Support**: how helpful and supportive patients are to other patients; how well staff understand patients and how willing they are to help and encourage; how encouraging and considerate doctors are to patients.
3. **Spontaneity**: the extent to which the environment encourages patients to act openly and express their feelings freely to staff and other patients.

The next four are treatment programme dimensions
4. **Autonomy**: how self-sufficient and independent patients are encouraged to be in their personal affairs, their relationships with staff and the influence of staff on patient suggestions, criticisms etc.
5. **Practical Orientation**: the extent to which patients’ environment orientates them to the external world and their discharge.
6. **Personal Problem Orientation**: the extent to which patients are encouraged to seek to
understand feelings and problems.

7. *Anger and Aggression*: the extent to which a patient is encouraged to argue with staff and express anger.

The last three items measure the *administrative structure*

8. *Order and Orientation*: measures elements such as what staff do to encourage order, how well the ward is kept, is there a regular schedule, do staff keep appointments etc.

9. *Programme Clarity*: the extent to which the patients know what to expect in the day to day routine, how explicit ward rules and procedures are etc.

10. *Staff Control*: the necessity of staff to restrict patients, eg. rules and regulations.

4. **Incidents on the ward**

These are recorded on all wards as a statutory nursing requirement, and are accompanied by a form filled in by the person who witnessed the incident. The numbers of incidents were collected from the ward manager before and after the intervention. There is a methodological problem here; ward incidents are evaluated by the nursing staff subjectively, and there is evidence that nurses under-report incidents, especially clients who are regularly violent (Lanza 1983; 1988; DHSS 1989). Nevertheless, there is a statutory requirement to record incidents, and changes in frequency had a face validity to ward staff.

5. **Sickness and staff turnover**

The figures were also collected from the ward manager, and are generally considered to be reliable, as they are recorded formally by the budget holder for the ward.

6. **Optimism-pessimism scores**

These were obtained from each of the subjects at the end of the semi-structured interview. Each was asked to rate himself or herself on a 10 point scale, with 0 representing extreme pessimism, and 10 representing extreme optimism about the job.

7. **Semi-structured Interviews**

The purpose of these interviews was to provide a richer qualitative picture of stress within the staff group, and to pick up the contexts in which individual stressors occurred. It was
also important to provide an opportunity for ward staff to talk about their experience of stress in a more informal setting, where follow-up questions would cast light on issues that may or may not have been covered in the questionnaires. McCarthy (1992) has shown that nursing staff talk more openly about handling stress within an informal format on the ward.

The type of sampling used was for maximum variation (Miles & Huberman 1994) and so all grades of staff were selected, both sexes, and a mix of differing ethnic backgrounds. A total of 15 interviews were carried out before and after the intervention.

The format of the interviews was the same for all grades of staff, since it was the intention to interview everyone who had completed a questionnaire, (see measures). Subjects were introduced to the interview as part of the overall ward audit, and were thanked for their cooperation. Reassurances about confidentiality were made, and nursing grade and number of months on the ward were recorded.

Subjects were asked about perceived personal stressors in the three months prior to interview. They were specifically asked to describe the most stressful day they had actually experienced. If they could not recall this, subjects were asked to imagine the most stressful day, and to identify what they saw as contributing to that.

They were then asked about alleviating factors, both personal and organisational that they had found or would find effective. Subjects were encouraged to name and describe personal resources and facilities, and personal and professional relationships that they used successfully, as well as those that were not. There followed two questions about the proposed reprovision in the new hospital and how stressful that might be, together with whether or not the subjects understood the purpose of audit, and if this was also seen as a source of stress.

Subjects were asked if the Trust could provide them with anything at all to help them with their stress, and what it might be. Lastly, subjects were asked if there was anything they wanted to ask the interviewer, and their comments duly noted.
Data Collection
This was carried out on the ward at all times. After all subjects were introduced to the study as a part of the ward audit, during a ward business meeting, envelopes containing numbered NSI, OSI and WAS questionnaires were left on the ward for completion and collection at a later date. Subjects were encouraged to approach the experimenter if there were any difficulties in understanding the task, but written responses were not shared.

The semi-structured interviews were carried out after the questionnaire data had been collected, and notes taken during and after each interview. Interviews took place in an office on the ward, by prior appointment. Due to limited access to staff, only fifteen interviews were obtained in each of the conditions. All grades were sampled, and the same questions were put to subjects in the two conditions.

Ethical Clearance
The East London and City Health Authority (ELCHA), does not formally require ethical clearance for staff audit. The following safeguards, however, were undertaken:

Nursing staff were assured about confidentiality, and that audit would be primarily concerned with a group effect. Questionnaires and interviews were carried out on the ward during working shifts; no names were used, and identifying characteristics of individuals were omitted from all documents.

Subjects were also told that they would be given oral and written group results after the repeated measure, with opportunity for feedback and discussion given at the time within a small staff group setting.

The benefits of cooperation in the study were explained; ie. it included the possibility of identifying and ameliorating causes of stress to nursing staff; patients’ care could indirectly be improved; lastly, the study would be submitted as part requirement of the degree of Psych D for the staff psychologist, who was the main experimenter in the study. Non-participants could not in any way be identified in the present or at a later stage.
A brief pilot was carried out in February 1995, where it was found that the OSI biographical questionnaire was judged by some staff to be too intrusive. The experimenter removed this part of the questionnaire from the design in response to this within the main study.

Because of the small numbers involved in the study, subjects were only asked to indicate on the questionnaires their nursing grade, and number of months' experience in working on this ward. A number was placed on each questionnaire, to access pre and post intervention scores, but subjects were not identified at any individual level.

**Experimental Design**

Pre-intervention measures were taken in the second, third and fourth weeks of March 1995. Post intervention measures were taken in the first, second and third weeks of July. The short intervention was influenced by the imminent move to a new, purpose-built hospital in the first week of August, a variable that could have substantially interacted with and influenced current nurse stress levels. A repeated post-measure will be carried out in mid-1996, together with ward and patient measures, once the ward has 'settled in'.

**RESULTS**

**Descriptive Analyses**

(All computerised analyses were carried using the SPSS for Windows Package, License no. 30869).

Means were substituted for any missing scores, and comparisons on each of the factors from the questionnaires made by visual analogues, such as piecharts. In the semi-structured interviews, a 10 point Likert-type scale was used to assess optimism/pessimism at the end of each interview. Means and variance on these scores have been calculated for both group conditions.

**Exploratory Data Analyses**

Boxplots show the inter-quartile ranges, the median score, and outliers for the groups. This allowed some visual scrutiny of differences in variance between the pre and post conditions, even non-significant skews. These have been presented throughout the results as they
provide more detailed information than means and standard deviations, and allow some interpretation of trends in the sample, as well as generation of further hypotheses (Tukey 1977). Decisions about the management of these nurses in the study population still have to be made, even if change is not statistically significant but proven.

**t-tests**

The sample for this study is presumed to be normally distributed, from examination of the boxplots. The number of subjects is small but represents the entire ward population available to the experimenter. Most of the requirements were met for a parametric design; and a related paired sample t-test was used for the OSI and NSI results.

Significance levels

A less stringent level of significance ($\alpha=0.05$) was chosen in advance for this study. Rejecting the null hypothesis incorrectly would not have had serious consequences for the management of the nurses. This study was a preliminary attempt to reduce stress, and nursing management requested any information that would allow them to make ongoing decisions about the ward, and ensuring its safety and viability.

**Qualitative Analyses**

These are reflected in all parts of the results. It is worth mentioning that the *social validity* (Miles & Huberman 1994) of the measures was an important indicator of nurses' motivation to complete the many tasks required of them. As well as these staff measures, nurses had not just their clinical duties, but other parts of the ward audit to complete. Most subjects needed to be able to complete measures which were rapid and spontaneous, and which had meaning for them. Measures that did not reach these simple criteria might themselves begin to contribute to stress, and a less reliable result. Nurses reported that the NSI had the highest degree of social validity; the WAS the least, and the OSI somewhere between the two.

**1.0 Nurse Stress Index**

Figure 1.1 shows the pre and post means and standard deviations, and shows some trends. The absolute group mean has reduced in stress, and is reflected in *Home/Work Interface*,.
Table Showing Means and Standard Deviations for the Nurse Stress Index Both Pre and Post Intervention

<table>
<thead>
<tr>
<th>VARIABLE</th>
<th>NUMBER</th>
<th>S.D. PRE</th>
<th>MEAN PRE</th>
<th>S.D. POST</th>
<th>MEAN POST</th>
</tr>
</thead>
<tbody>
<tr>
<td>MW1</td>
<td>21</td>
<td>3.67</td>
<td>11.43</td>
<td>4.19</td>
<td>11.90</td>
</tr>
<tr>
<td>MW2</td>
<td>21</td>
<td>3.64</td>
<td>13.28</td>
<td>3.89</td>
<td>12.14</td>
</tr>
<tr>
<td>OSI</td>
<td>21</td>
<td>4.72</td>
<td>14.31</td>
<td>4.35</td>
<td>14.24</td>
</tr>
<tr>
<td>DPR</td>
<td>21</td>
<td>2.57</td>
<td>11.10</td>
<td>3.29</td>
<td>11.38</td>
</tr>
<tr>
<td>HWC</td>
<td>21</td>
<td>3.13</td>
<td>10.00</td>
<td>2.84</td>
<td>8.57</td>
</tr>
<tr>
<td>CCR</td>
<td>21</td>
<td>3.89</td>
<td>12.21</td>
<td>3.29</td>
<td>11.62</td>
</tr>
<tr>
<td>JS</td>
<td>21</td>
<td>3.32</td>
<td>13.45</td>
<td>3.79</td>
<td>14.33</td>
</tr>
<tr>
<td>TOT</td>
<td>21</td>
<td>17.94</td>
<td>75.78</td>
<td>15.21</td>
<td>70.00</td>
</tr>
</tbody>
</table>

KEY:

MW1 Managing the work load 1
MW2 Managing the work load 2
OSI Organisational support and Involvement
DPR Dealing with patients and relatives
HWC Home work interface
CCR Confidence and competence in role
JS Job satisfaction
TOT Total amount of pressure experienced
Figures 1.2 and 1.3 are boxplots which map 50% of the sample on all NSI scores, showing little difference before or after the intervention. However, Figures 1.4 and 1.5 map the component stressors, where differences can be seen. The shape of the plots indicates greater pre-variance for organisational support and development, and confidence and competence in role as stressors. On inspection, there is an apparently greater post-variance along job satisfaction than before, which did not reach significance, \(F=1.30, \text{d.f.}=20,20, p>0.05\).

Figure 1.6 gives the t values for all seven stress factors, and on the total stress score. Results show no significant differences between the pre and post group.

The Occupational Stress Indicator

Figure 2.1 shows the means and standard deviations for total Type A behaviour; total View of Locus of Control; and total View of Job Satisfaction in the pre and post intervention conditions.

Figure 2.2 shows the means and standard deviations of the Sources of Stress subscales, including Factors Intrinsic to the Job; Career and Achievement; Home/Work Interface; Relationships with other People; the Managerial role; and Organisational Structure and Climate, in the pre and post intervention conditions.

Figure 2.3 shows the means and standard deviations for Coping Mechanism subscales, including Logic as a Coping Mechanism; Time as a Coping Mechanism; Social Support; Home/Work/relationships; and Involvement and Task Strategies, in the pre and post intervention conditions.

Figure 2.4 shows the means and standard deviations for the state of Health subscales, including mental and physical health, in the pre and post intervention conditions.

Figures 2.5 - 2.6 boxplot the individual characteristics - Type A Behaviour and Locus of Control, and indicate apparent less spread in the post intervention condition. Total Type A Behaviour was not significant, \(F= 1.17, \text{d.f.} = 20, 20 \ p > 0.05\). Locus of Control was not significant, \(F = 1.63, \text{d.f.} = 20, 20 \ p > 0.05\).
Figure 1.2
Boxplot Showing Total Pre Intervention Nurse Stress Index Scores

Figure 1.3
Boxplot Showing Total Post Intervention Nurse Stress Index Scores
Figure 1.4
Boxplot Showing Pre Intervention
Nurse Stress Index Scores

Figure 1.5
Boxplot Showing Post Intervention
Nurse Stress Index Scores

Stress Sources

**KEY:**
- MW1  Managing the work load 1
- MW2  Managing the work load 2
- OSI  Organisational support and involvement
- DPR  Dealing with patients and relatives
- HWC  Home/work conflict
- CCR  Confidence and competence in role
Table Showing Means, Standard Error of the Mean and Related T-Test Results for the Nurse Stress Index

<table>
<thead>
<tr>
<th>VARIABLE</th>
<th>NUMBER OF PAIRS</th>
<th>MEANS</th>
<th>S.E. OF THE MEAN</th>
<th>T-VALUE</th>
<th>DEGREES OF FREEDOM</th>
<th>2-TAILED SIGNIFICANCE</th>
</tr>
</thead>
<tbody>
<tr>
<td>MW1</td>
<td>21</td>
<td>0.52</td>
<td>1.10</td>
<td>0.48</td>
<td>20</td>
<td>0.638</td>
</tr>
<tr>
<td>MW2</td>
<td>21</td>
<td>1.14</td>
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<td>-0.32</td>
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<td>0.752</td>
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<td>HWC</td>
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<td>0.164</td>
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<tr>
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<td>0.82</td>
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<td>0.421</td>
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<td>JS</td>
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<td>-0.31</td>
<td>20</td>
<td>0.757</td>
</tr>
<tr>
<td>TOT</td>
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<td>5.24</td>
<td>4.64</td>
<td>1.13</td>
<td>20</td>
<td>2.72</td>
</tr>
</tbody>
</table>

**KEY**

MW1  Managing the work load 1  
MW2  Managing the work load 2  
OSI  Organisational support and involvement  
DPR  Dealing with patients and relatives  
HWC  Home work conflict  
CCR  Competence and confidence in role  
JS  Job satisfaction  
TOT  Total stress score
Figure 2.1
Table Showing Means and Standard Deviations for Individual Characteristics Subscale and Job Satisfaction Subscale of the Occupational Stress Indicator

<table>
<thead>
<tr>
<th>VARIABLE</th>
<th>NUMBER</th>
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<td>7.27</td>
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<tr>
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<td>21</td>
<td>17.85</td>
<td>15.33</td>
<td>80.90</td>
<td>80.33</td>
</tr>
</tbody>
</table>

KEY
TTA Total view type A behaviour
TLC Total view locus of control
TJS Total view job satisfaction

Figure 2.2
Table Showing Means and Standard Deviations of Scores for the Sources of Stress Subscale for the Occupational Stress Indicator

<table>
<thead>
<tr>
<th>VARIABLE</th>
<th>NUMBER</th>
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<td>INTRINSIC</td>
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<td>33.57</td>
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<td>31.90</td>
</tr>
<tr>
<td>MANAGER</td>
<td>21</td>
<td>6.99</td>
<td>8.81</td>
<td>36.86</td>
<td>33.76</td>
</tr>
<tr>
<td>STRUCTURE</td>
<td>21</td>
<td>9.17</td>
<td>8.60</td>
<td>43.10</td>
<td>39.62</td>
</tr>
</tbody>
</table>

KEY
Intrinsic Factors intrinsic to the job
Career Career and Achievement
Home Home/work interface
Relation Relationships with other people
Manager The managerial role
Structure Organizational structure and climate
Figure 2.3
Table Showing Means and Standard Deviations for the Coping Mechanisms Subscale of the Occupational Stress Indicator

<table>
<thead>
<tr>
<th>VARIABLE</th>
<th>NUMBER</th>
<th>S.D. PRE</th>
<th>S.D. POST</th>
<th>MEAN PRE</th>
<th>MEAN POST</th>
</tr>
</thead>
<tbody>
<tr>
<td>LOGIC</td>
<td>21</td>
<td>3.79</td>
<td>3.19</td>
<td>12.24</td>
<td>12.62</td>
</tr>
<tr>
<td>TIME</td>
<td>21</td>
<td>1.72</td>
<td>6.13</td>
<td>15.81</td>
<td>14.43</td>
</tr>
<tr>
<td>SOCIAL</td>
<td>21</td>
<td>4.84</td>
<td>3.10</td>
<td>18.48</td>
<td>16.14</td>
</tr>
<tr>
<td>HOME</td>
<td>21</td>
<td>5.34</td>
<td>4.57</td>
<td>17.33</td>
<td>16.48</td>
</tr>
<tr>
<td>INVOLVE</td>
<td>21</td>
<td>7.36</td>
<td>4.73</td>
<td>23.86</td>
<td>22.38</td>
</tr>
<tr>
<td>TASK</td>
<td>21</td>
<td>5.57</td>
<td>3.86</td>
<td>27.48</td>
<td>25.76</td>
</tr>
</tbody>
</table>

**KEY**
- LOGIC: Logic as a coping mechanism
- TIME: Time as a coping mechanism
- SOCIAL: Social support
- HOME: Home work relationship
- INVOLVE: Involvement
- TASK: Task strategies

Figure 2.4
Table Showing Means and Standard Deviations for the State of Health Subscale of the Occupational Stress Indicator

<table>
<thead>
<tr>
<th>VARIABLE</th>
<th>NUMBER</th>
<th>S.D. PRE</th>
<th>S.D. POST</th>
<th>MEAN PRE</th>
<th>MEAN POST</th>
</tr>
</thead>
<tbody>
<tr>
<td>MENTAL HEALTH</td>
<td>21</td>
<td>10.59</td>
<td>10.45</td>
<td>53.38</td>
<td>57.14</td>
</tr>
<tr>
<td>PHYSICAL HEALTH</td>
<td>21</td>
<td>8.53</td>
<td>13.26</td>
<td>30.29</td>
<td>33.95</td>
</tr>
</tbody>
</table>
**Figure 2.5**
Boxplot Showing Individual Characteristics
Scores Pre Intervention for the OSI

**Figure 2.6**
Boxplot Showing Individual Characteristics
Scores Post Intervention for the OSI

**KEY**
- TA  Type A behaviour
- LC  Total locus of control
Figures 2.7 - 2.8 boxplot the Nurses' Total view of Job Satisfaction, and indicate no apparent differences in the spread between the pre and post intervention conditions.

Figures 2.9 - 2.10 boxplot Sources of Stress, and indicate greater variance in the post intervention condition in Relationships with Others, and Home/Work Interface, but was not significant, (F=1.03, d.f. = 20,20, p > 0.05). Home/Work Interface was also non-significant, (F= 1.09, d.f. =20,20, p > 0.05).

Figures 2.11 - 2.12 boxplot Coping Mechanisms, and indicate apparently greater spread in the Use of Time, and in Home/Work Relationships. Use of Time was significant, F=1.37, d.f. = 20,20, p <0.05), but Home/Work was non-significant.

Figures 2.13 - 2.14 boxplot Physical and Mental Health, and indicate an apparently greater spread in both factors in the post intervention condition. Mental Health was n.s. but Physical Health was, F=2. 42, d.f. = 20, 20, p < 0.05).

Figure 2.15 gives the t values for the main subscales of the OSI. Results show no significant differences before or after intervention on Total Locus of Control, Type A Behaviour, or Total View of Job Satisfaction.

Figure 2.16 gives the t values for the Sources of Stress, including Factors intrinsic to the Job; Managerial role; Relationships with other people; Career and Achievement; Organisational Structure/Climate; and Home/Work Interface. There were no significant changes before or after the intervention.

Figure 2.17 gives the t values for Coping Mechanisms. There was a significant effect in Social Support between the two conditions; t (20) = 2.25; p = 0.036. Other mechanisms, including Task Strategies; Logic as a form of coping; Home and Work relationship; Time as a coping mechanism and Involvement showed no significant differences.

Figure 2.18 gives the t values for Mental and Physical Health and provides no significant differences between the nurses before or after the intervention.
Figure 2.7
Boxplot Showing Total View Job Satisfaction
Scores Pre Intervention OSI

Total View of Job Satisfaction

Figure 2.8
Boxplot Showing Total View Job Satisfaction
Scores Post Intervention

Total View of Job Satisfaction
Figure 2.9
Boxplot Showing Sources of Stress Scores
Pre Intervention for the OSI

Figure 2.10
Boxplot Showing Sources of Stress Scores
Post Intervention for the OSI

Sources of Stress

KEY
FIJ Factors intrinsic to the job
MR The managerial role
RWO Relationships with other people
CA Career and Achievement
OS/C Organisational support and climate
H/WI Home/work interface
Figure 2.11
Boxplot Showing Coping Mechanisms Scores Pre Intervention OSI

Figure 2.12
Boxplot Showing Coping Mechanisms Scores Post Intervention OSI

Coping Mechanisms

KEY
SS Social Support
TS Task strategies
L Logic
HWR Home/work relationship
T Time
I Involvement
Figure 2.13
Boxplot Showing Physical and Mental Health Scores Pre Intervention for the OSI

State of Health

Figure 2.14
Boxplot Showing Physical and Mental Health Scores Post Intervention for the OSI

State of Health
Figure 2.15
Table Showing Means, Standard Error of the Mean and T-Test Results for Total Locus of Control, Total Type A Behaviour and Total View Job Satisfaction Subscales of the Occupational Stress Indicator

<table>
<thead>
<tr>
<th>VARIABLE</th>
<th>NUMBER OF PAIRS</th>
<th>MEAN</th>
<th>S.E. OF THE MEAN</th>
<th>T-VALUE</th>
<th>DEGREES OF FREEDOM</th>
<th>2-TAILED SIGNIFICANCE</th>
</tr>
</thead>
<tbody>
<tr>
<td>TLC</td>
<td>21</td>
<td>-1.76</td>
<td>1.76</td>
<td>-1.00</td>
<td>20</td>
<td>0.329</td>
</tr>
<tr>
<td>TTA</td>
<td>21</td>
<td>-0.57</td>
<td>2.60</td>
<td>-0.22</td>
<td>20</td>
<td>0.829</td>
</tr>
<tr>
<td>TJS</td>
<td>21</td>
<td>-1.43</td>
<td>4.64</td>
<td>-0.31</td>
<td>20</td>
<td>0.761</td>
</tr>
</tbody>
</table>

KEY
TLC  Total locus of control
TTA  Total type A behaviour
TJS  Total view job satisfaction

Figure 2.16
Table Showing Mean, Standard Error of the Mean and T-Test Results For Sources of Stress Subscales of the Occupational Stress Indicator

<table>
<thead>
<tr>
<th>VARIABLE</th>
<th>NUMBER OF PAIRS</th>
<th>MEAN</th>
<th>S.E. OF THE MEAN</th>
<th>T-VALUE</th>
<th>DEGREES OF FREEDOM</th>
<th>2-TAILED SIGNIFICANCE</th>
</tr>
</thead>
<tbody>
<tr>
<td>INTRIN</td>
<td>21</td>
<td>2.52</td>
<td>2.31</td>
<td>1.09</td>
<td>20</td>
<td>0.287</td>
</tr>
<tr>
<td>MANAGER</td>
<td>21</td>
<td>3.09</td>
<td>2.59</td>
<td>1.19</td>
<td>20</td>
<td>0.248</td>
</tr>
<tr>
<td>RELATION</td>
<td>21</td>
<td>1.19</td>
<td>2.71</td>
<td>0.44</td>
<td>20</td>
<td>0.666</td>
</tr>
<tr>
<td>CAREER</td>
<td>21</td>
<td>1.90</td>
<td>2.45</td>
<td>0.78</td>
<td>20</td>
<td>0.446</td>
</tr>
<tr>
<td>STRUC</td>
<td>21</td>
<td>3.48</td>
<td>2.56</td>
<td>1.34</td>
<td>20</td>
<td>0.196</td>
</tr>
<tr>
<td>HOME</td>
<td>21</td>
<td>4.14</td>
<td>3.01</td>
<td>1.38</td>
<td>20</td>
<td>0.184</td>
</tr>
</tbody>
</table>

KEY
INTRIN  Factors intrinsic to the job
MANAGER Managerial role
RELATION Relationships with other people
CAREER  Career and achievement
STRUC   Organisational structure/climate
HOME    Home/work interface
### Figure 2.17
Table Showing Mean, Standard Error of the Mean and T-Test Results For Coping Mechanisms
Subscales of the Occupational Stress Indicator

<table>
<thead>
<tr>
<th>VARIABLE</th>
<th>NUMBER OF PAIRS</th>
<th>MEAN</th>
<th>S.E. OF THE MEAN</th>
<th>T-VALUE</th>
<th>DEGREES OF FREEDOM</th>
<th>2-TAILED SIGNIFICANCE</th>
</tr>
</thead>
<tbody>
<tr>
<td>SOCIAL</td>
<td>21</td>
<td>2.52</td>
<td>2.31</td>
<td>1.09</td>
<td>20</td>
<td>0.287</td>
</tr>
<tr>
<td>TASK</td>
<td>21</td>
<td>3.09</td>
<td>2.59</td>
<td>1.19</td>
<td>20</td>
<td>0.248</td>
</tr>
<tr>
<td>LOGIC</td>
<td>21</td>
<td>1.19</td>
<td>2.71</td>
<td>0.44</td>
<td>20</td>
<td>0.666</td>
</tr>
<tr>
<td>H/W</td>
<td>21</td>
<td>1.90</td>
<td>2.45</td>
<td>0.78</td>
<td>20</td>
<td>0.446</td>
</tr>
<tr>
<td>TIME</td>
<td>21</td>
<td>3.48</td>
<td>2.56</td>
<td>1.34</td>
<td>20</td>
<td>0.196</td>
</tr>
<tr>
<td>INVOLV</td>
<td>21</td>
<td>4.14</td>
<td>3.01</td>
<td>1.38</td>
<td>20</td>
<td>0.184</td>
</tr>
</tbody>
</table>

**KEY**
- SOCIAL Social support
- TASK Task strategies
- LOGIC Logic as a form of coping
- H/W Home and work relationship
- TIME Time as a coping mechanism
- INVOLV Involvement

### Figure 2.18
Table Showing Means, Standard Error of the Mean and T-Test Results for State of Health Subscale of the Occupational Stress Indicator

<table>
<thead>
<tr>
<th>VARIABLE</th>
<th>NUMBER OF PAIRS</th>
<th>MEAN</th>
<th>S.E. OF THE MEAN</th>
<th>T-VALUE</th>
<th>DEGREES OF FREEDOM</th>
<th>2-TAILED SIGNIFICANCE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical Health</td>
<td>21</td>
<td>-3.67</td>
<td>3.47</td>
<td>-1.06</td>
<td>20</td>
<td>0.303</td>
</tr>
<tr>
<td>Mental Health</td>
<td>21</td>
<td>-3.76</td>
<td>3.43</td>
<td>-1.10</td>
<td>20</td>
<td>0.286</td>
</tr>
</tbody>
</table>
3.0 The Ward Atmosphere Scale

Figures 3.1 - 3.2 describe the percentages of System Maintenance Dimensions Scores pre and post intervention, and indicate a shift away from Staff Control, and towards Program Clarity, with no change in Order and Organisation.

Figures 3.3 - 3.4 describe the percentages of Relationship Dimension Scores pre and post intervention, and suggest a shift away from Spontaneity, and towards Involvement and Support.

Figures 3.5 - 3.6 describe the percentages of Personal Growth Dimension Scores pre and post intervention, and show an apparent shift towards Anger and Aggression, and away from Practical Orientation, with little change in Autonomy, or Personal Problem Orientation.

Figures 3.7 - 3.8 boxplot the System Maintenance Dimensions of the WAS, apparently showing greater spread in the post intervention condition on all three factors, viz. Staff Control, Order and Organisation, and Program Clarity. F ratio was calculated for all, but was non significant.

Figures 3.9 - 3.10 boxplot the Relationship Dimensions of the WAS, and show apparently greater spread in the post intervention condition on the factors of Spontaneity and Involvement, but no change in Support. Only Spontaneity, however, reached significantly different variance; F = 7.58, d.f. = 7,7, p<0.05.

Figures 3.11 - 3.12 boxplot the Personal Growth Dimensions of the WAS, and suggest greater spread in the post intervention condition on the Autonomy factor, and less spread in Anger and Aggression. Anger and Aggression was significantly different; F = 2.93, d.f. = 7,7, p<0.05.

Figures 3.13 - 3.15 plot the WAS profiles between ideal and real pre intervention, the real pre and post-intervention, and the ideal and real post intervention and reveal that the real-ideal discrepancy between the two conditions has very slightly decreased.
Figure 3.1
Piechart Showing Percentages of System Maintenance
Dimensions Scores for Pre Intervention WAS

- Staff Control: 26.7%
- Order & Organisation: 30.2%
- Program Clarity: 43.0%

Figure 3.2
Piechart Showing Percentages of System Maintenance
Dimensions Scores for Post Intervention WAS

- Staff Control: 20.2%
- Order & Organisation: 31.5%
- Program Clarity: 48.3%
Figure 3.3
Pie chart showing percentages of relationship dimensions scores for pre intervention WAS.

Spontaneity: 41.3%
Support: 37.5%
Involvement: 21.2%

Figure 3.4
Pie chart showing percentages of relationship dimensions scores for post intervention WAS.

Spontaneity: 34.8%
Support: 40.2%
Involvement: 25.0%
Figure 3.5
Piechart Showing Percentages of Personal Growth
Dimensions Scores for Pre Intervention WAS

- Anger & Aggression: 28.6%
- Personal Prob Orien: 19.5%
- Autonomy: 22.1%
- Prac Orientation: 29.9%

Figure 3.6
Piechart Showing Percentages of Personal Growth
Dimensions Scores for Post Intervention WAS

- Anger & Aggression: 34.8%
- Personal Prob Orien: 18.4%
- Autonomy: 22.0%
- Prac Orientation: 24.8%
Figure 3.7
Boxplot Showing System Maintenance
Dimensions Scores for Pre Intervention WAS

System Maintenance Dimensions

Figure 3.8
Boxplot Showing System Maintenance
Dimensions Scores for Post Intervention WAS

System Maintenance Dimensions

KEY
OO  Order and Organisation
SC  Staff Control
PC  Program Clarity
Figure 3.9
Boxplot Showing Relationship Dimensions Scores for Pre Intervention WAS

Figure 3.10
Boxplot Showing Relationship Dimensions Scores for Post Intervention WAS

KEY
I  Involvement
S  Support
Sp Spontaneity
Figure 3.11
Boxplot Showing Personal Growth

Dimensions Scores for Pre Intervention WAS

Figure 3.12
Boxplot Showing Personal Growth

Dimensions Scores for Post Intervention WAS

Personal Growth Dimensions

KEY
A Autonomy
PC Practical orientation
PPO Personal problem orientation
AA Anger and aggression.
Figure 3.13
WAS Profiles Real-Ideal Pre-intervention

**SOCIAL CLIMATE SCALE PROFILE OF**

CHECK SCALE USED: CES WAS COPES URES CIES MEI WES FESGES

CIRCLE FORM USED: R S E I

NORM GROUP

DATE

OTHER

COMMENTS:

Scales Developed by Rudolf H. Moos and associates.
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**KEY**

1. Involvement
2. Support
3. Spontaneity
4. Autonomy
5. Practical orientation
6. Personal problem orientation
7. Anger and aggression
8. Order and Organisation
9. Staff Control
10. Program Clarity
Figure 3.14
WAS Profiles Real Pre & Post Intervention

SOCIAL CLIMATE SCALE PROFILE OF

CHECK SCALE USED: CES WAS COPES URES CIES MEI WES FES GES

CIRCLE FORM USED: R S E I

NORM GROUP

DATE

OTHER

COMMENTS:

KEY
I Involvement
S Support
SP Spontaneity
A Autonomy
PC Practical orientation
PPO Personal problem orientation
A+A Anger and aggression
O+O Order and Organisation
SC Staff Control
PC Program Clarity

Scales Developed by Rudolf H. Moos and associates.
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Figure 3.15
WAS Profiles Ideal-Real Post Intervention

Scales Developed by Rudolf H. Moos and associates.
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4.0 Incidents on the Ward

Figure 4.1 shows the number of violent or untoward incidents on the ward between the months of January and March (pre intervention), and April to June, (post intervention), showing a small, non-significant decrease in incidents.

5.0 Sickness and Staff Turnover

Figure 5.1 shows the number of sick days per month between the months of January and March (pre intervention), and April to June, (post intervention), showing no difference between the two conditions.

The total number of leavers from the ward for the months of January to March, (pre intervention), was four, and from April to June (post intervention), was three, indicating only a slight reduction in staff turnover.

6.0 Optimism-Pessimism Scores

Figure 6.1. tables the means and standard deviations for the optimism-pessimism scale for the pre and post intervention group conditions, and indicates no change in the group’s self-rating.

7.0 Semi-structured interviews

The semi-structured interviews revealed a rich divergence of views about stress, and ways of containing and reducing it within a professional nursing role, and at a personal level. Figure 7.1 shows an Effects Matrix elicited from notes taken at the interviews.
### Figure 4.1
**Table Showing Number of Violent Incidents Per Month**
**For Pre and Post Interventions**

<table>
<thead>
<tr>
<th>Variable</th>
<th>Pre Intervention</th>
<th>Post Intervention</th>
</tr>
</thead>
<tbody>
<tr>
<td>January</td>
<td>15</td>
<td>April 8</td>
</tr>
<tr>
<td>February</td>
<td>4</td>
<td>May 11</td>
</tr>
<tr>
<td>March</td>
<td>13</td>
<td>June 8</td>
</tr>
</tbody>
</table>

### Figure 5.1
**Table Showing Number of Sick Days Per Month**
**For Pre and Post Interventions**

<table>
<thead>
<tr>
<th>Variable</th>
<th>Pre Intervention</th>
<th>Post Intervention</th>
</tr>
</thead>
<tbody>
<tr>
<td>January</td>
<td>65</td>
<td>April 42</td>
</tr>
<tr>
<td>February</td>
<td>35</td>
<td>May 34</td>
</tr>
<tr>
<td>March</td>
<td>42</td>
<td>June 63</td>
</tr>
</tbody>
</table>

### Figure 6.1
**Table Showing Means and Standard Deviations For Optimism and Pessimism Scores Pre and Post Intervention**

<table>
<thead>
<tr>
<th>VARIABLE</th>
<th>STANDARD DEVIATION</th>
<th>MEAN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre Intervention</td>
<td>1.83</td>
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</tr>
<tr>
<td>Post Intervention</td>
<td>1.37</td>
<td>5.85</td>
</tr>
<tr>
<td>ISSUES</td>
<td>PRE-INTERVENTION</td>
<td>POST-INTERVENTION</td>
</tr>
<tr>
<td>------------------------</td>
<td>-------------------------------------------------------</td>
<td>-------------------------------------------------------</td>
</tr>
<tr>
<td>Personal Stressors</td>
<td>unsure of professional role</td>
<td>lack of specific information on arrival new job</td>
</tr>
<tr>
<td></td>
<td>new job</td>
<td>poor supervision</td>
</tr>
<tr>
<td></td>
<td>sexual harassment</td>
<td>marital/family demands on time vs overtime on ward</td>
</tr>
<tr>
<td></td>
<td>marital/family tensions</td>
<td></td>
</tr>
<tr>
<td>Ward Stressors</td>
<td>too few rules</td>
<td>too many rules</td>
</tr>
<tr>
<td></td>
<td>staff turnover</td>
<td>staff turnover- &quot;only the good ones are leaving&quot;</td>
</tr>
<tr>
<td></td>
<td>racist attitudes</td>
<td>authoritarianism</td>
</tr>
<tr>
<td></td>
<td>staff cliques</td>
<td>staff competence in rehabilitation</td>
</tr>
<tr>
<td></td>
<td>too liberal/too vague</td>
<td>not enough freedom in dress code e.g.</td>
</tr>
<tr>
<td></td>
<td>not wearing uniform</td>
<td>nose studs</td>
</tr>
<tr>
<td></td>
<td>only woman on ward</td>
<td>racist attitudes from some</td>
</tr>
<tr>
<td></td>
<td>dirty environment</td>
<td>locked environment/ absence of garden</td>
</tr>
<tr>
<td>Clients Stressors</td>
<td>constant importuning</td>
<td>noise</td>
</tr>
<tr>
<td></td>
<td>challenging behaviour</td>
<td>suicide on ward</td>
</tr>
<tr>
<td></td>
<td>patients' lack of privacy</td>
<td>patients' lack of personal belongings</td>
</tr>
<tr>
<td></td>
<td>violence</td>
<td>being hit by clients</td>
</tr>
<tr>
<td>Organisational Stressors</td>
<td>downward pressure from management</td>
<td>downward pressure from management</td>
</tr>
<tr>
<td></td>
<td>new trust</td>
<td>rep re provision</td>
</tr>
<tr>
<td></td>
<td>reprovision</td>
<td></td>
</tr>
<tr>
<td></td>
<td>audit</td>
<td></td>
</tr>
<tr>
<td>Coping Mechanisms</td>
<td>talking to friends/family/colleagues</td>
<td>supervision</td>
</tr>
<tr>
<td></td>
<td>tea/coffee/cigs/alcohol</td>
<td>talking to friends/family/colleagues</td>
</tr>
<tr>
<td></td>
<td>walks/relaxation/sleep/yoga/sex</td>
<td>tea/coffee/cigs/alcohol</td>
</tr>
<tr>
<td></td>
<td>positive attitude/forbearance</td>
<td>walks/relaxation/sleep/yoga/sex</td>
</tr>
<tr>
<td></td>
<td>increase self-awareness</td>
<td>positive attitude/forbearance</td>
</tr>
<tr>
<td></td>
<td>skipping lunch/having lunch</td>
<td>increase self-awareness</td>
</tr>
<tr>
<td></td>
<td>working to daily goals</td>
<td>skipping lunch/having lunch</td>
</tr>
<tr>
<td></td>
<td>sense of humour</td>
<td>working to daily goals</td>
</tr>
<tr>
<td></td>
<td></td>
<td>sense of humour</td>
</tr>
<tr>
<td>Ward/Team De-Stressors</td>
<td>teambuilding</td>
<td>teambuilding</td>
</tr>
<tr>
<td></td>
<td>supervision</td>
<td>professional development</td>
</tr>
<tr>
<td></td>
<td>recruitment</td>
<td></td>
</tr>
<tr>
<td></td>
<td>retention</td>
<td></td>
</tr>
<tr>
<td></td>
<td>increased establishment</td>
<td></td>
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Some themes which emerged include:

* Nobody seemed to have any difficulty in dealing with the concept of stress. It was a term that had meaning to the subjects, and by implication, a shared meaning with the interviewer. Nevertheless, the fact that subjects listed personal and ward stressors in a similar vein, suggests that such distinctions were more helpful for the experimenter than the subjects. The same was true for distinctions made between nursing and multi-disciplinary teams, and the effects matrix reflects an overlap of categories.

* All interviewees perceived their job as stressful, though there were differences about whether stress was construed as problematic or inevitable, or both. With few exceptions, subjects reported that they found it easier to identify stressors than to identify coping mechanisms or the alleviation of stress.

* The major stressors identified were related to the patient workload, and to the relentless demands made by clients of staff in any working shift. Two or three clients were mentioned time and time again as being particularly disruptive and stressful, and this stressor was more frequently cited by more junior grades, (Grade C and below). Noise, dirt, the lack of privacy for patients, the lack of a garden, the lack of group rooms, and the limited facilities for patients and nurses alike on the ward were all mentioned, but far less frequently, and with less intensity, than the behaviour of the clients themselves.

* Almost as frequently cited was lack of clarity of professional role. Typically, nurses of all grades reported that they did not know what was expected of them outside the administration of medical or physical nursing procedures.

* The third major stressor mentioned by subjects most frequently was poor relationships with other members of the nursing team. Although this took a variety of formats, subjects located stressors as being unsupported, unappreciated, criticised and given contradictory information about practices/procedures on the ward. This applied throughout all grades, but was more characteristic of nurses who had had less experience on the ward.

* The major alleviator of stress was judged to be systemic, but within the ward culture. The largest single response (11/15), to the question, what alleviates stress, was an increase in group cohesion (usually called 'teamwork'), followed closely (9/15) by
improved communication between all grades of nursing staff.

* The other major alleviator of stress was judged to be at the individual professional level. A total of nine (9/15) respondents mentioned increased support and supervision within their immediate ward working environment, and another seven cited improved nursing training and education.

* There were of course concerns about money, permanent contracts, improved transport, flexible hours, and work-related pay but these were mentioned only a third as often as the systemic and professional alleviators.

DISCUSSION

The Hypotheses

1. Results show little evidence to support the hypothesis that overall stress levels would be altered for the better since the intervention. There were a number of trends which will be discussed, including changes in the apparent amount of spread between the two conditions.

2. Results do not support the next hypothesis that nurses' stress as represented by loss of confidence and competence in role, and the lack of organisational support, would be improved by the intervention, although there was a trend in this direction.

3. The next hypothesis, that nurses would improve their coping mechanisms, was in small part supported by the one significant result ($p = .005$) on the OSI which showed that staff were using social support as a stress coping mechanism more after the intervention. Job satisfaction and Mental and Physical Health did not improve significantly, but the spread between the pre and post conditions suggested a more homogeneous response, and a clearer perception of the issues.

4. The WAS differential was not statistically analysed, due to small numbers, but the hypothesis that the real - ideal discrepancy would be reduced was in small part demonstrated.

5. Sickness levels, the number of incidents, and the number of leavers were not reduced, but were maintained in the post intervention condition. However, the reasons for leaving can be both positively and negatively skewed, and there may be a long run-in time before a stressor causes a nurse finally to quit work. In other words the leavers over this brief intervention may have already set their agenda long before anything on the ward had begun to change.
A number of additional stressors began to emerge in the intervention period that had not been foreseen within the design of this study. These included the suicide of one of the patients, who quite unexpectedly, threw himself from the fifteenth floor of a tower block when visiting friends, and while escorted by his key nurse. A second death occurred when another patient developed acute renal failure, and died quickly in a nearby medical ward. Patients and nurses were invited to and attended both funerals, and discussion about both deaths was shared extensively through formal and informal structures on the ward, but the impact of losing two out of fifteen patients should not be underestimated. The passage of time in any locked ward environment may well lead to untoward events, well outside the control of a single experimenter.

Furthermore, four members of the permanent nursing team who had much earlier planned their departure from the ward, actually left during the intervention period. These departures had been the result of longstanding difficulties within the ward, and were probably accelerated by the imminent audit, where differences would have been hard to hide or even contain. Three nurses left with almost no notice to the patients. The result was deeply traumatic to the ward community, and may have led to a serious assault on another nurse, and several arson attacks on the ward by a patient, together with some deterioration in the mental state of several other patients. Three more staff left immediately at the end of the intervention, but also in the wake of this very unsettled period.

The planned reprovision exercise took a toll on the anxiety levels of patients, many of whom had lived on the ward for more than two years. Nursing staff all perceived the actual move planned for the end of July as a stressor; the anticipatory anxiety for patients was certainly an additional and untoward stressor for the entire ward community.

Lastly, the interviews and anecdotal evidence suggest that all audit, however welcome, is perceived by staff as stressful. All staff interviewed reported that they could understand the purpose of audit, although this may not be the case, since several referred to it as though the ward were being surveyed. They also reported that they hoped their work would improve as a result. Nevertheless, professional practices were inevitably being scrutinised, and additional stress perceived.
It may well be that had these untoward events not occurred, that stress could have significantly lessened within the nursing staff. As it was, the fact that nurse stress did not actually increase and was contained during this period may be seen as an achievement.

Patterns of change will be discussed within the context of the intervention supports to staff.

**Critical Review**

It is necessary to stress that this study took place within a four month period, which might explain why some trends emerged, but most of the hypotheses were not confirmed. Changes on long-stay psychiatric wards tend to be slow, but the time span was governed in part by the imminent move to the new hospital. Furthermore, a full discussion was had with nursing management and the multidisciplinary team, and it was deemed necessary to carry out some type of intervention with the staff to reduce the effects that reported levels of stress were having on recruitment and retention. It will be important in the follow-through of this audit in 1996, to see if results can be achieved over time, or if the original assumptions are false. The interventions for nurses will continue in the new hospital - implicit in this decision is that providing more support, supervision and goal setting for nursing staff will increase job satisfaction and ultimately lead to reduced stress.

There remain some difficulties about how this study was explained to the nursing staff, and whether or not this impacted on the results inasmuch as subjects might have been 'expected' to show less stress. The experimenter was known to the subjects, and though not on the ward, at least a member of the multidisciplinary team. A better design would have used an outsider for all the data collection.

The question of other ward controls has been mentioned. Ideally, the NSI and OSI should have had a multiple baseline to establish the existence of a Hawthorne effect, or practice effect, as well as how it compared to a group of nurses in a similar environment without any intervention. In a work setting, controls are difficult. All wards are busy, dynamic places, subject to immense changes and never without some kind of 'intervention'.

The reliability and validity of the measures has been established with other nurse populations,
and have a face content that reflected the original concerns of the ward staff. There remains the vexed question of anxiety elicited by change. It is always the case that if an improvement is achieved, that change will have occurred, and with that possible implications for a change in the responsibilities assumed by the nurses. Nurses who did not want to register such a change, would have found it easy to present more stressed than they actually were in the post intervention condition.

The Nurse Stress Inventory
The NSI did show a slight reduction in stress, and the factors which changed are important. *Confidence and Competence in Role* has slightly improved - the lack of this had been reported as a major stressor during the semi-structured interviews. During this time, key-working had been upgraded, and MDT meetings convened more regularly, with clearer assignations of tasks within care plans. It is likely that this factor would have improved more if nursing supervision arrangements had been tightened up to ensure that all staff had weekly contact with a named supervisor. Some progress had been made here, as is suggested by the improvement in *Home/Work Conflict*. Nurses reported that they were more likely to use the supervisory relationship to deal with their feelings about their patients, and the conflicts they felt in relation to home relationships after the intervention.

However, the post intervention interviews revealed that this was not always the case; supervision appeared still to be optional and based on personal affiliation rather than professional need. This point has been fed back to nursing management, and it is hoped that this anomaly will be corrected.

The spread around organisational support and development, and *Confidence and Competence in Role*, indicates that although measures of central tendency remained similar, that nurses began to agree more in their perceptions of how well or not they were supported and how clear they were about their professional role. The administration of the questionnaires, the interviews, and the MDT staff groups did much to increase awareness about these issues, and to help nurses formulate a clearer picture of the issues, if not the solutions required.
The Occupational Stress Indicator

Overall, the main subscales - Total Locus of Control, Type A Behaviour, and Job Satisfaction have not shown any significant changes post intervention.

*Type A behaviour* is constituted of attitude to living, *Style of Behaviour and Ambition*, characteristically describes individuals who have excessive time consciousness, abruptness, and competitiveness. *Locus of Control* characterises organisational, managerial and individual processes that subjects see as unduly influencing their lives.

The boxplots indicate less spread on the *Type A and Locus on Control*, suggesting that subjects were more agreed about their judgements of these two factors, and that this is likely to have been in part because they were being discussed within the ward group, and also in the semi-structured interviews. It may well be the case, that a process of problem recognition had commenced in these areas, but that it is still too early for this to have impacted sufficiently to reduce causes of stress for the subjects.

There was greater spread in the *Use of Time* factors and *Home/Work Interface* after the intervention - a result very slightly obtained in the boxplots for *Home/Work Conflict* in the NSI. The most likely explanation for this increased spread is that there were staff who were getting regular and effective supervision post intervention, but several who were not. The semi-structured interviews revealed a distinct subgroup of nurses who used family relationships to resolve stress, and another subgroup who preferred to use supervision.

*Physical and Mental Health* factors did not vary in either condition, either by means, or by spread. These two subscales are related to each other, and tend to focus on phenomenological aspects of health, ie. how you feel or behave, as well as the physical symptoms of stress. The semi-structured interviews indicated that individuals' personal indices of stress, and their lifestyles had not altered within the span of this intervention, and there is therefore no reason to expect that health would have changed quite so speedily.

Indeed the only coping mechanism that showed a statistically proven improvement, was the use of social supports. There was some increased variance in the use of *Time*, but it appears
that the ability of subjects to use both professional and personal social networks was beginning to provide them with a tool to contain stress. The semi-structured interviews indicated that most subjects are sensitive to the approbation of their peers on the ward, and immensely stressed by its loss. The weekly staff groups, and weekly business meetings, whilst not able yet to meet some stress needs, at least gave subjects more opportunity to talk, to share, to open up to their peers their frustrations and fears, and to begin to collaborate on problem-solving. A good example of this involved the establishment of an Outings Group, whose brief was to help patients and nurses get off the ward more frequently for organised activities. Another example was the considerable social cohesion after the suicide, around the nurse who had accompanied the victim and had witnessed the fall. Nurses rallied and supported that nurse and each other in the aftermath of the Coroner’s Inquest and funeral. The increased social interaction between staff, between staff and patients, and between patients in the wake of this also led to greater social cohesion.

The Ward Atmosphere Scale
This scale allowed subjects to define stressors related to the ward environment, and although the numbers participating were smaller than those who filled in the questionnaires, some trends emerged.

In general, subjects perceived the ward as having greater Program Clarity than before, but with less Staff Control. Although this result may have therapeutic implications for the patients, it does not necessarily reduce stress for staff. One example of this was the introduction of tea and coffee-making for patients, which arose from one of the community meetings. Prior to this, staff had had control over the kettle and beverages, with many attached rules and regulations. The change was clearly to increase patients’ Autonomy, and Satisfaction with ward life. Staff were clear about what this meant, but this did not mean that they were not anxious about patients harming themselves, or at least using up their supplies too rapidly. In the event, patients decided how to regulate their own use, and opened the facilities at agreed set times in the day, keeping the supplies with nurses at other times.

Subjects also reported more Involvement in Ward Activities by patients, which was likely to
be the result of the daily community meetings. *Spontaneity*, however, a subscale which measures the extent to which patients are encouraged to act openly and express their feelings to staff and other patients, was reduced, and may well have been a measure of the staff's own anxieties about the implications for such a change.

The trends in *Personal Growth Dimensions* are interesting. The shift towards *Anger and Aggression* indicates that patients were encouraged more to argue with staff and to express anger. It may be that the community meetings had made it more easy for patients to express their hostility, rather than reverting to an increased psychopathology. The maintained number of incidents on the ward indicates, however, that patients may also have had more to be angry about. The staff changeover, the planned moves, and the deaths of two patients, did nothing to reassure patients that their world was secure. An audit of patients' satisfaction carried out during the intervention indicated that many patients did not always see the nursing staff as very kind. These combined effects could explain this trend.

The shift away from *Practical Orientation*, a subscale that measures the extent to which the patients' environment orientates them to the external world or discharge, can in part be accounted for by the emphasis placed on the immediate problems facing the ward during this intervention. Most of the clients have a wide range of problems that prevent them from being discharged into the Community. Challenging behaviour, dangerousness, and lack of any social network, are current concerns that will need to be addressed as well as the *Activities of Daily Living*.

The spread of several of the WAS subscales altered after the intervention and again, indicate the value of looking at spread, albeit for only seven respondents. Spread increased in *Staff Control, Order and Organisation, Program Clarity, Spontaneity, Involvement and Autonomy*, but decreased only on *Anger and Aggression*. The meaning of this seems to be subjects were less agreed in their perceptions of changes in the Ward Atmosphere. The audit has shown that there is much work to be done in helping the *Ward Team* come to some common understandings about the ward as a therapeutic environment. This was very well reflected in the semi-structured interviews, where subjects complained about their ward as being both too authoritarian and controlled, and at the same time being too unstructured and laissez-
faire. Subjects complained about there being too many petty restrictions for both themselves and their patients and complained about there not being clearer rules, policies, and/or structures for good nursing to occur - all stressors in either direction.

**Untoward Incidents**

The *Incidents* on the ward were not reduced at all. It is fair to say that nurses themselves worried less about this in the post intervention condition, but the level of violence and untoward events suggests that the ward is a long way from its potential as a therapeutic milieu. Patients may be encouraged to express their feelings, and they may well have reasons for feeling angry, but alternatives to provocative or challenging behaviour are rarely sought or deployed.

Patients with serious long-term mental illness, in a locked ward, with no garden and few facilities are a volatile population, but the ward had historically had fewer incidents in previous years, when the patients and physical environment were the same. The staff have changed, and though many have had training in *Control and Restraint*, there has been less emphasis placed on de-escalating violence, on negotiating, and on avoiding confrontation within current professional training. An education programme has been devised, but not yet implemented with staff. It will be interesting to see if training all members of the multidisciplinary team in the psychological management of aggression will impact on this score when repeat measures are taken in 1996. The reliability of this measure alone, however, and the difficulties around under-reporting have already been discussed in the *Method*.

**Nurse Sickness Levels**

The results show an identical and unacceptably high level of lost days on this ward due to sickness. One member of staff has been on long-term sickness for over a year, following an attack from a patient, and another nurse has been on sick leave since witnessing the patient suicide, despite immediate debriefing and counselling. If sickness is an index of stress, then there has been no change. There are, however, some longstanding issues here regarding the training and support of nurses in a locked environment, that cannot be resolved in three months. These results have been shared with all members of the team, and with nursing management, as a quality issue, and policies throughout the Trust are being
developed to achieve better overall figures. It should be mentioned that sickness here is a
loose term, and refers more accurately to absences from the ward, which may be attributable
to a number of factors, which could include sickness, injury, distress, or unresolved conflict.

**Optimism-Pessimism**

The scores here show no significant trend, although there has been a slight move towards
optimism. All nurses interviewed, reported that audit was stressful, and that it would take
some time before they could have better grounds for hope. Few, if any, recognised that
hopefulness itself is a useful resource in dealing with stress and violence in locked psychiatric
settings. The boxplot shows less variance, an indication that subjects are more agreed about
their levels of optimism in the post intervention condition. This is perhaps in part, because
nurses have had more opportunity than before to discuss their hopes and fears, and to
formulate a clearer picture of what they mean by optimism within a professional setting.
Although all interviewed said that it was essential in psychiatric settings, there were some
apparent contradictions. For example, several subjects thought that a coping mechanism for
stress, was *not* to have hopes, that would bound to be dashed by a negative experience.
Others used terms such as, 'expecting the worst', or, 'having to take the rough with the
smooth', as an indication that they did not expect that their working environment, and the
patient workload in particular, to get *any* better. It might also be the case that optimism and
pessimism is not a bi-polar construct, since realism is not included within it. The construct
was imposed by the experimenter, and it may be that a repertory grid technique applied to
this population might have produced a richer picture, showing optimism and pessimism
polarised away from realism.

**Semi-structured Interviews**

Despite the fact that there was a wide range of responses to these, there do appear to have
been some changing trends over the three months of this survey, see Figure 7.1. For
example, in examining the contributors to stress, more subjects cited the over-restrictive
environment post intervention, than beforehand, where the lack of rules had been quoted.

The naming of challenging behaviours in clients was more frequently mentioned in the pre-
condition, and the causes of these behaviours (noise; lack of social network; lack of personal
control), more likely to be mentioned post intervention. What this suggests is that nurses were beginning to reflect more about the needs of their patients, even though they were still reporting them as stressors in their working environment. It has already been mentioned that the interviews were defined in part by the experimenter’s constructs which may have had less meaning for the subjects in the pre intervention condition than the post intervention. However, nurses could tackle the causes of challenging behaviours in practical ways rather than perceiving them only as symptoms. The introduction of a befriending scheme on the ward and the implementation of key nursing will show in months to come whether or not this is the case.

In identifying multidisciplinary resources, interviewees talked about away-days and team building in very general terms prior to the intervention. Post intervention, they were more specific; they named a patient services officer, whom they wanted to give more financial advice about benefits to patients and their keyworkers. They named specific OT activities that they now valued as reducing stress on the ward, and specific individuals who had been appointed to the team. All in all, subjects were more focused and more articulate about stressors and coping mechanisms, even though they were still some way from dealing with it in such a way as to reduce stress.

There may have also been an over-reporting of stress, even when there were some signs of hope. It is possible that there is some social cachet in having a stressful job, that makes employees feel more valued, and more identified as a psychiatric nurse. To be freer of stress may be seen as not ‘really doing the job’. Indeed, this may have influenced the overall results, since nurses see stress as an integral and even an important component of their professional life. They may see it as something that has to be managed or contained, but not necessarily reduced. One interviewee mentioned that if he admitted to being less stressed than before, that maybe his line manager would give him more responsibilities, ie. more work. This issue will need to be addressed when stress measures are taken next year. It appears that staff may want to be less stressed, but not to be seen as less stressed. Measures so far have not made that distinction, and because their face content is so visible, could easily be falsified by subjects not wishing to be judged as having changed.
CONCLUSIONS

(Subjects will be followed in 1996 and compared with a number of other wards within the hospital, once it is possible to match the nursing staff more precisely).

Rees and Cooper (1990) showed that in comparison to white-collared workers in industry, health workers reported higher levels of work pressure, higher ratings of physical and mental ill health, less control over their work and lower levels of job satisfaction, but made frequent use of coping strategies. The results of this study have indicated one significant improvement in psychiatric nurse stress indices; social networking as a means of coping with stress.

This study has provided a rich source of information about the nature and perceived origin of stress for nurses working in a locked psychiatric ward setting. There is evidence of systemic as well as personal stressors, and an emerging picture of subjects who are beginning to identify more precisely the stressors and coping strategies that might help them be more effective in their occupational setting.

Some mention has already been made of nurses’ anxieties about change. Menzies (1970) in a case-study of nurses at a large teaching hospital in Inner London, observed the wide range of defenses, including splitting, depersonalization, categorization, and denial of the significance of the individual, detachment and denial, all as ways of coping with the immense anxieties of fulfilling the impossible and contradictory roles of nursing. It is important that these issues are seriously addressed through the staff group if any real progress is to be made with staff in reducing stress.

Miller (1979) describes another important hypothesis for workers, which is, the greater the control that the worker himself exerts over the productive process, the greater his job satisfaction, and the better his performance. Nursing is a hierarchical profession, and he observed in one ward undergoing change the importance of leadership in the transition from less to more autonomy. Again, the changes in this ward are being supported throughout the management structure of this Trust, but leadership at ward level is still at an early stage of development. There have been huge macro-organisational changes (three major restructurings of the Health Authority in two years), as well as micro-organisational changes.
within the ward.

The original hypothesis that a series of interventions on the ward aimed at improving the therapeutic milieu and mental state of the patients, would also reduce nurse stress has not been confirmed. Neither has a variety of other indices associated with stress been reduced, including *Job Satisfaction, Locus of Control, Physical and Mental Health, sickness or violent incidents*. None of these measures showed any deterioration either, and the pattern of stress, subjects' agreement as to its meaning, and the beginnings of some coping mechanisms suggest that perseverance will pay dividends in helping to support nurses as well as patients. So many subjects mentioned improved teamwork, personal professional development and greater input from the multidisciplinary team, that it seems likely that these processes will continue for some time to come.

After the reprovision, stress measures will continue to be taken of the staff, and it would still be the aim of the ward review to establish means of increasing nurses' job satisfaction and other signs of reduced stress. In conclusion, the intervention period of only four months before the move of hospital, may have been an unrealistic time period to have achieved significant impact on such a staff group facing so many occupational hazards. Some small changes suggest that in the course of the next twelve months, especially after the settling in to the new hospital, that overall stress could be reduced for most of the staff. Audit as such, however, remains a stressor; the fact that subjects thought that it was useful and might lead to an improvement in their working environment does not detract from the idea that to be audited is to be examined carefully, and to be held accountable for the services provided.

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ACKNOWLEDGEMENTS

The author of this report would like to thank the following people for the practical help and supervision provided throughout this research project:

All the nursing staff of the ward within the study, and the Senior Nurse Management of the City & Hackney Community Trust
Mr Simon Jakes, Consultant Clinical Psychologist and Supervisor
Miss Rebecca Cheatle, Assistant Psychologist for the collection of data
Mr John Rowe, Psychologist in Training for the collection of data
Mrs Tracy Wells, for the preparation of this manuscript
Mr Ian Grey, Head of Department of Statistics, Queen Mary College, London
COURSE SYLLABUS 1970-72

MSc Degree in Clinical Psychology

University of Leeds
### YEAR ONE

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AN INVESTIGATION INTO THE PERMANENCE OF INTELLECTUAL DETERIORATION IN CHRONIC ALCOHOLICS AS MEASURED BY THE WAIS

Dissertation submitted as part of the requirements for the MSc in Clinical Psychology, 1972, at the University of Leeds

Patricia M d’Ardenne-Kenyon BA
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by Patricia M. Kenyon, B. A.
SUMMARY

The existence of an intermediate stage of reversible intellectual dysfunction as a result of prolonged alcoholic abuse is hypothesised. This stage occurs after physical withdrawal but ceases not later than two months after this.

Twelve alcoholics who had been recently drinking but who were physically dried out were matched for age, socioeconomic status, education and approximate number of years' heavy drinking with twelve other alcoholics, all of whom had been abstinent for at least two months. Both groups were given the W.A.I.S. and their results were compared individually and in groups with ten psychiatric controls who were nonpsychotic and nonalcoholic. The experimental subjects and controls were also compared individually with a hypothetical level of unimpaired functioning based upon the groups' average Vocabulary subtest score.

Results showed that the recently dried out alcoholics were significantly poorer on several Performance subtests than either controls or abstinent alcoholics and that individually, these subjects' functioning was more variable. The hypothesis was confirmed but the exact nature of this dysfunction would need further experimental studies employing specific tests for cognitive dysfunction. The clinical implications of these results are also discussed.
CONTENTS

Summary

Introduction: A) Early Studies 1
B) Recent Studies 6
C) Studies Showing Reversible Dysfunction in Alcoholics 18
D) Conclusions 11

Experiment: A) Introduction 13
B) Method i) Test 14
ii) Design 14
iii) Subjects 15
iv) Procedures 22
C) Results i) Group analysis 22
ii) Individual Analysis 25
D) Discussion i) Exptl. Results 25
ii) Subjects' Behaviour 32
iii) Critique of Exp. 33
iv) Conclusions and Further Recommendations 36

References
GENERAL INTRODUCTION

That prolonged intensive abuse of alcohol may give rise to psychiatric symptoms is well known (20) but it is not clearly understood to what extent measurable impairment of intellectual functions is a consequence of such abuse. Not only this, but the permanence of such effects has been challenged (17), and the question of a reversible deterioration in alcoholics, following a relatively short term of total abstinence, either in or out of hospital, has also been raised. (13,14)

This paper does not seek to establish the precise nature of intellectual deterioration in chronic alcoholics, but rather, if it exists, to distinguish organic from functional involvement, and more importantly, to differentiate the effects of alcoholic poisoning from permanent deficits following physical withdrawal. The aim of this investigation also is to recommend a more cautious clinical application and interpretation of psychological tests of intellectual functioning in alcoholic patients.

Early Studies

The assessment of intellectual deterioration in alcoholics is not a new subject in clinical psychology, but it was not until alcoholism was generally recognised as an illness rather than a state of moral decadence (15) that more methodological and objective approaches were made. At first, studies concentrated on the more advanced pathology in chronic drinking. Lemere (10) for example wished to distinguish clearly the significance of psychological deficits in alcoholism by first isolating frequent concomitants such as anoxia due to cerebro-vascular
congestion, head injuries from repeated falls, toxicity from hepatic dysfunction, and avitaminosis, especially vitamin B.

He believed nevertheless that prolonged heavy drinking can produce permanent brain damage; also that the frontal lobes were the first to be anaesthetised by alcohol because this initial loss of control is damage which itself causes the addiction, personality being a secondary factor. He was particularly looking for intermediate stages of pathology before gross physiological changes were found.

Bennet, Hawery and Fort's study confirmed this idea of an intermediate stage between acute and chronic drinking phases, using clinical, electrophysiological and psychological criteria. Furthermore they suggested the urgent therapeutic implications of early diagnosis, of such a condition.

The first comprehensive review of changes in psychological functions as a result of alcoholism was by Jellinek and McFarland (1951). They clarified the distinction between psychological changes in induced alcoholic intoxication, (experimental studies) and changes in alcoholics already bestowed with a superstructure of chronic physical and psychiatric disorders, (clinical studies). They pointed out that because these are not the same thing, that when experimental and clinical studies are compared, quite different results are not necessarily contradictory. In the chronic drinker, there is a general loss in mental efficiency, and memory for recent events and the ability to form new associations are especially affected. So far as over-all intellectual ability is concerned, the
general rule seems to be progressive impairment of nearly all intellectual abilities, but there are great differences due to variation in individual tolerance to alcohol.

Weschler (31) reiterated the distinction between immediate and long term effects, noting that most investigations were cross-sectional studies, and not longitudinal studies, where age and other factors could be taken into account, and where changes after many years drinking could be assessed. In alcoholics manifesting no defined brain pathology, he predicted lack of persistence plus loss of goal in tasks requiring concentrated effort. He found that alcoholics could cope with simple paired-associate recall but deteriorated when tasks required logical analysis, synthesis and organisation at a higher level. He administered the Weschler Bellvue Scale I to a group of 29 chronic alcoholics without psychosis, or evidence of organic impairment. He divided his subjects into two groups, the first 36 - 42 years old, the second 42 - 55 years. His finding that similarities, Digit Symbol, Digit Span and Object Assembly subtests were lowered was offered as evidence of poor logical organisation. In his 1955 study using the W.A.I.S. Weschler found similar results except that Object Assembly was particularly low, with relatively good Picture Arrangement and Block Design - a picture he says is "almost pathognomonic of the chronic alcoholic". He also concluded that since the older group did less well than the younger, that there is a positive relationship between length of alcoholic drinking and degree of impairment. What Weschler did not say, however,
was whether the older group had actually been drinking longer than the younger. It is also a questionable point as to whether alcoholics may be compared as a homogeneous group with standardized norms. The lack of controls in these two studies is conspicuous.

Kalpersn's (12) work, does not suffer from this defect but his alcoholics and controls were not matched for age or intelligence. He administered the Borschbach, Level of Aspiration Test, Vocational Interests Blans and Weschler-Bellevue to both groups and came to the conclusion that the only intellectual discrepancy was a lowered digit span, which the author concluded was a distaste for numerical work rather than an intellectual deficit.

Another early study using the V-B scales and the Bender-Gestalt Test with alcoholics was Haldegg's investigation (18) which attempted a more careful collection of data about years of drinking, the period of abstinence before testing and the kind of drink taken. The alcoholics were compared with normal controls, psychosomatic patients, neurotics and migraine sufferers. The author calculated overall scores, and then examined subtest variation by simply counting the number of positive and negative deviations from the average vocabulary subtest score. Haldegg concludes, like Weschler, that Object Assembly suffers most with the alcoholic group - the reason being that whereas Digit Symbol is easily initiated, Block Design reproductive, Object Assembly requires productive planning and foresight, the very faculty he claims is impaired by drinking.

These sort of studies have been criticized by those who have carefully considered the structure of the W.A.I.S., noting that diagnostic profiles for such a heterogeneous psychiatric group may not be valid. Silverman (30) challenges the application of V-B subtest scores as an aid in psychiatric diagnosis. He claims that subtest patterns are inconsistent and of little such use,
suggesting that it might be just as well to inspect profiles for a few conspicuous and individual failures or successes rather than overall patterns. Gwynne Jones (16) in a later paper on the W.A.I.S., has also pointed out the changes of too readily interpreting subtest discrepancies as indicative of pathology and recommends that comparisons between specific tests be made, particularly if the direction of the difference is hypothesized beforehand.

Bauer and Johnson (3A) gave the W.A.I.S., the Weschler Memory Scale and Progressive matrices to 31 chronic alcoholics and a control of patients with emotional disturbances. Individual subtests did not differ significantly, but the alcoholics were better on personal and current information on the memory scale. These authors were struck, firstly, by the similarities between the groups, and secondly by the absence of any neurological deficits. Unfortunately, their results were confounded by the fact that the controls contained psychotic patients, making them less valid. There was also poor matching in these varied groups for age, education and socio-economic status.

In all of these early studies there have been difficulties, first, eliminating the effects of psychological function of associated but secondary physical, social and educational factors and also the provision of controls who differ only in respect of alcohol consumption. Using experimental subjects as their own controls is ideal: the alternative is careful one to one matching for all the other variables.
Recent Studies

Fitzhugh, Fitzhugh and Reitan (10) tried to overcome some of these problems: they administered the W-B form I, the Trail-making Test and 7 neurological measures to alcoholic patients, brain-damaged patients and controls (35 in each group). They maintain that although in gross score terms, alcoholics are indistinguishable from normals, that on tests requiring adaptive abilities they are more like the brain damaged groups. The alcoholics were divided at the 40 year level, and the older subjects resembled their brain damaged counterparts more than the younger, being better on accumulated information and less strong on immediate problem solving - what Fitzhugh calls "adaptive ability".

In a later study (11) by Goldstein and Shelley, a field dependence test was added to the battery but field dependence was found to be relatively independent of the more 'biological' abilities mentioned by Fitzhugh etc. Goldstein's patients were assessed shortly after admission and showed normal language function but poorer abstraction and problem solving, speed and manual dexterity, a pattern which Goldstein and Shelley considered to be a premature ageing process.

Kish and Cheyney (19) administered the General Aptitude Test Battery to chronic drinkers and again confirmed poor perceptual and manual dexterity as well as offering a numerical deficiency. The picture is qualified by the fact that impairment relates neither to the number of years drinking nor to the age of the subject. Older patients were not significantly worse even after many years drinking, which suggests, say the authors, a process partially reversible through sobriety. They therefore stress the necessity to 'delineate the relationship between measured aptitudes and length of time since last heavy
drinking.

Before moving on to studies which examine specific changes with time in dry alcoholics, an experiment (b) should be mentioned because it attempts more clearly by its methodology to eliminate the masking of minimal cerebral dysfunction in alcoholics due to poor education, environment or innate intelligence. Claeson and Clarkson quote Yacoszynski's finding that 12% of the general population have some kind of cerebral dysfunction anyway, but that it is likely to be less common among those who are educated, for example, to G.C.E.level, since memory and general intellectual functioning must clearly be more efficient at this level. They therefore selected alcoholics who had reached this level at school, excluding any histories of brain trauma, encephalitis or presenile dementia, and set an upper age limit of 54 to reduce the likelihood of cerebral changes due to age. The 20 alcoholic subjects were used as their own standards - by using each individual's school performance, and a standardised score was computed for each of ten tests: Synonyms, Figure Classification, Koh's Block Test, Figure Turning, Street's Gestalt Completion, Figure Identification, Gottschaldt's Embedded Figures, Schulze's 10-word, and the Benton Visual Retention Test. These were administered between the second and third week after admission and results were expressed in terms of upper or lower stanine units only. From these, the authors demonstrate that 10 subjects showed severe dysfunction, 5 moderate dysfunction, 7 mild dysfunction and 3 subjects no
dysfunction at all, though it is noted that these results refer only to the severity of alcoholic produced dysfunction and not to its type.

C. Studies Showing Reversible Dysfunction in Chronic Alcoholism.

Flumeat, Machover and Puzzo (24) gave the W-B intelligence scale to three groups of subjects, carefully matched for age, ethnic background, social circumstances and years of education: i) 22 alcoholics in remission (at least two years abstinence) ii) 22 unremitting alcoholics (sober for less than six months, and iii) 23 normal controls. The two experimental groups were identical as regards the duration and intensity of alcoholism. None of the groups was hospitalised during testing. Results showed that only in the Arithmetic subtest were there any significant differences, the unremitting alcoholics being worse than remitted or controls. A scatter index for the test profiles was used and gave significant differences between each experimental group and control group only. The fact that the two experimental groups were similar here, says Flumeat, confirms the reliability of the original finding. He argues against a significant relationship between length of drinking time and the scatter index (correlation .5) and against an organic account of the discrepancy because the usual subtests so associated (34) viz Block Design, Object Assembly or Digit Span were not affected. Instead he postulates that this uneveness of intellectual functioning "represents a long term process of erratic intellectual functioning symptomatic of a more generalised deviation in personality organisation and patterns of adaptation, which antedate the addiction to alcohol". What this does not
satisfactorily explain is why sobriety produces some reversal of
this effect if it is not dependent upon alcohol.

Jonsson, Cronholm and Isikawitz (17) studied intellectual
changes in two groups of 30 alcoholics and 29 controls matched
for age, place of residence (Stockholm), education, occupational
level, and psychiatric disorder. Since most of their alcoholics
suffered from various nonpsychotic disorders, the controls were
matched for these so that they were ideally different only in
respect of drinking habit. The first experimental group were
assessed as soon as the alcohol had disappeared from the blood
but not until after they were fully orientated and free from
Hallucinations and delusions (1 - 9 days, \( \bar{x} = 2.2 \)) the second
group were seen on average 28 days after admission (7 - 90 days).
Five tests of verbal understanding were used, one each of verbal
fluency and reasoning ability, two tests of spatial thinking,
three of memory, three digit symbol tests; also Information and
Picture Arrangement tests from a Swedish version of the Wechler
scale and Grassi's Block Substitution Test. The general trend
of the results suggested at least a partially reversible
impairment of intellectual ability immediately after intensive
abuse of alcohol, the significant tests being Digit Symbol and
Grassi's test. Surprisingly, Group II actually did worse than
the other two groups on some vocabulary measures, which the
authors suggest may be because of poorer education or even
lower general intelligence. Unlike Claeson and Clarkson's
selection, the subjects were all from poor environmental
backgrounds, and the authors ask this to be born in mind when
general conclusions are drawn from their results. They further
emphasise the heterogeneity of alcoholics as a group and that whereas individual results are often promising, it is still important to take careful and detailed data on all drinking practices.

Yet another kind of dysfunction was demonstrated by Weingartner, Paillace and Martley (3) who assessed patients after recent physical withdrawal and again after several weeks of abstinence. Hospitalised alcoholics recalled lists of random and related words as well as non-alcoholic patients. On the second trial the alcoholics showed less learning increment than the non-alcoholics, and the newly hospitalised alcoholics themselves showed less than those who had been dry for three weeks. This learning deficit is described as part of a post-alcoholic syndrome which included impairment in holding information, memory and storage, not accounted for by channel capacity, attention or concentration. This deficit is organic in nature, rather than the stress related performance tests in previous studies say the Authors, and appears to "represent a pattern, in miniature, similar to that found in Korsakoff patients and patients with temporal lobe lesions." The subjects in this study could not be used on a test-retest basis because of practice effects and the authors acknowledge the less desirable method of matching. They discuss fully the therapeutic and prognostic implications of this 'acute brain syndrome' and suggest that new learning, psychotherapy, behaviour therapy or group treatment would be better initiated after a psychological drying out period of approximately three weeks following heavy intoxication.
D. Conclusions

The literature on intellectual deficits as a result of chronic drinking is certainly equivocal. Some of the difficulties involved in the clinical selection and interpretation of data have been discussed. Clearly unless a long term study is being made, there will be evidence about the state and habits of the patient that will be lost, much of which itself affects the addiction. In their chapter on the effects of drugs on behaviour (7), Truton and Eysenck list the main variables influencing drug effects, immediate or long term. For each drug, there is the preparation (strength) the mode, the amount taken, and the time before testing to be considered: with the patient, there are such factors as personality (introversion - extroversion), physical and psychiatric state, work conditions, eating and sleeping habits and other forms of medication: with the patient's history, account should be taken of the drug's cumulative effects over time as well as the degree of habituation, tolerance and addiction to it. The list is formidable and from it one must conclude that the degree of valid and reliable interpretation made from tests administered to a heterogeneous group of drinkers is limited. Recent work is not always encouraging in this respect. Falconer (9) measured cognitive function in both prison and clinical alcoholics, using a test retest design with the Benton and Weschler Memory Scale to assess changes during Abstinence. Results showed that the prison drinkers significantly improved and that clinical subjects deteriorated slightly. The only common factor in
both groups was that they were male heavy drinkers; age, socio-economic status, period of drinking and drying-out time before testing were uncontrolled and results therefore, were impossible to interpret.

Of all the subtests that have been mentioned as affected by chronic drinking only Vocabulary and Information remain immune, both tests which hold up better with age than any others and which are fairly resistant to most kinds of deterioration (33). It seems likely that though Hofle (12) and many others have argued for selectively impaired tests for specific brain syndromes that in the case of chronic alcoholics the only overall impression is that their performance level is lower than their verbal level, a phenomenon that Weschler finds in most mental disorders (34) anyway.

The whole idea of physical and psychological withdrawal from alcohol must also be examined as well as Heingartner's concept of a "psychological drying-out period". The studies that have been quoted assessing alcoholics in relation to their period of abstinence have shown some reversible effects though the nature of these deficits seems varied and poorly accounted for.
INTRODUCTION TO THE EXPERIMENT

The idea behind this investigation came from observations on the Alcoholic Unit in Scarbor Park Psychiatric Hospital that patients who were intellectually assessed after physical drying-out fared worse than when seen some six weeks later. Furthermore, this improvement was not found when patients were seen on a third occasion, suggesting that practice effects did not account for the initial improvement. McAdam (21A) has made related clinical observations in eeg patterns of chronic alcoholics at the Crichton Royal Hospital, Dumfries. After physical hangover and where there is no delirium tremens, there is random diffuse dysrhythmia, particularly when there is clear intellectual blunting. As the impairment disappears, so does the dysrhythmia, together with an increase in the frequency of alpha rhythm. He concludes that should the patient learn to abstain, this e.e.g. will normalise and "full restitution of intellectual functions can be expected" about five to eight weeks following intoxication. Wiker's (35) experimental study estimates this period to be about four weeks. Although the abnormal e.e.g. here did not correlate with intellectual changes, what seems to be important is that these irregularities do eventually normalize.

It is therefore hypothesised that (1) if a group of alcoholics are intellectually assessed a week after admission and are matched with another group assessed after complete abstinence for at least eight weeks, that deficits found in the first group will not be found in the second and (2) if both those groups are compared either with a non-alcoholic psychiatric
group or standardised norms, that the abstinent patients will resemble a non-drinking population more than those recently dried out.

A. TEST

i) Test employed

So much has been said about the dangers of using the W.A.I.S. subtest scores as a diagnostic aid, that it should be remembered that the Weschler scale is still a valid, reliable, well-standardised measure of the concept of intelligence. Savage (2b) says it "should be used to make statements about the intellectual functioning of the patient, not his psychiatric diagnostic label". It was employed in this study firstly, for that reason, secondly because experimenter effects would be less in a test which was very familiar, and lastly because the W.A.I.S. is widely used in the initial assessment of intellectual deficits and it was hoped that some of the findings here would have direct implications for clinical practice.

ii) Experimental Design

The most efficient design for this experiment would have been each subject as his own control, using equivalent procedures for the subjects both immediately after being dried out and after eight weeks' duration. However it would be difficult to keep all the patients hospitalised and sober for this period of time. Moreover, since there is no parallel form of the W.A.I.S. the same procedure produces learning effects. The Weschler Bellevue scales were considered but they suffer from having no age scaled scores. Matched groups of alcoholics were therefore chosen and each was tested by
The procedures outlined on page

The control group were a non-psychotic psychiatric group rather than normals because most of the patients were suffering from functional impairment such as anxiety or depression and these effects must be distinguished from the effects of alcohol per se.

(iii) Subjects

The experimental subjects were originally 30 male alcoholics who had at some time been admitted to the Alcoholic Unit at Scalbor Park Hospital. All were between the ages of 29 and 55, and had been drinking heavily for at least two years. The subjects were either alcoholics of the alpha or gamma type according to Jellinek's classification (15). Alpha alcoholics represent purely psychological addicts who have often lost control over drinking but not the ability to abstain. Gamma alcoholics not only show loss of control but also physical withdrawal symptoms and cravings for alcohol, which progress to physical dependance during their illness - this is the most common form of hospitalised alcoholic in this country.

Group I consisted of 14 inpatients who were tested as soon as they had been dried out after prolonged and heavy intoxication. These subjects were either of above average level of educational achievement and were in socio-economic classes I, II or III, or were known to be of above average intelligence through previous assessment. The reason for this was to reduce the probable occurrence of minimal cerebral dysfunction not due to the effects of drink (6).

Group II were 16 alcoholics who were either outpatients...
at the unit or had finished treatment but still maintained contact for Alcoholics Anonymous. These were seen not earlier than two months following intoxication. Each of these subjects was matched with group I as closely as possible for age, years of alcoholic drinking, equivalent occupational status or educational achievements. The numbers in each group were then reduced to twelve.

The control group consisted of 10 male non alcoholic patients selected from the files at Scalbor Park Psychiatric Hospital and St. James' Psychiatric Unit, 5 of whom had been originally tested by the author. The patients were admitted for a variety of neurotic and personality disorders, and had been assessed for reasons which did not include the investigation of any kind of organic intellectual deficit. These subjects were matched for age, occupational status and/or educational achievements.

Further criteria were that: none of the subjects had any history of serious illness including epilepsy, head injury or liver disease; none were suffering from any psychotic disturbance at the time of testing or were receiving treatment known to retard intellectual function.

Information was also required about the kind of drink consumed by the alcoholics. Takala, Siro and Toivanen (29) found that spirits gave less spatial impairment than beer during hangover in experimentally induced intoxication. Though this study is not investigating such effects during hangover, it was of interest and possible future relevance.
to include this data in the drinking habits of the subjects.

A summary of the subjects data is given below in Tables IA, B, C and D.
<table>
<thead>
<tr>
<th>Object</th>
<th>Age</th>
<th>Occupation</th>
<th>Education</th>
<th>Years Drinking</th>
<th>Years Heavy Drinking</th>
<th>Days Abstinent</th>
<th>Kind of Drink</th>
<th>Marital Status</th>
</tr>
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<tbody>
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<td>1</td>
<td>46</td>
<td>Sea Captain</td>
<td>School Cert. 4 Subjects</td>
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<td>6</td>
<td>23</td>
<td>Rum</td>
<td>Married</td>
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<td>Manager/Tobaccoist</td>
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<td>3</td>
<td>7</td>
<td>Gin</td>
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<td>Headmaster</td>
<td>Teacher training</td>
<td>4</td>
<td>2</td>
<td>7</td>
<td>Whisky</td>
<td>Married</td>
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<tr>
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<td>Subnormality Nurse</td>
<td>Left Sch at 16 R.H.S. training</td>
<td>10</td>
<td>9</td>
<td>7</td>
<td>Beer/Cider</td>
<td>Married</td>
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<td>Left Sch at 15</td>
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<td>7</td>
<td>Beer</td>
<td>Married</td>
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<td>16</td>
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<td>Rum/Gin/Whisky</td>
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<td>Rum</td>
<td>Married</td>
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<td>Vodka/Gin</td>
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<td>City &amp; Guilds</td>
<td>20</td>
<td>10</td>
<td>7</td>
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<td>Married</td>
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<tr>
<td>Object</td>
<td>Age</td>
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<td>Education</td>
<td>Years drinking</td>
<td>Years Heavy Drinking</td>
<td>Months Abstinent</td>
<td>Kind of Drink</td>
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<td>Married</td>
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<td>General Practitioner</td>
<td>Medical School</td>
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<td>Married</td>
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<td>Grammar 'O' Lvl. R.A.F.Air Photographer</td>
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<td>Restaurant Manager</td>
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<td>Whisky/Single Gin/Lager</td>
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<td></td>
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<td>7</td>
<td>18</td>
<td>Gin</td>
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<tr>
<td>12</td>
<td>39</td>
<td>Baker</td>
<td>School Cert. 5 in S's City &amp; Guilds</td>
<td>10</td>
<td>2</td>
<td>24</td>
<td>Cider/Wine</td>
<td>Married</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Object</th>
<th>Age</th>
<th>Occupation</th>
<th>Education</th>
<th>Psychiatric State</th>
<th>Drinking Pattern</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>42</td>
<td>Publican</td>
<td>Left at 15 - but 'self-educated' since</td>
<td>Agoraphobia</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>52</td>
<td>Sales Manager</td>
<td>School Cert. 6 subj. many sales jobs</td>
<td>Schizoid Personality.</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>31</td>
<td>Junior Chemistry Lecturer</td>
<td>Ph.D.</td>
<td>Personality Disorder.</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>34</td>
<td>Engineering Works Manager</td>
<td>H.N.D in engineering (Abandoned)</td>
<td>Obsessional neurosis</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>46</td>
<td>General Medical Practitioner</td>
<td>Medical School</td>
<td>Behaviour Disorder.</td>
<td>All but two of these patients (Nos. 6 and 8) were social drinkers.</td>
</tr>
<tr>
<td>6</td>
<td>32</td>
<td>Architect's Assistant</td>
<td>'O' levels in 6 subjects. Architectural Tng.</td>
<td>Personality Disorder</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>50</td>
<td>Manager Night Club</td>
<td>A levels</td>
<td>Anxiety-Depression</td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>42</td>
<td>Debt Collector</td>
<td>School Cert 5 subjects</td>
<td>homosexual transvestite</td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>45</td>
<td>Engineering Firm Inspector</td>
<td>Left at 15 Apprenticeship</td>
<td>Depression</td>
<td></td>
</tr>
<tr>
<td>0</td>
<td>31</td>
<td>Shop Manager</td>
<td>'O' level. Army signal Corps.</td>
<td>Vocational Guidance.</td>
<td></td>
</tr>
<tr>
<td>Age</td>
<td>Years Drinking</td>
<td>Years Heavy Drinking</td>
<td>Period before Testing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>--------------</td>
<td>----------------</td>
<td>----------------------</td>
<td>-----------------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Group I</td>
<td>$\bar{x} = 40.50$ yrs.</td>
<td>$\bar{x} = 16$</td>
<td>$\bar{x} = 8.92$</td>
<td>$\bar{x} = 12.83$ days</td>
<td></td>
</tr>
<tr>
<td></td>
<td>$= 6.283$</td>
<td>$= 7.3$</td>
<td>$= 6.05$</td>
<td>$= 8.07$ n</td>
<td></td>
</tr>
<tr>
<td>Group II</td>
<td>$\bar{x} = 38.75$ yrs.</td>
<td>$\bar{x} = 13.75$</td>
<td>$\bar{x} = 8.20$</td>
<td>$\bar{x} = 17.73$ months</td>
<td></td>
</tr>
<tr>
<td></td>
<td>$= 6.283$</td>
<td>$= 7.02$</td>
<td>$= 8.35$</td>
<td>$= 8.35$ n</td>
<td></td>
</tr>
<tr>
<td>Control</td>
<td>$\bar{x} = 40.50$ yrs.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>$= 9.155$</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>
In group I most of the pre-test data was collected on the patients' admission. After a period of one week the W.A.I.S. was administered, although in three patients this delay was three weeks and in one patient four weeks after admission.

Group II was seen once abstinence of at least two months had been established. In fact the W.A.I.S. was administered to a group abstinent for an average of 17 months.

The control group data were collected from previous assessments using the W.A.I.S. where occupational and educational factors were known.

The raw data was then analysed in terms of group results. Individual profile differences were then calculated between the experimental subjects and the controls, and also between all three groups and a hypothesised level of unimpaired function.

B. RESULTS

1) Group Analysis

Table IIA and Fig. give a summary of the raw data in terms of group means and standard deviations on each subtest of the W.A.I.S., as well as verbal, performance and full scale I.Q's.

Table II B gives the results of t-tests carried out on each of these subtests, firstly between experimental group I and control, secondly between experimental group II and control, and lastly between the two experimental groups. The results show that none of the groups differ from each other significantly in
<table>
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<tr>
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<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Experimental I</td>
<td>( \bar{x} = 12.3 )</td>
<td>( \bar{x} = 13.6 )</td>
<td>( \bar{x} = 12.8 )</td>
<td>( \bar{x} = 11.8 )</td>
<td>( \bar{x} = 12.5 )</td>
<td>( \bar{x} = 14.2 )</td>
<td>( \bar{x} = 8.1 )</td>
<td>( \bar{x} = 10.9 )</td>
<td>( \bar{x} = 7.3 )</td>
<td>( \bar{x} = 8.5 )</td>
<td>( \bar{x} = 9.0 )</td>
</tr>
<tr>
<td>n = 12</td>
<td>12.7</td>
<td>14.6</td>
<td>3.2</td>
<td>3.2</td>
<td>2.7</td>
<td>3.3</td>
<td>3.7</td>
<td>2.1</td>
<td>3.6</td>
<td>1.9</td>
<td>2.3</td>
</tr>
<tr>
<td>Experimental II</td>
<td>( \bar{x} = 15.9 )</td>
<td>( \bar{x} = 14.4 )</td>
<td>( \bar{x} = 13.7 )</td>
<td>( \bar{x} = 11.5 )</td>
<td>( \bar{x} = 10.6 )</td>
<td>( \bar{x} = 14.7 )</td>
<td>( \bar{x} = 10.0 )</td>
<td>( \bar{x} = 12.4 )</td>
<td>( \bar{x} = 11.6 )</td>
<td>( \bar{x} = 10.4 )</td>
<td>( \bar{x} = 12.3 )</td>
</tr>
<tr>
<td>n = 12</td>
<td>14.5</td>
<td>2.9</td>
<td>1.2</td>
<td>1.4</td>
<td>2.3</td>
<td>2.0</td>
<td>1.50</td>
<td>2.5</td>
<td>2.2</td>
<td>3.0</td>
<td>2.8</td>
</tr>
<tr>
<td>Control</td>
<td>( \bar{x} = 13.7 )</td>
<td>( \bar{x} = 16.0 )</td>
<td>( \bar{x} = 12.6 )</td>
<td>( \bar{x} = 13.7 )</td>
<td>( \bar{x} = 13.4 )</td>
<td>( \bar{x} = 15.5 )</td>
<td>( \bar{x} = 8.7 )</td>
<td>( \bar{x} = 12.7 )</td>
<td>( \bar{x} = 12.8 )</td>
<td>( \bar{x} = 11.8 )</td>
<td>( \bar{x} = 12.3 )</td>
</tr>
<tr>
<td>n = 10</td>
<td>2.6</td>
<td>2.5</td>
<td>5.5</td>
<td>2.3</td>
<td>2.9</td>
<td>2.5</td>
<td>1.7</td>
<td>1.7</td>
<td>3.1</td>
<td>1.6</td>
<td>2.0</td>
</tr>
<tr>
<td></td>
<td>V.I.Q.</td>
<td>P. I. Q.</td>
<td>F.S. I.Q.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Experimental I</td>
<td>( \bar{x} = 117.50 )</td>
<td>( \bar{x} = 103.83 )</td>
<td>( \bar{x} = 112 )</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>n = 12</td>
<td>= 117.3</td>
<td>= 12.9</td>
<td>= 15.9</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Experimental II</td>
<td>( \bar{x} = 120.5 )</td>
<td>( \bar{x} = 114.8 )</td>
<td>( \bar{x} = 118.9 )</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>n = 12</td>
<td>= 7.7</td>
<td>= 9.2</td>
<td>= 7.5</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Control</td>
<td>( \bar{x} = 125.7 )</td>
<td>( \bar{x} = 116.7 )</td>
<td>( \bar{x} = 122.3 )</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>n = 10</td>
<td>= 11.7</td>
<td>= 8.4</td>
<td>= 9.5</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
TABLE IIB  2 Tailed t-tests on group data - scaled scores only.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Gp. I v Control</td>
<td>n.s.</td>
<td>n.s.</td>
<td>n.s.</td>
<td>n.s.</td>
<td>n.s.</td>
<td>n.s.</td>
<td>n.s.</td>
<td>.05</td>
<td>.002</td>
<td>.001</td>
</tr>
<tr>
<td>Gp. II v Control</td>
<td>n.s.</td>
<td>n.s.</td>
<td>n.s.</td>
<td>.02</td>
<td>.02</td>
<td>n.s.</td>
<td>n.s.</td>
<td>n.s.</td>
<td>n.s.</td>
<td>n.s.</td>
</tr>
<tr>
<td>Gp. I v Gp. II</td>
<td>.05</td>
<td>n.s.</td>
<td>n.s.</td>
<td>n.s.</td>
<td>n.s.</td>
<td>.05</td>
<td>n.s.</td>
<td>n.s.</td>
<td>.01</td>
<td>.05</td>
</tr>
</tbody>
</table>

V.I.Q  P.I.Q.  F.S.I.Q.

| Gp. I. v. Control | p    | n.s. | .02  | n.s.  |
| Gp. II v. Control | p    | n.s. | n.s. | n.s.  |
| Gp. I. v. Gp. II  | p    | n.s. | .05  | n.s.  |
Figure IIIA

MEAN AGE-SCALED SCORES FOR THE THREE GROUPS ON THE W.A.I.S. SUBTESTS.

KEY
- represents Exp. group I
- represents Exp. group II
- represents Control group
terms of Verbal or Full Scale I.Q. but that Group I is significantly lower in its performance I.Q. than either Group II or Control, which are not different from each other.

On the subtest scores, experimental group I are significantly poorer than controls on Picture Completion, Block Design, Picture Arrangement and Object Assembly.

Experimental Group II is significantly poorer than the Control Group on Similarities and Digit Span but not different on any other sub-test.

When the two experimental groups are compared, Group I has significantly lower scores on Information, Digit Span, Block Design, Picture Arrangement and Object Assembly sub-tests.

**Individual Analysis**

Lorr ( ) has remarked that when an individual's profile is being analysed, it may be considered to have three components 1) the mean scores 2) the extent of scatter and 3) the shape or distinguishing features of the profile.

By using the parameter \( B^2 \) it was hoped that each subject's age scaled scores in profile could take these factors into account. Table IIIA gives the \( B^2 \) for each experimental patient's profile from a standard based on the Control Groups Profile. The larger the \( B^2 \) the more the individuals scores differ from the Control Group. The experimental Group I have significantly higher \( B^2 \) scores than Group II. The variance however is high and because this may have invalidated the t score, a Fisher's Exact Probability Test was carried out on the frequency of \( B^2 \) above and below 100. In Group I, 6 subjects have \( B^2 \) above 120 whereas as only
1 subject in Group II is this different from the Control. The number of such subjects in Group I is greater than would be predicted by chance (p  .05)

In Table IIIIB every subject's individual scores are compared with a hypothetical level of unimpaired function based upon the vocabulary score of all three groups (Approximate age scaled score of 15). This criterion was selected because 1) Weschler claims that this sub-test is rarely affected by intellectual deterioration except in cases of dysphasia, from which no subject is known to suffer, and ii) it was the highest and most homogeneous score within and between groups. The $D^2$ scores indicate that group I is greater but it does not reach significance. The variance is again very high and the Fisher test was applied here once more for frequency of $D^2$ values above or below 100. Nine subjects in Group I have $D^2$ scores over 100, compared with 2 in Group II and 3 in the Controls. This is significantly more than would be predicted by chance (p  .05).

Figures IIIA and IIIIB are W.A I.S. record forms showing some of the more deviant profiles in the two comparisons. In Figure IIIA, experimental group I subject 7 and experimental group II subject 12 are selected and compared with the control standard. In figure IIIIB, experimental group I subject 10, experimental group II subject 1, and control group subject 4 are compared with the hypothetical unimpaired standard.
Table IIIA

$D^2$ for each Experimental Patient from the control group's average W.A.I.S. Profile, where $D^2 = d^2$

<table>
<thead>
<tr>
<th>Subject No.</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
<th>11</th>
<th>12</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exp. Op. I</td>
<td>24.8</td>
<td>70.2</td>
<td>140.0</td>
<td>33.6</td>
<td>39.0</td>
<td>116.4</td>
<td>39.8</td>
<td>80.8</td>
<td>165.0</td>
<td>243.0</td>
<td>88.6</td>
<td>807.2</td>
</tr>
<tr>
<td>Exp. Op. II</td>
<td>62.4</td>
<td>56.9</td>
<td>73.6</td>
<td>62.4</td>
<td>27.2</td>
<td>41.9</td>
<td>51.0</td>
<td>69.8</td>
<td>104.1</td>
<td>14.2</td>
<td>54.2</td>
<td>128.0</td>
</tr>
</tbody>
</table>

Experimental Group I $\bar{x} = 123.22$ $t = 2.575$  $p = .02$

Experimental Group II $\bar{x} = 59.32$  $t = 25.35$

Fisher's Exact Probability Test on the frequency of two values of $D^2$ in each group

$(D^2 : 100 : D^2 : 100)$

$p = .05$
Table IIIB

D^2 for the subjects in all Groups from a Hypothetical Profile at the Average Vocabulary Level for all 34 subjects.

<table>
<thead>
<tr>
<th>Subject No.</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
<th>11</th>
<th>12</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exp. Gp. I</td>
<td>61.1</td>
<td>142.1</td>
<td>109.1</td>
<td>55.7</td>
<td>69.0</td>
<td>204.9</td>
<td>291.0</td>
<td>110.1</td>
<td>254.6</td>
<td>360.3</td>
<td>167.1</td>
<td>412.1</td>
</tr>
<tr>
<td>Exp. Gp. II</td>
<td>121.5</td>
<td>92.9</td>
<td>64.2</td>
<td>80.1</td>
<td>25.0</td>
<td>62.7</td>
<td>38.7</td>
<td>60.8</td>
<td>97.6</td>
<td>80.3</td>
<td>79.8</td>
<td>115.8</td>
</tr>
<tr>
<td>Con. Gp.</td>
<td>39.4</td>
<td>86.2</td>
<td>47.6</td>
<td>108.3</td>
<td>57.9</td>
<td>67.6</td>
<td>90.0</td>
<td>16.9</td>
<td>117.9</td>
<td>314.9</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Experimental Group I \[ \bar{x} = 186.36 \] = 119.69
Experimental Group II \[ \bar{x} = 84.06 \] = 29.95
Control Group \[ \bar{x} = 94.69 \] = 83.48

Group I v. Control: \( t = 2.0362 \) n.s.
Group II v. Control: \( t = .1113 \) n.s.
Group I v. Group II: \( t = .4115 \) n.s.

Fisher's Exact probability Test for the Frequency of Two Values of D^2 in experimental and control groups (D 100; D 100)

\[ p = .05 \]
FIGURE IIIA.

Control Group Profile compared with Individual Age Scaled Profiles of One Subject from each Experimental Group where

\[ D^2 > 100 \]

\[ D^2 = 291.02 \]

\[ D^2 = 128.0 \]

---

Represents Control Profile

Represents Gp. I subject No. 7

Represents Gp. II subject No. 12
FIGURE IIIIB

Groups' Average Vocabulary Scaled Score Compared with Individual Age Scaled Profiles of One Subject From All Three Groups where $D^2 > 100$.

---

- Represents Groups' Vocabulary Level
- Represents Group I Subject 10 : $D^2 = 360.32$
- Represents Group II Subject 1 : $D^2 = 121.52$
- Represents Control Subject 4 : $D^2 = 117.92$
C. DISCUSSION

1) Experimental Results

The first hypothesis in this study was that if any intellectual discrepancies could be shown in Group I, that there would be a reversal of this state in Group II. The results generally confirm this trend, the significant differences lying mainly in Block Design, Picture Arrangement, Object Assembly, and Digit Span. There was also a difference in Information subtest which did not show up when Group I was compared with the Control Group. There is an overall difference in Performance I.Q. not significantly reflected in either Verbal or Full Scale figures.

If any overall pattern exists, it is difficult to say that it is anything other than a change in the Performance Factor on the W.A.I.S. The one subtest score quoted by many authors - ( ) as being impaired due to chronic drinking i.e. Digit Symbol is undifferentiated. A possible reason for this finding may be a cultural one. In American populations manual dexterity and speed are a more prominent aspect of intellectual ability than with their British counterparts. Neither experimental group nor controls scored highly on Digit Symbol and it is probably a poor measure therefore of changes due to temporary impairment. Other subtests differences such as similarities ( ) and Arithmetic ( ) which have been offered in the literature do not feature as either being impaired by drink or restored by abstinence.

The difference between the two experimental groups on
Information is interesting because this is a test relatively unaffected by impairment and is a more representative factor of general intelligence ( ) says Weschler. This might suggest that the two groups do actually differ in general intelligence, particularly as the control group is not different from either experimental group on this subtest. The Full Scale I.Q. figures indicate a lower trend in Group I, but not a significant one, and one which seems more attributable to the much lower Performance I.Q.

The second hypothesis was that if the two groups were compared either with a control or with the standardised norms representing their "ideal" level of functioning without any impairment, that Group II would resemble these non-drinking standards more than Group I.

Tables IIA and IIB show that the significant subtest differences between Group II and the Controls are Similarities and Digit Span, which are not reflected in the Group I/Control comparison. These are the two verbal tests Weschler suggests are most likely to be impaired by chronic drinking, yet there are no Performance differences, nor are there any on composite I.Q. scores. Group analysis shows that Group I is more like the Controls than Group II in respect of the number of subtests adversely affected, and because no Group II I.Q's are significantly different from the Controls.

Individual analysis gives a clearer picture in this respect. Table IIIA shows that the individual profiles in Group II are less different from the mean control profile, and less frequently different. There is also a much smaller
variance with the $D^2$ values of Group II's scores than Group I, demonstrating less range of subtest scatter.

Table IIIIB shows that when all subjects are compared with the W.A.I.S. norm that those in Group II have again less variance than Group I, or even the Controls, still indicating less range of subtest scatter.

The overall $D^2$ scores are not different between groups, but Group II and Controls have significantly fewer subjects with a high $D^2$ score (100). This again confirms the hypothesis that the Group II subjects are more like the Controls than those in Group I.

The individual profiles in Figure IIIA were selected to see if any distinguishing pattern could be found between them. Both have high, but not the most extreme $D^2$ scores, (because it was felt that those would be too anomalous). There appears to be no similarity between these two in terms of their specific deficits - and likewise between the background data on the two subjects.

Similarly, three subjects, one from every group have their age scaled profiles drawn in Figure IIIB in contrast to the groups' average vocabulary subtest score. Again, there appears to be no general pattern emerging about how drinking does or does not affect these scores.

In conclusion, the individual analysis does support the hypothesis that group II subjects resemble a non-drinking population (neurotic or standardised) in terms of intellectual function more than Group I. The way in which these similarities and differences occur fits no overall pattern, other than that Group II have a performance I.Q. more commensurate with their
verbal I.Q., than it is in those in Group II.

ii) Subjects' Performance

One or two comments should be made about the behaviour of the experimental groups during testing. Generally, there appeared to be a desire to impress the experimenter, coupled with an initial suspicion of the tests and much anxiety. Hence on Information subtest, there was the doctor (Group II No. 5), who could not name three kinds of blood vessels, and the baker (Group II No. 12) who was unable to describe how yeast causes dough to rise! This sort of situation arose frequently where subjects showed impetuosity, verbosity and poor concentration, and seems to have been a personality feature common to both experimental groups. Such people as Smart ( ) would argue that in drinkers clearly manifesting deterioration on the W.A.I.S., (his criterion was a V.I.Q. - P.I.Q. discrepancy 18) that this damage itself is an extraverting process which in consequence leads to further cognitive changes such as slower learning, or an increase in reminiscence and figural after effects.

Indeed if intelligence is considered as only one dimension of personality ( ) then the task of assessing cognitive changes as a result of drink becomes increasingly complex, since subjects must be matched for personality as well.

Once testing began most subjects clearly enjoyed the experimental situation, particularly Group II who felt themselves to be 'cured' due to their longer abstinence. Despite the fact that one of these subjects was readmitted to the unit shortly after testing does not alter the fact that Group II seemed better adjusted and more cooperative
than Group I, who had only just begun group therapy on the Unit and were still in a stage of social and emotional upheaval. This again brings home the notion of intellect being only one of many factors undergoing possible change during hospitalisation. Since no one lives in a vacuum, there will clearly be other changes occurring which may all contribute or detract from what happens in the test situation. This would again have further implications about the sort of controls or matching that must be made before testing. Subject 2 in Group I, for example, suffers from permanent trigeminal pain as the result of a car accident - something he has learnt to bear quite stoically. His admission to the unit, however, lowered his spirits considerably and rendered him less able to cope with this, a factor which might have subsequently affected his intellectual performance.

(iii) Critique of Experiment

As stated previously, the ideal design for this experiment would have been a test re-test method, using each subject as his own control. The difficulties of using such a design however, were also mentioned - the most prominent one being that Group I subjects frequently resorted to drink during hospitalisation. The only way we were able to ensure complete abstinence in the first week is that patients are under very strict supervision during this period from the nursing staff.

The next problem however is that the abstinence of the outpatient group may be in question. The necessity for at least two dry months was emphasised when subjects were
initially called for interview but this may not be guaranteed. Even if it is, then there is the situation of having two groups who differ in respect not only of their period of abstinence but also their ability to remain so.

The length of abstinence was another difficulty in this study. Ideally the subjects should have been tested after two months of abstinence since this is a maximum recovery time that would be suggested clinically by McAdam. On a test re-test basis they could then have been assessed yet a third time to establish whether there were other factors involved e.g. practice effects. In this experiment the two month period had to be considered merely as a baseline; the range was 6-36 months, with an average of 17.7, simply because the availability of patients was limited. Very similar problems arise with the wide range of years' heavy drinking in both groups. This did not necessarily correlate with age and it is to be hoped that the group averages and variances, which were the same in I and II cater for overall effects. At an individual level, little can be offered to explain these discrepancies in matching, but maybe Kish and Cheyney's ( ) finding that impairment is dependent neither on age or the number of years drinking means that this fault does not render the results unreliable.

An examination of Tables IA, B, C and D shows that the subjects were matched only in respect of one or two of the six variables e.g. subjects No. 5 in all three groups were 43, 41 and 46 respectively. Their occupations were headmaster,
The experimental subjects had both been drinking whisky heavily for two years. This represents one of the better matches. A poorer one is found with subjects No. 2 in the three groups. Their ages were 51, 42 and 52 respectively. The first two did have newsagent shops and similar school achievements and some army experience, but the control subject was a Sales Manager without the army background. Further investigation would show that the newsagent in Group I was greatly underachieving in his occupation and had one of the highest levels of intellectual functioning in the whole study. It would have been better therefore to have matched the subjects more precisely in terms of intellectual functioning by using a standard such as the Hill Hill Vocabulary and Progressive Matrices.

The control group also presented some problems. Although the experimenter had seen five of the subjects, the information on the other five was limited to the record sheets found in the files. As a psychiatric group, they are very heterogeneous and data about their drinking habits came only in negative terms. Even so, these controls were difficult to find and only 10 subjects could be found who approximately fulfilled the control criteria. It was still felt, nevertheless, that they were more valid to use than a normal non-psychiatric population, because firstly the alcoholic subjects had at some time been hospitalised and secondly because any effects of depression, anxiety and psychopathy needed to be accounted for as a separate factor from drink.

One to one matching was again rather poor in this respect,
but need not have been so had a wider range of access to a psychiatric population been available.

iv) Conclusions and Further Recommendations

The aims of this study have been to draw attention to the work and conclusions of those investigating general intellectual impairment as a result of chronic alcoholism and to highlight particularly those studies which have suggested a possible reversal of this process during abstinence. Some of the methodology has been discussed and improvements in design suggested. The experiment was to establish whether or not Weingartner's idea of a psychological "drying out" period existed after the physical equivalent - a theory reinforced by clinical findings at the Alcoholic Unit at Scalbor Park and by McAdam's e.g. observations in Dumfries.

Results showed that if two alcoholic groups are matched for age, socioeconomic status, education and approximate number of years heavy drinking, and the first group is tested on the W.A.I.S. immediately after physical drying out, that deficits will occur here that do not occur in the second group who have been abstinent for at least two months. These differences occur both between the two experimental groups and with a control group of non-alcoholic psychiatric patients. The precise nature of these deficits is not possible to ascertain, other than that they are mainly poor Performance scores, and that the overall pattern of functioning is more diverse from either the control group or from the Vocabulary level of all three groups. This is the kind of dysfunction Weschler finds with many kinds of mental disorder and the author of this study
rejects any claims to W.A.I.S. profiles which are pathognomonic of chronic alcoholism except in cases where specific brain damage is already established e.g. Korsakoff Syndromes ( ). Despite the fact that the W.A.I.S. has 11 subtests these are all measures of general intelligence. If specific deficits are hypothesised, then more specific cognitive tests will be needed to measure these. A follow-up from this study would attempt a more systematic investigation of visio-spatial dysfunction during this intermediate state of alcohol withdrawal. Warrington ( ) quotes the use of tests by Oldfield and Wingfield (1965) who assembled a set of pictures of decreasing word frequency which proved to be a clinically useful test of picture recognition. This was originally devised for patients suffering from right-hemisphere lesions, but it would be standardised on normal, psychiatric and alcoholic populations.

In any other experimental studies, consideration will have to be given to

1) The precise nature of the test used - both in terms of its validity and reliability,

2) Whether it is given to two matched groups or on a test, re-test and final test basis to assess practice effects,

3) the exact time factors involved and,

4) more carefully collated data about the general intellectual, educational, personal, psychiatric and drinking history of all patients. This is
necessary, not just for matching purposes, but even when the alcoholic is his own control, since these factors do fluctuate within the individual over time.

Many of these items have significance in the clinical assessment of chronic drinkers as well. In hospital, precise information about the medication, therapy and occupation of the patient following admission must be added.

It is further recommended that when a general test such as the W.A.I.S. is administered to an alcoholic that it should ideally follow eight weeks' abstinence. If this is simply not possible then account must be taken of any reversible deficits due to the effects of alcohol following physical withdrawal, and reassessment made at a later date.
PERMANENCE OF INTELLECTUAL DETERIORATION IN CHRONIC ALCOHOLICS AS
MEASURED BY THE W.A.I.S.

Choice of topic. Both clinically and socially relevant.

Literature review. A good general introduction to the relevant literature.

Experimental design & method. A more precise statement of the experimental hypothesis than is given on pages 13 and 14 would be desirable.

Sample. A fairly adequate selection of subjects (with full appreciation of its inadequacies).

Data collection & analysis. Satisfactory.

Discussion. A sensible discussion which makes some good points. For example, the remarks on pages 32 and 33, regarding the effects on intellectual test performance of the "social and emotional upheaval" attendant upon withdrawal of alcohol, hospitalization, and beginning group therapy, are pertinent and important. The conclusions drawn are suitably cautious.

References. These are generally well laid out with correct abbreviations of titles. Authors' names and dates of publication would be preferable to numerals in the text.

General style of presentation. Well organised, neatly typed and presented. Stricter proofreading would have been desirable, for example, for spelling errors and textual referencing.

External examiner's comment. A modest but well conceived and apparently efficiently executed study.

J. GRAHAM WHITE

JG:EH
Belfast.
23.6.72
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