A STUDY OF PRACTICE AND RESEARCH

Submitted for the Doctor of Psychology (Psych.D.) in Clinical Psychology

CONVERSION PROGRAMME

AN EXPLORATION OF FACTORS WHICH PREDICT CLIENT SATISFACTION

ANGELA DEVON
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SURREY UNIVERSITY
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SECTION 1

PERSONAL STUDY PROGRAMME PROPOSAL
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PSYCH.D. IN CLINICAL PSYCHOLOGY
CONVERSION PROGRAMME

Name: Angela Devon
Date of Registration: 1st January 1995
Registration No: 3417263

1. OVERALL AIMS AND OBJECTIVES

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

Prime Objective
To produce a portfolio of study, practice and research that will demonstrate increased competence in each of these three areas.

2. ACADEMIC

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

To increase knowledge in areas where current knowledge is lacking, needs updating or developing.

2.2 Objectives
To complete three critical academic reviews, one for each of the three specialist areas.

To acquire specialist knowledge in three areas.

To attend continuing professional development training workshops presented by the Clinical Psychology Continuing Professional Development
Committee or by the University of Surrey or other relevant conference or workshops as appropriate to the aims.

To increase depth of academic knowledge in areas in which are involved clinically.

2.3 Rationale
The rationale supporting the academic programme is to increase my personal and the Department's expertise by providing a strong academic knowledge base in three areas which have relevance to direct clinical work or to the functioning of the department. In addition, expertise will be gained which can then be a resource to be used in the future training of Clinical Psychologists when on placement in the department.

The first area chosen is that of Brief Psychotherapy. A psychodynamic approach is of interest to me and in the current NHS climate where there is an emphasis on cost effectiveness, long term psychotherapy is not generally a valid option to consider. Having attended a workshop on Brief Psychotherapy it seems that this is possibly an approach which could usefully be offered in that it is time limited and focuses on particular aspects of problems of psychodynamic functioning. This is an approach which I use clinically but would benefit from a more in depth academic study of the field. This is also seen as providing another strength to the department for future clients and for Psychologists in Training.

The second area of academic review will focus on Community Care Issues. As a member of a Community Mental Health Team and as a manager responsible for the development of Community Psychology, it is necessary to be well informed regarding the operation of the Clinical Psychologist's role in Community Mental Health Teams and of alternative ways of providing Clinical Psychology in the Community. In addition knowledge of issues such as Supervision Registers, Case Management and Care Programme approach will facilitate informed discussions with Senior Managers.

The knowledge gained from such an academic review could be made available to other members of the Department and to Clinical Psychologists in Training who will be working in the Department.
Many of the professionals working in the Community Mental Health Teams are experiencing difficulty in that the level of information and knowledge in the teams concerning Community Care issues is not well developed. This academic review could be used to provide a key person who can disseminate information concerning these topics.

The third area of academic review will be Boundary, Professional and Ethical Issues In Clinical Psychology and Psychotherapy. My awareness of a need to enhance my knowledge of this area resulted from my involvement supervising Clinical Psychology trainees who were unaware of many ethical and professional issues.

This led to the realisation that these issues were not covered in my training in an informed, academic manner but rather by a process of osmosis which seemed rather unsatisfactory. It seemed important therefore to explore this area further for my own development and to be able to present such issues in an informed way to trainees. This interest has led to me running workshops for Psych.D. second year trainees.

2.4 Plan
Academic Review: A Review of Brief Psychotherapy. To be completed by April.

Academic Review: Community Care Issues. To be completed by July.

Academic Review: Boundary, Professional and Ethical Issues In Clinical Psychology and Psychotherapy. To be completed by 1st October.

3. CLINICAL

3.1 Aims
To increase personal professional competence or to develop the services offered by my department or by my profession.
To develop a counselling service as part of the Clinical Psychology Department.

3.2 Objectives
To present a report that will describe service developments undertaken and their psychological framework.

To develop a counselling service as a part of the Clinical Psychology Service which would involve establishing the source of funding for at least two counsellors, the selection, supervision, management and evaluation of the counsellors who will be working in a primary care setting.

In addition a proposal for further development of this aspect of the service will be developed in conjunction with a Business Manager and will be presented to Mid Surrey Health Authority.

3.3 Rationale
The Mid Surrey Health Authority and FHSA Health Strategy 1994 recommended the establishment of "a joint DHA/FHSA community primary prevention mental health strategy that will include early detection and recognition of at risk people because of life events (and) the provision of early accessible and appropriate counselling". The Mid Surrey Health Authority's strategy for Mental Health Services comment on there being an "immediate counselling service offered from within the practices own personnel". The strategy recognised that counselling can help in reaching the Health of the Nation target to improve significantly the health and social functioning of mentally ill people, and also to reduce the suicide rate among the general population by 15% by the year 2000. This has resulted in the funding of counsellors to work in primary care settings. However, it has been recognised that little or no guidance has been provided in the appropriate selection of counsellors, there is little knowledge concerning the level of training necessary for counsellors, no arrangements for supervision have been made and no links between the counsellors and other parts of the mental health services such as Community Mental Health Teams have been organised. In addition little evaluation of efficacy is included. Several counsellors had approached the Psychology Service with requests for support and supervision. It was therefore considered to be worthwhile to establish a model of counselling operating from within the
Psychology Services so that issues of selection, supervision, training and evaluation could be addressed. This was discussed with the Health Authority who then requested a formal business proposal outlining such a service.

3.4 Plan
The source of funding and selection of the counsellors and commencement of work will be completed by January 1995. In addition the evaluation tool will have been selected or devised by January 1995 and will comprise of psychometric tests such as the GHQ and other questionnaires such as a Client Satisfaction questionnaire. Other outcome measures such as consultation rates and presenting rates may also be included.

The work of the counsellors will be evaluated during the period January-July 1995 - the work will be written up as a report for the inclusion in the PsychD portfolio.

A business proposal outlining the development of a Counselling Service as part of the Clinical Psychology Service will be submitted in February 1995.

4. Research

4.1 Aims
Both to increase research competencies so as to develop the services offered by the Department and to increase the knowledge available to the Department.

4.2 Objectives
To evaluate the Mid Surrey Health Authority Clinical Psychology Service which will involve designing satisfaction questionnaires. An investigation into which factors can predict satisfaction will be undertaken so that attention may be focused on creating changes in the service which will lead to an increase in client satisfaction. An understanding of factors leading to satisfaction will be gained.

4.3 Rationale
Within a Health Service context there is an increased need to evaluate the services being offered. It is necessary to be able to demonstrate efficacy of a service and of endeavouring to improve quality standards. It is also being
increasingly recognised that users views should be utilised in planning developments of services. Currently the Health Service faces financial challenges and difficulties relating to organising available services effectively and an ability to demonstrate audit and evaluation procedures is necessary if a service is to be developed. Clinical Psychology can advise upon different research methodologies and encourage evaluation and can apply research within the wider political framework of the organisation. The research skills involved in conducting evaluation of services could be offered on a consultancy basis.

The evaluation of the Psychology Service will involve:

1. The development of a Client Satisfaction Questionnaire which will assume that client satisfaction is a multidimensional construct. Scales measuring organisation, process, outcome and patient characteristics will be devised. The ability of these factors to predict satisfaction will be explored.

All questionnaires will be designed by the end of January 1995 and sent out by the end of February 1995. Results will be analysed by July 1995 and written up by October 1995.

5. PORTFOLIO OUTLINE

Section 1
Personal Study Programme Proposal

Section 2
Academic
A review of Brief Psychotherapy
A review of Community Care Issues
A review of Boundary, Professional and Ethical Issues in Clinical Psychology and Psychotherapy.
Account of Continuing Professional Development undertaking during the course of the PsychD to include conferences and workshops attended.
Section 3
Clinical
Report on the development and evaluation of a counselling service as part of the Clinical Psychology Department.

Section 4
Research
Original M.Psychol. dissertation entitled "A Controlled Investigation Into Some Factors In Non Accidental Injury".
An Exploration of Factors which Predict Client Satisfaction.

6. TRAINING EVENTS TO BE ATTENDED

6.1 Making Teams Work
Providing Effective Community Support for People with Serious Mental Illness. The Sainsbury Centre For Mental Health.

6.2 Working in Multidisciplinary Teams
Clinical Psychology Continuing Professional Development Committee.

6.3 Application of Social Cognitive Models in Health Psychology
Stephen Sutton Institute of Psychiatry

6.4 Sex & How to Handle It In Clinical Practice.
Clinical Psychology Continuing Professional Development Committee.

6.5 Mental Health Care in the Community
2 day conference

6.6 Two day multi agency Foundation Child Protection Training
Epsom Health Care Trust

6.7 Theoretical understanding of Identity
| 6.8 | **Quality in the Mental Health Service**  
     Psych.D. Lecture. Tony Lavender |
| 6.9 | **Expert Testimony Video**  
     Psych.D. Lecture |
| 6.10 | **Medico Legal Aspect of Care and Mental Incapacity**  
| 6.11 | **Measurement in major psychiatric disorder**  
     Psych.D. Lecture. Paul Devonshire |
| 6.12 | **Cognitive Models of Depression**  
     Psych.D. Lecture. John Teasdale |
| 6.13 | **Statistics**  
     Psych.D. Lecture. Sean Hammond |
| 6.14 | **Brief Psychotherapy**  
     Psych.D. Workshop. Roger Squier |
| 6.15 | **Clinical Audit**  
| 6.16 | **M.E.**  
     Psych.D. Workshop |
| 6.17 | **Supervisors Training Course**  
     Salamon Centre, 2 days |
| 6.18 | **The Relationship Between Clinical Psychology & Counselling Psychology**  
     Clinical Psychology Continuing Professional Development Course |
| 6.19 | **Cognitive Behaviour Therapy With Psychotic Symptoms**  
     CPCPD Course - 2 days |
7. SUGGESTIONS FOR TRAINING EVENTS

7.1 Managing change
- SPSS workshop
- Psychotherapy
- Eating disorders
- Obsessional/compulsive disorders
- Clinical Audit
- Marketing

Participant
Signature: ...........................................................................................................

Head of Clinical Department
Signature: .................................................................................................

Course Director
Signature: ..................................................................................................
SECTION 2

ACADEMIC AUDIT

2.1 A Review of Brief Psychotherapy
2.2 Community Care Issues
2.3 Boundary, Professional and Ethical Issues in Clinical Psychology and Psychotherapy
2.1 **A REVIEW OF BRIEF PSYCHOTHERAPY**

With the present economic climate, the prevailing market economy in the NHS and the need to demonstrate positive therapeutic outcomes, psychotherapists have found it difficult to justify the traditional long-term approach to treatment.

Brief psychotherapy is defined as encompassing those therapies which follow a psychoanalytically oriented model, therapy is time limited and a central issue is focused upon. It accepts for treatment a range of patients suffering from psychoneurotic problems.

The therapist takes an active stance rather than that of passivity which characterises longer term psychoanalysis. This activity consists of persistent confrontations and interpretations. Whenever possible Menninger's "triangle of insight" is used in offering interpretations, that is, the therapist tries to link interpretations to the historical past, to the patient's present life situation and interpersonal relationships, and to the transference relationship in the therapeutic situation. Active transference interpretations and the bringing out of negative as well as positive feelings constitutes an essential part of the technique of short term dynamic psychotherapy.

Magnavita (1993) suggests that demands on an over burdened mental health system and a greater emphasis on effective psychotherapy have led to the development of short term psychodynamic psychotherapy and comments that the features that distinguish short term psychotherapy from traditional psychoanalysis include an active stance, time limitations, focality, intensification of affect, extensive use of the transference and use of T-C P (transference current life figures and past figures) interpretations.

However there exists no standardised procedure for implementing brief psychotherapy and although attempts to improve methodologies in evaluating the outcome and exploring process variables have been made, from a critical viewpoint, much remains to be done.

Brief dynamic psychotherapy has its roots in the psychoanalytic tradition. It is interesting to note that the earliest psychoanalytic treatments conducted by Freud tended to be of relatively short duration. Bruno Walter (1946) has written of his successful treatment by Freud in six sessions in 1906 and Ernest Jones reported
that Gustav Mahler was relieved of an impotence problem in four sessions in 1908 (Jones 1955). At this point, brief psychotherapy was defined by number of sessions rather than a difference in therapy processes. Process factors were not made explicit. No outcome criteria were clearly defined, success was subjective, there was a lack of documentation and follow up. Uncontrolled case studies have a limited capacity to identify the factors responsible for therapeutic change. As the goals of psychoanalysis became more ambitions and its theoretical super-structure grew more complex, analytic treatments began to increase in length to such an extent that Freud in his later years pessimistically concluded that some of them were becoming interminable (Freud 1937).

Many of the early analysts were aware of this trend and were troubled by it but the first psychoanalytic pioneer to explore modifications in psychoanalytic technique with the aim of shortening the classical analysis was Sandor Ferenczi who in 1918 began to experiment with a technique that he called "active therapy." These efforts brought Ferenczi into collaboration with Otto Rank who first emphasised the importance of setting a time limit to the analytic process in order to achieve an earlier therapeutic focus on the problem of separation (Marmor 1992). Thus at a very early point in Rankian therapy, the importance of establishing a focus and setting time limits, essential features of brief therapy, were recognised. Even in the present day however, research has not indicated a recommended number of sessions for particular types of clients. It is the therapist's subjective choice to determine the number of therapy sessions.

Ferenczi and Rank (1925) emphasised the importance of utilising here and now transference interpretations. Without denying the importance of past material, they placed a greater stress on current events and reactions and their reflections in the transference situation than did most other theoreticians of their day. Differences in approach by brief and long term therapists were explored but no assessment in terms of process factors or outcomes were made. Most reports of brief therapy at this stage were opinions based on clinical impressions alone and so the quality of evidence is doubtful.

Alexander and French (1946) questioned the validity of certain traditional psychoanalytic dogmas and experimented with the frequency of interviews, the optional use of the chair or couch, and interruptions of long or short duration preparatory to termination as a way of increasing the emotional intensity and
efficiency of the therapeutic process. The manipulation of such variables was not conducted in a controlled manner or assessed using stringent criteria. Subjective judgements by the therapist regarding process and outcome factors were reported but could be regarded as subject to bias.

Alexander (1946) reiterated Ferenczi and Rank's belief in the central importance of emotional experiences in therapy. His view was that treatment should be conducted on as high an emotional level as the patient's ego could stand without diminishing its capacity for insight. This level varied from patient to patient. Alexander's concern with increasing patient affect during treatment as a means of increasing treatment effectiveness anticipated the strong emphasis modern short term therapists such as Davanloo (1978) placed on providing an emotionally intense therapeutic experience. From a research view, such concepts as "intense experience" and "as high an emotional level as the patient's ego could stand" are difficult to measure. Alexander's work was based purely on clinical experience and impressions and little attention was paid to follow up. Alexander and French (1946) reported one eight year follow up after two sessions analytically based treatment and "symptoms were relieved" but no details regarding if this change could be attributed to other factors were considered.

Alexander (1946) also introduced the concept of the "corrective emotional experience." He defined this as re-exposing the patient under more favourable circumstances to emotional situations that s/he could not handle in the past. Alexander believed the corrective emotional experience resulted from the difference between the original parent response and the response of the therapist during treatment. This is also a feature of present day brief therapy.

Malan (1963) reports that the case histories reported by Alexander and French (1946) suggest that therapists should go as "deep" as is necessary to help the patient. This is obviously highly subjective and dependent on individual therapist's judgements. In addition Alexander and French (1946) report cases in which some aspects of transference were handled by interpretation, some by acceptance and some cases were treated purely by providing a corrective emotional experience. Yet all are brief therapy - replication is impossible.

Alexander's ideas were controversial, to some they symbolised progress, to others analytic impurity. Today, however, the principles he elucidated have become part of the daily repertoire of almost every therapist utilising brief psychotherapy.
Alexander failed to conduct controlled studies to measure outcome or to operationalise the variables or to analyse the process factors in therapy. His greatest contribution is in providing the theoretical groundwork for later therapies.

Generally speaking then, starting with Alexander and including more recent brief therapists there is a belief that the time limit of therapy and the focusing on a central issue are the two basic requirements of brief psychotherapy. Among the best known contemporary contributions to the development of brief dynamic treatment models are David Malan (1963 & 1976), Peter Sifneos (1972, 1979), and Habib Davanloo (1978, 1980). Previously to these workers case histories were reported which were characterised by insufficient detail so that independent observers could not draw conclusions, clinical judgement of success was utilised and long term follow up neglected. The work of Malan, Sifneos and Davanloo represented an attempt to consider experimental methodology to assess the efficacy of brief psychotherapy.

The work of each of the three contemporary proponents of brief therapy will now be considered in turn.

David Malan's 1963 and 1976 work aimed to apply rigorous methods to clinical material with the aim of handling data on psychotherapy in such a way that hypotheses or conclusions could be based on something more than clinical impression. The approach was initially called focal therapy, later intensive brief psychotherapy. A four point scale for judging outcome was used. Evidence relating to symptoms formulation, therapy and outcome were presented which could then be judged by an independent evaluator. However reports on which this was based were provided by therapists who could be biased. No evidence is presented to suggest that changes noted were attributable to processes independent of therapy. A four point scale to assess the use of transference work in sessions represented an attempt to analyse process issues but still relied on the therapist's judgement which could be biased. The therapists knew the hypothesis to be tested which could influence the results.

Malan views that selection criteria are important factors in determining therapy outcome. Certain patients were eliminated before the interview process by means of referral information. These include alcoholics, drug addicts and those with a history of serious suicide attempts, long term hospitalisation, more than one course
of electro convulsive therapy, grossly destructive or self destructive acting out and incapacitating chronic obsessional or phobic symptoms. Malan (1963) indicated that important selection criteria for brief psychotherapy include a strong motivation for change and an identified area of conflict on which to focus treatment.

Malan (1963) reports that the hypothesis that it is patients with mild illnesses with recent onset who give the best results is not supported, and his results suggest that when the patient has already been selected in terms of suitability, in that they were willing and able to explore feelings, respond well to interpretations in therapy and gave material out at interview which is understandable in psychoanalytic terms which enables psychoanalysts to form some kind of limited therapeutic plan that they were able to work in a brief psychotherapeutic approach. An important criteria indicating a good prognosis is concerned with a high motivation for insight therapy but this is assessed subjectively by the therapist and is subject to bias.

Malan favours setting a definite time limit to treatment. Malan uses a 20 session limit with an upper limit of 40 sessions as a definition of intensive brief psychotherapy. Sledge et al (1990) report that the dropout rate for subjects in brief psychotherapy in which the length of therapy was specified at the outset, was about half the dropout rate for subjects in brief and long term individual psychotherapy. The difference could not be explained by patient demographic or diagnostic variables or by therapist characteristics, so setting a time limit may reduce patient dropout rate. This represents an interesting development in current research whereby patient therapeutic actions are linked to patient behaviour. Hogland (1988) suggests that setting a fixed termination of therapy brought separation issues to the forefront for well adjusted subjects and this group is more suited to a time limited approach than are the less well adjusted patients.

Successful treatment was found to be highly related to the ability to formulate a focus and patient motivation to work with this focus and in making the transference parent link. "Success" was not assessed using validated measures but was based on therapists evaluation of client change. Although Malan's 1963 and 1976 studies attempted to elucidate the relationship between interpretation and outcome, there are methodological problems in these studies. The 1963 study was purely retrospective. The ratings of outcome and interpretations were not independent and the latter were made from incomplete summaries of the therapy rather than from verbatim transcripts. This creates the possibility of bias as
therapists may only have recalled interpretations that fitted with the psychoanalytical method. Subsequent studies have demonstrated that transference interpretations have a potent influence on therapy (Joyce & Piper 1993). Episodes of patient therapist interaction were analysed and ratings of patient verbal behaviour before and after the interpretation were conducted. Results suggested that transference interpretations consistent with a careful formulation of the patient's difficulties is effective.

Sifneos (1972) and (1979) showed that there exists a type of patient suffering from circumscribed problems based on the male or female oedipal complex who can be substantially helped in a maximum of fifteen sessions. He calls the method Short Term Anxiety Provoking Psychotherapy (STAPP). It is entirely psychoanalytic in orientation and employs interpretation as its main therapeutic tool and makes extensive use of the transference. An essential selection criteria is that the patients must show themselves on an initial evaluation to be highly motivated and responsive. The criteria for undergoing STAPP have been developed over a 20 year period and tested extensively. Sifneos reports that its effectiveness for helping pick out appropriate candidates for this kind of psychotherapy has been repeatedly validated. These include the following:

1. A circumscribed chief complaint.
2. Meaningful give and take type of relationship in early childhood.
3. Good rapport with the evaluator.
4. Psychological sophistication and above average intelligence.
5. Motivation to change.

Many of these features are judged subjectively by the therapists but Sifneos (1972) listed seven criteria that are used to assess motivation to change:

1. An ability to recognise that the symptoms are psychological in nature.
2. An ability to give an honest and truthful account of one's psychological difficulties.
3. A willingness to participate actively in therapy.
4. Curiosity, introspection and ability to understand oneself.
5. A willingness to explore and to experiment.
6. Realistic expectation of the results of psychotherapy.
7. A willingness to make a tangible sacrifice. Such sacrifices may be financial or may involve the willingness to make an appointment when the time is inconvenient.

Patients who meet all 7 of these criteria have an excellent motivation for change, 6 out of 7 good, 5 out of 7 fair. Patients who score below 5 are considered to be questionably motivated or unmotivated. In order to be selected for STAPP patients must score 6 or 7 at the time of their evaluation. Sifneos developed a force choice questionnaire to assess motivation to change in a more objective manner. This reflects the recognition of the importance of utilising a research paradigm in such work. Sifneos (1968) reports that 22 of 25 patients who received STAPP and were considered to have improved had "fair" or "excellent" motivation but this was an uncontrolled study and improvement was not well defined.

Interestingly Hoglend (1993) examined the usefulness of the selection criteria used by Sifneos (1979) and Malan (1976). Forty three 20-53 year old patients were evaluated, treated and followed up by 7 psychologists. The success rate in predicting symptom changes two years after brief psychological therapy increased 20% by adding quality of interpersonal relations from a psychodynamic evaluation interview to DSM III diagnosis, Axis V and Axis II. The success rate in predicting dynamic change 4 years after therapy increased nearly 40% by adding the same variable. Selection criteria such as circumscribed focus, motivation and involvement in the evaluation interview were shown to be redundant as predictors. It can be seen that as specificity of therapy increases, so research can test out which factors are of importance.

Hoglend et al (1992) evaluated 40 outpatients for psychotherapy with a modified version of Sifneos' (1979) selection criteria. A factor analysis produced circumscribed focus, motivation, flexible interaction and quality of interpersonal relations as dimensions of suitability. A combination of these dimensions was a more significant predictor of long term dynamic change than were background variables or the presence of a personality disorder. Barth et al (1988) highlighted three selection factors in Sifneos' approach; ego resources, motivation for psychotherapy and motivation for change. Vaskanatans and Verveniotis (1986) reported that certain selection criteria are negatively correlated to early drop out, that is, circumscribed problem of the patient, high motivation for treatment and the existence of crisis. In contrast, however, other writers such as Kachele (1985) suggest that brief dynamic therapy can be offered to almost all patients without use
of stringent selection criteria. The important factors have not yet been isolated but important research questions are now being asked and tested. Nielsen and Havik (1989) maintain that the exclusive selection criteria used by Sifneos and Malan to select suitable patients limits the applicability of the systems.

Sifneos considers that the anxiety provoking quality of therapy highlights the importance of a detailed assessment of ego strength in candidates for short term therapy. Interventions most likely to produce anxiety are invariably associated with oedipal material and/or transference feelings. Such interventions are used repeatedly by the therapist to make the all important therapist/parent link. It enables the patient and therapist to examine these feelings "alive" in the interview. The opportunity to create an atmosphere for a corrective emotional experience takes place. The displacement onto the therapist of feelings, attitudes and behaviour patterns the patient experienced towards parent figures can be examined and analysed.

Sifneos places great importance on therapy as a learning experience. The patient learns not only about himself or herself but also new ways of solving emotional problems. Sifneos believes that the problem solving, cognitive component of therapy is just as important as the affective element.

In practice treatment averages four months with a range of two months to a year. The therapist utilises the patient's transference feelings in vigorous and explicit manner. The therapist confronts the patient with transference feelings and uses them as the main therapeutic tool.

Sifneos conducted systematic controlled studies of patients chosen according to explicit selection criteria. The patients were interviewed by two independent evaluators before and after therapy and were designated as either "experimental" or "control" and matched according to age and sex. The controls waited for the time it took their experimental counterparts to be treated and were assessed again for changes. They were offered STAPP. Both groups were followed up. 35 experimental and 35 controls were studied. Some were lost for follow up - 14 experimental and 18 controls were followed up. The majority in both groups showed "moderate" or complete resolution of their difficulties. Sifneos specified criteria for change which are listed below:

(a) Physical symptoms
At the end of therapy, patients are seen by a new "uncontaminated" evaluator and by one of the two original evaluators to assess the results of treatment to see if the outcome criteria specified for that patient during his evaluation have been fulfilled. The patients are seen in yearly follow ups by one of the original evaluators and by a new one. Clearly this represents a real effort to assess brief psychotherapy in terms of research criteria.

Intrapsychic changes as reported by the patients included moderate symptom relief, and increase in self esteem, more realistic expectation of therapy, new learning in problem solving, increased self understanding and absence of desire for more therapy. The findings demonstrated that while only partial symptom relief was achieved the patient's attitudes regarding their symptoms changed. The symptoms no longer seemed overwhelming nor did they interfere with normal functioning. Interpersonal relationships were scrutinised and overall improvement in relationships with key people in their environment were noted.

Psychodynamic changes were also observed. This involved substituting more adaptive and useful defence system mechanisms for maladaptive ones as a result of moderate or complete resolution of the underlying dynamic conflict. Long term follow up of up to four years reflected the overall trend of the above findings. The most significant follow up finding was that short term anxiety provoking psychotherapy with its emphasis on learning and problem solving continue to facilitate the solving of emotional problems long after treatment (Sifneos 1979). Sifneos (1979) uses patient and therapist ratings of outcome which may be subject to bias. A STAPP Therapist Competence Form has been developed which quantifies the degree that a therapist competently conforms to the STAPP strategies. This systematic approach is a promising analysis in psychotherapy of therapists functioning (Startberg 1989).
Habib Davanloo had been involved with short term dynamic psychotherapy since the early 1960's. The Davanloo technique is also grounded in the analytic tradition.

Malan (1992) reports that the reaction of many to Davanloo's technique was generally hostile, since it seemed that his patients were being hounded and persecuted. However, under this relentless pressure many of his patients recovered within about 20 sessions and it has now been recognised that Davanloo's techniques have much to offer. Davanloo audio taped and then video taped sessions in order to see which ingredient in his technique seemed to lead to progress and which to failure, such cases could also be used by independent evaluators. When he had identified an important factor he would systematically employ it in his next half dozen cases and would assess these factors in some depth. He came to see that when a particular subject made a patient resistant and uncomfortable the correct response was not to become passive and wait for future developments but to challenge the defences more and more forcefully. The result was a reversal of the trend to passivity set up originally by Freud. The constant interpretation of defences aroused anger in a patient which the patient then tries to conceal and utilise characteristic ways employed in his life. This is interpreted as with any other aspect of transference. Davanloo focused on three fundamental psychoanalytic principles of releasing patients hidden feelings by interpreting the resistance, paying strict attention to the transference relationship and linking this to both current and past relationships.

In 1992 Davanloo used 10 to 15 sessions with an upper limit of 25. Because of his way of challenging defences the technique was applicable even to some more resistant patients who had suffered symptoms and character problems for many years.

Malan (1992) reported the potency of Davanloo's therapy and stated that "Freud discovered the unconscious, Davanloo has discovered how to use it therapeutically." Davanloo (1992) reports that based on three systematic researches, four major groups of patients who have been treated with his techniques have been identified.

1. Patients suffering from neurosis with a primarily oedipal focus.
2. Patients suffering from neurotic conditions where the focus is loss.
3. Patients suffering long standing obsessional and phobic neurosis with more than one focus, e.g. a complicated oedipal focus as well as loss.

4. Patients with more severe psychopathology: those suffering with long standing psychoneurotic disorders and characterological problems where one cannot delineate a single focus.

Davanloo (1992) considers that the careful selection of patients is essential, initial evaluation is based on a focused interview style. The initial focus is on the evaluation of those major ego functions which are of primary importance in dynamic psychotherapy.

To establish a patient as suitable for short term dynamic psychotherapy a set of criteria must be fulfilled. These criteria are related to:

1. the ability to establish therapeutic focus
2. the quality of object relationships
3. the capacity to experience and tolerate anxiety, guilt and depression
4. psychological mindedness and
5. the motivation and response to interpretation (Davanloo 1980).

The operationalisation of these criteria is not explicit. The technique used in the initial interviews is essentially the technique used in therapy. The patient is gently but relentlessly confronted with his or her feelings in the current situation and the transference relationship and in the past and whenever possible links made within these three areas. This is termed trial therapy.

Magnavita (1993) presents a trial therapy of a male patient suffering from a passive aggressive personality disorder. The trial therapy of 4, 45 minute sessions revealed a focal problem and Davanloo's method penetrated the subject's defences effectively. Such case studies indicate the importance of trial therapy in assessing suitability for therapy and illustrate Davanloo's method clearly. Benoit (1990) illustrated Davanloo's approach by the use of transcriptions from the trial therapy of a 40 year old man suffering from a wide range of disturbances. Many case studies using Davanloo's approach are presented which enable an understanding of process issues to be achieved but the isolation of factors which lead to change is not achieved through presentation of case study material.
In Davanloo's largest research project lasting from 1963 to 1975 he evaluated 575 prospective patients, 130 of whom fulfilled the criteria for short term dynamic psychotherapy. Of the 130 patients, 115 were treated successfully within an average of 20 sessions. Success was still noted in these patients with follow ups of up to seven years (Davanloo 1980). The assessment of outcome of therapy involved interviews by the therapist and an independent evaluator immediately after termination and up to five years later. The patient also evaluates the process and outcome by observing five randomly selected audiovisually recorded therapy sessions and determines the changes and the variables he/she considers to be of specific importance in the treatment outcome. This is conducted six months after termination. Davanloo however discusses "successful" cases and defines success as "definite evidence of the total resolution of the patient's core neurosis", and this is manifested by "substitution of all the maladaptive patterns and defences by adaptive ones, and a screening of sexual and aggressive drives for constructive use in the patient's life, with a total change in interpersonal relationships". If this is a realistic aim and how it is assessed is not clearly defined.

Many case studies are reported whereby Davanloo's approach has been successfully utilised but again case studies can not produce firm conclusions. Lachenmeig and Kleiner (1993) discuss the treatment of a 35 year old man with panic attacks and agoraphobia in which the patient is initially acquainted with his defensive systems and transference feelings are interpreted which then highlight the underlying impulses. "Working through" involves systematic and repeated analysis of transference. This is highlighted in many studies of brief psychotherapy as being an essential ingredient of such therapy.

Outcome studies have analysed the efficacy of short term psychotherapy. Jones et al (1992) using a sample of 30 patients with a range of neurotic disorders demonstrated a significant change pre and post treatment and a majority of subjects met at least one criteria for clinically significant change. Crits-Christoph (1992) conducted a meta analytic review of 11 recent well controlled studies of the efficacy of brief dynamic therapy. The outcome measures compared were target symptoms, psychiatric symptoms generally and social functioning. Brief dynamic therapy demonstrated large effects relative to waiting list conditions but only slight superiority to non psychiatric treatments. Its effects were equal to those of other psychotherapies and medications. Data suggests that various psychotherapies do not differ in effectiveness, although this finding should not be generalised to all patient populations, outcome measures and treatment types. Therapist
intervention and patient responses have been related to outcome. Patient therapist interventions followed by patient affect bear a significant relationship to improvement at termination, whereas an intervention followed by defensiveness correlates negatively with outcome (McCullough et al 1991). Svartberg et al (1991) in a review of 19 outcome studies evaluated short term dynamic therapy (STDT). Overall STDT was superior to no treatment (NT) controls at post treatment but was inferior to alternative psychotherapies (AP). STDT was inferior to AP in treating depression and in particular to cognitive behaviour therapy for major depression. STDT was equally successful with mixed neurosis. Outcome studies need to consider many variables, e.g. problem type, therapy type, and the timing of the evaluation of efficacy of treatment. Winston et al (1991) assigned 32 outpatients with personality disorder diagnoses to one of two treatment conditions; short term dynamic or brief adaptational therapy. 17 subjects constituted a waiting list control group. Subjects receiving the therapy showed significant improvement on target complaints, the SCL-90 and a social adjustment scale as compared to controls. Process measurements showed that the short term diagnostic technique encouraged the expression of strong affect, the brief adaptational techniques dealt with resistance more by clarifying than confronting thinking. Process and outcome variables is an interesting and valuable way of analysing brief therapy. Another study produced interesting results (Taurke et al 1990). When subjects were grouped according to outcome scores, significant differences between the high outcome and the average to low outcome groups emerged. Early in treatment, subjects in both groups showed an average of 1 affective to 5 defensive responses. Late in treatment the high outcome group shifted to 1 affective response per 2 defensive responses while the low outcome subjects remained the same. There was a negative correlation between good outcome and the ratio of defensive behaviour to total patient activity. Barth et al (1988) assessed change in 34 patients at the end of short term dynamic psychotherapy (STDT) and at 1 year and 2 year follow ups. When a particular form of STDP is selected according to each subject's ego resources, motivation for therapy and for change, approximately 90% of the subjects will attain substantial symptom relief. The majority of subjects also gave evidence of positive change in adaptive functioning, while one third attained some dynamic/structural change as well. Clinically rated improvement was confirmed by changes in the subjects self reported distress level (SCL-90) and from psychological test findings on the MMPI. Improvement was sustained throughout the two year follow up. Other studies also show significant therapy gains (Nielsen et al 1988, Fairburn et al 1986). Efficacy of the treatment has received much examination, e.g. Barth et al
(1988) recommended the use of an evaluation form of Sifneos' (1979) criteria for STAPP. When STAPP and Malan's approaches were evaluated, 78% of the subjects completed their treatment in agreement with the original ascription to therapy with good results. A significant problem in the research is that work of short term dynamic psychotherapy is presented without reference to which model is being utilised. The studies illustrate the use of psychometric tests to assess change, of exploration of process factors and links to outcome.

Research is developing brief dynamic therapy further. Variables to consider in selection, process and outcome for different therapies are being highlighted. Gaston et al (1988) for example report that in behavioural, cognitive and brief dynamic therapy a higher degree of patient defensiveness was related to a lower patient contribution to the alliance as reflected in patient commitment and working capacity. Also the environmental support was positively associated with greater patient commitment. Jones et al (1987) investigated the influence of therapist gender, age and pre-treatment distress level on process and outcome of brief dynamic psychotherapy. Pre and post therapy assessments suggested that patients treated by female therapists experienced more symptomatic improvement and reported more satisfaction with treatment. However, patient age accounted for more and patient pre-treatment level of disturbance more than three times the outcome variance contributed by gender.

Process variables have been studied for example Messer et al (1992) report that patient interactions in therapy were rated on a psychodynamically oriented progress-stagnation scale and all therapist interventions were rated on scales measuring (1) their compatibility with the content of a psychodynamic formulation (plan) and (2) their quality. Plan compatibility of therapist interventions correlated significantly with patient progress in the early and middle phases and the quality of therapist interventions correlated significantly with patient progression in the middle phase.

Despite these promising suggestions, there is a lack of solid knowledge in many areas for example, the kinds of therapeutic changes one may expect, the most appropriate techniques for reaching these goals, identification of the "active ingredients", the necessary procedures for bringing about an optimal match between a suitable patient and an appropriate therapist. As a researcher, rich challenges exist. Research must address issues such as, what procedures should be avoided, how does one identify a "dynamic focus", what therapeutic activity is
necessary, how to assess the patients personality structure in relation to the presenting complaint and in relation to a specific objective?

Much of the literature consists of case studies or of uncontrolled or poorly controlled "demonstrations" of therapeutic effects. Patient and therapist characteristics are not specified or related to outcome. It is rare that therapeutic interventions are described with clarity to render their replication possible. Therapy is generally multifaceted with no isolation of effective ingredients. Outcome measures utilising psychometric assessment of patient functioning at pre and post therapy are rare. Usually the clinicians judgement of "success" or failure is reported. Long term follow up is not always reported and where it is reported e.g. Malan and Sifneos, the outcome measures are not always clearly delineated. Finally, the most influential clinical literature on brief therapy has involved a small number of therapists, Sifneos, Malan and Davanloo which leads one to the suggestion that it may be the personality or style of these therapists, rather than the techniques themselves which accounts for their success. The quality of the relationship between the patient and therapist needs to be considered and the characteristics of the patient and the therapist that enable them to work effectively needs to be isolated. The need to assess success is of great importance. In order to assess outcome it is necessary to articulate it at the beginning of therapy and should be assessed in relation to clear statements about the problems presented by the individual patient. The goal may be highly limited (alleviation of a specific symptom) or extensive (particular aspects of more adoptive functioning), there may be single or multiple problems, the problem may be stated in behaviourial or psychodynamic terms, or in some combination. Therapeutic operations should be maximally geared to the achievement of specific therapeutic objectives and consensus on the optimal time at which a treatment is to be assessed and the performance of change that is to be expected. Follow up is essential. Clinicians and researchers need to work together to develop measures that can be utilised in such work. Sifneos (1979) work represents a real attempt to subject brief psychotherapy to such a research oriented approach and his attempt to clearly delineate outcome criteria is laudable. Composing groups by matching pairs of patients on crucial dimensions such as severity of symptoms is desirable. Adequate description of the sample will permit exploration of specific interactions of therapy with type of patient. Two main outcomes should be considered, those related to specific symptom and those to general adjustment. Therapy processes could be judged by independent evaluators to determine if therapy given fits the intended form of treatment and could lead to an isolation of "active ingredients".
In conclusion therefore, it appears that the case for the efficacy of brief psychotherapy has not yet been proven.

The use of a randomised design to evaluate the outcome of brief psychotherapy is recommended. A long term follow up using a range of outcome measures which would include psychometric tests, behavioural observations, individualised criteria for change which have been determined prior to therapy as a result of the initial assessment process and pre/post therapy assessments of level of disturbance and functioning.

Selection criteria would need to be made explicit and operationalised and an assessment of which clients, if any, benefit from such therapy would be made.

Process factors in therapy would need to be made explicit and therapy evaluated by independent assessors to confirm that the stated process features were actually being conducted in therapy. Scales such as the STAPP Therapist Competence Form which assesses the degree to which a therapist conforms to the therapy strategies would be used. Features such as the number of transference interpretations and the number of interpretations relating to the agreed focus would be assessed as they are considered central to short term dynamic psychotherapy. Scales such as the Psychotherapy Process Q-Set (Jones et al 1992) which assesses process features could be utilised. The use of videos or verbatim accounts of therapy would be recommended.

Clearly a major research project investigating selection, process and outcome of short term psychotherapy is required so that an answer regarding the question of the efficacy of short term dynamic therapy can be gained. At present there are difference schools within brief psychotherapy. The therapies of Sifneos, Davanloo and Malan are different as are the clients for which the therapies are considered to be most helpful. It is therefore necessary in such an outcome study to clearly state which model is being assessed and how the model is operating on key process factors.

Such a project is essential as Psychologists need to know and to be able to demonstrate the efficacy of the therapies which they are utilising.
REFERENCES


2.2 COMMUNITY CARE ISSUES

"Care in the Community" is a concept which has long been recognised but has received increased impetus in the 1990s due to government legislation. A historical overview of Care in the Community initiatives will be presented with a focus on the 1990 NHS and Care in the Community Act. Following on from this Act the Care Programme Approach, Supervision Register, the operation of Community Mental Health Teams and the prioritisation of the needs of the severely mentally ill will be explored. The implications of such issues on the development of a Clinical Psychology Service will also be discussed.

The movement to establish community care is not new. However, in the late 80s and 90s the movement to provide community based services has received fresh impetus from government. As Lavender and Holloway (1988) comment, "this impetus is done both through a genuine desire to improve the quality of service and an equally genuine desire that the replacement services should be cheaper. Given these mixed motives the will to actually provide community care is fragile especially when it begins to become clear that the new services are likely to be more expensive and restrictions on public expenditure becomes a matter of government strategy."

The government's ideas were reported in a White Paper, "Caring for People" and this was legislated in the NHS and Community Care Act 1990. It aims to produce a shift in influence away from services in favour of users and their carers. It created a planning framework in which agencies must work more closely together and emphasises consultation and collaboration at every level. Services are expected to adjust to meet each person's needs rather than expect users to fit in with service requirements. Authorities must establish a shared appreciation of how local needs should be determined, they must agree objectives, targets and priorities and Local Authorities must publish their intentions in community care plans. Authorities must establish policies in operational areas including the co-ordination of care through commissioning care management and assessment procedures (Audit Commission 1992).

Central to the new approach is the separation of responsibility for purchasing and providing of services. Purchasers or commissioners roles are concerned with assessing the needs of the population and commissioning, specifying, planning and organising services to meet these needs in terms of the community care proposals.
Care Management roles are often regarded as falling within this purchaser category. Effective decision making by Care Managers will involve balancing a whole combination of factors including the budgetary position. Provider's roles are concerned with the actual delivery of services to clients rather than specifying the services needed. The purchaser/provider split aims to clarify goals and objectives, ensure planning and budget setting are driven by the needs of the population, improve the quality of services through specifications of the services to be provided and cost, including unit costs for providing a service to a client (DPT Health Implementing Community Care 1991). Needs led assessments, increased client choice and unmet needs assessments will be facilitated.

In Local Authorities the concept of care management has been promoted as the cornerstone of high quality care with the Care Manager "acting as a broker to services across the statutory and independent sector," DHSS (1990). The Care Manager arranges through service agreements for providers to provide services. The Care Manager purchases services to implement a care plan and then monitors and reviews the plan. The process of implementing this inevitably generates new difficulties and requires other adjustments which in turn trigger further requirements in an ever increasing cascade of change" (Audit Commission 1992). A major shift in the provision of care advocated is that service eligibility criteria are to be established and when someone does not qualify under the criteria or there are inadequate resources, the private or independent sector may be recommended (Audit Commission 1993). Health and Social Services are expected to work closely together but power struggles, competition, different ideologies and resource limitations, limit this severely (Ramorn 1988).

A particular problem is that Social Services who are operating a care management system and Health Authorities may have different targeting criteria and yet are expected to work together to provide care. Little appears in the literature concerning this issue which is creating real difficulties for clinicians. Care Managers are Social Services based and make decisions about which services to buy. Providers of services can identify services which clients require but the budgetary position of care managers can prevent them from funding such services. This can cause conflict between purchasers and providers both between and within Health Authorities and Social Services. Diagnostic and clinical factors are often used by health service workers for the purpose of service provision. However, social factor are far superior in predicting the onset and outcome of mental distress (Huxley 1990). Greater emphasis needs to be placed on factors such as security of
accommodation (Onyett 1992). A survey of 500 users saw their problems as predominantly personal or social rather than medical (Onyett 1992). Services are also guilty of neglecting basic material needs (Hatch and Nissel 1989). Services now need to be integrated with a high degree of service flexibility which is acknowledged in the literature but clinically the structures of social services and health authorities with separate care programme approach and care management systems maintains the lack of co-ordinated and integrated care. In addition, health authorities are driven by Commissioners and by the fundholding GPs, both of whom have different targeting criteria and incentives for caring for different groups. This position causes a situation occurring whereby the aims of community care as stated in the literature are not able to function effectively in practice. In addition, because of the many demands on social service departments due to legislation such as The Children’s Act (1990) resources are extremely stretched and care managers in practices are unable to fund many services which are identified as being desirable for clients. Research is needed in this area to consider alternatives to the present systems. Possibilities for consideration will be presented in the conclusion.

There are many who feel uneasy about these changes, they are concerned about the introduction of apparently alien commercial concepts into services whose prime function is to care for people and they are especially concerned at any prospect of the need of users and their carers being resolved in the marketplace. However despite the plethora of government policy documents (House of Commons 1985, 1990, Audit Commission 1986, Griffiths 1988, Secretaries of State for Health 1989, 1990) little specific guidance has been given as to what should constitute the components of comprehensive local psychiatric services. Nor has any central agency assisted districts in the development of the organisational framework necessary (Strathdee & Thornicroft 1992). There is a consensus that closure of large psychiatric hospitals is preferred (Thornicroft et.al.1992 and Bebbington 1988) but there has been little agreement on how to structure the services which replace them (Strathdee and Thornicroft 1993). In current practice, community developments are frequently determined by financial expediency, lacking any theoretical basis and focus more on buildings than on the flexible recruitment and deployment of personnel (Holloway, 1988). The lack of clarity allows for different strategies to emerge and "reflects the absence of any overall vision about community care (Ramon 1988). Huxley (1993) comments that to produce effective intervention, services must have clearly identified objectives, closely
specified target groups, interventions that match the objectives, and they must employ related outcome measures.

Mental health service developments in Great Britain have tended to be based on replications (often uncritical) in America or Europe, rather than as a product of a well considered local strategy (Strathdee & Thornicroft 1992).

Studies which have compared community based psychiatric care to hospital based care have generally found that clinical and social outcomes are similar or better in community based care (Burns et al 1993(a)). In addition the total treatment cost is significantly larger for standard hospital care when controlled for diagnostic grouping (Burns et al 1993(b)). A controlled study comparing home care or standard hospital care reported that home care reduced hospital use by 80%, with patients being admitted for a mean of 14 days, compared with 72 days for the standard group, but this bed saving made no difference in direct treatment costs. Home care offered individualised treatment and many patients required continuing support with the emphasis on areas such as finances and housing (Muijen et al 1992). When home care has been compared with inpatient care, home care shows greater improvement on clinical symptoms, social functioning and patient and carers satisfaction (Fenton et al 1982, Hoult et al 1983). No approach can claim to "cure" mental illness. At the end of the studies non inpatient samples still have considerable symptoms and disability. After home care is withdrawn and substituted by standard care, the experimental groups lose their superiority over the controls (Davies et al 1992, Stein & Test 1980).

Rosenfield (1992) reports that community care enhances patients quality of life (QOL) and that services providing economic resources and an empowerment approach to service delivery involving increasing client's economic resources and status are related to overall QOL. QOL is measured using Lehman's measure which has an internal consistency reliability of 0.73. This study used tests with good psychometric properties though the QOL does rely on subjective overall QOL. Objective QOL was however studied in terms of housing, social relations and health, though did not contribute to the overall QOL score. Marks (1992) reports that patients and relatives prefer community to hospital care, and community care tends to be cheaper. Any gains are lost if the community services are not resourced, co-ordinated and maintained indefinitely.
Community care has been shown not to be the most effective for some groups. Goldberg (1991) reports two UK studies which have shown advantages in the treatment of acute psychosis with brief hospitalisation followed by day care. What emerges is that a wide range of services should be available to meet the needs of individual clients and that neither hospital nor community care is better for all clients.

Linke and Taylor (1987) in a UK study compared behavioural rating scale scores (REHAB). REHAB requires that ratings are completed on the basis of behaviour observed during the previous week and has normative data on patients living in traditional psychiatric hospitals, thereby providing a basis of comparison for clients living in the community. Baker & Hall (1983) reported that subjects in the community were better than those on admission wards but worse than half the people from a traditional psychiatric setting. It is suggested that community care is successful in so far as this group were able to remain in the community. To confirm this view of success an analysis of needs would have to be conducted.

Much of this approach has been based on research projects usually run by highly motivated and skilled staff with extra funding. The generalisability of this to the NHS and Social Services is unknown as yet. Assessments are the centre around which all else is built but the combination of needs which should trigger a response is not clearly outlined. These difficult questions must now be confronted. Authorities will have tough decisions on priorities and eligibility criteria. Government recommendations focus on the seriously mentally ill but as yet no nationally agreed definition of serious mental illness exists. Historically services have been available to all levels of mental health problems. GPs expect such services as CPN attachments in primary care and counselling services to continue, but resources are being redirected and G.P. dissatisfaction may result.

Caring for People (CM 849, 1989) recommended the use of Care Programme Approach (CPA) to ensure that patients treated in the community receive the health and social care they need. The HMSO Policy Guidance Document (1990), Community Care In The Next Decade and Beyond, acknowledged that adequate arrangements for patients had not always been achieved and so the CPA was developed further and involved an assessment to be made of the continuing health and social care needs of the patient and all the professional staff expected to contribute to its implementation agree that it is realistic to make the required contributions. The arrangements then need to be monitored, the key worker is
established to keep in touch with the patient and to monitor that the agreed health and social care is given and may advise professional colleagues of changes in circumstances which might require review and modification of the care programme. A reasonable effort should be made to maintain contact with a patient and where appropriate his or her carers. The exact form the CPA would take would be determined locally and health authorities were to meet any costs arising from CPA out of existing resources.

North et al (1993) examined the implementation of the CPA in four health authorities. The major criticisms from professionals was the bureaucratic and over-structured procedures that CPA was seen to require and that it was unrealistic to introduce CPA without additional resources. The relationship between CPA and Care Management was unclear - this is discussed later. CPA was considered to be inappropriate for people with one off episodes of illness, perhaps crisis related or those involved with only one professional. The tiered approach of CPA was not understood. The lack of suitable accommodation was highlighted as being a failure to respond to the needs of this group. Staff found the implementation of reviews often difficult to organise. Of prime concern was the procedure impingement on clinical practice and resentment of what was seen as government imposed procedure when good practice policies were felt to be in place (North et al 1993).

However, such information was seen as a help in identifying where resources were lacking. Schreider (1993) examined the use of CPA in three health districts and reports that contrary to guidelines, the CPA is being implemented selectively and was not being applied to every new patient. There were also discrepancies in how the CPA was being applied to different age groups. One of the main complaints was that it demands too much time to implement as planned.

The way in which the CPA integrates with Social Services Care Management is an important issue, but one which many services have not yet resolved.

Care Management and Case Management are seen as being quite distinct entities in the literature although there are areas of overlap. Care Management is seen as being in the purchaser's domain and is involved in assessing needs and making service provision decisions within budgetary limits while actually not providing any service to the client directly. Case Management however is seen as being a provider function which focuses on engaging the client assessing needs, planning
care, working on the clients' environment by linking with community resources and families, expanding social networks, working with the client which may involve counselling, training in daily living skills and psychoeducation and crisis intervention and monitoring. The case Manager is seen as helper, service broker and advocate for the client. This role straddles care management and a provider role but case management is seen as being helpful to those with difficulty in engaging with services who require a very specialist systems of care. Care managers may purchase case management for these clients and then may hand over some of the function of care managers. A key difference reported in the literature between care and case managers appears to be the degree to which they can engage in developing and maintaining an empathic, supportive relationship with the client which could encompass a counselling function but in reality this very much seems to depend on the individual care/case manager. It is the degree to which direct work with the client is undertaken which seems to differentiate between care and case management. However, this is not always identified and causes some confusion in clarifying the differences and the efficacy of the two systems. Care Management is always cited in purchasing whereas case management is usually although not always in the provider realm. Care management has focused more on the provision of social service needs whereas case management includes a more holistic view of the client which can cause difficulties for the case manager who is traditionally trained in one field yet is now expected to assess a whole range of needs and involves crossing many professional boundaries. At one level, case management has a lot in common with both the care programme and with care management. All three are concerned with assessment, developing care plans, monitoring and review. There are however some striking differences. Both the care programme and care management can be seen as overriding organisational processes. As such, their main task is to ensure that the functions of assessment, care planning, monitoring and review are undertaken. Only in case management, however is one named person explicitly involved in the whole process from assessment to review; only in case management is this same person also involved in direct work with the client. The relative benefits and problems of these approaches have not been explored in the literature and causes confusion for clinicians. The model being used in practice is also often not made explicit, leading to confusion often care and case management are used interchangeably in practice. Care programme focuses on health provision but when social needs are identified this becomes the domain of care managers and conflict may develop between social services and health services when services identified as being needed by one service cannot be purchased by the other service. Health and social services should agree
definitions of types of care and targeting criteria but in reality this is proving difficult and research in the area is sorely needed.

Case Management is another approach which is being utilised in some areas and confusion does exist between case management, care management and care programme. Case management involves having a single person responsible for maintaining a long-term supportive relationship with the client. The Case Manager is a helper service, broker and advocate for the client. Assessment, coordination of packages of care, monitoring and review are placed within service provision (Ryan et al 1991). Case management developed in America in the late 1960s and early 1970s as a response to critiques levelled at the mental hospital as a system of care (Ryan et al 1991). Case management represented a development of a community approach (Stein and Test 1980) for long stay patients who were difficult to discharge. This approach focused on teaching daily living skills, avoiding hospitalisation where possible, working with families to provide support, direct work with the client to encourage the ability to cope with daily community living, establishing close working relationships with community agencies and assertive outreach.

Harris and Bergman (1987) identified twelve different types of case management but most incorporate continuing care, the central importance of the case manager-client relationship, appropriate ongoing level of support, the flexible availability of a wide range of interventions and facilitating clients resourcefulness by building on existing resources, strengths and support networks of the client. It can be seen therefore that case management is not a unitary concept and this makes the assessment of the research evidence concerning case management a complex task as most studies give a poor description of the service received by case management or control clients. Case management is a broad term and different models exist. Many studies involve a new service delivery of which case management is only one element. There is a poor conceptual definition of what to expect in terms of outcome for the long term client. There is generally an abundance of "no change" outcomes, which may be due to authors using traditional medical expectations of cure. This may be inappropriate for the long term client where expectations may be more reasonably focused at stability, independence of living and quality of life. Having considered these limitations, there are some tentative conclusions that can be drawn from studies. A much used outcome measure is admission to hospital and their length and frequency.
The major studies of Stein and Test (1980) replicated by Hoult and Reynolds (1983) and by Test et al (1989) all show significantly reduced use of hospital beds. These services included case management alongside other services such as crisis intervention and aimed to reduce admissions. However, there are studies such as Franklin et al (1987) which show that hospitalisation can increase with the introduction of case management. In this study hospitalisation was not targeted. Borland et al (1989) reported a 75% reduction in case managed patients days in hospital but this reduction was offset by a 93% increase in structured residential care days in the community. Subjects level of functioning on the Global Assessment Scale and other measures remained the same. This finding suggest that it is unrealistic to expect great changes in symptomatology. The aim of care is perhaps not to decrease symptoms but to increase quality of life. Originally, institutions were seen as leading to an increase of symptoms and community care was aimed at reducing symptoms, but it now appears that community care does not necessarily reduce the number of symptoms but can improve the quality of life of such clients.

Shepherd (1986) argues that rehabilitation is a process of assessment, treatment and long term disability management rather than a process of short term assessment, treatment and care.

There are many studies which show increased use of other non hospital services eg Wasylenki et al (1985).

This is to be expected with case management but does have cost implications. The original Stein and Test (1980) model increased costs and benefits, whilst Hoult and Reynold (1983) in a replication, reported lowered costs and increased benefits. The amount of input needed may not be expected to decrease until the 4th or 5th year of case management if at all (Harris & Bergman 1988) which has implications for costs.

For a service to remain cost neutral, the overall cost of case management must be offset by decreased hospital use.

Mental state is assessed in many studies with few showing changes. Studies such as Stein and Test (1980) where clients were taken on at the point of admission, show improved symptomatology for experimental and control clients. The experimental groups were significantly more improved at 14 months compared to
the controls. The experimental intervention ceased at 14 months and by 28 months there was no difference. Hoult and Reynolds's (1983) replication showed significantly greater gains on one measure of mental state for the experimental group but not on the other. Symptoms and satisfaction with services compared to standard systems of care were better in some studies (Merson et al. 1992). Wasylenki et al. (1993) reported using case management and significant changes in psychopathology as well as improvements in social functioning and residential stability. However, no control group was included but an excellent controlled study in the UK reported no difference between case managed and controls in number of needs, quality of life, employment status, quality of accommodation, social behaviour or severity of psychiatric symptoms. There was a significant reduction in deviant behaviour in the case managed group (Marshall et al. 1995).

"It is unfortunate in view of the limited effectiveness......, that social services case management was not evaluated in randomised controlled trials before its implementation in the UK" (Marshall et al. 1995).

It seems important for properly controlled trials to be undertaken before community projects are conducted. Marks et al. (1994) evaluated home based care and standard care. Outcome was superior with home based care up to 20 months but it was difficult to evaluate which components of care were responsible for the improvement because the components were not separated and treated as independent variables. It would be necessary to introduce each component alone and analyse its effect. A negative result was also reported from the USA where assertive case management was compared to traditional outpatient psychiatric services. The case managed group used more mental health services than the control group but no differences were observed in number of hospitalisations or hospital days. The groups were matched on diagnosis, age, number of previous hospitalisations and days in hospital. (Goering et al. 1988). This study focused on improving patients functioning rather than providing crisis intervention and so avoiding hospitalisation.

This throws into question the causative effects of changes observed in other studies and demonstrates the need for a detailed exposition of what is meant by "case management" in a particular study. Curtis et al. (1992) in a USA study reported that no differences between case managed and standard psychiatric care were found in terms of readmission rates and reported that there was no difference between the groups in terms of community mental health service use. It may be that uptake of the latter in other studies accounts for their positive results. It
seems necessary to look for mediating factors resulting from case management which can explain positive results such as that illustrated by Thornicroft & Bergman (1991) who reported that a case managed group which had been in the programme for longer than a year manifested improved social functioning and in their quality and quantity of social networks.

There are huge levels of congruence between the underlying principles of CPA and case management (CM), namely identification of people in need, assessment of need, planning and securing delivery of care, monitoring and review. The relationship between the two approaches seems to be for CPA to provide assessment, monitoring and review and CM would slot in as a specialist service delivery system for those with complex health and social needs (Ryan et al 1991). Clarity over aims, priorities and definitions of team members, respective responsibilities and lines of accountability are needed. In a context of unrestrained market forces, limited resources and confused responsibility, Care Managers may find themselves in quite disparate roles as advocates for users or rationers of scare provisions. However, with effective joint planning, and adequate resourcing appropriate provision, Care Managers may find themselves in an ideal position to help achieve better services for users and carers (Onyett 1992)

An additional problem is that of resources. The burden of legislative responsibility upon Social Service departments has increased enormously over the years. The 1990 Children Act required a greater allocation of resources to child care and therefore mental health resources are under pressure. The Reed Court Diversion Scheme has properly placed clients in mental health care who would have gone to prison. Community resources are not yet well developed and so hospitalisation may have to occur. These factors tend to encourage a demand for more in-patient resources thus diverting investment from community support.

It has to be recognised that Care Managers will have to perform a gate keeping function with respect to resources in the community. Criteria for entry into services are likely to be rigorous, many people requiring assistance may not get it. Separating out assessment from delivery of services makes sense at the strategic planning level as a means of targeting available resources but care needs to be taken that it is not a daunting process for vulnerable clients. There had been an expectation that new services would reduce time in to psychiatric hospitals, however, this has not occurred, services may provide for previously unsupported people in need and may lead to a pressure on beds (Mahoney 1988).
Assessment of need is a cornerstone of these approaches. However, measurement of need is extremely difficult. Two questionnaires, The Camberwell Assessment of Need and FACE are well piloted and validated mechanisms for determining need in mental health care. However, these methods do not draw on service users' own feelings about illness and lifestyle. Analysis of the needs of individuals can be matched with analysis of operational information on actual demand. The interplay between factors can be analysed, e.g. clients with more than 3 repeat admissions in a 2 year period can be identified and then case notes may be audited and improved care programmes can be developed for individual clients.

The Department of Health also issued HSG(94S) which required that all Health Authorities establish and maintain a Supervision Register in order to identify those people who are subject to the CPA/Section 117 who may be at significant risk to themselves or others. The register is not a legally enforceable procedure but failure to follow Government guidelines could be used as evidence in legal proceedings. It could be seen as a political method for reconciling public concern over occurrences like Clunis (HMSO 1994) and Robinson (Blom Cooper 1995). Politicians have concluded that the greater use of compulsion with the seriously mentally ill is desirable. However, the use of compulsion is not likely to increase the chances of increasing the users' co-operation and agreement to treatment.

An alternative strategy would be a package of measures which could include an adequate resource base of hospital beds including medium secure provision, effectively implementing CPA, ensuring that care management and needs led assessment works, applying case management principles, compliance enhancement, psycho-education for users and carers, improving engagement, addressing side effects of medication, simplifying treatment, and relapse prevention techniques. Beefeath et al (1994) report that supervised discharge and "at risk" registers are seen by most users as an extension of social control rather than concern. These developments would "create a policing relationship between users and workers, which will prove divisive and prevent the formation of trusting relationships."

Beefeath et al (1994) argue for case management as providing a better solution for users to such coercive measures. The report by Beefeath et al (1994) represents an evaluation of case management by users and utilised questionnaires which had initially been devised by professionals at the Sainsbury Centre for Mental Health which were then modified by the users. The surveys and questionnaires were conducted by users and the conclusions drawn can be seen as representing user's views.
Community Mental Health Teams (CMHTs) are a central component of most local services and are comprised of professionals from a wide range of disciplines. There is currently debate as to whether such teams should prioritise the severely mentally ill. Offering a "comprehensive" service to all mental health service users is a cornerstone of CMHT ideology (Morris & Davidson 1992) and involves increased accessibility to a wide range of services to a wide range of people (Sayce, Craig and Boardman 1991). At present people with severe and long term mental health problems comprise on average 57.1% of the teams caseload (Onyett et al 1994). Urban teams had a higher proportion of severe and long term mental health problems (63%) that did rural (47%) or mixed or suburban team (53.4%). 56.7% reported offering the first contact point for all mental health referrals in the locality and such teams had smaller proportions of people with severe mental health problems on their caseloads (Onyett & Heppleston 1994).

Patmore and Weaver (1991) ascribe the failure of CMHTs to prioritise people with severe and long term mental health problems (SMH) as an abdication by senior management of their responsibility for determining CMHT policy. CMHTs allocation of resources to those with SMH problems is likely to be maintained by provision of relevant services such as out of hours and weekend access, work opportunities, practical assistance with everyday problems and work on activities of daily living. (Onyett & Heppleston 1994). Although the government is encouraging a prioritisation of the "seriously mentally ill", this group is rarely specifically defined (Strathdee & Thornicroft 1992). Marks (1992) reports that community psychiatric nurses see more anxiety/depression than SMH and their patients come increasingly from GP's. This illustrates the conflict of the prioritisation of the SMH and the clients referred to the service.

Teams offering access after hours and at weekends, services for people whose behaviour is "challenging" work opportunities, practical help with everyday problems and assessment of activities of daily living had a higher percentage of severely mentally ill on the caseload. Such roles are not typically offered by Clinical Psychologists who more often work with those with moderate mental health problems.

The role of Clinical Psychologists with CMHTs has been debated. Issues such as lack of role clarity, differentiation, generic versus specialist mental health worker, competitiveness between professions and deprofessionalisation have been raised (Anciano, Trepka and Marsh 1990). Methods of avoiding or dealing with such
problems involve adopting a consultative role within a team so that Clinical Psychologists may be employed as advisers to other professionals as well as working directly with clients (Ryan et al 1991). It is suggested that Clinical Psychologists are specialists in psychological approaches and could be utilised as such in any service provision (Anciano and Kirkpatrick 1990). The consultative role of the Clinical Psychologist who provides a specialist service has attracted much support (Searle 1991). The role of the Clinical Psychologist within the team could be made explicit, issues regarding generic versus specialist workers could be explored, specific skills to be offered and necessary "professional rights" such as inter-professional contact and time for research and study could be highlighted before operating with the team (Ryan et al 1991). Clinical Psychologist's core roles and skills could be negotiated with CMHTs and the specific skills and service to be offered by a specific Psychologist delineated as length and type of experience and skills varies between Clinical Psychologists.

Psychologists have experienced difficulty working in CMHTs. Anciano and Kilpatrick (1990) reported that staff had to define their own roles in teams with little day to day support from more senior psychologists and many disciplines adopted a generic mental health worker stance which confused equal rights with equal skills. This results in an arbitrary allocation of referrals and many disciplines claimed specialist skills that are traditionally part of a psychologist's training. Due to poor role differentiation there existed a degree of competitiveness between the professional. Psychologists were expected to undertake work which seemed an inappropriate use of their skills such as running a social club for clients. Psychologists in the CMHTs felt isolated and deprofessionalised. Such tasks as research, prevention, teaching and working through other professionals were neglected as the teams were overwhelmed by direct client work. Alexander (1992) reports on the use of psychological techniques by other professionals in CMHTs and that many NHS professionals, particularly CPNs increasingly seek a role in counselling or therapy and that this creates difficulties for Psychologists. Searle (1991) reports on the experience as a Psychologist in a team being negative with problems of the arbitrary allocation of referrals, a lack of inter-team working, different ideologies operating by different professionals and conflict regarding the elitist role of the Psychologist.

Alexander (1995) comments that psychologists will receive increasing pressure to join CMHTs but doubts that this will be a realistic or attractive option for psychology in the longer term. Alexander (1995) anticipates that CMHTs will
work predominantly with those with enduring mental health problems and considers that such a prioritisation will lead to role blurring and the development of generic mental health workers. The implementation will be that particularly experienced psychologists will have to justify to management their higher salaries (Webster and Thornhill 1993) and this can only be does if it is accepted that psychologists do work of "added value", i.e. are not generic workers. This may, comments Alexander (1995), entail conflict with other team members who may be antagonistic to psychologists being seen in this role. Alexander (1995) considers that other problems exist as a consequence of being in a CMHT - the over-emphasis on face to face contacts at the expense of consultation, training and research, inflexibility of service development and professional isolation, with quality and morale consequences.

Alexander (1992) comments that the best strategy may be for Clinical Psychology to form a secondary service which provides the CMHT (and other clinical services) with specialist psychological assessment, therapy and consultation - the prime task is to define its parameters and focus. This could involve the extensive use of service level agreements with CMHTs, GP fundholders, Social Services and other purchasers. It has been suggested that Clinical Psychologists ought to be alert to opportunities for organisational and functional leadership and to become involved in high profile activities such as service planning and evaluation (Trepka & Marsh 1990). This is seen as increasing role status.

The issue of role clarification and differentiation is particularly relevant to multidisciplinary team working. Claims of therapeutic equivalence can be made by other team members which can lead to feelings of being deskilled. Role definition is often left for individual Clinical Psychologists to negotiate with their teams. Such negotiation and clarification could be carried out at a senior management level and may mean opposing models of team organisation which emphasise role blurring and functional equality (Trepka & Marsh 1990). Involvement in CMHTs is likely to bring opportunities for Clinical Psychologists to involve themselves with different client groups and diversify into areas like mental health promotion, training, and consultancy, and service organisation and evaluation. Clinical Psychologists in CMHTs would benefit from being sufficiently experienced to cope with taking on new roles and external arrangements for professional support are likely to be necessary. Role clarification and differentiation is extremely important. Claims for therapeutic equivalence can be made tacitly or overtly by other team members who may not be as skilled in using particular therapy approaches. This
can lead to Clinical Psychologists feeling deskilled. Negotiation and clarification of roles of team members addresses this issue. It has been suggested that Clinical Psychologists need to state how best they can be utilised and not conform to the generic mental health worker ideal and that it is necessary for Clinical Psychologists to be clear about what they need in order to carry out their role in a professional manner (Ryan et al 1991).

Another issue is due to the Government's prioritisation of the severely mentally ill. (Audit Commission 1993, Patmore & Weaver 1991). CPA and Supervision Registers have been seen as driving CMHTs towards offering services to the severely mentally ill. Yet Onyett et al (1994) in a survey of Community Mental Health Teams reported that there was significantly less input from Clinical Psychologists where teams provided services specifically for people whose behaviour was seen as "challenging". Services for people with severe and long term mental health problems were associated with practical hands on help and day care or other occupation. There is clearly a problem for some Clinical Psychologists within teams if such teams prioritise the services for the severely mentally ill. Resources for CMHTs are to be focused on this population, while GP fundholders will be in the position to purchase mental health services for people with moderate or mild mental health problems which may or may not involve the purchasing of Clinical Psychology Services. The development of an idiosyncratic service based on GPs perceived estimate of client need and service costs will occur. Clearly with many rapidly occurring changes as a result of community care, Clinical Psychologists need now to be "marketing" our services and ensuring that we can respond flexibly to service development initiatives.

Many models co-exist which include Clinical Psychologists within CMHTs, the establishment of a secondary level Clinical Psychology Service or of a trading agency, contracts with GP fundholders and other purchasers, the establishment of a Psychological Approaches Service which would involve other disciplines such as counsellors etc. Clearly much discussion and negotiation needs to occur within Clinical Psychology Departments and Trusts as to the best way forward for service development.

In conclusion, it is a time of great change for mental health care. In terms of such a magnitude of change, it could occur that staff moral will decrease. It seems that Clinical Psychologists can have an important role to play in helping manage such change.
Michie (1993) comments on the rapid and profound changes occurring in the NHS and that psychologists have obvious expertise in stress management and offers a service which includes a two day stress management training course, an individual counselling service and a consultancy service to managers. Psychologists have role to play in helping with staff stress and in managing change effectively.

An integration of research findings into planning services is necessary and it is considered that a major role of a psychologist is to be conversant with the relevant research and to present it to managers and to be involved in the planning of mental health services in the light of research findings. Evaluation of such services is also seen as a major role which could be provided by psychologists. Currently the author is involved in evaluating keyworkers views of the implementation of CPA with the aim of improving its implementation.

The literature suggests that a whole range of services are necessary for the provision of care for the seriously mentally ill. For a service to be effective it is necessary to define the aims and objectives of a service. If, for example, the aim is to reduce hospitalisation then the service would be very different from one whose aim is to improve the social skills of the mentally ill. Psychologists need to be involved in clarifying aims and objectives and in designing appropriate services.

An analysis of the needs of individuals in a mental health service needs to be undertaken and matched with an analysis of demand. Psychologist could be involved in such work.

It is considered that CMHTs should prioritise the seriously mentally ill and social services and health authorities should merge to provide integrated care. Fundholding GPs could purchase counsellors, Clinical Psychologists, CPNs directly from health authorities which could set up contracts with the GPs for the provision of this service. It is considered however, that health authorities should have the funding for the provision of care for the seriously mentally ill. CMHTs should provide services which have been found to be of use to those with serious mental illness such as access after hours and at weekends, practical help, work opportunities and housing support need to be provided. Clinical Psychologists with skills which are useful to those with serious mental illness should be recruited for CMHTs. Clinical Psychologists can offer a range of skills in such work as cognitive behavioural approach to the treatment of hallucinations and delusions,
relapse prevention and medication compliance. Consultative work, evaluation, staff support and stress management for staff are also necessary.

Primary care influences such as fundholding GPs influence health authorities, GPs may express the desire for services for those with mild and moderate mental health problems while Government legislation focuses on the provision of services for the seriously mentally ill. In healthcare, the split between primary and secondary care is more exaggerated as fundholding GPs influence purchasing strategies, but there are no clear or consistent strategies emerging from the literature. Health authorities are given incentives to close wards but this influences social services requirements. Severely mentally ill people require housing, work and leisure which affects social services provision. The result is that mental healthcare is fragmenting rather than being steered to common objectives. Muijen and Hadley (1995) recommend that priorities need to be established. If the seriously mentally ill are prioritised then the health authorities should be strengthened and primary care purchasing for this population excluded from the fundholding package. If priority was to be given to those with mild and moderate mental health problems then total fundholding for mental health would be desirable.

Clinical Psychologists are considered to have a major role in community care but it is also considered essential to have major structural changes such as merging social and health care for those with severe mental health problems so that they can indeed receive an integrated and effective system of care.
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2.3 BOUNDARY, PROFESSIONAL AND ETHICAL ISSUES IN CLINICAL PSYCHOLOGY & PSYCHOTHERAPY

Highly visible and dramatic examples of unethical practices, such as sexual relations between therapist and client, receive much publicity but they also focus attention away from something which is just as important, the general ignorance amongst practitioners of the ethical basis to their work. Common and widely accepted practices can give rise to significant ethical concerns, but these are often ignored. For example, 64 per cent of a group of counsellors in two upstate New York counties admitted being aware of at least one colleague whom they judged to be incompetent, but had taken no action to remedy the situation (Stein 1990). In another American survey, reported in Pope and Vasquez (1991), 62 per cent of clinical psychologists admitted unintentionally violating client confidentiality. The toleration of incompetent practice and the laissez-faire attitude to breaches of confidentiality are probably widespread. Yet they constitute a serious disregard for appropriate ethical conduct.

The British Psychological Society has produced a Code of Conduct for Psychologists which represents the Society's statement of the minimum standards to be observed in the practice of any kind of psychology. The Division of Clinical Psychology has also produced the Current Guidelines for the Professional Practice of Clinical Psychology which are specific to Clinical Psychology and set out to provide a target of good practice for all Clinical Psychologists to aim at. It is evident therefore that there are clear ethical principles to be adhered to.

Lindsay (1992) conducted an analysis of the codes of many associations in Europe, including the B.P.S. and that of the American Psychological Association and reported that agreement regarding the content of ethical codes at the level of expert committees was obtained. However, much research suggests that the situation is not so simple (Lindsay 1995). Pope et al (1987) asked members of the American Psychological Association to rate certain practices as ethical. 98% considered that "disrobing in the presence of a client" was not ethical but "limiting treatment notes to date and fee" produced a flat distribution suggesting a lack of agreement about the ethical nature of this activity. "Hugging a client" produced a bimodal distribution, suggesting important differences of opinion. The relationship between ethical opinions and behaviours is also of interest. Garrett and Davis (1994) surveyed 1000 members of the B.P.S. Division of Clinical Psychology and reported 3.4% of the sample admitting to having engaged in sexual contact with
current or discharged patients. It is clear that psychologists vary in their opinions concerning the degree to which behaviours are ethical or unethical and also in the extent to which they engage in behaviours which might be considered unethical. A closer examination of the issues and recommendations for addressing these issues is detailed below.

It appears to be necessary to focus the attention of both trainees and qualified psychologists on professional and ethical issues which will increase awareness of potential problems and possibly decrease the likelihood of ethical difficulties occurring.

A major concern regarding professional issues is that of competency. The British Psychological Society (BPSs) Code of Conduct for Psychologists addresses the area of competence and states that "Psychologists shall endeavour to maintain and develop their professional competence, to recognise and work within its limits and to identify and ameliorate factors which restrict it." Psychologists are further advised to refrain from laying claim to qualifications and competencies they do not possess, and to assist those who require services outside of their personal competence to obtain such services.

It has been recognised that some patients become worse as a consequence of therapy in terms of their difficulties. Lambert, Bergen & Collins (1977) and Bergen (1971) considered the evidence of harms and injuries as a consequence of psychotherapy. Bergen (1971) coined the term, "the deterioration effect," and concluded that treatment process can precipitate anxiety, depression, psychosomatic and even psychotic reactions. Although approximately 10% of patients experience such effects it is not possible to distinguish what proportion of these cases could have been caused by the clients and what part by the therapists. Lambert et al (1977), believe that some patients who were already deteriorating might have been helped by more competent therapists and more appropriate interventions. In such cases the activity of the therapists was indirectly harmful because the patients did not seek out alternative, possibly more effective, treatments. It is necessary therefore to consider alternative treatments.

Lambert et al (1977) also identified deterioration effects that they claimed were directly caused by the intervention of therapists in which the patient's equilibrium was upset by therapist's attitudes or actions precipitating deeper deterioration. It seems regarding competency issues that there are two main areas for consideration.
The first is when psychologists need to recognise their limitations and weaknesses in terms of their ability to conduct appropriate assessment and therapy. This relates to their knowledge and experience base. In addition the second area is the ability to explore one's own motives and relationships fully and to ensure that these do not interfere with the process of therapy which needs to be aimed at being in the interests of the client.

Regarding the first area for consideration, it is critical that psychologists recognise the boundaries of their competence and the limitations of their techniques. The profession as a whole has struggled with the problem of defining professional competence and incompetence. Ethical codes, standards of practice, professional review committees, registration of psychologists have all been attempts to resolve some of these difficulties. However, incompetent behaviour is often difficult to prove and much possibly is left undetected. Within Clinical Psychology for example, as Keith-Spiegel and Koocher (1985) report on one scenario being that a Clinical Psychologist might have been well trained in psychotherapy and assessment but then may lack the forensic knowledge to evaluate a defendant's competence to stand trial. Psychologists do tend to have competencies in specific areas but cannot be expected to be competent in all areas in which a psychologist may be working. Keith-Spiegel and Koocher (1988) ask, "what constitutes the basic qualification needed to practise personnel consultation, forensic evaluations or child psychotherapy? Are these specialities or sub-specialities or are they merely special types of competence or skills? Psychology currently has now answered these questions and in virtually all cases individual psychologists are expected to know and practise within their own areas of competence." It seems important for psychologists to recognise the boundaries of formal training and it is best to consult colleagues who are widely regarded as experts in the particular area for their guidance regarding adequacy of both training and practice standards if any doubt exists.

Clinical Psychologists' training attempts now to consider trainees competencies in certain areas as a method of being able to define such competencies and recognise when independent working would be inappropriate. Certain specific areas must be included in a programme of training and a detailed record of clinical experience provided. Close supervision and direct observation by senior colleagues on methods of ensuring competencies in people being trained seems essential. It is also necessary to maintain competence. Post qualification estimates indicate that
the half life of a doctoral degree in psychology in the USA as a measure of competence is about 10-12 years (Dubin 1972).

On the basis of a review of the literature pertaining to competence in the health care professions, Norman (1985) develop these ideas further by proposing a categorising scheme of clinical competence describing the 5 domains of professional activities deemed essential to competent performance. Knowledge and understanding, clinical skills, technical skills, problem solving and clinical judgement and personal attributes. Norman's schema provides a useful framework for delineating the domains of professional competence. Overholster & Fine (1993) take each of these 5 areas in turn. Firstly, incompetency due to lack of knowledge. Knowledge is gained on training courses but it is important for psychologists to update knowledge. Unfortunately many under utilise the published literature (Morrow-Bradley & Elliott 1986). A clinician is never competent in all areas but can display competent behaviour in certain domains of professional functioning (Koocher 1979). It is therefore vital for clinicians to recognise to limit their practice in which they have sufficient expertise to perform in a competent manner.

The second area is incompetence due to inadequate clinical skills. Olverholser & Fine (1993) highlight three areas of incompetence regarding generic clinical skills.

a) Informed consent may be inadequately obtained.
b) Advice giving can be over used. Such directive approaches may produce rapid but short lived changes in behaviour (Rachman 1976). In addition giving advice can render clients dependent upon their therapist for additional direction and guidance (Thomson 1983).
c) Therapist self disclosure can be excessive. This can confuse clients by blurring distinctions between the roles of professional and friend.

The third area is incompetence due to deficient technical skills. This refers to the ability to use special procedures or techniques in a clinical setting. Psychologists should openly acknowledge the limits of their expertise and in many cases should refer clients elsewhere to receive the speciality skills possessed by professionals in other fields.
The area is incompetence due to poor judgement. Problem solving and clinical judgement refer to the abilities to apply knowledge and clinical skills to assess or treat a particular client. Such skills can apply to case conceptualisation, treatment planning or judgement in crisis situations.

These skills are more sophisticated than generic clinical ones because they require the ability to plan for and manage a variety of clinical problems (Schoon 1985).

The fifth area is professional incompetence due to disturbing interpersonal attributes. This refers to personality characteristics, social skills and emotional problems that may affect the ability to function in professional capacity. Personality factors play a role in the type and style of psychotherapy used by the therapist (Strupp 1978). Thus when disturbances of personality exist, the therapy process may be disrupted. Although it is not a sign of incompetence for professionals to suffer from emotional problems, it is considered incompetence if they continue to provide services when unable to function adequately (Keith-Spiegel 1977). At this point clinicians should refrain from their activities until the problems can be resolved. Unfortunately 60% of psychologists admit to occasionally working when too distressed to perform effectively (Hope et al 1987). The B.P.S. Code of Conduct for Psychologists addresses this issue and clearly states that Psychologists should "refrain from practice when their physical or psychological condition, as a result of for example alcohol, drugs, illness or personal stress, is such that abilities or professional judgement are seriously impaired." However, surveys such as that reported by Hope et al (1987) suggest that in practice this perhaps does not occur.

Therapists make judgements about their own competence to treat specific problems. Every therapist must consider whether the demands of a particular case are within his or her competence. It is important to be aware of one's own limitations. There is, however, a lot of ambiguity about certain cases and it seems essential for the therapist to be able to consult with others about doubtful or difficult cases. It is necessary for trainees to learn to mask a lack of confidence and maintain an aura of quiet expertise until they gain sufficient experience of success to own it. However, this can only be done in the context of receiving supervision which will enable them to explore their doubts and difficulties and to plan assessment and therapy programmes having made a good formulation of the problem. An additional factor is that therapists must also question their ability to help because of the severity or types of problem the client confronts them with or
because of some difficulties in their own lives. It is necessary to focus on the effects of one's own psychological state on the client. A therapist must be aware of his or her own inner state and how it bears on the present client. Competence is based in part on education and on experience involved in treating clients. It is usually only in the course of practise that the necessary skills are developed.

About a decade after receipt of the doctorate, half of the knowledge that went into that training is obsolete. Jenson (1979) poses the interesting question of how one can retain any modicum of professional competence over a 30 year career. Various strategies have been advanced to ensure that professionals strive to maintain competence including continuing professional development courses. These however are advised but are not a necessary condition to receive a certificate to practise clinical psychology.

Keith-Spiegel & Koocher (1985) comment that part of the difficulty in implementing plans to monitor practitioner competence is a definitional problem. What constitutes steps towards maintaining one's competence? Is it attending workshops or writing articles or being re-examined or attending courses or is experience in clinical field necessary for demonstrating competence. It seems that psychologists need to be aware of their own limitations, recognising that these limitations can increase over time after training has ended and the psychologist must seek constructive remedies to keep the skills necessary for effective practising of clinical psychology.

The second major area of competence is how the emotional and personal lives of clinicians interfere with professional activities. It may be that changes in the clinician's personal life such as divorce or marital problems may affect the ability to conduct therapy or it could be that the psychologists experience burnout as defined by emotional exhaustion resulting from excessive demands on energy, strength and personal resources in a work setting (Freudenberger 1975). It may involve the loss of concern for people with whom one is working as well as a loss of positive feelings, sympathy and respect for one's clients. Another major component is that of aversion to the client at times mixed with elements of genuine malice (Maltsberger & Buie 1974).

Mustin (1979) discusses the need to be able to respond appropriately to client's challenges to the therapist's competence. The client may voice a concern that the therapist is too old, too young, too wedded to a particular approach, or express the
feeling that therapy is useless or getting nowhere. The therapist may face accusations of incorrect interpretations. Direct challenges to the therapist's competence can be most threatening to the therapist. Therapists may view the critical statements as irrelevant or symptomatic. However, therapists must consider the validity of the criticisms and how they may have contributed to the situation. In Lang's (1976) view, client's challenges are inevitably related to aspects of the therapist's behaviour. Failure to recognise this can lead to therapeutic impasses and can jeopardise the client's self esteem and personal dignity. Psychodynamic therapists may interpret criticisms as transference aspects of a client's communication rather than relating it to the therapist's behaviour. Ignoring a client's criticism or reacting to it solely as a reflection of the clients "own material" does not foster a positive therapeutic alliance. Such defensive reactions are violations of the client's right to have the reality component of his or her reactions respected and validated [Greenson 1977, Langs 1976].

Therapists are members of a culture that emphasises achievement and so fear of inadequacy may be a sensitive issue. Denying a clients critical comments may serve the purpose of preserving the therapists self image as a competent person. Therapists may also avoid confronting criticisms in order to decrease the chances of dealing with clients angry feelings. Supervision may help therapists to gain objectivity and to learn methods for handling criticism.

Eckler-Hart (1987) reported that clinical psychology students learning psychotherapy were seen to develop various self protective competencies which are conceptualised in terms of the theory of the true self and the false self, [Winnicott, 1965]. The concept of the "psychotherapist false self", representing the self protective competencies is linked to commonly used terms such as "professional identity" and "identity as a psychotherapist". It seems necessary to gain basic competencies which then can seem too rigid and are challenged so allowing the emergence of the true self which is more spontaneous and creative. Kaslow et al (1992) also noted that postdoctoral trainees seem to gain in self confidence and competence and as trainees identities as psychologists become more cohesive and professional "true" selves emerge, they are more able to use their creative resources and their work is enhanced. Eckler Hart (1987) comments that "it is no small task to become a capable, careful and ethical psychotherapist and yet to be alive and creative in one's psychotherapeutic work". Thus it is seen as important to gain competencies but not to be too rigid in one's adherence to them while maintaining ethical conduct - a difficult balance.
Mollon (1989) comments that novice therapists can experience turmoil when the patient is hostile, rejects what is offered and attacks the therapist's professional identity. Trainees can experience feelings of incompetence when learning therapy and the basic training and professional culture and ideals of clinical psychology can create particular problems. Clinical psychology is characterised by learning from an appraisal of research literature, high academic competency is highly regarded and so feelings of incompetency can be particularly difficult to accept and may be defended against. The professional ideal is one of scientific objectivity and so the therapists own feelings and fantasies receive less input than perhaps necessary. Clients therefore who attack the professional identity and competency of the psychologist can create significant problems for the therapist. Mollon (1989) suggests that an understanding of the clients dynamics is essential but just as important is supervision whereby "space for thinking" in which feelings and fantasies about the client can be brought into awareness and examined. "It is important to bring the psychologists anxiety and mental pain into the discourse, included in this pain are narcissistic injuries and shame to do with feeling incompetent and with disillusionment over grandiose therapeutic aspirations" (Mollon 1989). Allowing an opportunity to express such issues can prevent ethical problems from developing.

Important client factors related to staff burnout include the client's prognosis, the degree of personal relevance the client's problems have for the psychologist and the client's reaction to the psychologist (Moslak 1978). Important potential remedies for the troubled colleague might involve supportive consultation by peers, mutual support groups for psychologists and the recognition of professional burnout.

Regarding the ability to explore one's own motives and relationships, it is necessary to ensure that these do not interfere with therapy. This includes counter transference issues that can raise many boundary, professional and ethical issues. The task of therapy is to improve client's welfare and well being. However, it is impossible to have the same response to the problems and personality styles of different patients (Lakin 1988). Most therapists have experienced the frustration of unchanging patients and this can be perceived as personal failure for a therapist. Therapists must therefore deal with their own anger and irritation and not allow it to provoke unwarranted confrontations or competitive interventions. The urge to show off and demonstrate one's superior knowledge and wisdom must be contained (Lakin 1988). Counter transference relates to the feelings and
difficulties that belong to the therapist, though not enhancing the therapeutic process. The therapist is in a position of power and the potential abuse of the influence that the therapist has does exist. One method of effectively addressing counter transference issues is through supervision of one's work.

The therapists narcissistic needs may also interfere with the therapy process. All therapists have the potential for becoming vehicles for the self-gratification of therapists beyond the legitimate one of promoting patient welfare (Lakin 1988). One such potential problem area is when a need to be liked is so strong that the therapist is driven by it rather than by considerations of what really is in the patient's best interests. Therapists may need to have positive emotional regard from their clients to aid their feelings of self-esteem and one's own needs can get in the way of understanding what is going on with the patient and it is essential to continually think of those whose needs are being met - the therapists or the patients. An additional narcissistic need which becomes apparent is the need for therapists to demonstrate how effective they are. This can be translated by the therapist making demands on their clients.

Regarding the boundaries of the therapeutic relationship, it is a fundamental responsibility of the psychologist to clarify the boundaries of the relationship. Two of the most important boundaries are the beginning and ending of the therapy. The individual seeking help needs to know whether he or she is a client and whether or not he or she can expect a particular clinician to act to fulfil the responsibilities of the role of therapist (Hope & Vasquez 1991). Therapists must be alert to possible complications and confusion. It is also necessary to establish when and under what circumstances the therapist will be available for further communication and what resources will be available for the client when the therapist is not available. This protects the client from the effects of unexpected situations and prepares for therapeutic needs that are difficult or impossible to anticipate. The clarification of the client's access to the therapist or to other therapeutic resources forces therapists to think carefully about the effects that the therapist's availability and unavailability have upon the client and upon the course of treatment. Therapists must consider carefully the approach to time boundaries and this will be influenced by the therapist's theoretical orientation and personal needs. The effects upon individual clients needs to be considered and the client should understand the policy. Boundaries regarding therapists availability between sessions also needs to be considered. Some therapists may see ad hoc sessions as therapeutically useful for some clients, for example, particularly fragile or needy
clients who might otherwise require day treatment or periodic hospitalisation. Other therapists believe that such extra sessions are counter therapeutic as they are going beyond the templar boundaries of the session. What seems important is that the therapist should think through the issues carefully in terms of consistency with the theoretical orientation and the implications for the client and that both therapist and client clearly understand what the ground rules are. It is also necessary to make contingency plans if the therapist is incapacitated, for example, if he or she will notify the client, there should be a clear easily accessible list indicating scheduled appointments and phone numbers and addresses for contacting clients and if cover from colleagues for a therapist is provided. Clients need to have adequate access to the help they need particularly in times of crisis if the therapist is not readily available.

Sexual involvement is seen as a clear ethical breach of the therapy relationship. The B.P.S. Code of Conduct for Psychologists discusses and states that "Psychologists should conduct themselves in their professional activities in a way that does not damage the interest of the recipients of their services" and shall "not exploit any relationship of influence or trust which exists between ..... those in receipt of their services to further the gratification of their personal desires." However, the relationship between ethical opinions about what is correct and so is encoded in ethical guidelines and Codes of Conducts and actual behaviour of Psychologists is less clear. Some studies suggest that sexual intimacy between clients and therapists does occur. Holroyd and Brodsky (1977) obtained a 70 per cent response rate to a postal survey of 1000 licensed psychologists. They found that 8.1 per cent of men and one per cent of women admitted to at least one episode of sexual relations with a client during or within three months of the end of therapy. More recently, Pope et al (1986) surveyed 575 psychotherapists, and found that 9.4 per cent of men and 2.5 per cent of women therapists, admitted to sex with clients. Bouhoutsos (1985) found that 75-80 per cent of therapists repeated the abuse with another client. The consequences of client-therapist sexual contact is overwhelmingly harmful to clients. Bouhoutsos and Holroyd (1983) report that clients are damaged in 90 per cent of cases, according to their study of 559 clients, 11 per cent were hospitalised and 34 per cent suffered a negative impact on their personal and social adjustment, shown by levels of emotional disturbance and so on. It is crucial to stress at this point that it is the abusing therapist's conduct which is the major problem not the therapist's feelings. Lakin (1988) discusses what there is about the therapy situation that elicits sexual responses from therapists. He comments that the surroundings, the privacy and
cosiness of most therapy settings, the content of therapy which are often intimate details about one's sexual feelings and frustrations and the transference potential of an emotional dependence on the therapist's responsiveness combined to exert a powerful erotic influence on the therapy relationship. Lakin (1988) comments, "rare is the therapist - perhaps even insensitive and ineffective - who has never felt sexually stimulated by any client." It may occur in response to the client's attractiveness or because of the client's narrative with its implicit emotional appeal for a tender and caring, even loving responsiveness in return.

The consequences for the client seem to cluster into 10 very general categories:-

1. Ambivalence
2. Guilt
3. Emptiness and isolation
4. Sexual confusion
5. Impaired ability to trust
6. Confused roles and boundaries
7. Emotional liability
8. Suppressed rage
9. Increased suicidal risk
10. Cognitive dysfunction

Other consequences occur in the areas of concentration and memory and can involve flash backs and forbidden images and nightmares (Hope 1988). The most effective predictor of whether a client will become sexually involved with a therapist is whether that therapist has previously engaged in sex with a client (Bates & Brodsky 1989). Holroyd & Brodsky (1980) report that there is no indication that physical contact with patients made sexual contact more likely. Hope et al (1991) suggest that if the therapist is personally comfortable engaging in physical contact with a patient and maintains that theoretical orientation for which therapist/client contact is not unethical, has competent use of touch and decides whether or not to make physical contact with a particular client based on the careful evaluation of the clinical needs of the client at that moment that such contact is acceptable. When thoroughly based on clinical needs and clinical rationale, touch can be exceptionally caring, comforting, reassuring or healing. When not justified by clinical need and therapeutic rationale non-sexual touch can also be experienced as intrusive, frightening of demeaning. The decision must
always be made carefully and in full awareness of the powers of the therapist and the trust and vulnerability of the client.

Sexual attraction to clients is a common occurrence. The vast majority of therapists report that they had experienced attraction towards the client. Attraction was experienced by a greater percentage of male (95%) than of female (76%) clinicians (Hope et al. 1987). The overwhelming majority 82%, of clinicians who reported experiencing attraction noticed that they had never seriously considered engaging in sex with a client. Nevertheless, merely experiencing the attraction made most, 63%, of the therapists feel guilty, anxious or confused. One fifth of them kept the attraction a complete secret, they did not mention it to the client or to their own therapist. It is important to recognise that the research suggests that sexual attraction to a client is a common experience. To feel attraction is not unethical. To acknowledge and address the attraction promptly, carefully and adequately is an important ethical responsibility. It seems important to acknowledge the attraction openly but also to recognise that it is a good opportunity for the client to learn to have a deep non-sexual relationship. This is seen as being the benefit of the therapeutic relationship. Some consultation with colleagues will be useful. For others obtaining formal supervision for work with that client may be necessary. It may be necessary to consider making a referral to another therapist.

Very few courses in clinical psychology in the past at least, have directly addressed ethical concerns such as this. More generally, the models we have of the nature of the therapeutic relationship do not appear to allow us to understand what can happen emotionally between therapists and clients. Notions of transference and countertransference which could help to explain have been prematurely abandoned. Yet such understanding of the development of powerful bonds between client and therapist are needed, if abuse is to be prevented. Such issues and concepts need to be openly discussed in supervision, even by clinicians who see themselves as primarily behavioural or cognitive in orientation. Furthermore, it should be recognised that these issues, and the need for case supervision do not disappear when training ceases; all competent psychologists should continue to allow their work to be discussed critically and supportively by others throughout their professional careers.

Most generally of all, we need greater awareness of the power differential that exists between all therapists and clients, and in particular the gender issues which
allow or even encourage males to exploit females in our society. Psychologists are not immune to these forces, they may lead some of us to abuse clients, and other of us not to inquire further about or report suspected abusers.

Garrett (1993) discusses that the psychoanalytic approach has traditionally located the issue of therapist-patient sex within the patient transference reactions but that Marmor (1972) acknowledged that the therapist could be seductive and could exhibit countertransference acting out. Klopffer (1974) lists possible reasons for the development of "erotic transference" including the repetition of past frustrating situations in relationships, the desire to conquer the therapist and so prove he or she can not be trusted, and a desire to confound the relationship with sex and love, so as to prevent the examination of other more difficult issues. A client may become sexually seductive towards a therapist if he or she has been successful in winning approval and power over others in the past by sexual means. Freud viewed the countertransference as a reaction to the transference. Therapists who fall in love with their clients are seen as suffering from a countertransference neurosis (Greenson 1974) which arises from therapist's instinctual and narcissistic needs as well as life events. However, failure to acknowledge and examine countertransference can lead to therapists acting out a sexual attraction to a client (Pope et al. 1986). It would seem imperative to encourage trainee and qualified psychologists to develop an understanding of the concepts of transference and countertransference and their relation to sexual feelings in therapy. It happens to all therapists, as Garrett (1993) comments "let us take action to open the discussion and dispel the taboo".

Jehu (1993) when considering the issue of sex between therapists and former clients concludes that rather than condoning or banning all sexual relationships between former clients and their therapists it seems preferable to proscribe them selectively when certain conditions exist. These include breach of trust, the psychological vulnerability of clients, the misuse of power by therapists, the absence of valid consent, the infliction of harm or distress on clients, any impairment of the therapeutic process, the nature of therapy, termination for the purpose of starting a sexual relationship, and its commencement too soon after treatment is ended. Such conditions could be standardised in the Society's guidelines or ethical codes or they could be individualised on a case by case basis in disciplinary proceedings. Either course would entail the problems of ascertaining the existence of relevant proscriptive conditions and of regulating any waiting period imposed.
A dual relationship occurs when a therapist is in another significant but different relationship with one of his or her patients. Most common is where the second role is social, financial or professional. Dual relationships jeopardise professional judgement, client welfare and the process of therapy itself for the therapist is engaged in meeting his or her own needs as well. Further, in dual relationships therapist's recognition and management of transference and counter transference becomes all but impossible. Because of the therapist/patient relationship the patient cannot enter into a business or other secondary relationship with the therapist on an equal footing. Borys (1989) comments that sexual involvement between therapists and clients may be the culmination of the more general breakdown in roles and relationship boundaries which begin on a non-sexual level. Borys (1989) suggests that the role boundaries and norms in a therapeutic relation serve as protective function and serve to prevent exploitation. Exploitation that results from both sexual and non-sexual dual relationships is perpetrated overwhelmingly by male professionals on an overwhelmingly female population (Borys 1989).

Ward (1993) comments that abuse in the professional relationship between client and therapist is mostly seen as sexual or financial. However, emotional abuse is not generally acknowledged as a significant problem. Ward (1993) reports that a client can easily become dependant on the therapist and that by seeing this as a transference phenomena is devaluing the feelings and such feelings which include those of grief at the termination of therapy can not be worked through in the artificial atmosphere of the therapist's office. Ward advocates therapists taking some of the responsibility for the relationships which have been engendered in therapy. Ronad (1993) replied to Ward's comments and states that an acknowledgement by the therapist of the validity of intense feelings to the therapist is helpful.

Confidentiality is an issue which requires serious consideration by the therapist. The B.P.S. Code of Conduct for Psychologists states that "Psychologists shall maintain adequate records, but they shall take all reasonable steps to preserve the confidentiality of information acquired through their professional practice of research and to protract the privacy of individuals or organisations about whom information is collected or held. In general, and subject to the requirements of law they shall take care to prevent the identify of individuals, organisations or participants in research being revealed, deliberately or inadvertently, without their expressed permission" However, Lindsay and Colley (1995) report that in a
survey of 1000 randomly selected members of the B.P.S. 17% reported experiencing confidentiality dilemmas. It seems that agreeing on ethical standards and Codes of Conduct is relatively easy, but that in practice difficulties can emerge. Over half, 69%, of psychologists responding in one study reported unintentionally violating their patients confidences (Hope & Bajit 1987). Another national study found that most frequently reported unintentional violation of the law of ethical standards by senior prominent psychologists involved confidentiality (Hope & Bajit 1988). The most frequent errors psychologists make concern consent for release of confidential information which is to fail to obtain consent in writing. It is necessary to keep records about clients out of sight of people who are not authorised to see that information and it is necessary to protect the patient's name as even the fact that the person is consulting a mental health professional is a fact worth treating confidentially. Extra care should be taken with phone messages and other communications regarding the patient, answering machines can also create special pitfalls and confidentiality needs to be assured.

It is important to be aware of the ideologies of psychotherapies and the values of psychotherapists, Lakin (1988) discusses the fact that the therapist has a system of beliefs about the causes and cures of psychopathology. These beliefs translate into interventions and are also filtered through the personalities and values of particular therapists. The concepts of therapy may therefore convey moral implications. Therapists cannot help influencing the goals their clients set. Whichever approach is taken by the therapist, value choices are entailed. Through the processes of interacting with the client the therapist may act as a transmitter of cultural norms and values. The client's difficulties invite the therapist's intervention and open the door to the intrusion of the therapist's values. Menninger (1958) pointed out years ago that "what the therapist believes, what he lives for, what he loves, what he considers to be evil and what he considers to be good inevitably become known to the patient and influence him enormously." Practitioners cannot be unaware of their roles in sanctioning and discouraging various actions of their patients. They know that they are eagerly watched for signs of approval or disapproval. The ethical challenge confronting therapists is to be aware of the value positions they take and those they communicate to their patients.

Lakin (1988) comments that the delicate balance between achieving relief and imposing values which may not be appropriate to the patient is not easily attained. Because of the relationship's asymmetry care must be taken to consciously enlist the patient in the choice of goals and the articulation of values.
Robitscher (1980) proposes that therapists must become more aware not only of the values and motives behind their interventions but also recognise the power and potential influence they wield and the need to exercise self restraint. Two methods which would appear to offer some resolution of this problem is to establish a therapeutic alliance with one's clients and also to arrange consultation and supervision with other colleagues to monitor one's values and their influence in therapy.

The B.P.S. Code of Conduct for Psychologists addresses the issue of the necessity of obtaining consent and states that "Psychologists shall normally carry out investigations or interventions only with the valid consent of participants, having taken all reasonable steps to ensure that they have adequately understood the nature of the investigation or intervention and its anticipated consequences."

Marzillier (1993) suggests that it is imperative to obtain informed consent to treatment which would involve the giving of information about possible therapy alternatives, outcomes and processes and an agreement concerning the type of therapy to be conducted. This is seen as an ongoing process with frequent reviews so that the clients emotional vulnerability is acknowledged and by allowing a period of time for a decision to be made increases the possibility that a rational and informed choice will be made by the client and the emotional vulnerability of the initial interview is offset by a cooling off period as well as the opportunity to consult others. The autonomy of the client is respected by giving information and this conveys an acknowledgement of respect of the rights and dignity of the person. Hare Mustin et al (1979) state that it is important for therapists to integrate ethical standards into their practice so that client's rights will be an integral part of therapy. Providing clients with information to make informed decisions about therapy and the use of contracts in therapy are seen as working towards this goal.

It is possible to make recommendations for confronting, addressing and resolving some of these ethical difficulties. Some suggestions are included in the B.P.S's Code of Conduct, for example the principle of consulting experienced professional colleagues is recommended when considering withholding information about an investigatory procedure. The use of discussions with colleagues about ethical dilemmas and of obtaining supervision of one's work to ensure that ethical standards are maintained is considered crucial. A Supervisor's role should encompass addressing such issues as the therapist's competence to undertake
particular work, confidentiality, obtaining clients' consent and ensuring that therapists contracts are established. An awareness of ethical considerations needs to be established early on in training and ought to be included explicitly on training courses. The B.P.S. Code of Conduct needs to be presented to trainees but just as importantly an awareness that despite such a Code of Conduct, ethical dilemmas do exist. As Lindsay (1995) comments, although there seems to be a high level of agreement at the level of expert committees on the content of ethical codes, research suggests that the situation is not so simple. Ethical dilemmas need to be made explicit during training and workshops addressing ethical issues conducted.

It also would appear to be necessary to conduct such workshops and training events focusing on ethical issues as part of a continuing Professional Development Training Programme. It would appear important also to make explicit a number of training events and type of training to be undertaken as part of Continuing Professional Development Training before a Practicing Certificate be issued to ensure the maintenance of a certain level of competence by qualified Psychologists.

Peer support groups need to be available to help psychologists who are suffering from emotional or stress related difficulties. The recognition of professional burnout and the acceptability and desirability of limiting work load is also to be encouraged.

Napier (1993) suggests that many allegations and actual incidents of misconduct of therapy arise because psychologists do not seek or obtain enough peer supervision. Napier (1993) considers that the practice of therapy without supervision ought to be in itself an act of misconduct. Napier (1993) also recommends the use of regular audit, and audit of specific untoward incidents, as an invaluable safeguard against slowly eroding standards of practice.

The emphasis on training on obtaining competences and of detailing and logging training and clinical experience is important in creating a recognition by the trainee of their competencies and limitations. Bender (1990) recommends that training be structured around core skills; that these should be rigorously assessed to common standards across training courses, and supervisors skills in teaching these core skills should be assessed. Clearly B.P.S. Accreditation of Courses addresses the issue of common standards to some degree but considerable variation still exists and supervisors skills are not formally assessed. Bender (1990) comments that the assumption in our profession that a psychologist, by the mere act of being a senior, can supervise is false and that we need to move away from accreditation for a
lifetime to having regular updating seminars regarding core skills with some assessment of competence.

The proscription of certain behaviours under certain conditions such as the American Psychological Association's Code which requires a time lapse of at least two years following termination of therapy and the start of an intimate relationship between a therapist and former patient seems to be necessary and will develop through B.P.S. guidelines and the results of disciplinary procedures.

In conclusion, Napier (1993) comments on his experiences of just over two years of serving as Clerk to the Investigatory Committee and Disciplinary Board of the Society that "many allegations of misconduct of therapy and I claim, most actual incidents of misconduct, arise because people do not seek or get enough peer supervision......... We are or should be highly motivated to address these issues, but they are conceptually difficult and there are severe penalties for getting it wrong. The answer to such a conflict is to confront and work with it, not avoid it, lest worst befall". We need to listen and act on his words.
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SECTION 3

CLINICAL AUDIT

Counselling in Primary Care
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COUNSELLING IN PRIMARY CARE

1.0 INTRODUCTION

In Mid Surrey Health Authority, referrals to Community Mental Health Teams and to the Clinical Psychology Department from General Practitioners (GPs) for counselling increased dramatically but these services are not a counselling service. The use of The Care Programme Approach (CPA) and Supervision Registers caused an increased prioritisation of the service for the severely mentally ill which means that the teams were experiencing difficulty in coping with the large numbers of requests for counselling. Work in primary care settings and feedback from GPs revealed that there was a need for counselling services. GPs had difficulty sometimes in assessing training and experience and suitability for counselling posts. They were also unsure about how to provide supervision for counsellors. Counsellors themselves had approached the psychology service requesting support and supervision and although the FHSA was funding their GPs to provide counselling services in their practices, there were no firm recommendations for training or supervision and no formal links existed between the counsellors and the mental health services or with social services. For these reasons, it was considered that it would be useful to conduct an evaluation of counselling in primary care settings and then to make proposals for the development of future counselling services. An application for joint finance was therefore written by the author. (Please see Appendix 1 - Application for Joint Finance). Although the application received much interest, due to a significant reduction of joint finance money available, the application was unsuccessful.

It was recognised that a literature survey investigating the efficacy of counselling and an examination of the issues around counselling in primary care was necessary. This was prepared and circulated to Business Managers, the Primary Care Mental Health Advisor and the Medical Advisor & Head of Clinical Development, Eastern Surrey Health Commission. The literature survey is detailed below in Section 2.0.

This proved to be an effective tool to increase the awareness of issues relating to the setting up of a counselling service and did indeed form the basis for discussions concerning the Health Authority's response to set up a counselling
I am now involved in meetings which are considering the use of a private counselling service, the funding of individual counsellors or the use of the psychology service to manage a counselling service. A pilot project using the latter option is reported later.

"Counselling" is often not defined in many studies and seems to encompass a range of skills which can include for example a Rogerian approach to therapy, Gestalt therapy, transactional analysis and psychodynamic counselling. For the purpose of this study, counselling is seen as encompassing those skills which focus on emphasising a listening, empathic approach which focuses predominantly on life event crises and acute problems with the aim of allowing cathartic relief and a clarification of issues which then leads on to changes in the person's functioning. Clinical Psychology is seen as dealing with more complex, chronic and severe conditions which require, in addition to the aspects discussed in relation to counselling, also the need for a higher level of analysis which depends on the utilisation or psychological models and in developing a formulation of the person's problems and leads to an individual treatment approach which may use a cognitive behavioural or a psychotherapeutic model. Clinical Psychologists are also seen as different from counsellors in that counsellors work predominantly with adults, whereas Clinical Psychologists are trained to work with a wide range of client groups including those with adult mental health problems, child mental health problems, those with learning difficulties, the elderly, those in forensic services, in general medicine and in neuropsychology. Clinical Psychologists are also trained to use psychometric tests for assessment and diagnostic purposes. In addition, research skills are an integral part of all Clinical Psychologists training but are not necessarily a part of a counsellor's training. It is the opinion of the author that counsellors can be employed within a Clinical Psychology Department and contracted out to primary care settings. It is, however, necessary to evaluate the efficacy of such counselling services and this forms a major part of the present study.
2.0 LITERATURE SURVEY OF COUNSELLING IN PRIMARY CARE

2.1 Prevalence of Psychological Distress in a Primary Care Setting

Most individuals who experience some degree of psychological distress or difficulty are cared for within the primary care setting.

Ormel et al (1991) reports that amongst new attendees to primary care who have no diagnosis of psychological disorder within the previous 12 months the following picture emerges.

Table 1 - Prevalence Among New Attendees to Primary Care

<table>
<thead>
<tr>
<th>Condition</th>
<th>Prevalence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anxiety state and phobia</td>
<td>9.3%</td>
</tr>
<tr>
<td>Neurotic depression</td>
<td>0.6%</td>
</tr>
<tr>
<td>Severe depression</td>
<td>2.7%</td>
</tr>
<tr>
<td>Anxiety and depression</td>
<td>12.8%</td>
</tr>
</tbody>
</table>

The development of counselling in primary care has arisen as a response to such prevalence rates.

Mann et al (1981) indicated that in a representative cohort of GP attendees with identified minor psychiatric morbidity the outcome was:-

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improved within the first 6 months</td>
<td>24%</td>
</tr>
<tr>
<td>Followed a variable intermittent course</td>
<td>51%</td>
</tr>
<tr>
<td>Had chronic persistent symptoms</td>
<td>25%</td>
</tr>
</tbody>
</table>

National remission therefore appears in only 24% of clients. Counselling is perhaps seen as being potentially useful to the clients whose symptoms do not remit.

2.2 Identification of Psychological Problems in General Practice

The use and success of counselling depends to quite a large extent on the GP, on his or her ability to pick up emotional or relationship problems which are often disguised as physical disorder or illness.
Research on the prevalence of emotional disorder in general practice and on the
ability of doctors to identify patients with emotional problems suggests that a
significant number of these patients are not identified (Marks et al 1979,

These and other studies show prevalence of at least 30% of emotional or
psychiatric disorder in patients attending their doctor.

McLeod (1988) commented that in a practice that she studied it was clear that
the majority of GPs who had appointed counsellors were already looking for
emotional disorder and were interested in psychotherapy. It seems likely then
that these doctors identify a high proportion of emotional disorders among their
clients, some of whom they refer to counselling.

This picture suggests that there are significant numbers of patients presenting
with anxiety and depression in primary care but some of this is detected by the
GPs and some of this is treated effectively within the setting. Approximately
25% of those patients with minor symptoms will improve spontaneously.
However, a significant number of those patients with more severe problems
may be undiagnosed, misdiagnosed or do not receive effective treatment. This
may indicate that there is a need for increasing GP detection of anxiety and
depression, increasing access to mental health assessment and of increasing
access to effective treatment for anxiety and depression.

2.3 Uptake of Counselling

Webber et al (1994) evaluated the use and uptake of a counselling service in an
inner city general practice. The mean referral rate for counselling was 13.5
referrals per thousand general practitioner consultations and the rates of the
three general practitioners range from 8.1 to 18.9. The practice made 1.7
referrals per thousand general practitioner consultations for psychiatric out
patient services over the same period.

Primary and secondary reasons for referral included alcoholism, bereavement,
depression, financial problems, housing problems, relationship problems and
general stress. By far the largest number of referrals were for relationship
problems (45%), followed by problems causing general stress (23%). Webber
et al (1994) comments that their analysis highlighted the wide range of
problems referred and showed that practical advice on self help such as
breathing and relaxation techniques or information about local group resources
was often required. This needs to be noted when planning a counselling
service.

Webber et al (1994) commented that a general practitioner would occasionally
refer a patient in order to alleviate pressure on him or herself and gain extra
support. Patients were also sometimes referred if difficulty with
communication between doctor and patient arose. Feedback both from the
analysis and from individual counsellor/client contacts regarding the
appropriateness of referral led to a better understanding and collaboration
between GP and counsellor. One fifth of patients were referred on for longer
term counselling and/or psychotherapy.

Analysis showed that 25% of patients failed to keep initial appointments or
complete their contract and Webber et al (1994) comments that a lack of
patient preparation by the GP sometimes appeared to be a factor in patients not
attending their first appointment. Patients were sometimes referred for
counselling at a time when they did not feel confident enough to explore their
attitudes, behaviour and feelings. Webber et al (1994) comments that it would
be useful to target patients who did not complete their contract as it would then
give a better indication of reasons for defaulting. It seems that referring
behaviour is a complex activity which is beginning to be addressed empirically.

It seems necessary to have guidelines for appropriateness of referral and a
mechanism in place to discuss what appears to be inappropriate referrals.

2.4 The Efficacy of Counselling in General Practice

2.4(1) Satisfaction Surveys
Subjective accounts suggest that counsellors in general practice lead to much
consumer, counsellor and GP satisfaction. One study by Waydenfeld &
Waydenfeld (1980) found that 44 out of the 47 clients who completed a client
satisfaction questionnaire indicated that help was received. The same study
investigated the outcome of 25 patients referred to a counsellor who had been previously referred to the psychiatrist. They found that 20 patients were considered by the doctor and/or the counsellor to have been either very much or somewhat improved by counselling. 4 considered to have been not improved and 1 was made worse according to the doctor. General rather than specific questions were used in this study which minimises the reporting of negative comments. Using counsellors and doctors to rate improvement can also be a source of bias.

Anderson & Hassler (1979) sent questionnaires to patients referred to a counsellor, 55 patients returned them (69%). Of this group 47 agreed that counselling should be available in general practice; 43 would use the counselling service again and 46 would recommend it to their relatives or friends. Clients also considered that they had been helped considerably including improvements in close personal relationships, changes in the way they felt about their current situation, increased self confidence and changes in how they coped with their current mood. This study again reported high satisfaction rates.

2.4(2) Utilisation of Medical Services as an Outcome Variable in Counselling Surveys

Studies Using Prescription Rate and Consultation Rate

Other studies have considered whether counselling has had any effect on the utilisation of medical services. The results have been used as a measure of outcome. Many studies have indeed shown a reduction in visits made to the doctor after cessation of counselling in contrast with the period before (Marsh & Barr 1975, Waydenfeld & Waydenfeld 1980). A similar number of studies have found a reduction in the number of psychotropic and other drugs prescribed (Meacher 1977). Other studies have indicated that there is a reduction in referrals to psychiatrists after a counselling attachment had been instigated (Illman 1983, Corney 1987a). However, the reduction in medical utilisation rates has also been used to argue the case with the cost effectiveness of counselling. Consideration needs to be given to whether we should try to argue the case for attaching counsellors in general practice in terms of cost effectiveness. A successful attachment of a counsellor may result in more time being spent in discussing cases with other members of the primary care team. It may also result in a primary care professional spending more time in their consultations with patients as they start to adopt a more caring patient centred
approach. While this change in approach may have far reaching consequences in terms of comprehensive care, the effects may be extremely difficult to trace and cost. Studies into the efficacy of counselling requires a range of outcome measures rather than a narrow focus. There may be a wide range of benefits which would not be assessed if the focus for outcome was merely on utilisation of medical services.

Martin & Martin (1985) investigated whether having a counsellor in the practice had altered GP behaviour. 300 patients who had been continually registered with the practice since 1974 were studied. The number of psychosocial problems and the number of prescriptions for psychotropic drugs recorded in the years 1975, 1979 and 1982 were examined. They found that the number of patients who had had a psychiatric diagnosis recorded in their notes during one year fell between 1975 and 1982, the number of prescriptions for antidepressant drugs fell - a 17% decrease - the prescription for tranquillisers and sleeping tablets rose - a 30% increase. They had hypothesised that the change in psychotropic prescriptions could have induced the doctor to become more willing to consider psychogenic problems as being precipitated by stress rather than by a chemical change. The reduction in patients being given a psychiatric diagnosis could be due to early attention to patients' emotional needs preventing later breakdowns. The authors conclude, however, that no major changes were detected over the 7 year period. Martin & Martin (1985) also conducted a second survey comparing the outcome of a group of 87 patients receiving counselling with a matched group of patients drawn from the age sex register. They found no major differences in outcome between the two groups although this is only measured in terms of attendance rate and psychotropic drug prescription.

Studies have indicated that after cessation of counselling, clients make fewer visits to the doctor, fewer psychotropic drugs are prescribed and fewer referrals made to psychiatrists (McLeod 1988). Other studies, however, have not found such positive results. In one clinical trial carried out by Ashurst & Ward (1993), 726 patients from general practice were randomly assigned to counselling or to routine GP treatment. These patients were aged between 16 and 65 years, had consulted the GP for neurotic disorder and high proportions had been prescribed psychotropic drugs. The two counsellors generally favoured a non directive approach and although a large proportion of clients valued the help received there were no striking differences in outcome between
groups although the authors felt that some individuals benefited considerably. One of the flaws with this pioneering study was that some clients did not specifically want counselling help thus possibly reducing treatment effects.

As stated, two measures of effectiveness that are commonly used are the rate of consultation with the doctor and the rate of prescription of psychotropic drugs. In many surveys both of these variables decreased when a counsellor worked in the practice. Several of the surveys covered less than one year (Anderson & Hassler 1979 and Waydenfeld & Waydenfeld 1980). The authors of one survey recognised that the short follow up may have biased their results (Anderson & Hassler 1979). Robson et al (1984) describe a beneficial outcome over one year but changes were not maintained (Pearl & Kimley 1982). Freeman & Button (1984) showed no lasting benefit from individual treatment after allowing for the clinical cause of the problems. It would appear to be useful to include consultation and prescription rate to monitor changes but also to assess other outcome measures. In addition after it has been established if these rates increase, decrease or do not change, it will be possible to then monitor other aspects such as GPs behaviour in the consultation which may affect consultation rates. It could be that as a counselling service is established, the GPs awareness of psychological factors and the GPs skills in addressing these issues increases.

Studies Using a Variety of Outcome Measures
Meecher (1982) evaluated counselling services in general practice and reported that where the counsellors use premises separate from those of the GPs the service was less successful from the point of view of the doctors. The placement of counsellors in the GP surgery seems to be the preferred option. Of the 81 patients in the study, GPs returned reports on 66 and in 54 of these cases the GP felt that some improvement could be discerned, though the improvement ranged from "slight" to "has met the patient's needs." The GPs assessments were slightly less favourable from those of the patients themselves according to which only 3 had not been helped by the service. In all these 3 cases, however, the patients recommended the service for other people. 95% of those who responded to the questionnaire considered that their visits to the counsellor had helped them, though in 20% of the cases the counselling had helped only a little. The frequency of prescribed drug use at the time of referral was compared to prescribed drug use at the cessation of counselling. 30 patients were prescribed drug users at the time of referral and by the end of
counselling period 15 of these, 50% were using prescribed drugs less frequently. For 12 of the patients the frequency of drug use remained unchanged while the remaining 3 used drugs more frequently.

Boot et al (1994) conducted a randomised controlled trial of the short-term impact of counselling in the general practice setting. Compared with patients who received the usual advice from their GP for acute problems such as relationship difficulties, anxiety and depression those who received counselling from qualified counsellors working within the primary health care context showed greater improvement in psychological health as measured by the General Health Questionnaire. Significantly fewer of those counselled were prescribed antidepressant drugs by the GP in this study or were referred to psychiatrists or Clinical Psychologists for care. In addition those patients who attended sessions with the practice counsellor were more likely to report that they were satisfied with their treatment and more expressed feelings of well being. This study measured outcome using a psychological test, the GHQ, referral rate to other professionals and prescription rates as well as client satisfaction. This seems to represent a useful range of outcome variables.

2.4(3) CPNs, Practice Counsellors and Clinical Psychologists - Funding Source and referral patterns.

Sibbald et al (1993) used postal questionnaires and telephone interviews to survey a sample of about 1 in 20 General Practitioners in England and Wales. 1880 GPs were contacted, of whom 82% completed questionnaires. Results indicated that the 586 counsellors were distributed among 484 of the 1542 practices. Three types of professions predominated, community psychiatric nurses (187), practice counsellors (145) and Clinical Psychologists (95). 197 of the professionals had training in counselling, the qualifications of 85 were unknown to the GP. The principal source of funding was the District Health authority for CPNs and Clinical Psychologists and the FHSA for Practice Counsellors. All counsellors were referred a wide range of problems. GPs referral patterns were found to vary with the type of professional on site reflecting GP perception of the likely skills of their counsellors. Affective and psychotic disorders tended to be directed to CPNs which suggests that GPs see these nurses as skilled in the management of psychiatric illness. Clinical Psychologists tended to be referred problems such a psychosexual difficulties, eating disorders, phobias and obsessive compulsive disorders which are
believed amenable to behavioural therapies practised by these professionals. Bereaved patients were almost always directed to practice counsellors which suggests that GPs view bereavement as a problem which responds to the non-directive forms of counselling associated with these professions. Sibbald et al (1993) concluded that counselling services are wide spread in general practice but a high proportion of counsellors lack qualifications and many may be referred problems outside their knowledge. The attachment of counsellors works well in General Practice with much consumer and GP satisfaction but it does appear to be necessary to define the type of problems referred, type of therapy conducted and to include a wide range of outcome variables. These factors would need to be considered when setting up a counselling service.

There are great variations between GPs and their views of psychological problems, their interest, knowledge and skills in dealing with people who have mental health difficulties and their use of mental health services (Broughton 1988 and Wilkins & Smith 1987). This affects referral to the services in general and also appears to affect the decision to refer to particular mental health professionals (Creed et al 1990). It would appear to be necessary to clearly delineate the types of referrals which would be appropriate to the different professionals working in mental health and to have a forum for discussion of such aspects when one is setting up a counselling service.

The BPS (1990) notes that there is a demonstrable need for psychological therapies in primary care and that these are often inadequate, unevenly distributed and poorly co-ordinated. It appears that there has been little attempt to evaluate the use and satisfaction with these services, although the need for this has frequently been emphasised (Strathdee (1990), Kincey & Creed (1991), Stallard & Chadwick (1991).

Griffiths and Cormack (1993) assessed GPs current use of mental health services in one health authority. On a rating scale of 1 -"never", to 5-"a lot" the mean values for referrals to all mental health professions were psychiatry 3.3 (SD 1.02), Psychology 2.94 SD 1.06), CPN 2.26 (SD1.06) and Psychiatric Social Workers (PSW) 1.67 (SD0.93). More referrals were made to psychiatrists than to psychologists and to CPNs and PSWs. 73% stated that lack of availability of some mental health professions influenced their referral pattern. 26% of GPs stated their practice employed a counsellor.
The presence of a practice counsellor did not affect the frequency of referral to psychology or other mental health professions. The presence of a counsellor did not affect whether GPs felt availability of mental health professions was restricted. These GPs were just as likely to want to refer more patients to psychologists as GPs who did not have a counsellor in the practice. It has been suggested that practice counsellors see the same client groups as Clinical Psychologists (Jerome et al 1982). These results imply that counsellors see different client groups to psychologists. It could also be that despite the presence of a counsellor there still remains a large pool of unmet need. On a rating scale of 1 - "not at all" to 5 "very" the mean levels of satisfaction with the four mental health professions were Psychiatry 3.46(SD1.21), Clinical Psychology 3.47 (SD1.19), CPN 3.51 (SD1.02), Psychiatric Social Worker 2.86 (SD1.06). Lack of availability of psychologists was the most frequent reason for dissatisfaction. Level of satisfaction with services for adults who had emotional and personal difficulties was higher for those GPs who referred to a psychologist based at a health centre. GPs who referred to a psychologist based at a health centre were less likely to feel availability of mental health services was restricted. GPs who referred to a hospital based psychologist who had sessions at the health centre however were as likely to feel availability was restricted as those who referred to a psychologist who saw patients elsewhere. The relative frequency of referral to psychiatrists was significantly reduced if GPs referred to a psychologist who saw patients at the health centre.

The implications for a Counselling Service is that counsellors being based within the GP surgery is likely to be more satisfactory to GPs than a centralised service. In addition counsellors are perceived as offering a very different service to a different client group than Clinical Psychologists. The differences and similarities require to be made explicit when setting up a counselling service.

2.4(4) Comparative Studies of Mental Health Treatment in Primary Care.

Balestrieri et al (1988) conducted a meta analysis of 11 British studies of specialist mental health treatment in general practice. In each study the outcome of treatment by a specialist mental health professional located in general practice was compared with the outcome of usual treatment by GPs. The main finding was that treatment by mental health professionals was about 10% more successful than that usually given by general practitioners.
Counselling and behaviour therapy and general psychiatry were similar in their overall effect. The influence of counselling seemed to be greatest on social functioning whereas behaviour therapy seemed mainly to reduce contact with the psychiatric services. Smith et al (1980) conducted a meta analysis of 500 evaluative studies which indicated that most forms of psychotherapy and counselling produce more improvement than a controlled group, with a mean effect size of 0.85. A subsequent re-analysis of 32 studies (Prioleau 1983) which both contain the psychotherapy and placebo treatments suggested that counsellors were more effective with less disturbed individuals. The meta analysis by Smith, Glass & Miller (1980) failed to show any difference between different forms of treatment no matter how different they were in philosophy or procedures, e.g. group or individual or according to which disorder was being treated. Ashurst & Ward (1983) stated that the type of counselling used was far less important than the relationship developed between counsellor and client.

It appears to be important to include a measure of degree of disturbance, treatment type and problem type in a study of the effectiveness of counselling.

2.4(5) Conclusions

It is suggested that when setting up a counselling service, it would be beneficial to use psychometric tests pre and post therapy to assess outcome. In addition, consumer satisfaction questions would be advisable as an outcome measure but also to provide an opportunity for clients and referrers to highlight problems with the service. Open ended questionnaires would need to be included in such a questionnaire. Prescription and consultation rates could be collated in cost benefit analysis of services. However, the literature concerning the effect of counselling on these as independent variables is not clear. Control groups would be utilised ideally but can be difficult to organise in a primary care setting due to ethical problems of using a waiting list control group or standard GP treatment.

2.5 Assessing Efficacy

Corney (1990) comments that studies of consumer opinion almost universally suggest that clients find counselling helpful. There is also the widely held belief that counselling is beneficial and should be available to the troubled and
distressed. However, evaluative studies should identify those patients who can benefit most.

There are major problems in trying to assess effectiveness and improvement. To evaluate a treatment, assessments need to be made both before and after treatment, preferably by a researcher unaware of the actual treatment received. But how to measure improvement? Can it be measured by assessing the amount of GP involvement and a reduced drug bill or by a change in the client's physical and mental health or by both? The effectiveness of marriage guidance counselling for example could not only be measured by reduction of couples divorcing, counselling may for example ease the process of the couple separating from a destructive relationship. Measures of outcome could include objective ratings, this can include criminal offences, health records and measures of illness behaviour, for example attendance rates and psychototropic drug taking. Corney (1990) also comments that more subjective assessments are important, views and opinions of clients and relatives and other professionals involved are necessary, although most clients will indicate that they were satisfied with the help received. A study of clients' views reveals insights into what clients find most or least helpful. There is also the problem of when to reassess clients after treatment. Studies with short follow up assessments were often criticised because certain therapies do not have an immediate effect. However, reassessments after a more lengthy follow up period are frequently more difficult to carry out, leading to more drop outs. In addition a longer follow up period might miss short term treatment effects. Studies with more than one follow up assessment are usually to be recommended.

2.6 The Relationship Between Counsellors & Clinical Psychologists

2.6(1) Counsellors Employed in Clinical Psychology Departments

Green (1994) discusses the development of a Clinical Psychology Department employing counsellors. Clinical Psychologists experienced anxieties in terms of role differentiation, skills and the threat of loss of a clearly identified Clinical Psychology department. Green (1994) reports that tensions between the two groups were clear. The Clinical Psychologists wanted to view the counsellors as assisting their work and to refer patients to them who needed support.
counsellors wanted to be recognised as skilled therapists and equal professionals. Green (1994) however comments that the skills mix is developing well though the process has not been easy.

Green (1994) comments that many of the fundholders were concerned by a review of counselling services in general practice conducted by Sibbald et al (1993) which concluded that many of those employed lacked qualifications and were referred problems beyond their expertise. Fundholders had been particularly keen to buy a range of practice-based psychological assessment and therapy services from one single source. Clinical Psychology departments could aim to provide clear guidance to GPs as to the likely level of psychological needs within their practice and the ways in which these might be met by a flexible and quality service.

2.6(2) Counsellors Contracted Out to GPs by Clinical Psychology Departments

An alternative is for the counsellor to be employed by a Clinical Psychology department and contracted to primary care purchasers. New or unfilled psychology posts may be re-designated as counsellor or therapist posts. Miller (1994) comments that the range of duties and remuneration vary widely, often depending on the appointee's previous career. Salaries may reflect Whitley Council scales such as clinical scientist, nursing or occupational therapy, or be decided on an ad hoc basis. Part time hourly rates range from £8.00 up to £14.00.

Miller (1994) questions whether or not this should be happening as such developments may devalue and undermine Clinical Psychologists professional role. It is suggested that there is a dilution of the quality of psychological care. Counsellors or therapists however good are not Clinical Psychologists. They cannot therefore offer the same breadth and depth of skilled input. Their development within a Clinical Psychology service may misrepresent the nature of that service. A further accusation which must be considered carefully is that Clinical Psychologists are taking the role often attributed to psychiatry, attempting to limit and control the development of another profession in order to maintain our hierarchy or dominance. Other professionals have the right to develop their own skills.
The MPAG (Manpower, Planning Advisory Group, Clinical Psychology Report, June 1990) report recommended that Clinical Psychologists should not undertake work that can be done equally well by other staff provided adequate support and supervision is available. This benefits clients whose expectations of having these needs met will be poor if delivery depends solely on Clinical Psychologists. Quality in psychological practice by others should be encouraged. In this way it is possible to demonstrate awareness of the needs, demands and constraints faced by purchasers.

Miller (1994) comments that if counsellors are to be employed under the umbrella of Clinical Psychology services, certain assurances will be needed. Firstly consideration must be given to the balance between qualified Clinical Psychologists and other therapists within the service. This includes implications for the demand for Clinical Psychologists, their training and recruitment and the impact on the Assistant Psychologist grade. Purchasers must be aware that counsellors and therapists supplement rather than replace existing Clinical Psychology Services. Qualified and experienced Clinical Psychologists will be required to manage and supervise other therapy staff in the psychology service. Purchasers should be aware of what counsellors and therapists cannot do that would normally be undertaken by Clinical Psychologists.

2.6(3) Counsellors Background and Training

Applicants often have a professional background in health and social care and are seeking a late career change, returning from a career break or under threat of redundancy or redeployment. Some are psychology graduates unwilling or unable to enter Clinical Psychology. Generally all have further training (Miller 1994). Alternatives vary from short introductory courses through certificate courses of 15-20 weeks part-time to validated diploma courses lasting 2 years. In addition there are nursing courses leading to specialist grades. It is necessary to scrutinise training content particularly in terms of a supervised practice component which many courses lack or cover inadequately. Quality is variable and it is not possible to take qualifications at face value. Miller (1994) commented on the use of second year counselling diploma trainees who do a minimum of one session per week of case work in return for payment of once weekly supervision. Scrutiny of the skills and experience is essential. Qualifications cannot be taken at face value as training is extremely variable.
2.7 Accreditation and Training

As a general guideline roles and workloads should be defined and documented in job descriptions or contracts including honorary job descriptions for voluntary staff. These must include clear arrangements for accountability. A commitment to further training and development is necessary to ensure operation within acceptable psychological models. Regular and close supervision of 1-2 hours per week is the minimum and joint screening of new referrals with the supervisor is desirable at least until competence is established. A counsellor working 1:1 for 20 hours a week will need at least 3 hours of supervision weekly (BAC guidelines for the employment of counsellors in general practice 1993). Information to purchasers and clients could include explanations of the role of counsellors and therapists including supervisory arrangements to avoid misleading expectations. The BPS (1991) has indicated this may be a service offered by a firm of Chartered Psychologists. The Chartered Psychologists, however, must be in a position to oversee and assume responsibility for the work. The same principle may be applied to Clinical Psychology services. Management and supervisory arrangements must recognise the professional status and aspirations of counsellors and therapists so that they do not become second class citizens. Counsellors and therapists need the same opportunities as Clinical Psychology staff for annual professional review and continued personal and professional development.

The British Association for Counselling (BAC) examines training schemes, accrediting those that are satisfactory. The Association accredits counsellors who have suitable training, have had at least three years experience, accept the Association's code of ethics and undertake continuing supervision. This accreditation has to be reviewed every five years. The British Psychological Society offers Chartered Counselling Psychologist status to appropriately trained psychologists. These two professional bodies offer a close examination of a counsellor's training and experience and accreditation or chartership implies a high level of functioning of the counsellors.

Pringle & Lavity (1993) state that practices would be wise not to appoint unqualified people just because they seem to have good listening skills. However well intentioned an amateur counsellor may be there are profound professional, ethical and clinical issues not least of which is confidentiality that
must be considered. Sibbald et al (1993) reports that fewer than half of counsellors have received specialist training in counselling. Counsellors should be accredited by the British Association for Counselling or be Chartered by the British Psychological Society.

2.8 Expectations by the Primary Health Care Team

Expectations of the counsellor by other members of the team may be different. The counsellor may be expected to undertake any work with any patient having emotional problems or to work with only a discreet group like the recently bereaved. These and many other issues indicate the necessity for negotiation at the outset between the new member and the existing team. As full a discussion as possible is needed about what the aims of counselling are in that particular setting in order to negotiate a suitable model and an approximate mix of short and long term methods of working (Ryle 1990). This process may also need to contain an exchange of information, style and content of each others jobs and the beginnings of an outline of good practice and relevant protocols as perceived by those workers and if possible by the clients they serve.

2.9 Administrative Issues

Control of methods of information and aims within counselling may be an issue, whether any member of the staff or the patient him or herself can refer and what if any feedback is required needs discussion. If the patient is very depressed and if medication is being prescribed it is necessary to agree the method by which this will be monitored. An additional issue is that of responsibility. As yet there has been no legal case at primary care level but governmental regulations and the law would probably be interpreted as implying that any patient treated in general practice remains the ultimate responsibility of the doctor (Higgs & Dammers 1992).

2.10 Confidentiality

For a counsellor entering the medical field it comes as a shock to find that issues of confidentiality are not tightly handled in the medical practice (Sigler 1982) and that primary care is considered hard to conduct without a more relaxed response to family members than the counsellor would have met in
working in private practice (Christie & Hoffmaster 1986). Concerned partners or family members call to express their views or ask how things are going. Likewise a doctor or nurse who refers will expect feedback in the form of a letter or conversation from another professional who is being consulted.

2.11 Funding Counsellors

Since 1990 the general practice contract has allowed reimbursement of the cost of employing counsellors. The staffing budget is cash limited and some practices may have to accept less than 70% reimbursement if their application is successful. Fund holding practices have more control over staffing and many consider counsellors along with physiotherapists and chiropodists to be their highest priority (Pringle & Laveity 1993). Since the contract was introduced another possibility has emerged. Many practices have applied to run health promotion clinics for managing stress which is thinly disguised counselling sessions. The clinic fee is almost sufficient to cover a counsellor's sessional fee, thus costing the practice a minimal amount.

2.12 Health of the Nation Targets

Health of the Nation identifies mental health as a key area and publications by the NHS Management Executive indicate that Family Health Services Authorities should in their corporate contracts work to secure a comprehensive range of local mental health services. It encourages practices to offer services aimed at the primary prevention of mental illness, for example, counselling services, self help groups and stress/anxiety management groups.

2.13 Areas of concern in Counsellor Provision

Salinsky & Jenkins (1994) comment that there are three main areas of concern.

1. Competency.
The current yardsticks are the completion of a recognised code of training, adequate supervision and perhaps personal therapy for the counsellor. Unfortunately some counsellors working in primary care do not fulfil even the basic requirements.
2. **Lack of mutual understanding of each other's roles on the part of GP and counsellor.**

Different ethical values, different models of illness, conflicts over diagnosis and confidentiality are all obstacles to effective collaboration. Any practice wishing to start a counselling service will need to find ways to overcome these obstacles if the service is to succeed. For instance, counsellors need to be included in practice meetings and given plenty of time for joint consultations so that they can be fully integrated into the practice teams.

3. **The development of a working relationship between primary care and secondary mental health services (Thomas & Corney 1993).**

Counsellors who identify a difficult problem may find that their clients are referred to practitioners such as Community Psychiatric Nurses whose levels of counselling or psychotherapeutic competence is lower than their own. Hospital psychiatric outpatient departments can offer referral to a psychologist or psychotherapist in theory but the over loading of their resources and the length of their waiting lists may prevent help being provided at the time when it is needed. Some Community Mental Health Trusts have provided an integrated service and have developed a comprehensive counselling service employing and providing supervision for counsellors whose service can be acquired by fund holding practices and other purchasers (Fahy & Wessely 1993).

2.14 **Advantages of Counselling in a Medical Setting**

For the counsellor the medical setting has a number of advantages including a ready source of referrals, easy access to medical information, interchange with other members of the helping professions and a place to work without expensive overhead costs. The counsellor is able to see patients early before patterns of non-functioning are established (Marsh & Barr 1975). For the patients the availability of a counsellor in a familiar setting, one whom their doctor trusts and knows and without the stigma of a psychiatric referral has been shown to result in better appointment keeping and higher uptake of appointments (Heisler 1979 & Marsh & Barr 1975). It may also reduce prescribing rates (Anderson & Hassler 1979). The appropriateness of referrals often varies between different partners in a practice but appear to improve as the counsellor becomes known and her/his work valued and better understood (McLeod 1989).
2.15 Disadvantages of Counselling in a Medical Setting

1. Many counsellors have no set room and have to work in doctors consulting rooms. This may increase the difficulty of presenting a role which differs from that of the doctor. The counsellor who depends on the use of a room when it is free may not be in the surgery when most of the doctors are there. Personal contact is important if referrals are to be appropriate and issues of confidentiality overcome.

2. There are difficulties over pay either through counsellors charging a fee whereas a free service is offered by the professionals or through their feeling under valued alongside highly paid medical staff.

3. Professional isolation and sometimes hostility and misunderstanding from other staff.

4. The non-professional image of a counsellor as a voluntary worker still lingers.

5. In a general practice setting the counsellor may be tempted to alter her/his mode of working sacrificing the precious commodity of time for a rapid turnover of patients. It is clear that some counsellors have difficulty in seeing patients and recording and discussing their findings in the time available.

6. McLeod (1988) commented that for the majority of counsellors the medical setting is new. They lack knowledge of medical terminology and drugs and they are often unaware of the pace of work in general practice, the way a practice is organised and the variety of people involved in primary care team. In a medical practice doctors and nurses are seen to be active and decisive, the turnover is rapid and patients are normally offered short appointments. The counsellor's different use of time through clearly stated boundaries and limitations and their work of listening and talking causes uncertainty and resentment among other staff (Graham & Sher 1976). McLeod (1988) commented that counsellors have found it important to start by explaining how they worked in specific referrals with the doctors. They had also fostered good relations with other practice staff including the receptionists so the objectives and potential of counselling were better understood.
7. Many doctors keep control of the initial referrals to the practice counsellors and therefore govern the nature and number of patients seen (Martin 1988). This contrasts with counselling in other settings in which patients refer themselves.

8. Communication between counsellor and doctor may also present a problem (Martin 1988). A recent survey has shown that some counsellors found doctors reluctant to meet with them as often as they wish (McLeod 1988). It would appear to be useful to ensure that counsellors are supported by supervision by a professional who is familiar with working in primary care settings and that has contact with other mental health services.

3.0 THE USE OF COUNSELLORS WITHIN GP PRACTICES WITHIN SURREY

3.1 Introduction

GPs across Surrey have reported that the instance of new cases of schizophrenia and severe mental illness is uncommon. Only a handful of new cases are reported each year. In sharp contrast to this, a large number of patients attending their surgeries complain of stress, mild depression, bereavement, panic attacks and other mental health problems. Frew Brown (1995) reports in a FHSA report in 1995 that the figure most frequently quoted by GPs is around 25% of consultations for such patients and that these are increasingly turning to their GPs for help with their psychosocial problems. Many are now requesting counselling rather than treatment with drugs or referrals to psychiatrists or other hospital based mental health specialists. They are reluctant to attend the local psychiatric unit because of the stigma attached. It is clear that GPs are expressing a need for counselling support rather than extra resources being targetted purely for the seriously mentally ill. A need for counselling provision was recognised by the FHSA.

Frew Brown in the FHSA (1995) reported that GPs were in favour of organising their own counselling services which were more easily accessible. Surrey FHSA therefore provided some funding for counselling services from its development fund. 11 GP practices received funding for the counsellors within their surgeries. The funding is for a duration of 3 years. This was the first time the FHSA had committed funding on this scale for counselling
services in Mid Surrey and was seen as reflecting the commitment of the FHSA to assist GPs in caring for patients with mental health problems. The expectation was that counselling could be used as a means to promote mental health, prevent mental illness and reduce reliance on antidepressants, hypnotics and psychotropic drugs.

After a year of the counselling service, 743 patients were referred to counsellors in 11 practices which is an average of 65 patients seen per practice. The total number of consultations is 2,010, each patient having received an average of 3 consultations. A variety of patients were referred to practice counsellors and consisted mainly of individuals with mild psychiatric conditions or psychosocial problems. Among the patients seen were those experiencing stress, bereavement and loss, emotional problems, behavioural disorders, relationship difficulties and other associated problems (Frew Brown 1995).

Patients with serious psychiatric illnesses, drug and alcohol problems and those with whom there was a possibility of deliberate self harm were normally referred for specialist psychiatric services rather than to counsellors. Due to insufficient and incomplete data, Frew Brown (1995) comments that it was not possible to present an accurate figure on the number of referrals to mental health specialists. However, 89 patients out of a total 743 (13%) were reported as needing to be referred to a mental health specialist after being seen by the counsellor. The majority were referred either to the CPN or the psychiatrist. 7 out of the 11 practices surveyed reported decreases in the dosage of medication among patients who received counselling. The total number of patients who had their neuroleptic medication decreased after counselling was 92. This amounts to 12% of all patients seen or 26% of those reported on medication. Of the 92 patients whose medication had been decreased, 24 related to antidepressants while 68 related to hypnotics/psychotropic drugs 6.3% out of all patients had no change in their medication. It would appear that counselling may be a contributing factor in the reduction of antidepressants and drugs used in mental health care.

The report produced by the FHSA commented that a lack of standardisation in counselling training and qualification made the employment of counsellors appear rather complex for some GPs and that some GPs had been satisfied and are pleased to continue employing counsellors that they were able to trust even though the counsellors had minimum qualifications.
3.2 Assessment of need in Surrey

The Mid Surrey Health Authority and Surrey FHSA Health Strategy (1994) needs assessment indicated that 40,000 people in Mid Surrey experienced a recognisable mental health problem each year and the suicide rate was 9.1 per 100,000 in 1991 and 1992. The Surrey lifestyle survey (Harrison Surrey Lifestyle Survey Executive Summary February 1995) results indicate that a significant number of younger adults have sleep difficulty or feel stressed and anxious. Many adults use alcohol, cigarettes or drugs to ameliorate these feelings. The 1991 census (OPCS London 1991) results show that 7% of households in Mid Surrey consist of a lone pensioner. Since elderly people are comparatively likely to experience chronic illness, social isolation and bereavement, the overall risk of depression is also increased. It is likely that all these groups could benefit from counselling.

The recommendations from the Surrey FHSA report (Frew Brown 1995) on the use of counsellors in general practice are detailed below

1. Evaluation of the roles of counsellors in general practice should be continued.

2. More precise data collection and analysis should be carried out at regular intervals.

3. A method of monitoring patients' satisfaction should be devised.

4. Training should be provided to enable appropriate health professionals to undertake counselling within the practices.

5. Further investigation should be undertaken as to the dual role of the CPN as counsellor, especially if this is effective in primary and secondary care.

6. Counsellors and community psychiatric nurses should be encouraged to participate in primary health care team meetings and activities, written guidelines/protocols should be agreed for the counsellors in each practice.

7. Lack of formal qualifications and training should be taken up at national level.
All apart from points 5 and 7 are being dealt with by the project reported below.

4.0 REPORT FOR PURCHASERS ON COUNSELLING IN PRIMARY CARE SETTINGS

Interest in counselling in primary care was very marked and much concern was being expressed about the employment of untrained, unqualified and unsupervised counsellors in general practice. The author as a representative of the Psychology Department was therefore asked to present a proposal for counselling in primary care settings. This is illustrated in Appendix 2. Consultations are still being undertaken with purchasers about the best way of taking developments for a counselling service in Mid Surrey further.

5.0 THE EMPLOYMENT OF COUNSELLING PSYCHOLOGISTS IN PRIMARY CARE SETTINGS

Given the interest in developing counselling services and the recognition by GPs of the need for counselling in primary care, their difficulty in assessing counsellors as to their suitability and the monitoring of their performance and in view of the slow progress in purchasers formulating policy regarding this matter it was considered to be a useful strategy to conduct a small pilot project. A new approach to the delivery of such services was formulated in that counselling psychologists would be employed within the psychology department and GPs would be offered the opportunity to purchase counselling sessions from the Department of Clinical Psychology. GPs in one of the localities in Mid Surrey were therefore circulated a letter explaining the benefits of such a service (Please see Appendix 3).

The benefits for the GP were seen as being that they would have the reassurance of knowing that Counselling Psychologists have been assessed by Clinical Psychologists as to their training and experience which had been gained. In addition supervision of the counsellors was to be offered by Clinical Psychologists from the department as well as addressing the issues which were of much concern to GPs regarding the suitability of training and supervision arrangements. It was also considered beneficial to employ Counselling
Psychologists based within a psychology department within a Mental Health Trust in that links to other parts of mental health service would be facilitated.

Two GP practices identified themselves as being interested in participating in such a scheme. One practice unfortunately had no funding for such a service and so was not able to be considered. The other practice has a list size of 15,000. The practice is split into two sites, Practice 1 which has a list size of 8,000 and which has a list size of 7,000. There are 4 GPs based at each practice.

The population served by each of the practices is rather different. Practice 1 accepts patients from (1) SeeAbility, a residential training centre for visually impaired people who have multiple problems of which mental health problems may be one. (2) A Night Hostel, which is a facility for short term accommodation for homeless people who frequently have mental health problems and (3) the many nursing homes in the area. Practice 2 however has few people with such special needs. There is a higher proportion of social classes 3 and 4 in Practice 1 and a higher proportion of social classes 1 and 2 in Practice 2. One Psychology Counsellor was assigned to Practice 1 and one to Practice 2. However, given the paucity of referrals from Practice 2 that counsellor also began to accept referrals from Practice 1 GPs. This was seen as reflecting the different social and psychological needs of the population in the two areas but also perhaps reflects GPs referring patterns and interests.

The practices were receiving money from the FHSA for payment of a counsellor. Negotiations and discussions took place between the GPs in the practice and the Clinical Psychologist leading the scheme. These discussions covered areas such as suitable referrals, method of referral, confidentiality, feedback, report writing, administrative details, usage of rooms, model of counselling to be adopted, supervision arrangements, audit and evaluation of the service. These discussions proved to be very beneficial in that the parameters for the operation of the service were very clearly outlined before the service was established. Counselling Psychologists were then interviewed by the Clinical Psychologist and the two considered most suitable were then interviewed by GPs who confirmed that they felt that the Counselling Psychologists were going to be of benefit to the practice and that the GPs would wish to employ them. Both counsellors were eligible for B.P.S. accreditation as Counselling Psychologists and received two thirds of the
money paid by the FHSA and the Psychology Department retained one third as payment for the provision of supervision. In reality, however, it is considered that the counsellors did not receive enough remuneration and if the model was accepted a more elevated payment rate is necessary.

5.1 Supervision of the Counsellors

Supervision was offered for one and a half hours on a fortnightly basis for each counsellor and was undertaken by the author. Supervision focused on discussions of cases but also encompassed issues of confidentiality, administrative issues, methods of feedback etc. In the course of the year of the project, formal meetings involving GPs and Counsellors were held to discuss the counselling service and issues such as appropriateness of referrals were discussed. Four meetings involving the two Counselling Psychologists, the supervising Clinical Psychologist, and a practice nurse who ran a stress management group under supervision of the Clinical Psychologist met to discuss issues relating to the operation of the counselling and psychology services in the practice and any difficulties that the counsellor or the psychologist were experiencing. This was with the aim of being supportive and to eradicate problems.

5.2 Evaluation of the Counselling Psychology Service

1. A Beck Depression Inventory, a State Trait Anxiety Inventory (STAI) and the General Health Questionnaire (GHQ) were administered before therapy began and at the end of the counselling sessions as a measure of outcome. These questionnaires were chosen as depression and anxiety have high prevalence rates in primary care and are often the reason for referral to counsellors. The GHQ was included as an index of level of psychological distress so that the severity of the problems being addressed by the counsellors could be assessed.

2. A Counselling Service Client Satisfaction Questionnaire was completed at the end of therapy (see Appendix 4). This was given to clients at the end of the final session of therapy and clients were asked to complete the questionnaire in the waiting room and to return the completed questionnaire to the receptionist. Clients were assured of the confidentiality of the questionnaires, that only group data would be seen by individual counsellors and that no information
concerning the results would be placed in case notes. This was an attempt to reduce bias by assurance of anonymity of responses.

3. Consultation and prescription rates were compared for two months preceding referral for counselling and for two months after counselling had been terminated. This information was obtained through the clients casenotes at the G.P. practice.

**Therapeutic Approach Used by the Counsellors**

Counsellors offered short term contracts of six sessions and involved the use of non directive counselling, psychodynamic counselling, transactional analysis and some behavioural approaches as appropriate. In some instances, a second contract of a further six sessions could be offered depending on client needs.

**Lack of control group**

A major methodological shortcoming in this study is the lack of a control group. Initially, a waiting list control group had been planned as it was expected that numbers referred would be large and would necessitate a waiting time before initial appointment and that these clients could be assessed. However this did not occur as clients referred were able to receive counselling relatively rapidly. It did not appear to be ethically justified to force clients to wait so that a control group could be formed.

**Sample Characteristics**

75% of the samples were females which could bias the results in that for example a sex difference may occur regarding outcome of counselling. A repeated analysis of variance was conducted and illustrated a significant difference between males and females on the Beck Depression Inventory, with males showing greater levels of improvement in scores before and after therapy ($F = -3.02$, $df = 10$, $p = 0.01$) though no such differences were found with the STAI or GHQ scores.

Referrals had an age range of 11 to 78.

The majority of clients referred were in the 20-50 year range with a good spread in these age ranges. Comparatively few 50 - 70 year olds were referred.
The problems for which people were referred and the problems identified during counselling are detailed in Table 1 below. Problem type was determined by asking the counsellors to record what they felt the main and additional problems were. It is interesting to note that some problem types identified are symptoms e.g. depression but some are causes such as sexual abuse or unemployment. Some are causes and some are effects.
Table 1 - Problems for which Referred and Additional Problems Identified During Counselling

<table>
<thead>
<tr>
<th>Problem Type</th>
<th>Frequency of Problems</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Main Problem</td>
</tr>
<tr>
<td>Relationships</td>
<td>8</td>
</tr>
<tr>
<td>Self esteem/confidence</td>
<td>5</td>
</tr>
<tr>
<td>Suicide-thoughts of, attempt, self harm</td>
<td>1</td>
</tr>
<tr>
<td>Individuation from parents</td>
<td>2</td>
</tr>
<tr>
<td>Parents separating/divorcing</td>
<td>1</td>
</tr>
<tr>
<td>Separation/divorced from partner</td>
<td>4</td>
</tr>
<tr>
<td>Redundancy</td>
<td>1</td>
</tr>
<tr>
<td>Unemployment</td>
<td>2</td>
</tr>
<tr>
<td>Pregnancy</td>
<td>2</td>
</tr>
<tr>
<td>Economic problems</td>
<td>1</td>
</tr>
<tr>
<td>Other transitions/change in life/life events</td>
<td>1</td>
</tr>
<tr>
<td>Reaction to abortion</td>
<td>1</td>
</tr>
<tr>
<td>Sexual identity - questioning + lifestyle</td>
<td>1</td>
</tr>
<tr>
<td>Abused as a child/adolescent/currently</td>
<td>1</td>
</tr>
<tr>
<td>Illness of relative/friend</td>
<td>2</td>
</tr>
<tr>
<td>Death of other</td>
<td>2</td>
</tr>
<tr>
<td>Panic</td>
<td>1</td>
</tr>
<tr>
<td>Anxiety - generalized</td>
<td>1</td>
</tr>
<tr>
<td>Anxiety - phobic</td>
<td>1</td>
</tr>
<tr>
<td>Stress</td>
<td>1</td>
</tr>
<tr>
<td>Depression</td>
<td>2</td>
</tr>
<tr>
<td>Bulima</td>
<td>1</td>
</tr>
<tr>
<td>Weight loss/gain</td>
<td>1</td>
</tr>
<tr>
<td>Reaction to birth of Downs syndrome baby</td>
<td>1</td>
</tr>
<tr>
<td>Reaction to own illness</td>
<td>1</td>
</tr>
<tr>
<td>Seasonal Affective Disorder</td>
<td>1</td>
</tr>
<tr>
<td>Obsessive Compulsive Disorder</td>
<td>1</td>
</tr>
<tr>
<td>Aggression and feelings towards parents</td>
<td>1</td>
</tr>
<tr>
<td>Son as school refuser/M.S.</td>
<td>1</td>
</tr>
<tr>
<td>Obsessive tendencies and aggression</td>
<td>1</td>
</tr>
<tr>
<td>Anger</td>
<td>1</td>
</tr>
<tr>
<td>Loss of own identity and aging</td>
<td>1</td>
</tr>
<tr>
<td>Post Traumatic Stress Disorder</td>
<td>1</td>
</tr>
<tr>
<td>Fear of madness</td>
<td>1</td>
</tr>
</tbody>
</table>

N.B. Some clients had more than one problem as main or additional problem.

It is evident that many of the main problems identified are life event stresses (N=13) and relationship problems (N=8). Anxiety and panic as a main problem was identified in only 2 cases, and depression in 2 cases. In 24 cases life event
stresses were identified as additional problems, depression in 18 cases and anxiety in 7 cases. Bulimia was evident in 1 case and post traumatic stress disorder in 1 case.

It is apparent therefore that life event stresses are seen as the major reasons for referral to counsellors but there is evidence of psychiatric morbidity also.

Table 2: The number of referrals made by individual GPs is shown in Table below.

<table>
<thead>
<tr>
<th>GP 1</th>
<th>0</th>
</tr>
</thead>
<tbody>
<tr>
<td>GP 2</td>
<td>0</td>
</tr>
<tr>
<td>GP 3</td>
<td>1</td>
</tr>
<tr>
<td>GP 4</td>
<td>3</td>
</tr>
<tr>
<td>GP 5</td>
<td>6</td>
</tr>
<tr>
<td>GP 6</td>
<td>6</td>
</tr>
<tr>
<td>GP 7</td>
<td>8</td>
</tr>
<tr>
<td>GP 8</td>
<td>9</td>
</tr>
</tbody>
</table>

As can be seen from Table 2, two GPs made no referrals and the remaining GPs ranged from making 1 to 9 referrals. Clearly as one would expect some GPs utilise Counsellors more than others. This difference in referral rate is seen as indicting that GPs operate different models for addressing the difficulties and problems with which their patients present. Some may be operating a more strictly medical model while others a psychological model. Some may construe patients' problems as encompassing or resulting from psychological problems in which case counselling is seen as appropriate, while others utilise a different model.

As reported by Broughton (1988) and Wilkins and Smith (1987) there are great variations between GPs and their views of psychological problems, their interest, knowledge and skills in dealing with people who have mental health problems and their use of mental health services. This affects their referral to mental health professionals (Creed et al 1990). This seems to be reflected in the differing referral rate by the GPs in the present study.

Number of Appointments, Failures to Attend (DNAs) and Cancellations

A total of 256 sessions were offered by the Counsellors with 12 DNAs and 17 cancellations (6.64%) which is a total of 29 failed appointments (11.33%).
Number of returned questionnaires

Table 3 showing the number of returned questionnaires from clients who received Counselling

<table>
<thead>
<tr>
<th>Items returned by Clients</th>
<th>No. of Clients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Returned Questionnaire + all S.T.A.I.s, B.D.Is and G.H.Qs</td>
<td>12</td>
</tr>
<tr>
<td>Returned Questionnaire + first S.T.A.I., B.D.I. and G.H.Q.</td>
<td>1</td>
</tr>
<tr>
<td>Returned Questionnaire + second S.T.A.I., B.D.I. and G.H.Q.</td>
<td>2</td>
</tr>
<tr>
<td>Returned Questionnaire only</td>
<td>7</td>
</tr>
<tr>
<td>Returned first S.T.A.I., B.D.I. and G.H.Q.</td>
<td>5</td>
</tr>
<tr>
<td>Returned first B.D.I. and G.H.Q.</td>
<td>1</td>
</tr>
<tr>
<td>Returned first S.T.A.I. and B.D.I.</td>
<td>1</td>
</tr>
<tr>
<td>Nothing returned</td>
<td>4</td>
</tr>
</tbody>
</table>

Table 3 shows the number of returned questionnaires from clients who received counselling. Complete data was obtained from 12 clients. This illustrates the difficulty in obtaining data from clients in evaluation studies, the results of which will have no major effect on the clients in the study.

Four clients have no questionnaire data at all. This is because two were adolescents and it was considered clinically inappropriate to administer such questionnaires. Two clients started counselling before questionnaires were available and failed to return questionnaires after therapy despite a reminder.

One client failed to return post therapy questionnaire except the Client Satisfaction Questionnaire despite two reminders. Two clients began therapy before questionnaires were available but did complete post therapy questionnaires. Seven clients returned the Client Satisfaction Questionnaire after therapy but did not return BDI, STAI or GHQs despite a reminder.

Five clients returned forms to be completed before therapy began but did not return forms after therapy. This represents one homeless person who could not receive a reminder, one who moved to live in Switzerland, one who stopped therapy after two sessions, one who was assessed and it was decided that counselling was inappropriate and one who received one counselling session and then moved out of the area.

Two clients returned several questionnaires pre therapy but did not return completed sets pre therapy or the post therapy questionnaires despite a reminder. This difficulty in obtaining clients completed questionnaires is clearly a significant
problem. Perhaps clients can be asked to come 20 minutes before the scheduled appointment and a receptionist could ask them to complete them. Clearly the receptionist involved would need to be trained to give the appropriate instructions and would need to be available to conduct this work. This can present problems in a busy G.P. surgery but if measuring efficacy is considered important in the practice, it could perhaps be given priority. Alternatively, counsellors could allow time in the first session for completion of the forms. This also can be problematical as counsellors generally prefer to be establishing a relationship and questionnaire completion can be seen as hindering this process.

Concerning the poor return rate of questionnaires, clients could be encouraged to remain after the final session to complete the questionnaires. Naturally, this will not be possible in every case. A telephone reminder from the counsellor rather than a letter may be assessed as to if it increases return rate. The data may be biased in terms of those who returned those who returned and those who failed to return the questionnaires.
Results

Comparison of Scores on Beck Depression Inventory (BDI) before and after counselling

The BDI was administered to 12 clients before and after counselling. Complete data was not available for all clients who were seen by the counsellor for the reasons discussed earlier in the section on number of returned questionnaires.

Table 4: Frequencies of Clients Experiencing Depression prior to and following Counselling

<table>
<thead>
<tr>
<th>Method of measurement</th>
<th>Number of clients indicating the presence of depression</th>
<th>Number of clients indicating no signs of depression</th>
</tr>
</thead>
<tbody>
<tr>
<td>Beck Depression Inventory score prior to counselling</td>
<td>12</td>
<td>8</td>
</tr>
<tr>
<td></td>
<td>60% of respondents</td>
<td>40% of respondents</td>
</tr>
<tr>
<td>Beck Depression Inventory score following counselling</td>
<td>4</td>
<td>10</td>
</tr>
<tr>
<td></td>
<td>28.6% of respondents</td>
<td>71.4% of respondents</td>
</tr>
</tbody>
</table>

The results indicating the number of clients experiencing depression before and after therapy are included in Table 4. A cut off of 11 was used to define the presence of depression. The scores used by Beck to define different levels of depression are presented below.

0-10 no depression
11-18 mild to moderate depression
19-29 moderate to severe
30-63 severe

It can be seen that 60% of clients were experiencing depression prior to counselling.

The percentage of those experiencing depression before counselling (60%) dropped to 28.6% after counselling. Complete before and after therapy BDIs were obtained for 12 individuals. The mean score on the BDI dropped from 13 (before) (SD = 6.7) to 7.1 (after) (SD = 7.1) with a range of 4 to 27 before counselling and a range of 0 to 24 after counselling. A mean score of 13 which is in the mild range of depression suggests that clients referred are not experiencing significant levels of depression. However, in those cases where higher levels of depression were observed, that is clients 10 and 11, scores on the BDI decreased by 16 points (client 10) and by 23 points (client 11) post therapy. Client 10's score
pre therapy was at the high end of the moderate to severe range pre therapy and dropped to the lowest possible score in the mild to moderate range. Client 11's score dropped from the moderate to severe level of depression to no depression. It appears that the clients with more severe depression have a better outcome following counselling. It would be possible to suggest a BDI would be given to depressed clients before therapy to ensure that only those clients with significant problems receive therapy. The present sample did not appear to be experiencing depression as a major problem, but other problems were apparent. May be the choice of the BDI as an outcome measure was not the best choice in view of the problems the sample were experiencing. If consider table 1 other problems were more evident than depression, e.g. relationship difficulties. No significant difference in scores on the BDI before and after counselling were observed ($z = 1.64$, $p = 0.09$).

Table 5 Clients Scores on BDI before and after Counselling

<table>
<thead>
<tr>
<th>Client No.</th>
<th>Beck 1 (prior to counselling)</th>
<th>Beck 2 (after counselling)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>9.0</td>
<td>0.0</td>
</tr>
<tr>
<td>2</td>
<td>15.0</td>
<td>0.0</td>
</tr>
<tr>
<td>3</td>
<td>11.0</td>
<td>4.0</td>
</tr>
<tr>
<td>4</td>
<td>7.0</td>
<td>9.0</td>
</tr>
<tr>
<td>5</td>
<td>4.0</td>
<td>16.0</td>
</tr>
<tr>
<td>6</td>
<td>13.0</td>
<td>4.0</td>
</tr>
<tr>
<td>7</td>
<td>11.0</td>
<td>8.0</td>
</tr>
<tr>
<td>8</td>
<td>16.0</td>
<td>6.0</td>
</tr>
<tr>
<td>9</td>
<td>6.0</td>
<td>4.0</td>
</tr>
<tr>
<td>10</td>
<td>27.0</td>
<td>11.0</td>
</tr>
<tr>
<td>11</td>
<td>23.0</td>
<td>0.0</td>
</tr>
<tr>
<td>12</td>
<td>14.0</td>
<td>24.0</td>
</tr>
</tbody>
</table>

Individual clients scores on the BDI are presented in Table 5. Three clients scores increased, whilst 9 decreased. Table 6 shows the levels of depression prior to and following counselling which indicates that counselling may help in depression. But clearly the sample is too small for conclusive results to emerge about the efficacy of counselling depressed people.
Table 6: Showing the levels of depression indicated by the B.D.I scores prior to and following counselling

<table>
<thead>
<tr>
<th>Score indicates no depression</th>
<th>Score indicates mild-moderate levels of depression</th>
<th>Score indicates moderate-severe levels of depression</th>
<th>Score indicates severe depression</th>
</tr>
</thead>
<tbody>
<tr>
<td>No. of Clients</td>
<td>8</td>
<td>8</td>
<td>4</td>
</tr>
</tbody>
</table>

B.D.I. Questionnaires completed after finishing counselling: N=14

| No. of Clients | 10 | 2 | 1 | 1 |

Comparison of Scores on the State Trait Anxiety Scale (STAI) before and after counselling

The STAI was administered to 12 clients before and after counselling.

Table 7: Individuals scores on the STAI before and after counselling

<table>
<thead>
<tr>
<th>Client No.</th>
<th>STAI (before counselling)</th>
<th>STAI (after counselling)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>113</td>
<td>47</td>
</tr>
<tr>
<td>2</td>
<td>122</td>
<td>63</td>
</tr>
<tr>
<td>3</td>
<td>102</td>
<td>65</td>
</tr>
<tr>
<td>4</td>
<td>75</td>
<td>59</td>
</tr>
<tr>
<td>5</td>
<td>115</td>
<td>122</td>
</tr>
<tr>
<td>6</td>
<td>118</td>
<td>92</td>
</tr>
<tr>
<td>7</td>
<td>97</td>
<td>93</td>
</tr>
<tr>
<td>8</td>
<td>85</td>
<td>94</td>
</tr>
<tr>
<td>9</td>
<td>69</td>
<td>88</td>
</tr>
<tr>
<td>10</td>
<td>137</td>
<td>86</td>
</tr>
<tr>
<td>11</td>
<td>148</td>
<td>43</td>
</tr>
<tr>
<td>12</td>
<td>133</td>
<td>114</td>
</tr>
</tbody>
</table>

In 3 cases STAI scores increased after counselling but decreased in 9 cases. The mean STAI score before counselling was 109.5 (SD of 24.68) and after counselling was 80.5 (SD of 25.1). The difference was significant (z = 2.23, p = 0.02).

Comparison of Scores on the GHQ before and after counselling

The GHQ was administered to 12 clients before and after counselling.
Table 8: Showing the frequencies of clients within the psychiatric case range.

<table>
<thead>
<tr>
<th>Method of measurement</th>
<th>Number of clients within psychiatric case range</th>
<th>Number of clients below psychiatric case level</th>
</tr>
</thead>
<tbody>
<tr>
<td>G.H.Q. score prior to counselling</td>
<td>14</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>73.7% of respondents</td>
<td>26.3% of respondents</td>
</tr>
<tr>
<td>G.H.Q. score following counselling</td>
<td>5</td>
<td>9</td>
</tr>
<tr>
<td></td>
<td>35.7% of respondents</td>
<td>64.3% of respondents</td>
</tr>
</tbody>
</table>

Using a threshold score of 12 on the GHQ for indicating that a client was sufficiently psychologically distressed to be considered a psychiatric "case" it was apparent that 73.7% respondents were within the psychiatric case range. This indicates that GPs are referring patients with a level of psychological disturbance which places them in this psychiatric case range as defined by the GHQ. The number of cases within the psychiatric case range following counselling fell to 35% respondents. The change in GHQ scores before and after counselling was significant ($z = 2.44$, $p = 0.01$). The mean score before counselling was 25 (SD = 16.15) before counselling and was 9.4 (SD = 11.57) after counselling. This can be seen as operating as a type of control in that the clients are being compared to normative data. This is of interest particularly because of the lack of a no treatment control group.
Table 9: GHQ scores of individual clients before and after counselling

<table>
<thead>
<tr>
<th>Client No.</th>
<th>GHQ (before counselling)</th>
<th>GHQ (after counselling)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>47</td>
<td>0</td>
</tr>
<tr>
<td>2</td>
<td>16</td>
<td>0</td>
</tr>
<tr>
<td>3</td>
<td>39</td>
<td>15</td>
</tr>
<tr>
<td>4</td>
<td>7</td>
<td>1</td>
</tr>
<tr>
<td>5</td>
<td>22</td>
<td>36</td>
</tr>
<tr>
<td>6</td>
<td>9</td>
<td>5</td>
</tr>
<tr>
<td>7</td>
<td>15</td>
<td>5</td>
</tr>
<tr>
<td>8</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>9</td>
<td>25</td>
<td>11</td>
</tr>
<tr>
<td>10</td>
<td>36</td>
<td>13</td>
</tr>
<tr>
<td>11</td>
<td>51</td>
<td>0</td>
</tr>
<tr>
<td>12</td>
<td>32</td>
<td>26</td>
</tr>
</tbody>
</table>

The results detailed in Table 9 indicate that only in one case did the GHQ score increase after counselling. It is apparent therefore that a large proportion of clients referred to counsellors by GPs do exhibit a considerable degree of psychological disturbance and that scores on the GHQ decreased after counselling. Raw score data for the tests have been included as they contain more information than cut offs. However, cut offs are also included as they provide a comparison with normative data which is particularly important due to the lack of a control group.

THE COUNSELLING SERVICE CLIENT SATISFACTION QUESTIONNAIRE

OVERALL SATISFACTION

Overall satisfaction was measured by question 1 which related to the quality of the service and question 30 which related to the degree of satisfaction with the service. The frequencies of response to these items are presented in table 10. Data on the 22 clients who completed the questionnaires is presented in table 10.

Table 10: Client Responses to Overall Satisfaction of the Service and Quality of the Service Received

Overall I was satisfied with the service I received (Q.1)

<table>
<thead>
<tr>
<th>Frequency of response</th>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Uncertain</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>19</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>
The quality of the service received has been good (Q.30)

<table>
<thead>
<tr>
<th>Frequency of response</th>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Uncertain</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>19</td>
<td>3</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

It can be seen in Table 10, 100% of the sample either agreed or strongly agreed with the statement "the quality of the service I have received has been good." 21 of the sample agreed or strongly agreed with the statement "overall I was satisfied with the service I received." Only 1 client was uncertain about the degree of satisfaction with the service received. This suggests that either overall satisfaction and opinion about the quality of the service is high or would be that this typically positively skewed distribution of responses is purely a result of social psychological factors such as the halo or the Hawthorne effect.

**APPOINTMENT SATISFACTION**

Some questions related to:

1. waiting time between referral and receiving an appointment (Q.2)
2. if this was considered too long or a short length of time (Q.3)
3. satisfaction with the length of appointments (Q.4)
4. the length of appointments ranging from less than 30 minutes to over 60 minutes (Q.5)
5. the frequency of appointments (Q.6)
6. satisfaction with frequency of appointments (Q.7)
7. waiting time for appointments (Q.8)
8. satisfaction with waiting time (Q.9)

1. **Waiting Time Between Referral and Receiving an Appointment**

The results regarding waiting time between referral and receiving an appointment are presented in Table 11.
Table 11: The relationship between satisfaction/length of waiting time for appointment after referral and actual length of waiting time.

Rows: Satisfaction with waiting time for appointment after referral.
Columns: Length of waiting time for initial appointment after referral.

<table>
<thead>
<tr>
<th>Length of Waiting Time for Initial Appointment</th>
<th>Less than 2 weeks</th>
<th>Less than 6 weeks</th>
<th>Less than 2 months</th>
<th>Less than 3 months</th>
<th>Less than 4 months</th>
<th>More than 4 months</th>
</tr>
</thead>
<tbody>
<tr>
<td>Much too long</td>
<td>2</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Quite a long time</td>
<td>1</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not long</td>
<td>1</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reasonably short</td>
<td>4</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Very short time</td>
<td>7</td>
<td>3</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

It is apparent that 86% of the sample of 22 waited less than 6 weeks for an appointment and 32% less than 2 weeks. One client waited for more than 4 months. In general it seems that the waiting time for initial appointments is reasonable but also highlights the need to monitor waiting times to prevent an unacceptable waiting time for individual clients arising.

Clients were questioned as to if they considered the time they waited for an initial appointment was considered as being too long or a short length of time. This data is presented in Table 11 above.

It is apparent from Table 11 that there was a greater variation in response to this item than previous items. The mean response was 3.7 (5 represents very short time, 1 represents much too long), but 3 considered that they had to wait "much too long." It appears that this question reflects the clients perception of the waiting time and is subject to individual differences operating which affects the value judgements assigned. Individual differences could include psychological state, past experience of health care, beliefs and expectations. It does appear however that actual length of waiting time is related to the perception of satisfaction with waiting time ($r = 0.75$, $p \sim 0.00$).

**Length and Frequency of Appointments**

On examining Table 12 it is apparent that 18% clients were uncertain, disagreed or strongly disagreed with the statement that they were satisfied with the length of the appointments but that most, 92% of appointments were 45-60 minutes (20 out of 22) which is considered standard for counselling. It would have been interesting to have determined what was unsatisfactory about the length of appointments and what would have been preferred. This could be addressed in a future study. Again a variation in response to the client's opinion about their satisfaction with the length of appointments was obtained. It is interesting that such variation is
Table 12: The relationship between agreement of being satisfied with satisfaction with length of appointment and actual length of appointment

<table>
<thead>
<tr>
<th>Rows: Satisfaction with the length of appointment</th>
<th>Length of appointments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than 30 minutes</td>
<td>30-45 minutes</td>
</tr>
<tr>
<td>Very Satisfied</td>
<td>1</td>
</tr>
<tr>
<td>Quite Satisfied</td>
<td>1</td>
</tr>
<tr>
<td>Satisfied</td>
<td>2</td>
</tr>
<tr>
<td>Fairly Satisfied</td>
<td>1</td>
</tr>
<tr>
<td>Not Satisfied</td>
<td>1</td>
</tr>
</tbody>
</table>

92% of appointments were reported as occurring weekly with one reporting fortnightly appointments. Satisfaction with the frequency of appointments was high with all clients agreeing or strongly agreeing with the statement "I was satisfied with the frequency of my appointments." It is interesting to note therefore that weekly appointments lead to high satisfaction regarding the frequency of appointments. However it is impossible to determine if a longer interval between appointments would also lead to high satisfaction scores because of the skew in the distribution of responses to this question.

Waiting Time After Expected Appointment Time

No clients waited longer than 15 minutes for their appointment with 18 of the 21 who responded to this item waiting less than 5 minutes. All clients agreed or strongly agreed with the statement that they were satisfied with the waiting time for their appointments. It is interesting to note that this fulfills the Patients Charter requirements.

Table 13 shows the number of appointments received. Only 17% were dissatisfied with the total number received and would have preferred more sessions. It appears, therefore, that short term contracts are generally acceptable to clients. In some cases Counsellors extended contracts and this flexibility would seem to be a necessary part of a counselling service.
Table 13: The number of appointments and actual number of appointments received by clients

<table>
<thead>
<tr>
<th>Number of appointments received by clients:</th>
<th>3-5 appointments</th>
<th>6-8 appointments</th>
<th>9-11 appointments</th>
<th>12 appointments</th>
<th>More than 12</th>
</tr>
</thead>
<tbody>
<tr>
<td>Frequency of response</td>
<td>3</td>
<td>11</td>
<td>2</td>
<td>2</td>
<td>0</td>
</tr>
</tbody>
</table>

The total number of sessions ranged from 1 to 12 sessions with a mean of 7 sessions. In 43% cases the number of appointments was a joint decision between client and Counsellor, in 43% cases was the Counsellor's decision and in 14% was the client's decision. The intention had been to test the hypothesis that satisfaction would be correlated with who had terminated therapy with higher levels being reported where a joint decision had been made. However, due to the fact that the numbers involved were so small it was not possible to test this hypothesis.

Preferred Place of Appointment

When clients were asked if they preferred hospital or community based clinics for their sessions, 95% clients preferred the GP surgery and only 5% would have preferred to be seen at home, although all were seen in the GP practice. Satisfaction with sessions being held in GP surgeries is high. This supports the view that Counsellors should be employed to work in GP surgeries rather than clients being referred to a centralised counselling service. This supports the model suggested by Clinical Psychology whereby clients would be seen in GP practices by the Counsellor. However it must be acknowledged that the findings may reflect a satisfaction with where they were seen and may occur if they were seen in an alternative setting. The high ratings may also reflect social psychological factors operating.

Satisfaction with Clinic Staff

Satisfaction with the clinic staff was high with 86% of clients reporting agreeing or strongly agreeing with being satisfied and 3 being uncertain.

Satisfaction with the Environment at the Clinic

It appears that satisfaction with the clinic environment is high with 95% agreeing or strongly agreeing that the clinic environment was satisfactory and 5% being uncertain.
**General Therapy Satisfaction**

All clients felt that their referral to a counsellor was quite appropriate or very appropriate. This indicates that discussions with GPs prior to the setting up of the counselling service which involved discussions of what would be appropriate referrals have been effective.

All clients felt that the therapist was either quite understanding or very understanding.

**Outcome**

62% clients reported strongly agreeing that they had a greater understanding and 38% reported agreeing that they had an understanding of their problems. This is seen as a good outcome for counselling.

The responses to satisfaction with clinic staff, environment at the clinic, appropriateness of referral, counsellors and clients understanding of problems are positively skewed and suggest the operation of social psychological effects operating. Clients have not utilised the negative categories regarding these items.

85% clients felt that treatment contributed to improvement. 10% clients were uncertain that treatment contributed to improvement with only 5% disagreeing that treatment contributed to improvement. This is encouraging as a criticism of providing counselling is that clients may improve spontaneously as that improvement may not be related to treatment. Clearly in this study clients felt that it was treatment that contributed significantly to improvement. Four of the five categories of response were utilised in this question although the distribution was still positively skewed.

40% of those who answered this question report that they disagree that the difficulties which the clients had when first came for treatment affect their lives now with 35% being uncertain. Only 25% clients agreed in having the difficulty as before. A greater variation in response is seen in the responses to this item which argues against the operation of social psychological artifacts.

Only 1 client reported strongly disagreeing with the statement that they felt better after treatment. 19 reported strongly agreeing, agreeing or uncertain. 68% of the
19 reported strongly agreeing that they felt better than when they first came for treatment. This is seen as an excellent outcome of treatment and exists with some variation in the responses.

62% of the sample of 21 clients reported that their lives had been generally easier and more enjoyable since treatment. 28% clients were uncertain and 10% strongly disagreed with the statement that since treatment life had been generally easier and more enjoyable. This is seen as a reasonable outcome. A spread of scores is apparent in this item. Previous questions were answered predominantly as strongly agreed or agreed which raises the possibility of a halo effect operating. A spread of scores reduces the probability of a halo effect accounting for the responses.

80% clients reported that treatment helped to deal with the problems the client had when referred with 14% being uncertain and 6% disagreeing. This is seen as a good outcome for counselling.

90% clients either agreed or strongly agreed with the statement relating to being satisfied with the counsellor. This attests to the quality of the relationship between clients and counsellor being positive. This is what would be expected in that the counselling relationship is a most important part of therapy. It could also reflect a "grateful testimonial" (Lebow 1979) or the operation of other social psychological factors.

**Relationship between overall satisfaction and aspects of the service**

Appropriateness of referral was highly correlated with satisfaction ($r = 0.52$, $p = 0.01$), however feeling understood by the counsellor ($r = 0.19$, $p = 0.39$) was not significant. The opinion that treatment contributed to improvement was highly correlated with satisfaction ($P = 0.59$, $p = 0.004$). Satisfaction with the therapist was correlated with overall satisfaction ($r = 0.70$, $p < 0.00$) but was not correlated with the number of appointments ($r = 0.02$, $p = 0.9$). Satisfaction with the clinic environment was correlated with overall satisfaction ($r = 0.42$, $p = 0.05$) but satisfaction was not correlated with satisfaction with clinic staff ($r = 0.02$, $p = 0.91$). However feeling understood by the counsellor was positively correlated with the opinion that the quality of the service received was good ($r = 0.49$, $p = 0.01$).
Outcome measures were correlated with satisfaction as detailed below:

1. Feeling better was correlated with satisfaction ($r=0.73$, $p=0.0$).
2. Life being more enjoyable and easier was correlated with satisfaction ($r=0.43$, $p=0.05$).
3. Treatment helped patients to deal with the problems correlated with satisfaction ($r=0.74$, $p=0.0$).
4. Treatment being seen as contributing to an improvement in the problems correlated with satisfaction ($0.59$, $p=0.004$).

Factors such as waiting time for initial appointment, number and length of appointments, clients increased understanding of their problems, and waiting time after expected appointment time were not correlated with satisfaction.

The correlations reported are Spearman's Rho correlations as the sample was small, the distribution was skewed and was conducted on ordinal variables.

**Suggestions for Improvements to The Service and Comments Regarding the Service**

**Table 15: Comments and suggestions made by clients in the questionnaires**

<table>
<thead>
<tr>
<th>Comment no.</th>
<th>Comments/Suggestions</th>
<th>Frequency of comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>More sessions preferred</td>
<td>1</td>
</tr>
<tr>
<td>2</td>
<td>Service should be advertised at clinic etc.</td>
<td>1</td>
</tr>
<tr>
<td>3</td>
<td>Home visits should be available</td>
<td>1</td>
</tr>
<tr>
<td>4</td>
<td>Follow up appointments/checks should be available</td>
<td>1</td>
</tr>
<tr>
<td>5</td>
<td>Home visits and follow up checks should be available</td>
<td>1</td>
</tr>
<tr>
<td>6</td>
<td>Generally very positive comments</td>
<td>8</td>
</tr>
<tr>
<td>7</td>
<td>More comfortable environment preferred</td>
<td>1</td>
</tr>
<tr>
<td>8</td>
<td>Wider availability of appointments/counsellors requested</td>
<td>2</td>
</tr>
<tr>
<td>9</td>
<td>Service should be more readily available by GPs</td>
<td>1</td>
</tr>
<tr>
<td>10</td>
<td>More privacy/separate waiting room requested</td>
<td>1</td>
</tr>
<tr>
<td>11</td>
<td>Communication should be improved between referrers</td>
<td>1</td>
</tr>
<tr>
<td>12</td>
<td>Requests for shorter waiting time for initial appointment</td>
<td>1</td>
</tr>
</tbody>
</table>

The most frequent comments were positive statements about the service. The questionnaires continue to be administered and comments/suggestions recorded to determine if any comment receives larger numbers and attempts will be made to address the issue.
GP Consultation Rates Before and After Counselling

1. The total GP consultation rate for both physical and mental health problems for 2 months before and after counselling was collated for 28 clients. The mean consultation rate prior to counselling was 2.25 (SD = 1.45) and after counselling was 1.46 (SD = 1.45) which was a significant difference (t = -2.64, df = 27, p = 0.1). This confirms the hypothesis that GP consultation rates will decrease after counselling. This aspect of the study is to be repeated using a six month period before and after counselling. In addition the GP consultation rate specifically for mental health problems was collated for 2 months before, the period during counselling, and for 2 months after counselling. The mean consultation rate for mental health problems prior to counselling was 1.36 (SD = 1.19) and during counselling was 0.6 (SD = 1.26), a difference which was significant (t = 3.22, df = 32, p = 0.003). It is interesting that there is such a significant decrease in GP consultation rates and is an argument for the efficacy and benefits of counselling. The mean GP consultation rates for mental health problems prior to counselling was 1.36 (SD = 1.19) and after counselling was 0.41 (SD=0.82) which is significant (p<0.0) As stated these results only apply to a two month period after counselling and it will be interesting to assess if these results are stable over time and are evident six and twelve months after the cessation of counselling.

Prescription Rates as an Outcome Variable

Prescription rates for the 2 months before and for the 2 months after counselling were collated. It is recognised that the 2 month period before and after counselling is too short and data will be collected so that prescription rates 6 months before and after counselling will be collated. The 2 month period was chosen because of the time constraints of the present study and is used to demonstrate the methodology to be employed.

Data was collected on 28 clients. The mean prescription rate prior to counselling was 0.89 (SD = 0.95) and after counselling was 0.82 (SD = 0.81). This was not a significant difference. The hypothesis that prescription rates would decrease after counselling was not confirmed (t = 0.39, df = 27, p = 0.7). However, the prescription rate for mental health related prescriptions fell during counselling as compared to before counselling (t = 0.94, df = 32, p = 0.03).
DISCUSSION

Scores on the BDI before and after counselling were not significantly different. The sample size was, however, small and data will continue to be collected until a larger sample size is obtained. The STAI scores decreased significantly when scores before and after counselling were compared and so it seems that counselling is extremely useful with clients displaying symptoms of anxiety.

The GHQ results are interesting in that 73.7% respondents were within the psychiatric case range before counselling which reinforces the view that those referred to counsellors do have significant psychological problems. The scores decreased significantly after counselling affirming the view that counselling is effective in reducing psychological disturbance.

Prescription and consultation rates were compared for the two months before and after counselling. No changes in prescription rates were observed but clearly the project will need to be extended so that prescription rates for at least 6 months before and after counselling can be compared. GP consultation rates before, during and after counselling were significantly different in that consultation rates decreased during and after counselling. Again this will be extended to six months before and after counselling. Clearly if consultation rates do decrease as a consequence of counselling, this has implications for the cost benefit of counselling. Clearly the sample size is small and the study will be continued so that a larger sample size will be attained. In addition, results for prescription and consultation rates will be collated for longer periods prior to and after counselling. A waiting list control would be difficult to justify ethically but a CPN recently employed to work in the practice is to use the same outcome and evaluation measures so that a comparison can be made. On a practical level, only three clients waited for between six and sixteen weeks, all other clients waited less than six weeks. The quick response rate meant that there were insufficient numbers for a waiting list control.

It can be seen that client satisfaction with the Counselling Psychology Service is high. Overall satisfaction with waiting times for initial appointments, the number and frequency of appointments, punctuality of appointments and length of appointments was evident. Clients preferred to be seen in the GP surgery. The referrals were appropriate demonstrating the efficacy of discussions regarding suitability of referrals prior to the setting up of the service. In many instances where a rating scale utilising 5 values was employed, only 2 or 3 of the values were
utilised. This is typical of much of the satisfaction research and may be due to response biases and halo effects. An attempt had been made to reduce bias by the assurance of anonymity of responses but appears not to have been very effective:

Outcome measures included on the Client Counselling Service Satisfaction Questionnaire demonstrated very positive outcomes in terms of the clients having a better understanding of their problems and that quality of life was better and that the problems which they had on referral had decreased. Clients generally reported feeling better than when referred and that treatment had helped them to deal with their problems. Other outcome measures which showed a significant change included a significant reduction in anxiety levels, a significant reduction in the number of clients who could be classed as exhibiting levels of psychological distress which classify them as a "psychiatric case" on the General Health Questionnaire and a significant reduction in GP consultation rates.

In satisfaction studies, positive judgements of services are very common and could be seen to be due to the operation of social psychological effects. It has therefore been pleasing that some items show a range of response. Satisfaction surveys are often a useful evaluation tool as the client's opinion of the service should be sought. However, it is considered more useful to use standardised questionnaires such as the BDI, STAI and GHQ.

The one group pre test-post test model was used as the planned waiting list control group did not materialise.

Barker Bausell (1986) comments that the pre test/post test model provides a meaningful comparison in that if the second mean is significantly lower than the first then the change is not simply due to chance fluctuations and so such a study meets the minimum requirement generating causal or relational inferences. However alternative explanations could be posed for the results. This was considered in that counsellors were asked to report to the researcher if any life event occurred which could have affected the dependant variables. This was not found to be the case. Referral to and intervention by other agencies was also monitored as this was seen as possibly affecting the dependent variables. This onward referral occurred in two cases after the study finished. The time interval between pre and post tests was as brief as possible so reducing the possibility of an effect from another variable. Tests were conducted on the first and the final sessions.
A significant problem is that the results could have been due to natural remission. However, the waiting time for appointments was minimal and treatment generally lasted for only six weeks. This reduces the likelihood of natural remission occurring. When clients are referred by the same practice to the Clinical Psychologist, a longer waiting time for initial appointment is evident but there is little evidence of a high drop out rate or reports of improvement which would provide evidence of natural remission occurring in this relatively short time span.

Barker Bausell (1986) comments that restricting the treatment interval can help to prevent any substantive natural remission from occurring.

Clients were also asked if they attributed the change to treatment so giving them the opportunity to indicate that other factors operated to create the change. Owens et al (1989) comment that although experimental procedures are accepted as an appropriate means of conducting research in the mental health field, there are often reasons in clinical practice that render a tight experimental design impractical. It is recognised that in many cases no treatment control groups may be unacceptable on ethical grounds and in such cases it may be appropriate to provide treatment to all individuals involved, reporting the results of such interventions as they stand without direct comparison with similar untreated individuals. Owens et al (1989) comment that including relevant and robust pre intervention/post intervention measures can minimise alternative interpretation of data and so the inclusion of psychometrically sound measures was seen as necessary for this study. Owens et al (1989) comment that the presence of confounding variables may limit the confidence which may be placed in the results, but the information provided may none the less be of considerable value.

Shepherd (1989) in a discussion of research in service planning and evaluation comments that in small scale studies simple pre-post evaluations can be useful. Although the causal inferences cannot be made, the trends are nevertheless interesting for service evaluation. Kendall and Norton-Ford (1982) comment that when a control group cannot be arranged such as at a clinic that never has a sufficiently large waiting list to hold people the full time period of therapy, a quasi experimental alternative is offered by contrasting the therapy groups scores on the assessment measures with normative standards. The researcher may demonstrate that the therapy group scored in the normal range on assessment measures by the end of therapy, after having scored on the dysfunctional range prior to therapy.
This offers a tentative approximation of the control provided by true control groups. The present study considered if there was a significant change in levels of depression (BDI) and psychiatric morbidity (GHQ).

Before and after studies are accepted in evaluating programmes because if little change is demonstrated then the treatment is probably having little effect and it may not be worthwhile continuing or subjecting it to more rigorous evaluation. This kind of preliminary reconnaissance may be particularly apt for evaluation because (1) experience shows that many programmes produce little gain and (2) most of the contaminating factors artificially elevate the level of gain. If change does appear, the programme can be subjected to further study under experimental conditions to determine how much of the change is attributable to the programme (Weiss 1972). Evaluation studies are often less rigorous than research studies in that they are also answering questions posed by organisations such as regarding waiting times for appointments and preferred place of appointments. Such questions often require answers in a short time frame and the organisation does not require a strict research paradigm. It seems the aim is to be as rigorous as possible while meeting the demands placed on the evaluator by the organisation.

Quinn Patton (1982) when discussing evaluation, reports that evaluation does not have to follow a strict research methodology. Often resources are limited, deadlines are short and intense political pressure exists. A belief of evaluators is that "doing something is better than nothing, so long as one is realistic and honest in assessing and presenting the limitations of what is done." Technical concerns for data accuracy should be made in conjunction with concerns for utility, feasibility and propriety. The final test for an evaluation study seems to be if it achieved the necessary aim. This has been achieved in the present study in that the aim was to stimulate awareness of the model of Counselling Psychologists being employed in a Clinical Psychology Department and being contracted out to GPs. The fact that 2 further Counselling Psychology contracts have now been established is witness to the success of the endeavour.

An additional problem is due to selection bias. Many clients failed to return questionnaires and so the group who returned pre and post questionnaires could be seen as being a distinct and perhaps different group from the non responders. The latter group may have different satisfaction and outcome results from those completing therapy and returning the questionnaires.
In summary the study has the methodological shortcoming of a lack of the planned waiting list control group and selection biases but for the reasons discussed can still be seen as providing some useful information.

Evaluation studies are being requested by NHS Trusts and are useful in that they fulfil several functions eg:

(1) monitor quality issues such as waiting time for appointments
(2) explore user's perceptions of the service and provide an opportunity for feedback and information regarding service development.
(3) explore variables to be considered when judging the efficacy of programmes.
(4) investigate the efficacy of programmes.

Regarding points three and four, it appears from this study that significant savings in terms of prescription and GP consultation rates after counselling probably are not achieved. However, as already stated, the data will be collected over a longer time span so that this can be tested further. The present study indicates that GP visits are reduced by one in a period of two months which would not represent a cost saving. This raises the possibility that other possible benefits would be of greater importance such as changes in depression, anxiety and GHQ scores. There is some evidence that the latter two scores do decrease and this is seen as a justification for allocating resources to conduct more thorough research to address this issue.

Such information will aid decision making about the future of counselling services. The present study has been utilised to demonstrate a particular model which is of counselling psychologists being employed by a Clinical Psychology Department and being contracted to work in primary care. The study has provided preliminary information about possible efficacy and has monitored quality issues which are of importance to managers and purchasers of services. This has led to the service being expanded to two further practices and a more detailed evaluation has been agreed. Resources have been allocated for this evaluation.

There exists a difficulty in setting criterion for "success" of the scheme. Is it to be gauged in terms of a specific reduction in scores on the psychometric test or movement from, for example, a score in the severe range to a score in the normal range of depression scores? A statistically significant change may be accepted as
the accepted level of success but is this equal to a clinically significant change? It
could be argued that a criterion for success would be client's self reports of
satisfaction or change but given the budget implications and resource limitations
this may seem unacceptable.

Questions concerning the criterion to be used for success need to be agreed by
managers and clinicians eg:

(1) a significant decrease in depression as measured by the BDI
(2) a significant decrease in anxiety as measured by the STAI
(3) a significant decrease in psychiatric morbidity as measured by the GHQ.

Such information can also be used to inform the development of the service, for
example if it is confirmed that anxious rather than depressed people benefit more
from counselling then this has implications for the targeting of clients with
particular problems.

One criterion for success for the Psychology Department is undoubtedly if other
GP practices and then Eastern Surrey Commissioners accept the model of
counselling psychologists working in Clinical Psychology Departments and
establishing contracts.

Such evaluations are seen as ongoing and increasing in level of complexity eg. from
a preliminary study investigating possible efficacy, to waiting list control group
design, to alternative treatment control group design, to exploring the effect of
counselling on different client groups etc. Evaluations is seen as providing
information (Weiss 1972)

(1) to continue or discontinue the programme
(2) to improve its practices and procedures
(3) to add or drop specific programme strategies and techniques.
(4) to institute similar programmes elsewhere
(5) to allocate resources among competing programmes.

When evaluation is seen as an ongoing process the it can offer useful information
which can be utilised to develop the programme so enhancing efficacy.
The present study has provided information which suggests that more detailed evaluations are worthwhile. It has also raised the possibility that some client groups ie. anxious rather than depressed people do better with counselling. In addition it has led to similar programmes being set up elsewhere and has raised the profile of Psychology as being involved in the development of Counselling Services.

The results from the pilot study will be circulated to G.P.s in Mid Surrey, to the Commissioners and the Health Authority. It is to be hoped that the present study may be modified and developed and may serve as a protocol for future evaluative surveys of counselling in primary care in Surrey.

My recommendation would be to utilise standardised psychological tests as outcome measures and consultation rates. The usefulness of the satisfaction survey is more limited, although certain aspects regarding organisational issues would be retained. The questionnaire could also be utilised by other mental health care professionals operating in the primary health care team so that comparisons could be used. Particularly interesting would be a comparison of types of problems, degree of psychological disturbance and outcome.

Regarding establishing a counselling service, I would recommend the placement of such a service within a Clinical Psychology Department as has occurred in other Regions. The advantages include the screening of qualifications by experienced practitioners, supervision, peer support, links to the other aspects of Mental Health Services and an N.H.S. based service managed by those with experience of the N.H.S.

As a consequence of this work, one fund holding G.P. practice has recently requested costings for 4 sessions per week of counselling supervised and managed by the Clinical Psychology Department and this is planned to commence in April 1996. The evaluation methods recommended in the present study will be utilised as an ongoing method of assessing the efficacy of the service. The literature survey has proved invaluable in raising issues and providing information for the G.P.'s which has facilitated discussion and negotiation about such a service and the parameters of the service have been able to be made explicit.
REFERENCES

British Association for Counselling (1993) Guidelines for the employment of counsellors in general practice. Darby: British Association for Counselling, Counselling in Medical Settings Division.


Martin, B. (1985) Counselling in General Practice. Journal of the Royal Society of Medicine, 78, 186-188.


1. Title of Scheme

An Evaluation of Counselling in Primary Care Settings

2. Details of Lead Applicant (to whom all correspondence will be addressed)

Name: Vicky Hobbs
Designation/Job Title: Psychology Services Manager
Postal Address: Surrey Heartlands, West Park Hospital, Horton Lane, Epsom, Surrey
Post code: KT19 8PB Telephone: 0372 727811 Extension: 4219

3. What are the objectives of the scheme and how will the outcome(s) of the scheme be measured against these?

The aim of the scheme is to assess the present counselling services in primary care in Mid Surrey and to then make proposals for the development of future counselling services guided by GP's, counsellors and users' views. Literature reviews and information concerning the model in use in other Health Authorities will also be gained and used to aid the development of recommendations. A report detailing questionnaire results, the literature review and the resulting recommendations will be produced.

4. Briefly describe the scheme, including any innovative aspects, and indicate how it will promote the effective use of resources.

Basic information concerning hours of counselling offered, the training of counsellors and supervision arrangements will be obtained. Three additional questionnaires will be used. 1. A GP questionnaire assessing the present service and views concerning future service needs. 2. A User questionnaire to assess the benefits and problems with the service and simple outcome assessment which will focus on both the users' subjective experience of counselling and on their health gains. 3. A Counsellor questionnaire to assess the problems they experience in offering the service and to determine their needs. Information concerning the training of counsellors, supervision arrangements, links to the Mental Health Services and types of suitable referrals will be presented. This will then be used to make recommendations for service development, e.g., the minimum level of training required, if supervision should be mandatory, if a management structure is necessary.

5. (Please indicate how your scheme meets the local criteria set out in Appendix I to the Guidance Notes which accompany this form.

The scheme fulfills the criteria in that it will be assessing a service and will then be making proposals to guide Mid Surrey Providers and Purchasers. A counselling service can be seen as contributing to the Health of the Nation targets of reducing the work of death through suicide within the District. The scheme therefore contributes to the successful implementation of the Mid Surrey Health Authority Strategy for Mental Health Services and the joint Surrey RHSA/Mid Surrey Health Strategy. It contributes to the development of services which will prevent or delay people with medium or low dependency levels from becoming "high need" clients so enabling them to live in their own homes and avoid the need for hospital admission. It will provide recommendations that can be used by purchasers and providers.

*See separate sheet.
6. Which client group(s) will the scheme serve? [Please tick box(es)].

<table>
<thead>
<tr>
<th>Client Group</th>
<th>Ticked</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children</td>
<td></td>
</tr>
<tr>
<td>Elderly</td>
<td></td>
</tr>
<tr>
<td>Health Promotion/Health of the Nation</td>
<td></td>
</tr>
<tr>
<td>Learning Disability</td>
<td></td>
</tr>
<tr>
<td>Mental Health</td>
<td></td>
</tr>
<tr>
<td>Physical Disability</td>
<td></td>
</tr>
<tr>
<td>Substance Misuse</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
</tr>
</tbody>
</table>

7. How will the scheme be managed?

The head of Psychology would be responsible for the scheme. The day to day manager of the scheme would be Mrs Angela Devon, Principal Clinical Psychologist (Community). She has undertaken to carry out the work in consultation with Penny Schonach, Care Advisor, and David Slater, Independent Medical Adviser, would receive copies of work planned before implementation.

8. No. of clients served

9. Locality(s) served

Mid Surrey

10. What assessment of client need has been undertaken in preparation for this application?

The Mid Surrey Health Authority & Surrey FHSA Health Strategy's (1994) needs assessment indicated that 40,000 people in Mid Surrey experience a recognisable mental health problem each year and the suicide rate was 9.1 per 100,000 in 1991 and 1992. The Surrey Lifestyle Survey results indicate that a significant number of younger adults have sleep difficulty or feel stressed and anxious. Many adults use alcohol, cigarettes or drugs to ameliorate these feelings, and some resort to suicide. The 1991 census results show that 7% of households in Mid Surrey consist of a lone pensioner. Since elderly people are comparatively likely to experience chronic illness, social isolation and bereavement then overall risk of depression is also increased. It is likely that all these groups could be thought to benefit from counselling it is imperative that any counselling service should be planned and well monitored.*See separate sheet.

11. Names of those who have been consulted in statutory and voluntary agencies. (Please attach written confirmation of support wherever possible.)

<table>
<thead>
<tr>
<th>Name</th>
<th>Post Held</th>
<th>Authority/Organisation</th>
</tr>
</thead>
<tbody>
<tr>
<td>David Slater</td>
<td>Independent Medical Advisor</td>
<td>FHSA</td>
</tr>
<tr>
<td>Penny Schonach</td>
<td>Primary Care Advisor</td>
<td>FHSA</td>
</tr>
<tr>
<td>Ruth Jordan</td>
<td>Placement Co-ordinator, Lecturer</td>
<td>PhD in Counselling Psychology</td>
</tr>
<tr>
<td>Drs Maymen, Lowes</td>
<td>GPS</td>
<td>Linden Hs. Surgery, Leatherhead</td>
</tr>
<tr>
<td>Dr Birtwistle</td>
<td>GP</td>
<td>Kingston Rd Surgery, Leatherhead</td>
</tr>
<tr>
<td>Lo May Tsung</td>
<td>Locality Team Manager</td>
<td>Mid Surrey Health</td>
</tr>
<tr>
<td>Linda Durman</td>
<td>Director for Public Health</td>
<td>Mid Surrey Health</td>
</tr>
<tr>
<td>Claire Moonan</td>
<td>Health Promotional Manager</td>
<td>Mid Surrey Health</td>
</tr>
</tbody>
</table>

12. Service Provision - (Please tick the appropriate box to indicate how the project will affect current service provision.)

<table>
<thead>
<tr>
<th>Service Provision</th>
<th>Local Authority</th>
<th>County Council</th>
<th>Voluntary Organisation</th>
<th>Health Authority</th>
</tr>
</thead>
<tbody>
<tr>
<td>Addition to service provision</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Improving an existing service</td>
<td></td>
<td></td>
<td></td>
<td>*</td>
</tr>
<tr>
<td>Maintaining an existing service which may otherwise be prematurely abandoned.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Will affect primary care and health authority by evaluating current service so that may make recommendations for service development which may help purchasers, providers, GPs, FHSA, Health Authority.
PAGE NUMBERS CUT OFF IN ORIGINAL
13. Breakdown of funding requested. (Please do not include allowance for inflation or pay awards.)

<table>
<thead>
<tr>
<th>Cost components</th>
<th>Non-recurrent start-up costs</th>
<th>Annual Revenue costs</th>
<th>Capital items</th>
</tr>
</thead>
<tbody>
<tr>
<td>Salaries, including employers’ N.1 and superannuation. (State staff numbers, titles/grades)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.0 Basic Grade Psychologist</td>
<td></td>
<td>15428</td>
<td></td>
</tr>
<tr>
<td>22 sessions Grade A psychologist</td>
<td></td>
<td>1216</td>
<td></td>
</tr>
<tr>
<td>Transport/Travel</td>
<td></td>
<td>1500</td>
<td></td>
</tr>
<tr>
<td>Premises (heat, light, rent, insurance, etc.)</td>
<td></td>
<td></td>
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<tr>
<td>Printing/publications</td>
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<td>1000</td>
<td></td>
</tr>
<tr>
<td>Postage/Stationery/Telephone</td>
<td></td>
<td>500</td>
<td></td>
</tr>
<tr>
<td>Office Equipment</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other (Please specify)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>TOTAL:</td>
<td></td>
<td>19644</td>
<td></td>
</tr>
</tbody>
</table>

14. Future Funding

(a) Is this a time-limited, one-off project?

Tick box: Yes [x]  No [

(b) If you have ticked NO, please give below details of how you anticipate the project will be funded when Joint Finance ceases.

(c) Before Joint Finance can be granted, confirmation is required that the recipient intends to meet the full costs of the project as the Joint Finance contribution reduces. Please give details of proposed tapering arrangements in the table below:

<table>
<thead>
<tr>
<th>% Pick-up and year</th>
<th>Agency Name &amp; Address</th>
<th>Name &amp; designation of agency representative</th>
<th>Signature of agency representative</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
15. Price level basis for information given in answer to 13 above (i.e. effective date of estimate). 01.04.93.

16. Proposed Timeframe for Scheme

<table>
<thead>
<tr>
<th>Estimated Start Date</th>
<th>Month</th>
<th>Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Joint Finance Period (i.e. length of time over which Joint Finance is sought)</td>
<td>No. of years</td>
<td>months</td>
</tr>
</tbody>
</table>

17. Expenditure Profile over term of scheme

<table>
<thead>
<tr>
<th>Year (start-end)</th>
<th>Non-recurrent start up costs</th>
<th>Revenue Costs</th>
<th>Capital Costs</th>
<th>Total Amount requested from joint finance</th>
<th>Income (e.g. client contribn., fundraising)</th>
<th>Income from other agencies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yr 1 (1.4.95 - 31.3.96)</td>
<td>11,422</td>
<td>9,822</td>
<td></td>
<td>9,822</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yr 2 (1.4.96 - 31.3.97)</td>
<td>11,422</td>
<td>9,822</td>
<td></td>
<td>9,822</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yr 3 (1.4.97 - 31.3.98)</td>
<td>11,422</td>
<td>9,822</td>
<td></td>
<td>9,822</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yr 4 (1.4.98 - 31.3.99)</td>
<td>11,422</td>
<td>9,822</td>
<td></td>
<td>9,822</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yr 5 (1.4.99 - 31.3.2000)</td>
<td>11,422</td>
<td>9,822</td>
<td></td>
<td>9,822</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cumulative Total</td>
<td>57,644</td>
<td>49,122</td>
<td></td>
<td>49,122</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

18. Please detail alternative or complementary sources of funding being sought.

19. Application authorised on behalf of sponsoring organisation by:

Signature of authorising officer: Psychology Services Manager

Date: 28 September 1994

Please return your completed application form to:

Joint Planning Officer
Mid Surrey Health Authority
West Park Hospital
Horton Lane
Epsom KT19 8PB
5. (Please indicate how your scheme meets the local criteria set out in Appendix I to the Guidance Notes which accompany this form) cont'd.

The Mid Surrey Health Authority and FHSA Health Strategy 1994 states that "by 1995/96...... a joint DHA/FHSA community primary prevention mental health strategy, that will include early detection and recognition of at risk people because of life events, the provision of early accessible and appropriate counselling and support, the provision of training in coping skills.....". The present proposal is seen as assessing the present levels of such a service and to be able to guide the development of an effective counselling service to Mid Surrey.

The Mid Surrey Health Authority's strategy for Mental Health Services comments on there being an "immediate counselling service offered from within the practices own personnel." The strategy recognises the need to offer a counselling service to prevent the experience of traumatic life events from leading to serious mental health problems and acknowledges that counselling can help in reaching 'The Health of the Nation' target to improve significantly the health and social functioning of mentally ill people, and also to reduce the suicide rate among the general population by 15% by the year 2000.

10. What assessment of client need has been undertaken in preparation for this application cont'd.

Community Mental Health Teams receive many referrals from GPs for counselling, yet the Community Mental Health Team is not a counselling service. Working in primary care settings, GP contact reveals that there is a huge need for a counselling service.

Counsellors have approached the Psychology service requesting support and supervision. The FHSA is currently funding many GPs to provide counselling services at their practices. There are no firm recommendations for training or supervision of counsellors and no formal links exist between the counsellors and the mental health services or social services.
Dear Dr.

The Department of Psychology is able to offer one 3-hour session of counselling per week for the next year to one GP in the Locality.

The counselling would be undertaken by a Counselling Psychologist. Supervision would be provided by a qualified Clinical Psychologist from the Department of Psychology based at West Park Hospital.

The advantage of this arrangement is that the counsellor has been screened for suitability, will be rigorously supervised and will have access to support from the Mental Health Services in the Locality.

The rate for the counsellor will be £12 per hour and this will then be used to finance the supervision arrangements.

If you are interested in taking up this offer, would you please contact me so that we could discuss it further? Thank you.

Yours sincerely

Angela Devon
Principal Clinical Psychologist
& Specialist in Community Psychology
INTRODUCTION
The Mid Surrey Health Authority and Surrey FHSA Health Strategy's (1994) needs assessment indicated that 40,000 people in Mid Surrey experience a recognisable mental health problem each year and the suicide rate was 9.1 per 100,000 in 1991 and 1992. The Surrey Lifestyle Survey results indicate that a significant number of younger adults have sleep difficulty or feel stressed and anxious. Many adults use alcohol, cigarettes or drugs to ameliorate these feelings and some resort to suicide. The 1991 census results show that 7% of households in Mid Surrey consist of a lone pensioner. Since elderly people are comparatively more likely to experience chronic illness, social isolation and bereavement then the overall risk of suicide is also increased. It is likely that all these groups could be thought to benefit from counselling. The Mid Surrey Health Authority and FHSA Health Strategy (1994) recommends the establishment by 1995/96 that a joint DHA/FHSA community primary prevention mental health strategy, that will include early detection and recognition of at risk people because of life events, the provision of early accessible and appropriate counselling and support, the provision of training in coping skills. The Mid Surrey Health Authority's strategy for Mental Health Services comments on there being an "immediate counselling service offered from within the practices own personnel". The Strategy recognises the need to offer a counselling service to prevent the experience of traumatic life events from leading to serious mental health problems and acknowledges that counselling can help in reaching the Health of the Nations target to improve significantly the health and social functioning of mentally ill people, and also to reduce the suicide rate among the general population by 15% by the year 2000.

THE CURRENT SITUATION
The FHSA provide funding for counsellors working in some GP practices. Other GPs fund such counsellors from their own resources. There is a generally recognised difficulty in that there is no nationally agreed policy on the training necessary for a counsellor and there is no registration or monitoring necessary for all counsellors by a recognised body. This lack of standardisation in counselling training and qualification and no central regulating body leads to difficulties in that GPs may have difficulty in assessing the qualifications and skills of applicants for counsellor posts.

An additional problem is that supervision of counsellors work is generally recognised as being necessary for effective counselling though no formal arrangements for providing such supervision are in operation in Mid Surrey. Counsellors generally also have no links with Community Mental Health Teams and so are unable to make use of this resource.

Ongoing training of counsellors is necessary to develop their skills, update their knowledge, of offer them support and ensure a high quality service. At present this is not provided within Mid Surrey.
COUNSELLING SERVICE
APPENDIX 4
CLIENT SATISFACTION QUESTIONNAIRE

This questionnaire is designed to assess the quality of the counselling service which you have received. It will only take a few minutes of your time but it is important for the planning and development of the service and will be used to improve the service for people who will be using the Counselling Service in the future. You may agree with some whilst disagreeing with or being uncertain about others. Please read each statement and put the number which corresponds to your view in the appropriate box.

1. The quality of the service I have received has been good.

2. How long did you wait to get an appointment with the Counsellor after you had been referred? (Please tick the appropriate box).

<table>
<thead>
<tr>
<th>Less than 2 weeks</th>
<th>Less than 6 weeks</th>
<th>Less than 2 months</th>
<th>Less than 3 months</th>
<th>Less than 4 months</th>
<th>More than 4 months</th>
</tr>
</thead>
</table>

3. Was this:

<table>
<thead>
<tr>
<th>Much too long</th>
<th>Quite a long time</th>
<th>Not long</th>
<th>Reasonably short</th>
<th>Very short time</th>
</tr>
</thead>
</table>

4. I was satisfied with the length of appointments

   Using the scale above please put the number which corresponds to your view in the box.
<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly Agree</td>
<td>Agree</td>
<td>Uncertain</td>
<td>Disagree</td>
<td>Strongly Disagree</td>
</tr>
</tbody>
</table>

5. How long were your appointments? (Please tick the appropriate box)
- Less than 30 minutes
- 30 - 45 minutes
- 45 - 60 minutes
- More than 60 minutes

6. How frequent were your appointments? (Please tick the appropriate box)
- Weekly
- Fortnightly
- Monthly
- Less than monthly

7. I was satisfied with the frequency of my appointments
   Using the scale at the top of the page please put the number which corresponds to your view.

8. Generally, how long did you wait after the expected time of your appointment?
   (Please tick the appropriate box)
- Less than 5 minutes
- 5-15 minutes
- 15-30 minutes
- More than 30 minutes

9. I was satisfied with the waiting time for my appointment
   Using the scale at the top of the page please put the number which corresponds to your view.

10. What was the approximate date of your last appointment?___________

**Clinic Satisfaction**
11. How many appointments did you receive?________________________

12. Was the number of appointments you received:
    (Please tick the appropriate box)
    - Your decision
    - The Counsellor's decision
    - A joint decision between you & the Counsellor.

13. Were you satisfied with the number of appointments you received?
    (Please tick the appropriate box)  **YES** | **NO**
<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Strongly Agree</td>
<td>Agree</td>
<td>Uncertain</td>
<td>Disagree</td>
<td>Strongly Disagree</td>
</tr>
</tbody>
</table>

14. If 'no' would you have liked: (Please tick the appropriate box)

- More
- Fewer

15. Where were you seen for your appointment (Please tick the appropriate box)

- West Park Hospital
- Community Mental Health Team Base
- Local Clinic
- Your GPs surgery
- Other - please specify

16. I was satisfied with the place I was seen for my appointment?  

   Using the scale at the top of the page please put number which corresponds to your view in the appropriate box.

17. Would you have preferred to have had your appointment at any of the locations listed below? (Please tick the appropriate box)

- West Park Hospital
- Community Mental Health Team Base
- Local Clinic
- Your GPs surgery or health centre
- Other - please specify

18. I was satisfied with the clinic staff whilst waiting to see the Counsellor  

   Using the scale at the top of the page please put the number which corresponds to your view.

19. I was satisfied with the environment at the clinic  

   Using the scale at the top of the page please put the number which corresponds to your view.


General Therapy Satisfaction
Using the scale at the top of the page please put the number which corresponds to your view.

20. My referral to a Counsellor was appropriate

21. I felt my counsellor understood my problems I was experiencing

22. I understand my problems more now

23. Treatment contributed to my improvement in my problems

24. The difficulties I had when I first came for treatment still affect my life

25. I feel better than when I first came for treatment

26. Since my treatment I have found life to be generally easier and more enjoyable

27. I felt treatment contributed to an improvement in my problems

28. Treatment has helped me to deal with the problems I had when I was referred

29. I was satisfied with the counsellor who was involved in my care

30. Overall, I was satisfied with the service I received

31. Have you any suggestions for improvements which could be made to the service?
32. Have you any other comments?

Thank you for completing this questionnaire. It will provide us with information which we can then use to improve our service for people who will be referred in the future. Would you please return the questionnaire in the stamped addressed envelope provided.

Thank you.

Ref: AD/SG/033b
SECTION 4

RESEARCH AUDIT

Study 1: A Controlled Investigation Into Some factors In Non Accidental Injury

Study 2: An Exploration Of Factors Which Predict Client Satisfaction
A CONTROLLED INVESTIGATION INTO SOME FACTORS IN NON
ACCIDENTAL INJURY

Angela Devon

Submitted as partial requirement for the degree of M. Psychol. (Clinical Specialisation). University of Liverpool, August 1982.
ACKNOWLEDGEMENTS

I would like to thank Jean Sandbrooks for her help in the implementation of this study and Dorothy Fielding for her useful comments throughout the planning, implementation and writing up of this project. Particular thanks also to Susan Brockley for her help in the rating of numerous questionnaires.
Abstract

Forty children from an area characterised by a preponderance of socio-economic groups IV and V, poverty, inadequate housing and high levels of unemployment, were allocated into one of two groups depending on their inclusion or exclusion on the Non-Accidental Injury Register.

The children were compared on sociological factors such as parental unemployment and education, family, size, family composition and race. The children were also compared on IQ, social maturity, the frequency of certain behaviours and prematurity.

The parents of the children were compared for their accuracy and expectations of child development and for the methods that they report that they use to discipline their children.

The results indicated that very few variables differentiate between abused and non-abused children when social class is controlled. It is suggested that resources should be directed at the socio-economic groups IV and V rather than specifically at the abused groups alone.
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1.0 Introduction

In recent years there has been an increasing interest in the abuse of children. Various estimates of the extent of child abuse for children under 4 years of age have been made. Oliver et al (1974) suggests 3,500 cases with 350 deaths, whereas Mounsey (1975) suggests 1,600 cases a year with 250 fatalities. A questionnaire sent out to all local authorities by the DHSS (1976) reveals that 97 English authorities, accounting for about 90% of the child population, recorded some 5,700 cases (forty of which were fatal) of known or suspected non-accidental injury coming to their notice during the last three quarters of 1974. Clearly, child abuse is a very serious problem.

In 1962 Kempe directed attention to the seriousness of child abuse by coining the term "the battered child" and this was the stimulus for many investigations into the area.

Theoretical studies have explored many different types of variables, psychological, sociological and cultural. A number of studies interrelate several types of variables, but the majority analyse only a single type. Experimental studies in the area are commonly of poor quality and have tended to focus on a single model or factor.

A review of literature suggests that three major models of causation are operating. The Sociological model, the factors in the child model and the factors in the parent model.

This project represents a controlled investigation into variables from each of these models.
2.0 Child Abuse

The literature approaches the area of child abuse by considering its causes and consequences with the greater proportion of the work focusing on the former. The following sections deal firstly with the problems of defining child abuse. Secondly the cause of child abuse are considered. The final section deals briefly with some of the consequences of child abuse that have been documented in the literature.

2.1 Definitions of Child Abuse

The difficulties in reaching an agreed definition of child abuse are clearly illustrated in the literature.

The most common way of defining abuse has been in terms of the physical injuries to the child. A typical definition of this kind is given by Oppé (1968). 

"a battered baby is an infant who shows clinical or radiological evidence of injuries which are frequently multiple and involve mainly head, soft tissues, or the long bones and thoracic cage and which can not be explained unequivocally by natural disease or simple accident."

The list of injuries has been steadily expanded and made more explicit so that it now includes bleeding into and around the skull (Burrell and Burrell 1968), severe bruising (Silverman 1968), mutilation (Cameron 1972), bites (Sims et al 1973), cigarette burns and scalds (Smith and Hanson 1974) and even then the list is not exhaustive. Such medical descriptions cannot in themselves constitute a definition - they are examples of the phenomenon only. Factors other than purely medical ones must be acknowledged as important. These include changes in explanation given by
the parents, delays in reporting the injury, and the quality of the parent child interaction. It has been argued that any definition which does not acknowledge the motivation of the perpetrator as a very important element is inadequate. Gil (1970) has recognised this aspect and included it in the following manner:

"abuse of children is the intention, non-accidental use of force or intentional, non-accidental acts of omission on the part of the parent or caretaker interacting with the child in his care, aimed at hurting or destroying the child."

Although from a theoretical point of view this definition is better it raises new difficulties of an even more complex nature. First, there is the problem of the ambiguous case where "deliberate intent" cannot be confidently inferred, or where unconscious motives may be in operation. Giovanni (1971) argues that neglect and abuse may be usefully distinguished for the purpose of explanation but that the distinction has no practical value at the level of intervention. Young (1964) disagrees and considers that physical abuse and neglect can be distinguished at both a causative and a treatment level and she treats the two groups separately. Such a clear distinction is misleading, however, since it often happens that severe abuse cases also include elements of neglect. Renvoize (1974) tried to distinguish three categories - neglect, abuse and battering. Neglect involves insufficient care, abuse in non-accidental physical attack and battering is physical abuse by a caretaker who loves the child but is over fussy and protective. No attempts have been made to validate this typology.
Psychological stress and mental abuse have also been mentioned in the literature (Cherry and Kirby 1971) but they present difficulties and problems for the researcher. It is true that emotional damage deliberately inflicted on a child may have just as serious consequences as any physical battering, but in practice the difficulty of establishing such parental practices where there are no visible scars makes detection practically impossible and so is usually omitted from definitions and from research studies.

The question of severity and frequency of physical injury has been discussed with a view to defining the limits of the spectrum of abuse but here again there are difficulties. Steele and Pollock (1968) argue that child murder should be kept distinct because its motivation is quite different. However, as Gibbens (1972) points out, whether a child dies or survives an attack may be entirely fortuitous. At the other end of the spectrum are the difficulties involved in trying to distinguish punishment - which is considered to be legitimate violence towards children - and abuse which is considered to be excessive, inappropriate and illegitimate. What is considered to be an acceptable level of violence depends on the patients' conception of their role, their own experience of children, their religious or moral beliefs, and the cultural environment of which they are part.

The NSPCC (1976) define abuse as -

"all children under four years of age, where the nature of the injury is not consistent with the account of how it has occurred, or other factors indicate that it was probably caused non-accidentally."
The imposition of an age limit reflects a more recent trend based on research which indicates that it is the children under four years of age who are most at risk from abuse (Skinner and Castle 1969, Castle and Kerr 1972).

This discussion of the different definitions of abuse highlights the difficulties which exist in drawing conclusions from studies which have taken different definitions as their starting points.

2.2. The Causes of Abuse

2.2.1 The Sociological Model

The sociological model suggests that it is factors which are operating in society rather than in the individual which are primarily responsible for the occurrence of child abuse. The quality of research which examines such factors tends to be poor. Poor measures are commonly used, for example, Johnson and Morse (1968) included a study schedule on each child which was completed by a child welfare worker and was based on the welfare worker's "case records, and his knowledge, observations and judgement." Similarly, Hunter et al (1978) utilised a twenty four item inventory which was used to record "interviewer's impressions." Frequently no control groups are included into research into this area as is the case with Green et al (1974). Often social class is not controlled. Kaduslurn and Martin (1981) refer to the selective sources of referral which operate in many of the studies and which tend to accentuate a skewed class affiliation of reported abuse. Frequently public hospitals and clinics are used as sources of subjects (Smith and Hanson 1975) rather than the private hospitals or family
physicians. Low income people are in contact with the first institutions, middle class and upper class people are more frequently in contact with the private, voluntary sources of help. The results reported below must therefore be viewed with caution.

Unemployment

Unemployment is often sited as being found in families in which abuse occurs. Gelles (1976) reports that in families where the husband was unemployed the rate of physical violence was 62% greater than for the other families. In homes where the husband was employed part time the rate was nearly double the rate of violence in homes where the husband was employed full time. These findings are consistent with those of other investigators in suggesting that unemployment is related to child abuse (Young 1965, Baldwin and Oliver 1975). Gil's (1971) survey of 13,000 of reported cases of abuse in the United States suggested that nearly one half of the fathers of those children were not employed throughout the year in which the abusive incident occurred. After employing elaborate statistical procedures to control for the biased reporting evident in Gil's data, Light (1973) demonstrated that the unemployment factor most frequently differentiated abusers from non-abusers. Several authors have postulated mechanisms by which unemployment may lead to abuse, for example, Justice and Justice (1976) suggest that it is the stress created by idleness and the lack of a certain source of income which predisposes a family to abuse. One report postulates that the sense of
powerlessness which results from being dethroned as family provider may serve as a catalyst for abuse, particularly if power can be regained by exercising one's force against defenceless children (Gelles 1976). Alternatively, abuse may ensue because a parent not experienced in coping with the everyday pressures created by children, finds himself spending longer periods of time in their presence without the necessary coping skills.

It must be noted that the finding that unemployment is related to child abuse may be an artifact of the methodology used in the studies in that the studies tend to include a high proportion of working class families and typically a higher incidence of unemployment tends to be associated with that class.

**Education**

Many investigators have implicated inadequate education as influencing the occurrence of abuse. Galdston (1965) for example, regards insufficient education as predisposing to abuse. Smith and Harrison (1975) in a study which did not control for social class, found that compared with their controls a significant proportion of the abusing parents attended special schools, but in Baker's (1976) study there was no evidence to suggest that any of their parents were educationally subnormal or attended special schools. No control group was included in this study. Results regarding the influence of education in abuse are clearly contradictory. Gil (1970) for example, reported that abuse was more common among the least educated and Gilles (1980) reported that
parents who are high school graduates have the highest rates of abusive violence toward children. Men and women with less than an eighth grade education were found to have the lowest rates of parents violence, as do those with some college education. Gilles (1978) attempts to reconcile the findings by concluding that a minimal education increases the likelihood that an abusing parent will be identified and labelled as a child abuser whereas perhaps it may be more stressful to have a moderate education than to have little education as will have achieved the average education yet will still be blocked from the high status, well paid professional jobs.

Inadequate housing
Several authors regard substandard living accommodation as a particularly important stress that contributes to abuse (Young 1964, Sattin and Miller 1971). Scott (1973) also mentioned that accommodation problems are important stress factors operating within families in which abuse has occurred. Yet Smith et al (1974) produced conflicting results for when adjustments were made for social class no difference existed re the greater occurrence of poor accommodation in an abused than in a non-abused group. This highlights the possibility that many of the variables in the sociological model may be an artifact of the lack of control of social class in many of the studies.
Social Isolation

An often cited characteristic of abusive families is their general isolation from the rest of the community (Giovannoni and Billingsley 1970, Light 1973). Smith et al (1974) reported that abusing parents have infrequent or no contact with family and have no social activities. These parents do not avail themselves of social support at crises. Social isolation and a reluctance to acquire social support has been observed by many researchers, e.g. Weston (1968), Nurrse (1966), Elmer (1967). Loneliness, distrust of neighbours and feelings of alienation from the local community characterised most of the mothers in Baher's (1976) sample. Baher reported a general impression that the parents' lack of social and emotional resources of friendship, support and understanding was primarily a result of their own lack of trust and self-confidence.

Two sociological explanations exist to account for the relationship between social isolation and child abuse. A theory of social conformity points that aberrant behaviour such as child maltreatment can only occur under conditions in which normal social sanctions regarding child care practices are lacking. Families that have few contact with the outside world are unlikely to have their caretaking scrutinised. An alternative, though not mutually exclusive explanation assumes stress to be the critical factor (Garbanno 1977). According to Kempe (1973) what the abusive families lack is a "lifeline." During particularly difficult times they have no means of escape, no friends or relatives to turn to for help.
Family Size and Spacing of Children

The number of children in the family and the spacing of these children appear to be related to the incidence of child abuse (Giovanni and Billingsley 1970). Gil's (1971) national survey revealed that not only did the proportion of abusing families (39.5%) with four or more children exceed the proportion found in the general population (19.6%) but that the proportion of abusing families with one or two children (18% and 30% respectively) was less than that found in the population at large (32% and 30% respectively). Young's (1964) early study of maltreated children reported almost identical figures. Further evidence of the association between family size and child abuse can be found in Light's (1973) recent analysis of abuse data from New Zealand and Great Britain. Analysis of spacing data also indicates that families with children close in age more frequently maltreat their offspring. It is likely especially in families in which economic and human resources are already over-extended that both close spacing and excessive numbers of children foster abuse by raising levels of stress beyond tolerable limits.

Marital Disharmony, Unstable Marriages, Divorce, Separation

The marital relationship in families where abuse has occurred often appears to be problematic. Baher (1976) in an uncontrolled study, reports that in 72% of cases the marital relationship was a major source of tension in the family. Many abusing families have a high incidence of divorce, separation and unstable marriages (Kemp et al 1962). Various studies which unfortunately do not control for social class, repeat
Kempe's findings (Green 1976, Elmer 1967, Smith 1975). Marital difficulties have been regarded as an overt symptom of an underlying disorder (Court 1974) or as central to the problem of abuse (Smith 1975). Lukianowicz (1971) and Fernstein et al (1964) suggest that the frustrations engendered by unsatisfactory marital relationships are displaced on to the child. Gibbens (1972) suggests that the child becomes a scapegoat for those aspects of the marital relationship which must be eliminated. It has been suggested that the dependency needs of both parents binds them together in an extremely close yet often hostile relationship in which neither partner can gain satisfaction (Ounsted 1975). The role of the child as a competitor for the affections of the spouse has been discussed by Court (1970). Some support for this hypothesis comes from Lynch et al (1975) who describe the presence of pathologically jealous parents among their families receiving treatment.

Ethnic Factors
Schloesser (1964) and Kempe et al (1969) assert that baby battering is not related to ethnic or cultural factors in contrast to several American studies, e.g. Ebbin et al (1969), Simons et al (1966) which have demonstrated that proportionately more battered children are coloured. However information on the ethnic background of battered children in the U.K. has been limited. Skinner and Castle (1969) observed that 6.5% of their sample were West Indian and Asian, while Scott (1973) in a study of fatal battered baby cases observed that 10% of fathers were coloured and a high proportion were Irish, but neither author reported control figures. Ebbin et al (1969) has suggested that the type of injury inflicted is not related to ethnic factors. This is supported by Smith et al (1974).

Social Class
Many studies suggest that abuse occurs predominantly in lower socio-economic groups, e.g. Gil (1971 and Benme and Sclare (1969). Possible mechanisms have been
suggested, for example, Steele and Pollock (1968)) consider that social and economic
difficulties and stresses to the parents which then intensify personality rooted
etiological factors. An additional mechanism which has been pointed out by Blumberg
(1964) is that social classes four and five utilise violence more often than do social
classes one and two. Gil (1971) argues that the socio-economic pressures on the
lower class weaken the caretakers's psychological mechanisms of self control. Gil feels
that the poverty of the lower classes produces frustration that is released in a physical
attack on the child.

**Poverty**
A number of well designed researches have repeatedly found support for the
contention that abuse is more prevalent among poorer families. Garbarino (1976) for
example, indicated that economic stress was the best single predictor of abuse rates in
the United States. Giovanni and Billingsley (1970) demonstrated that even within a
lower social class group, income level differentiated between adequate and neglectful
families. As Gil (1975) emphasised, "poverty, per se, is not a direct cause of child
abuse in the home, but operates through an intervening variable, namely, concrete and
psychological stress and frustration."

**Summary**
The sociological model identifies many factors which may cause abuse. However,
considerable difficulties arise in the interpretation of these findings because of the
methodological inadequacy of many of the studies outlined previously. A particular
problem is the failure of many investigations to utilise a control group of similar socio-
economic status to that of the "abuse" groups.
Consequently, many of the relationships established between child abuse, for example,
factors such as unemployment, family size or inadequate housing, may be explained by
social class alone.
There is an obvious need for well controlled investigations examining the features outlined previously in order to determine their true relationship to child abuse.

2.2.2. Factors in the abuser model

This model encompasses suggestions that range from those which point to psychiatric disturbance in the abuser to those which reflect more normative and especially developmental processes. Proponents of this model contend, therefore, that efforts to prevent and remediate child maltreatment ought to be directed at the perpetrator of the abuse.

Psychiatric Disturbance

Child abuse seems to be unthinkable to many people so there is a tendency to regard child abusers as sick or mentally ill. Woolley and Evans (1955) and Miller (1959) posited a high incidence of neurotic or psychotic behaviour as a strong etiological factor in child abuse. Cochrane (1965), Greengard (1964), Platon et al (1964) and Simpson (1968) concurred. Adelson (1961) and Kaufman (1962) considered that only the most violent and abusive parents as having schizophrenic personalities. Impaired impulse control (Green et al, 1974) and grossly immature personalities (Ounsted et al 1975) are diagnoses which have been attached to child abusers. Smith and Hanson (1975) found that 62% of the battering parents they worked with had personality disorders of mild or moderate severity. Additionally, one third of the fathers had severe personality or psychopathic disorders. In contrast Kempe (1968) reported in his study that only 2% or 3% of his fathers were psychopathic.

The suggestion that psychiatric disturbance causes abuse does not appear to be very useful as it would have very few indicators for the prevention or treatment of abuse. Medication, for example, can lead to disinhibition and although such an approach would not lead to an attempt to solve underlying causes. In addition many of the studies do not control for social class, such as Smith et al (1975) and yet it has been reported that working class women have higher rates of psychiatric disturbance than
other women and that this is at its peak when those woman have children under six years of age.

**Childhood Experiences**

Abusing parents are commonly found to have been themselves abused or neglected as children (Steele and Pollock 1969). As infants and children, the parents were deprived of basic mothering. In an uncontrolled study surveying 10 mothers who were hospitalised for murdering their children, Tuteur and Glotzer (1966) reported that all had grown up in an emotionally cold and often overtly neglecting family environment in which parental figures were often absent. Ounsted et al (1975) reported that 60% of the mothers in their study had unhappy, emotionally deprived childhoods. It is the emotional abuse which appears to be considered of particular importance with the emphasis on experiences of rejection, hostility, emotional coldness and "emotional loss" during childhood, with little opportunity for positive identification with parental figures. (Spinetta and Rigler 1972). In their study of abusing parents, Steele and Pollock (1968) reported that although actual physical abuse or neglect was not experienced by all their parents, "all had experienced however, a sense of intensive pervasive, continuous demand from their parents, expectations of good submissive behaviour, prompt obedience, never making mistakes, sympathetic comforting of parental distress and showing approval and help for parental actions. Love was either withheld completely or given to them conditionally upon their meeting parental needs. In addition, they were constantly criticised, often harshly disciplined and some were over-protected and infantalized, seriously restricting their freedom to mature and develop as individuals of worth in their own right. Baher et al (1976)'s anecdotal evidence from their study support Steele and Pollock's (1968) clinical impression of the parents of abused children. Green et al (1974) describe the difficulties with their parents which may mothers of abused children experience. These relationships are marred by criticism, rejection and physical punishment. Unfortunately, few of the studies quoted above employ adequate control groups. In addition, terms such as
"overtly rejecting", "Cold emotionally", "emotionally deprived" and "emotional loss" have not been quantitatively measured or defined.

However rather better support for the hypothesis that the abusing parent was once an abused or neglected child is found in a systematic and well controlled study (Mehick and Hurley, 1969) which compared two small, socio-economically and racially matched groups on 18 personality variables. Melnick and Hurley found among other things, a probably history of emotional deprivation in the mother's own upbringing.

**Parental expectations of their children**

It has been suggested that abusing parents have unrealistic expectations of their children. Steele and Pollock (1968) for example, suggest that the parents in their study group expected and demanded a great deal from their infants and children and did so prematurely. The parents appear to deal with their children as they belonged to an older age group. This view is supported by Galdston (1965) who expresses the opinion that abusing parents treat their children as adults and appear to be incapable of understanding the particular stages of development of their children.

It has been reported that abusing parents have a high expectation and demand for the infant's or child's performance, and a corresponding disregard for the infant's or child's own needs, limited abilities and helplessness. (Hiller, 1969, Gregg, 1968, Helfer and Pollock 1967, Johnson and Morse 1968, Morris and Gould 1963). Steele and Pollock (1968) in an uncontrolled study reported that the parents themselves had had parents who had unrealistic expectations regarding them. "Such parental demands were felt to be excessive, not only in degree, but possibly more importantly, in their prematurity. Performance was expected before the child was able to fully comprehend what was expected or how to accomplish it. Accompanying the parental demand was a sense of constant parental criticism. Inevitably, the growing child felt, with much reason, that he was unloved, that his own needs, desires and capabilities were disregarded, unheard, unfulfilled and even wrong." Steele and Pollock (1968) consider the excessive expectations to be of great importance in child abuse. Their study reported
anecdotal evidence only and made no attempt to quantitatively measure parental expectations of their children. The suggestion that abusing parents have high expectations of their children finds support in the reports of the NSPCC Battered Child Research Team (1976).

It has been reported that the majority of mothers have high expectations of the child's physical or emotional behaviour or both (Baher, 1976). This was assessed by workers using a 5 point scale from very high to very low expectations. This study represents the first attempt to document this component of parental attitudes more precisely. Unfortunately no control group was adopted. In the study many of the mothers were desperately keen for their children to be advanced in all aspects. They appeared to have little idea of normal child development and expected a high level of physical performance and an ability to anticipate and respond to their own moods and needs and to obey orders far beyond the child's capabilities. Belsky (1978) summarising clinical impressions in the literature reports that the expected age of onset of various behavioural landmarks such as walking, talking and bladder control are often poorly estimated. According to Belsky the frustration created when these poor estimates are in the direction of expecting too much, too soon, coupled with the already exitent disappointment over the child's failure to fill his prescribed role, is sufficient to push the parents' anger beyond the limits of self control.

The research investigations reported above have rarely employed non-abusive families in comparison groups which control for factors such as social class, race, age, culture and education and so it is difficult to determine whether the attributes ascribed to abusers are specific to these individual or more generally characteristic of the population at large. Belsky (1978) reports an unpublished doctoral dissertation which represents the single, well controlled, empirical investigation in this area. The study failed to find support for the contention that abusive parents have excessively high expectations regarding their children's performance. However Belsky (1978) reports that measurement problems exist which severely limit the conclusions that can be drawn from this study. Given the repeated clinical observations testifying to the
influence of excessive expectations there seems to be good reason to investigate this factor more thoroughly.

Parental attitudes to discipline

With one or two exceptions, researchers have tended to make only general references to this topic rather than detailed observations. Elmer (1967) in a study of abusive and non-abusive families which did not control for social class, reports that although there was no difference in the frequency of punishment between the two groups, "the non-abusive families tended to use a few types of punishment consistently while some abusive families used a broad range, which suggests they were desperately trying to find some way of managing their children". A second study reported that all of the abusive families were inconsistent in disciplining the children and that punishment and power were dominant family themes (Young 1964). Smith and HansoWs (1975) study reported that both the mothers and fathers of battered children were found to use physical punishment far more than was to be expected for their age and class. Mothers were also characterised by being punitive on other indices, in their tendency to use love withdrawal as a sanction against misbehaviour, in their use of material rewards (pacifiers) and in their demands for obedience. Baher (1976) comments that "it was apparent from discussions" with the mothers that great emphasis was laid on discipline and control even with very young children. In practice they mainly tended to fall into two groups, either being consistently strict and controlling or vacillating between indulgence and strictness. "A general impression" which was noted was that few couples were united in their approach to discipline and control. Smith et al (1975) report that many of the mothers of abused children had "little concept of appropriate child rearing practices" and that "battering may at best be regarded as an ineffectual method of controlling their child's behaviour", yet no quantitative measure of child rearing was included this study. In addition, 76% of the abuse group were from social class IV and V compared with only 33% in the control group. Such a discrepancy could clearly bias the conclusions to be drawn from this study since it has been
frequently found that the methods by which parents discipline their children are strongly related to social class (Newson and Newson 1968). Wasserman (1967) reported that parents considered punishment a proper disciplinary measure and strongly defended their right to use physical force. This finding has been replicated by Johnson and Morse (1968) and Fontana (1973). In an uncontrolled investigation Steele and Pollock (1968) further suggest that such parents consider that their children must acknowledge their authority and must show exemplary behaviour or they will be punished. Such ideas are prevalent in child rearing but the difference between abusing and non-abusing parents is that the former implements such standards with exaggerated intensity.

Dubanoski et al (1978) point out that particular subcultural or broader social factors influence discipline styles. One report has suggested that in Britain 95% of parents use smacking as a means of punishment at one stage or another in a child's rearing (Newson and Newson 1968). Dubanoski et al (1978) suggest that if punishment is a strongly established means of control then the parents may need help to be taught alternative ways of changing behaviour.

Whilst many of the studies quoted above report interesting findings concerning the disciplining styles of "abusing parents", many problems exist in interpreting the findings. Many of the studies quoted are methodologically unsound. In the absence of adequately controlled studies, further research is necessary to clarify the relationship between child rearing practices and child abuse.

Summary

Four factors within this model have been discussed, namely, childhood experiences, attitude to discipline, parental expectations and psychiatric disturbance. It is apparent that a large body of literature exists though many studies are of poor quality and so their conclusions must be regarded with caution.

2.2.3. The Effect of the Child on Caregiver Model
The theoretical recognition that children can influence the behaviour of their own parents (Sameroff 1975), coupled with the frequent observation by practitioners that a single child within a family is often selected to be the target of abuse (Brown and Daniels 1968), has led investigations to question whether or not there is something that the abused child is doing that would implicate him as a causative agent in the process.

**Prematurity**

Prematurity in the form of low birth weight and early gestational age has been identified as characteristic of abused children (Martin et al 1974). In a study of twenty battered children in the Chicago area it was found that 33% were premature (Elmer and Gregg 1967), Bishop (1971) supports the view that premature babies are particularly vulnerable. It is suggested that some premature babies are hypersensitive to all stimuli, and may even object to gentle handling. Musson et al (1974) also stated that the premature child is more likely to be restless, distractible and difficult to care for than a full term baby, especially during the first year of life. A reason for this is that prematures are more prone to anoxia and colic, and irritability in the newborn period can result from these conditions. In addition Dreyfuss-Brisco (1974) has pointed out that disturbances in sleep organisation are very common among premature babies. It has been reported that the colicky child syndrome was a prominent feature during the infancy of abused children (Ounsted et al 1974).

Maternal attitudes towards premature infants must play a role. Elmer and Gregg (1967) suggested that the mother may perceive a child as being abnormal simply because it is premature. Klaus and Kennell (1970) also raised the question of whether the battered child syndrome is in part related to hospital care practices that frequently separate mothers from their premature infants for prolonged periods of time.

The research finding that a disproportionate number of premature and/or low birth weight children are abused, is well supported. Stern (1973) found prematurity to be a factor in a study of child abuse of twelve children. Prematurity dictated a need to maintain the child in the hospital following the mother's return home. Consequently
the early interpersonal relationship between mother and child was altered in an undesirable direction. The development of an early close attachment was delayed. Klein and Stern (1971) found that 23.5% of 51 battered infants studied were low birth weight infants. Another study which investigated 78 abused English children noted a high incidence of babies described as premature (Castle and Skinner 1969). Holman and Kanware (1975) found prematurity and low birth weight, and consequent early mother-child separation, as factors associated with child abuse in a study of 28 abused children. Similar findings are reported by Baldwin and Oliver (1975) and by Martin et al (1974). Many of the studies referred to in this section do not use control groups (Martin et al 1974, Holman and Kanwar 1975, and Stern 1973). Prematurity may be related to social class and so many of the studies quoted above may be invalid as many have not controlled for this factor.

Mental Retardation
Several researchers have reported that a high incidence of mental retardation among battered children (Elmer 1965 and Sandgrund et al 1974). The complexity of the phenomenon and the large number of interacting variables makes any conclusive statement regarding the role of this factor, very difficult.

Physical Handicaps
Johnson and Morse (1968) reported on a study with 97 abused children. Based on child welfare worker reports, it was noticed that nearly 70% of the children exhibited either a mental or physical deviation prior to the reported abuse, 17% had retarded speech development. Burrell and Burrell (1968) in an analysis of 42 cases of abuse found congenital abnormalities in 25%. However this finding has not been substantiated by other studies, e.g. Martin et al (1974).

Individual differences in infants
Korner (1971) has found differences in crying patterns among infants, and differences in soothability once they begin to cry. She pointed out the implications this could have for a young and inexperienced mother with a difficult to soothe child. These differences can directly affect the mother's feelings of competence as a caregiver. Phlowe and Lourie (1964) reported the existence of irritable characteristics in the abused children in their study. These characteristics included an irritable cry, an unappealing nature and were difficult to manage. Ounsted et al (1974) reported that 2/3 in their study complained that their children actively resisted close physical contact. This may lead to a feeling of being rejected by the child.

A study by the Denver Department of Public Welfare of 107 abused children highlighted the contribution the children made to the abusive interaction. Child Welfare Workers considered 52 of the children under 5 years of age as "whing, fussy, listless, chronically crying, restless, demanding, stubborn, resistive, negativistic, unresponsive, palled, stickly, emaciated, fearful, panicky and unsmiling". (Johnson and Morse, 1968). This study was not controlled and so no comparisons with normative data are given.

A study comparing 255 abused children with 108 non-abused children from similar kinds of families found the abused children to be more frequently below average intelligence, less physically attractive, and more likely to be either "extremely sluggish" or "overactive". (Fergusson et al 1972).

In comparing the behaviour of 134 abused children with a control group of 53 non-abused children, Smith et al (1975) found that a significantly greater percentage of abusive mothers compared with control mothers considered their child to be difficult. This finding is supported by Green (1976) who reports a study of 60 abusive mothers and 30 non-abusive controls, which suggests that the abusive mothers more frequently consider their children to be problems at home and in school. Morse et al (1970) found that 60% of the 25 battered children whom they studied were considered to be "difficult" by their parents.
2.3 The Consequence of Abuse

1. Medical/Neurological Consequences
The medical consequence range from death, to scars, burns, loss of limbs or damage to various organs. Martin et al (1974) in a five year follow up study of abused children reported that 53% of abused children had some neurologic abnormalities, of which 31% were moderate to severe and were handicapping the child's everyday function.

2. Speech and Language
While little detailed research exists regarding the speech and language of abused children, there are reports of significant delays in this area of function (Martin et al, 1974, Elmer et al, 1975).

3. Intelligence
Martin and Rodeheffer (1976) report that "for most abused children, the development of intelligence is severely compromised and distorted." Elmer and Gregg (1967) reported that of a sample of 22 children who had suffered multiple bone injuries as a result of physical abuse, 57% were found to have I.Q.'s of below 80 upon examination in a follow up study. In a normal population, 11% would be expected to have I.Q.'s of below 80. Similar results were reported by Morse et al (1970) who studied a group of 25 abused and/or neglected children who had been hospitalised three years previously for injuries or illnesses. Of these abused children, 42% were reported to be mentally retarded at the time of follow-up. Similar percentages were reported by Martin (1972) and Martin et al (1974). Sandgrund (1975) studied 120 children to assess the impact of abuse on cognitive development. 25% of the abused children had I.Q.'s below 70. This was compared to 20% on a matched group of neglected children who were not known to have been abused. A matched group of non-abused children produced a more typical 3%. Investigators concluded that both abuse and neglect are strongly associated with mental deficiency and noted that it was impossible to assess the degree of neglect in the background of abused children.
I.Q. deficits in abused children is one of the most common and consistent findings in child abuse. Such studies have typically been retrospective in nature and so it seems impossible to distinguish whether or not I.Q. deficits are a cause or effect of abuse.

4. Personality

Until recently very little has been known about the personality of abused children. Martin et al (1974) in a follow up study of 58 abused children ranging in age from two to thirteen years, identified nine characteristics which are listed below:

1. impaired capacity to enjoy life
2. psychiatric symptoms
3. low self esteem
4. school learning problems
5. withdrawal
6. opposition
7. hypervigilance
8. compulsivity
9. pseudo mature behaviour

Martin et al (1976) report some observations of abused children during psychotherapy which includes such children showing an intense need for both physical and emotional nurturance, lack of trust, regression, little capacity for pleasure, low self esteem, a rigid superego and docility.

Summary

Studies have reported delays in the development of speech, language, intelligence and the existence of certain personality characteristics as a consequence of abuse. Such studies typically do not include a comparison group which controls for social class (Silver et al 1969, Morse et al 1970, Martin et al 1974). Elmer (1975) in a follow up study of abused and accidently injured children eight years after their referral strongly suggests that lower class membership, with all its concomitant disadvantages and
stresses, is more potent than abuse for the subsequent development of the children. The majority of the children came from social classes IV and V and a matched comparison group was employed. When pertinent demographic variables were taken into account, (age, sex, race and socio-economic status), a few overall differences were found between abused and comparison group children. Among the characteristics examined were health, language, development, inellectual status at school, self concept and behaviour. The majority showed some degree of emotional disturbance and many had language difficulties, and the incidence of allergies was high. the abused children differed significantly from their peers only in weight (they were heavier) and in some measures of impulsivity and aggression. Clinical impressions supported the absence of substantial differences between the abused children and their matched comparisons. Elmer concludes, "the use of matched comparison groups to evaluate the outcome four abused children offers a means to correct conclusions based on the study of abused children alone". Validation of the results of this study await similar controlled investigations using a larger number of subjects living in other communities.

2.4 Overview

The previous discussion has alluded to many of the factors which have been implicated in child abuse. In particular, three models have been discussed which are assumed to cause abuse. Rather fewer studies consider the consequences of abuse and some of these are considered.

It is apparent that flaws exist in many of the studies and so only limited credence can be attributed to the conclusions reported. The most striking variable which needs to be controlled in any study of child abuse is that of social class. A multiplicity of factors have been implicated in abuse and studies must ensure that they consider those factors which may compound the main variables to be investigated.

Studies have usually focused on one model only and it is suggested that this is misguided because this tends to lead to poorly controlled studies whose conclusions
can only be regarded with caution. The literature on the whole assumes a cause-effect model of abuse and studies generally consider either the causes or the consequences of abuse. It seems that this is problematic as many of the studies are retrospective and so it is difficult to differentiate between causes and effects. It appears necessary to conduct either a prospective study, or to conduct a well controlled study which investigates many of the factors indentified by the literature as being implicated in abuse. These factors should be drawn from the three models of causation and from the suggested consequences of abuse.
3.0 Experimental Methodology

3.1 Aim of Present Investigation

It is clear from the discussion of the literature that there is much work to be done in the area of child abuse.

Firstly, controlled studies investigating the factors which have been implicated in child abuse are necessary so that a formulation of child abuse can be made. Secondly, it would be necessary to devise and assess the efficacy of treatment and prevention procedures which would arise from the formulation. The aim of the present study was to focus on the first consideration, that is to test out some of the factors which have been identified as being involved in child abuse.

The factors in the sociological model which were considered, are listed below:

- Family composition
- employment
- education
- ethnic class
- area of residence/housing/social class

The factors in the parent model which were studied included:

- attitudes to discipline/child rearing
- parental expectations of children

The variables in the factors of the child model which were considered included:

- I.Q.
- prematurity
- social maturity
- behaviours of the children such as: -
  - aggression, temper tantrums, proximity maintaining behaviours, mood and dependency.

These factors were assessed in a group of abused children and were compared with a control group of non-abused children. A particular feature of this study is that the children from both groups were selected from a deprived area which is characterised
by a predominance of working class families, inadequate housing and poverty. It was considered important to ensure that both the abused and the control group were selected from the same deprived, working class area as many studies have reported that abuse occurs predominantly in the working class. Other studies have reported factors such as inadequate housing, poverty, ethnic class and inadequate education as being important in the causation of abuse - these factors could be thought to correlate highly with social classes four and five. Many studies have not controlled for social class as has been reported in section 2. Abuse was defined as presence on the Non Accidental Injury Register.

3.2 Design of the Study

A two group design was adopted. Subjects were randomly selected from the children who attended the day nurseries located in Liverpool7 and 9, and who were two, three or four years of age. Subjects were assigned to one of two groups as below:

Group A - Present on N.A.I. register
Group B - Not present on N.A.I. register

The criteria for inclusion on the N.A.I. register are detailed in Appendix 1.

All the children or their parents were assessed on each of six measures.

3.3 Assessment Procedures

Six assessment procedures were completed and are listed below:

1. Information Sheet
2. Merrill Palmer Intelligence Scale
3. Vineland Social Maturity Scale
4. Child Scale
5. Child Development Questionnaire
6. Child Problems Questionnaire

1. Information Sheet
The information sheets were completed by the matrons of the day nurseries and elicited factual information which focused mainly on variables of the sociological model such as composition of the family, number of children in the family, parental employment, education and race. It also considered factors in the child model such as prematurity, mental retardation and physical handicap. It was short and simple to complete and was easily quantifiable. (See Appendix 2 for the Information Sheet).

2. Merrill Palmer Intelligence Scale

This was administered by a psychologist. It was included in the study firstly because it is a well established research finding that the I.Q. scores of abused children are lower than that of the general population and so needed to be assessed for generalisability reasons. Secondly, it was included as a control variable in order to assess the possibility that any results which may have arisen out of the study could be due to I.Q. differences between the groups. (See Appendix 3 for the Merrill Palmer Intelligence Scale).

3. Vineland Social Maturity Scale

This was completed with the nursery staff who were most involved in the children's care. The scale assesses the capacity of children to look after themselves and for participating in those activities which lead toward ultimate independance as adults. The items of the scale are arranged in order of increasing average difficulty, and represent progressive maturation in self help, self direction, locomotion, occupation, communication and social relations. This maturity in social independence may be taken as a measure of progressive development in social competence.

4. Child Scale

The child scale was derived by the author and measured the frequency of nineteen behaviours which are commonly seen. This represented an attempt to assess whether or not abused pre-school children behave differently from non-abused pre-school children. The scale was completed by the nursery staff who were most closely involved with the care of the children.
A reliability study of the scale was undertaken which involved the completion of the scale for 20 children by two independent raters. The details of this study are presented in section 4.1. The scale is presented in Appendix 4.

5. **Child Development Scale**

This scale consisted of 18 cards measuring 5 inches by 3 inches. Each card described a behaviour which children acquire before five years of age. (See Appendix 5 for the behavioural descriptions used). The precise behavioural descriptions were taken from the Griffiths Mental Developments Scale and from the Gesell Development Schedule, as were the ages at which the average child acquires such behaviours. The scale aimed at eliciting parents' knowledge and expectations of child development. The scale was administered to one of the parents of the children when they arrived to bring or to collect their children when they arrived to bring to or collect their children from the nursery. An attempt was made to chat to the parents prior to the administration of the scale in an effort to alleviate their anxiety.

The parents were told that the author was investigating certain aspects of child development and that all two, three and four year olds in the city centre day nurseries were being considered. The parents were asked for their agreement to participate in the study.

The parents were then told that this part of the investigation was looking at parents' ideas of child development. The parents were then shown a scale ranging from 0 to 60 months (see Appendix 6) and were told that they were to be given a card on which a description of a child's behaviour was written and that they would be required to say at what age the average child would be able to do that behaviour. They were told that they could point to the scale to indicate their answer if they so desired. The card was then placed in front of the parent and was read aloud by the author. The answer was recorded using the Child Development Scale Record Sheet (see Appendix 7).

The answers were then used to determine accuracy and expectation scores. The accuracy scores were determined by comparing parents' responses with the norms determined by Griffiths and Gesell. The absolute differences between the parents'
responses and the norms were obtained for each question for the two groups and these were then summed for each of the groups so producing accuracy scores for each item on the questionnaire and a total accuracy score.

The expectation scores were obtained by a similar method to the above but differed in that it was the difference rather than the absolute difference between the parents' responses and the norms which were considered.

6. **Child Problems Questionnaire**

The questionnaire aimed at determining child rearing/discipline practices which parents verbally report that they would use in response to a problem situation with their child and represents a modification of that used by Jackson (1967) with college students. The Child Problems questionnaire consisted of thirteen hypothetical situations (see Appendix 8), three of which (situations 3, 7 and 11) were included in the final analysis. The situation was devised to appear realistic to the parents although this was not quantitatively assessed in the study. Each situation was written on a card measuring 5 ins. by 3 ins. The questionnaire was administered to the parents at the same time as the Child Development Scale. Parents were told that this part of the study was investigating how parents were managing to cope with their children's problems and their behaviour.

A card detailing a situation was placed on a table in front of a parent and was read aloud by the author. Examples of the situation used are given below:

**Situation 1**

You tell your child that he cannot have any biscuits before tea. He says "I want some" and begins to hit you with his fists.

**Situation 2**

After telling your child that he can't go out you hear him swearing at you.

Parents were asked what they would do if such a situation arose with their child. Their replies were written longhand by the author using the Child Problems Questionnaire Answer Sheet (see Appendix 9). This procedure was repeated until replies to the thirteen situations were obtained.
The answers were then analysed and coded according to the procedure which is detailed in Appendix 10. Coders were given four pieces of documentation, (1) a copy of the procedure to be used, (2) a summary of the categories to be used (appendix 11), (3) sample responses to the questionnaire which had been elicited from the mother of a three year old (see Appendix 12), (4) answers to the sample responses. (Appendix 13). Documents 3 and 4 were used to train the coders. Coders were initially given document 3 and asked to code the responses. Document 4 was then given to the coders. This procedure was undertaken to ensure a degree of familiarisation with the codes and categories to be used.

A reliability study was conducted on the coding procedure in that two independent coders were classified the responses of the first twenty parents. The coders were unaware of which children belong to group A or group B. Details of the reliability study are presented in section 4.1.

The final twenty responses to the questionnaire were classified by one blind coder only. The data was analysed in terms of frequency of use of each of the codes. Where a discrepancy arose between raters, the coding used in the final analysis were selected on a random basis. The responses elicited were verbal reports and so cannot be assumed to indicate how parents would actually behave in such a situation though this may be the case. The responses indicate what parents feel that they ought to reply and could reflect cultural and social beliefs.

4.0 Results

This section will be divided into parts. Part one is concerned with the reliability of the assessment procedures used in the study. The second part discusses the background characteristics of subjects in the study. The next section, part three, examines the sociological variables which were studied. The fourth part is concerned with those variables which have been implicated in the factors in the parent model and the variables concerned with the factors in the child model are examined in part five. The penultimate section, part six, reports the results which investigate the possibility that
previous results were due to random effects. The final section concerns an attempt to isolate those variables which best predict group membership.

4.1 Reliability of Assessment Procedures

As has been mentioned in an earlier section (3.4), reliability studies were conducted for two of the measures used, namely the child scale and the Child Problems Questionnaire. The reliability study for the Child Scale consisted of two independent nursery assistants completing the scale for 20 children. The scales were then quantified by allocating a score from 1 to 5 with "less than once a month" receiving a score of 1, and "more than twice per day" receiving a score of 5. A Pearson's Product Moment Correlations was obtained for each child and these were then transferred to Fisher's Z', scores. The Z scores were averaged over the twenty children and then converted back to a correlation coefficient. This was significant ($r=0.87, N=20, p<0.01$). The lowest correlation for an individual child was $r = 0.5432$ and this was significant ($p<0.02$). This suggests that the scale is sufficiently reliable to be used in the study.

The reliability study for the Child Problems Questionnaire consisted of two independent coders, a Principal Child Psychologist and a mother of a four year old, rating the responses of 20 parents. The frequency of the coder's use of the different categories for each parent's response were correlated and averaged ($r = 0.92, N = 20$, significant at the $p<0.01$ level). No correlation fell below $r = 0.7367$. This was significant ($p<0.005$).

Table 1 presents the mean frequencies of the use of the categories over the twenty parents by the two raters. The reliability for each category is also presented. It is evident that where the categories have been used by both of the raters, the reliabilities are high ($p<0.01$ or $p<0.02$). Two categories, category O (create fear) and category T (feel strongly) were not used by either of the raters. Category Q (avoids situation) was only used by rater 1. It seems that the Child Problems Questionnaire is a reliable instrument. This is an encouraging finding because it represents the development of a
method for eliciting verbal reports which relate to the use of different forms of discipline.

4.2 Background characteristics

The study examined a number of background characteristics to ensure that the groups were equal on certain respects.

Length of time of attendance at the nursery

The first characteristic considered was the length of time that the children had attended the nursery. Table 2 shows the mean time that the children had attended. The difference between the two groups was not significant on the analysis of variance performed ($F=0.025, df=1, N.S.$).

Table 2: Mean Length of Time That Children Had Attended the Nursery

<table>
<thead>
<tr>
<th></th>
<th>Group A: $n=20$</th>
<th>Group B: $n=20$</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean</td>
<td>24.8 months</td>
<td>25.5 months</td>
</tr>
<tr>
<td>S.D.</td>
<td>14.27</td>
<td>13.91</td>
</tr>
</tbody>
</table>

Children's Age

It was considered necessary to ensure that there was no difference between the groups in terms of the children's age. The results are displayed in Table 3. The analysis of variance revealed no significant difference between the groups ($F = 2.93, df = 1, N.S.$).

Table 3: Mean Age of Children in the Groups

<table>
<thead>
<tr>
<th></th>
<th>Group A: $n=20$</th>
<th>Group B: $n=20$</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean</td>
<td>37.80</td>
<td>43.15</td>
</tr>
<tr>
<td>S.D.</td>
<td>11.45</td>
<td>8.0</td>
</tr>
</tbody>
</table>

Area of Residence

All subjects were from the same area of residence, Liverpool 8. This area is characterised by poverty, inadequate housing and a predominance of social classes four and five.

Summary

It is apparent therefore that the two groups are comparable in terms of subject characteristics, such as the length of attendance at the nursery, age and area of
residence. Therefore it can be assumed that any differences between the groups are not due to differences on these variables.

4.3 Sociological Variables

The study examined a number of sociological variables which are presented in table 4. Variables 1 to 4 in the table are concerned with the employment status of the parents of abused and non-abused children. The variable relating to mother's employment was significant in that more mothers of abused children are unemployed ($\chi^2 = 7.035$, df = 2, $p<0.03$). The data relating to fathers employment was not significant.

The next set of variables, from number 5 to number 10 refer to the composition of the family. No significant differences emerged between the abused and the non-abused families regarding these factors.

Parental education was considered in variables 11 to 14 in table 4. No significant differences were found to exist between the two groups.

The final factor considered, number 15, was concerned with the race of the family. It appeared that there was no significant difference between the groups in this factor.
Table 4: A comparison of 15 sociological variables for the abused and the non-abused families.

<table>
<thead>
<tr>
<th></th>
<th>Abused Group</th>
<th>Non abused Group</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Mothers who are employed</td>
<td>3 (15%)</td>
</tr>
<tr>
<td>2.</td>
<td>Mothers who are unemployed</td>
<td>15 (75%)</td>
</tr>
<tr>
<td>3.</td>
<td>Fathers/Cohabitors who are employed</td>
<td>3 (15%)</td>
</tr>
<tr>
<td>4.</td>
<td>Fathers/Cohabitors who are unemployed</td>
<td>12 (60%)</td>
</tr>
<tr>
<td>5.</td>
<td>Biological father present</td>
<td>9 (45%)</td>
</tr>
<tr>
<td>6.</td>
<td>Cohabitor present</td>
<td>6 (30%)</td>
</tr>
<tr>
<td>7.</td>
<td>Single Parent families</td>
<td>9 (45%)</td>
</tr>
<tr>
<td>8.</td>
<td>Families with one sib</td>
<td>9 (45%)</td>
</tr>
<tr>
<td>9.</td>
<td>Families with two sibs</td>
<td>3 (15%)</td>
</tr>
<tr>
<td>10.</td>
<td>Families with three or more sibs.</td>
<td>3 (15%)</td>
</tr>
<tr>
<td>11.</td>
<td>Mothers educated to 16 years of age or less</td>
<td>17 (85%)</td>
</tr>
<tr>
<td>12.</td>
<td>Mothers educated to 16+ years of age</td>
<td>3 (15%)</td>
</tr>
<tr>
<td>13.</td>
<td>Fathers/Cohabitors educated to 16 years of age or less</td>
<td>15 (75%)</td>
</tr>
<tr>
<td>14.</td>
<td>Fathers/Cohabitors educated to 16+ years of age</td>
<td>5 (25%)</td>
</tr>
<tr>
<td>15.</td>
<td>Families of mixed race</td>
<td>10 (50%)</td>
</tr>
</tbody>
</table>

4.4 The Factors In The Parent Model

As discussed in section 2.2.2, several factors have been postulated as characterising the parents of abused children. Some of these factors were investigated in the study and the results will be presented in this section.

Parental Attitudes to Discipline

Twenty rating categories which reflect methods of discipline were used by coders when rating parental responses to the Child Problems Questionnaire. The number of times
coders used each category when rating individual parents' responses was summed over all the situations. A one way analysis of variances was performed on this data, the results of which are represented in Appendix 14. The levels of significance and the mean frequencies are presented in table 5. The only significant difference between the groups was regarding the use of category B, that is the use of explanation or discussion. It appears that the abused group report that they use this method of discipline more than the non-abused group.

It is apparent from table 5 that categories A, B, J and K were the most commonly used categories, these referred to the methods of discipline listed below:

- acceptance
- explanation and discussion
- deprivation
- physical punishment

The next most commonly used category were F and G which referred to reprimanding and asserting authority respectively.

Some categories were used very little and included C, L, M, N, O, Q, R, S and T. The respective methods of discipline were used below:

- natural consequences
- forced admission of error or guilt
- retribution
- creation of shame
- create fear
- avoids situation
- distracts
- depends on circumstances
- feels strongly

Parental Knowledge of Child Development and Their Expectations of their Children

The Child Development Scale was utilised to determine the accuracy of parental knowledge and their expectations of child development.
Table 6 displays the mean ages at which the parents estimated that the average child would achieve the behaviours in question. Only two significant differences exist between the groups with regard to the parents' estimates - these relate to the time that the average child can drink from a cup if it held for them, and the age at which a child can eat from a spoon. In both these cases, it was the abused group who expected the children to achieve these behaviours earlier than the non-abused group. With regard to their estimates of drinking from a cup if held, the abused group were actually more accurate in their estimate as determined by the norms of Gesell and Griffiths. However the abused group were less accurate in their estimates of when the average child could eat with a spoon.

The accuracy of parental knowledge of child development was also assessed. Parental answers to specific questions were compared with the norms and were analysed separately. These were then combined to produce a total accuracy score (This procedure is detailed in section 3). The analyses of variance on this data is presented in Appendix 15. Table 7 illustrates the degree of inaccuracy of the scores - the larger the score, the greater the inaccuracy.

It is interesting to note that parents of both groups were very inaccurate in their estimates of the age at which the average child displays certain behaviour. The most inaccurate estimate related to the age at which children are dry at night. The next two most inaccurate estimates referred to walking upstairs and the ability to distinguish between the front and back of clothes and put them on correctly.

The least inaccurate estimates related to the age at which children toddle a few steps, drink from a cup which is held for them and say one word appropriately.

The range of inaccuracy was from 2.15 months to 17.1 months. It is evident that only on three questions were the degree of parental inaccuracies different between the groups. These three questions refer to when parents are asked to estimate the average age at which

1. the child shows pleasure in a picture book
2. a child says his full name
3. eats with a spoon

On the first two questions, the non-abused group were more inaccurate than the abused group. Only on the third question above were the abused group more inaccurate than the non-abused group.

When all the answers were combined to estimate total accuracy, no difference was apparent between the two groups.

The expectancies were summed to provide a total expectancy score for each of the two groups. No significant difference between the groups was found \((F=3.289, \ DF=1, \ p<0.07)\). The data relating to the analysis of variance was presented in Appendix 16.

Table 8 illustrates the results regarding parental expectancies of their children. The procedure for determining expectancies is detailed in section 3. The table details the number of months by which parental estimates fell below (negative numbers) or above (positive numbers) the norms. In 26 of the 36 cases, parents expected children to achieve the behaviours earlier than could be expected from the norms. 14 of these underestimates occurred in the abused group and 12 in the non-abused group. It is apparent that this population as a whole seem to have high expectancies of children.

In two cases, the abused and the non-abused groups differed significantly from each other. This related firstly to the estimate referring to the age at which a child can drink from a cup when it is held to the lips and secondly, to the age at which a child could feed itself with a spoon. In both these cases the abused group had higher expectancies than the non-abused group.

4.5 The Effect of the Child on the Caregiver Model

The factors in the child model which have been studied include intelligence, social maturity, term of pregnancy and certain behaviours. The results pertaining to these factors will now be presented.
Child Behaviours

The Child Scale assessed the frequency of nineteen child behaviours. Appendix 17 displays the results of the analysis of variance which was performed on this data. Table 9 displays the mean frequencies of the behaviours for the two groups. It is evident that only one of the behaviours was there a significant difference between the groups and this suggests that the abused children kiss other children more than non-abused children. Thos most frequent behaviours for both groups were fighting and arguing with other children. Bullying other children was a frequent behaviour for both groups but occurred more in the non-abused group than in the abused. Fighting with staff was a fairly frequent behaviour. So it was apparent that all the "aggressive" behaviours were the commonest behaviours for the two groups.

Intelligence

Two indices of intelligence were used in an analysis of variance, that is the mental age and the sigma value obtained on the Merrill Palmer Intelligence Scale.

No significant difference between the two groups was found either regarding mental age (F=1.558, N.S.) or regarding sigma value (F=1.086, N.S.).

The mean values and the standard deviation for the two groups are presented in table 10.

Social Maturity

The social maturity of the children was assessed on the Vineland Social Maturity Scale. No significant difference between the groups emerged from the analysis of variance which was conducted on the data (F=0.997, N.S.). The mean values and the standard deviations for the two groups are presented in table 10.
Term of Pregnancy

Only one child in the abused group and no children in the non-abused group were premature.

Table 10: A comparison of the means and standard deviations of the mental age, sigma value and social maturity of the abused and non-abused groups.

<table>
<thead>
<tr>
<th></th>
<th>Mental Age (in months)</th>
<th>Sigma Value</th>
<th>Social Maturity (in months)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abused Group</td>
<td>39.76 (12.76)</td>
<td>5.4 (1.82)</td>
<td>33.3 (12.50)</td>
</tr>
<tr>
<td>Non Abused Group</td>
<td>44.65 (12.04)</td>
<td>4.8 (2.21)</td>
<td>36.7 (8.55)</td>
</tr>
<tr>
<td>Level of Significance</td>
<td>NS</td>
<td>NS</td>
<td>NS</td>
</tr>
</tbody>
</table>

Figures in the main body of the table refer to mean frequencies.

Figures in brackets refer to standard deviations.

The sigma values are coded in the table as below:

0 = -2.5
1 = -2.0
2 = -1.5
3 = -1.0
4 = -0.5
5 = 0
6 = 0.5
7 = 1.0
8 = 1.5
9 = 2.0
10 = 2.5

4.6 Results investigating the probability that the results obtained were due to chance.

It was considered that the significant results which had been obtained could have been due to chance and so the probabilities obtained from the tests of significance of each set of variables for each model, the sociological, the factors in the parent and the effect of the child on the caregiver, were compared to the expected uniform distributions using the Kolmogorov test. No significant results were apparent as is evident from
table II. This suggests that the original significant results seem to have been due to chance. When the variables from the three models were combined, significance was achieved \( (p<0.05) \). This suggests that when variables from all three models are combined, a significant difference between the two groups does emerge. This result must be treated with some caution however, as it must be noted that a large number of variables \( (N=83) \) were used in this analysis.
<table>
<thead>
<tr>
<th>Model</th>
<th>Critical Value</th>
<th>Sig. Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sociological Model</td>
<td>0.39</td>
<td>NS</td>
</tr>
<tr>
<td>Factors in the Parent Model</td>
<td>0.1801</td>
<td>NS</td>
</tr>
<tr>
<td>The Effect of the Child on Caregiver Model</td>
<td>0.1801</td>
<td>NS</td>
</tr>
<tr>
<td>All three models combined</td>
<td>0.1433</td>
<td>p&lt;0.5 signif.</td>
</tr>
</tbody>
</table>

Table 11  Results of the Kolmogorov Analysis Conducted on the Three Models Separately and Combined
4.7 Predicting Group Membership From the "Best" Variables

An attempt was made to isolate a limited number of variables which could be used to predict group membership. Therefore a discriminant analysis was conducted on the variables of each group and then on the groups combined.

The three "best" variables from the sociological model included:

- the term of pregnancy
- present of a cohabitor
- number of sibs in the family

The ten "best" variables from the factors in the parent model were six method of discipline:

- acceptance
- explanation or discussion
- natural consequences
- information giving
- retribution
- creation of shame

Replies to questions 14, 16, 17 and 18 on the Child Development Scale.

The thirteen "best" variables from the factors of the child model include Child Scale Behaviours:

- often destroys own or others belongings
- argues with other children
- smiles
- laughs
- asks to be cuddled
- often appears to be afraid of things or people
- clings to teacher
- clings to mother
- holds adult hand by choice
Social Security

Mental Age On the Merrill Palmer Intelligence Scale

Sigma Value On the Merrill Palmer Intelligence Scale

A discriminant analysis of all of these "best variables from the three models was then performed. Sixteen variables were considered the "best" predictors and these are listed below:

- terms of pregnancy
- presence of cohabitor
- number of sibs in the family

4 methods of discipline:

- acceptance
- explanation of discussion
- natural consequences
- retribution

Reply to question 18 on the Child Development Scale.

8 Child Scale Behaviours:

- argues with other children
- bullies other children
- smiles
- laughs
- asks to be cuddled
- often appears to be afraid of things or people
- holds adult hand by choice

Social Maturity

The discriminant analysis using all the data illustrated that these variables perfectly predicted group membership.

A further discriminant analysis was conducted on the data and involved calculating the coefficients on one half of the data and using them to predict group membership in the other half of the data. The results are displayed in figure 1. It is apparent that
predicting group membership from the variables listed above results in 7 of 20 being incorrectly classified. Using these variables for prediction does not seem to be useful.

<table>
<thead>
<tr>
<th></th>
<th>Predicted Group</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Abused Group</td>
</tr>
<tr>
<td>Abused Group</td>
<td>4</td>
</tr>
<tr>
<td>Actual Group</td>
<td></td>
</tr>
<tr>
<td>Non Abused Group</td>
<td>1</td>
</tr>
</tbody>
</table>

Figure 1. Comparison of actual and predicted group membership using a discriminant analysis.

5.0 Discussion of Results and Conclusion

This final section will consist of six main components. Part One will consider the two questionnaires which were devised for the study. In part two the comparisons of the variables of the three models between the two groups will be discussed. Part three will consider whether the significant results found are due to chance. The next part, part four, will present the information relating to the attempt to predict abuse. The penultimate section, part five, will consider some criticisms of the study. Finally, part six will attempt to present the main conclusion from the results of the project as a whole and will address itself to the problem of how to approach the area of child abuse.

5.1 The results and conclusion relating to the Child Scale and the Child Problem Questionnaires

This study has involved the development of two assessment instruments. The first, the Child Scale, has represented an attempt to devise a scale which records the frequency of certain child behaviours. It has been found that the scale is reliable and is useful in
determining the frequency of nineteen behaviours which could be thought of as relating to aggressive behaviours (items 1-6), temper tantrums, (item 7) proximity maintaining behaviours (items 7 to 13), solitariness (item 14), mood (items 15 and 16) and dependency behaviours (items 17 to 19). It is suggested that the scale could be used in nurseries and schools to highlight the behavioural difficulties and strengths of children. In addition it is suggested that the scale is a useful tool for future research.

The second assessment instrument is the Child Problems Questionnaires which incorporates a questionnaire for parents concerning their handling of children, a teaching device for raters, and a classification system for categorising the results of the questionnaire. The questionnaire has been found to be highly reliable for individual category scores. It seems that in the population in which the instrument was used that certain categories need not have been included for example, categories (create fear) and T (feel strongly). It is suggested that these could be omitted if the instrument were to be used in a similar population. It seems that this instrument could be reliably used in future research and it would be interesting to compare the results obtained from different populations. The questionnaire could possibly also be used as an assessment device for detailing parental child management skills and could provide a focus for discussion and teaching.

A difficulty with the instrument is that it elicits verbal reports which do not always correlate with actual behaviour (Mischel 1965). It must be noted therefore that the questionnaire may be thought of as reflecting socially desirable responses which in turn reflects the culture in which a person lives as well as in some instances eliciting what the person would actually do in a certain situation. This may not necessarily be seen as a weakness of the instrument as it is often interesting to be able to assess the impact of culture with regard to child management. Further observational research is required to establish the relationship between the actual behaviour of the parents and their reported behaviour.
5.2 Comparison of variables of the three models between the abused and the non abused group

Only one variable in the sociological model was found to demonstrate a significant difference between the abused and the non abused groups. This related to maternal employment - more of the mothers of the abused children were unemployed and could be postulated to explain the mechanism by which maternal unemployment could contribute to abuse, e.g. financial hardship leading to increased stress, no escape from the family home, frustration, and as increasing the opportunity for abuse to occur.

The factors in the parent model which were considered included parental attitudes to discipline and parental knowledge and expectations of child development. With regard to parental attitudes to discipline, only one discipline category was used significantly differently by the abused and the non abused groups and that related to the use of explanation or discussion. It was the abused group which used this category more frequently. This could be thought of as being a socially desirable response or it could reflect the possibility that abusive parents do frequently use this type of discipline or feel that it would be the correct response in a certain situation. However, in other different types of stress, in different situations, they may use physical abuse. The Kolmorogov analysis presented in section 4 suggests that this finding could be due to chance. Clearly further studies are needed to follow up this finding.

It was interesting that the four most commonly used types of discipline for all parents were acceptance, explanation, deprivation and physical punishment. It could be postulated that acceptance and explanation are at one end of a continuum of discipline and deprivation and physical punishment being at the other. The continuum would relate to permissiveness - non permissiveness. It appears that in the population considered that these conflicting norms are present and may create difficulties with regard to the use of discipline.

It appears that in this population the use of physical punishment is common and it is suggested that "aubse" is at one end of the continuum of physical punishment rather than being qualitatively different from the method of discipline used by other members
of the population (Hutchings and Jones 1979). Inclusion on the N.A.I. register could be thought of as relating to detection of certain parents using a common method of discipline in the culture. The factors relating to detection may include the fact that parents are using extreme physical punishment but it is possible that other factors lead to detection, one of which may be chance. It highlights the difficulties where a middle class social services is defining "abuse" with little regard to the cultural norms operating in subsections of the community must be considered.

Other commonly used methods of discipline included reprimanding and asserting authority. The literature suggested that power and punishment were dominant discipline methods used by abusing parents (Young 1964) but this study suggests that this does not characterise abusing parents alone, but characterises this subgroup of the population. The use of these methods was not found to preclude the use of other more "permissive" methods. Elmer (1967) suggested that non abusers use a few methods consistently, whereas abusers used a whole range of methods - this study does not support that suggestion as there was very little difference in the pattern of use of the different categories. It seems therefore that when social class is controlled, very few differences emerge between abusers and non abusers. This study supports the finding that the methods by which parents discipline their children are related to social class (Newson and Newson 1968). Future research could replicate this study in other subcultures with other social classes.

A difficulty with the interpretation of the data regarding parental attitudes to discipline is that it is unclear as to the degree that one can extrapolate the findings to the actual behaviour of the parents.

The second area considered in the factors in the abuser model was that of the parents knowledge and expectations of child development. Three sets of variables were considered -

1. mean parental estimates of the age at which the average child would display certain behaviours
2. the accuracy of the estimates
3. parental expectations

With regard to the first set, it was apparent that only with regard to two items were the abusing and the non abusing groups significantly different in their estimates. It is interesting that the two items related to feeding. This item is difficult to interpret because the abusive parents were more accurate with regard to one of the behaviours although they had high expectations with regard to the other behaviour. When the accuracy of the estimates were considered, it was evident that the abusive group was not significantly different from the non abusive group in terms of total accuracy over all the questions. However, when individual questions were considered it was apparent that both groups of parents were inaccurate on many of their estimates of child development. Only on three items was there a significant difference between the accuracy of the parents' estimates and in just one of these cases was the abusive group more inaccurate than the non abusive group. It appears therefore that in the population studied, parents were not accurate in their estimates of the ages at which children display certain behaviour. Inaccuracies ranged from 2.15 to 17.1 months discrepancy from the norm. It would be interesting to compare these findings with a replication of this study in a different population. The literature suggests that abusing parents are poor at estimating the age of onset of various behavioural landmarks but it appears that this is true of certain populations rather than solely true of abusive parents.

A large quantity of the literature suggests that abusive parents have high expectations of their children. This study suggests that this finding is perhaps a function of social class because in the population studied no difference on total expectations emerged between the abused and the non abused groups. Both groups had high expectations of children. When responses to individual questions were considered, the abused group had higher expectations than the non abused group for 2 of the 18 behaviours only. These 2 behaviours related to feeding - it is possible that feeding is a particularly sensitive set of behaviours for abusing parents and one where they have high
expectations. The effect of the child on the caregiver model focused on intelligence, social maturity, term of pregnancy and on the frequency of certain behaviours. With regard to the latter, it was evident that both groups display similar behaviours. They differed only with regard to the fact that the abused children kiss other children more than the non abused children. The children as a whole tended to display "aggressive" behaviours more frequently than other behaviours. This seems to be consistent with the finding that physical punishment is a frequent method of discipline. It could be postulated that this subpopulation seems to condone "aggressive" behaviours more than perhaps other subpopulations would.

No differences were found between the groups with regard to social maturity or intelligence. When social class is controlled the commonly reported findings of a difference between abused and non abused children on these factors does not emerge.

The final variable studied in this section was that of the term of pregnancy. Only one child in the whole study was premature and that was in the abused group. This finding is unexpected in view of the higher rates of prematurity in socio-economic groups IV and V. This raises the possibility that the population may differ perhaps on other factors common to socio-economic groups IV and V. Other factors such as a high number of single parent families, presence of cohabitees, absence of biological fathers, mixed race, and high unemployment are present in the group. It would have been advisable to have measured factors such as standard of housing and financial difficulties directly but this was not possible in the present study due primarily to the type of enquiries this would have necessitated in a population which is sensitive to questioning.

5.3 Significant Results or Chance?

Section 4.6 reported an analysis of the results which considered the possibility that the results obtained were due to chance.

It seems that the significant findings within each model were due to chance. However, when all the variables from the three models were combined, it appeared that there was a significant difference between the groups. However, as reported in
section 4.6, 83 variables were used in the analysis and so this result must be regarded with caution. It would seem reasonable to make two suggestions from this data. Firstly that this data supports the notion that when social class is controlled the factors which have been highlighted as differentiating abusers from non abusers fail to do so. Secondly, it could tentatively be suggested that considering individual models of causation is doomed to failure, and that it is necessary to postulate an interactional model of child abuse. Such a model assumes that it is an interaction of variables that leads to abuse, that is, that each variable acts upon and is acted upon by other variables. It is the combination of these variables which causes abuse.

5.4 Prediction of Abuse
An attempt was made to isolate variables which could be used to predict abuse. It is apparent from section 4.7 that using the factors which were included in the study yielded no "good" predictive variables. This was to be expected in view of the lack of significant findings and the suggestion that the significant findings which did emerge were possibly due to chance. Even an interaction of variables from the different models failed to be able to predict group membership.

5.5 Criticisms of the study
One way to view the lack of significant results is to suggest that the measures were insensitive. This criticism really could only be levelled realistically at the Child Problems Questionnaire and the Child Development Questionnaire. Perhaps more questions could have been included but if there was a possibility of significant results, one would have expected trends to occur in the data that was collected - this was not the case. It could be argued that the Child Problems Questionnaire was inappropriate as it was assessing attitudes not behaviour. An observational study would have been necessary to assess actual behaviour and this would have been interesting and potentially useful, but unfortunately was beyond the scope of the present study. It was considered that a study of attitudes was important in view of the vast quantity of unsound research which has investigated this area.
5.6 Conclusions and future developments for research in child abuse

The main conclusion that emerges from the study is that when social class is considered, very few differences emerge between an abuse group and a non abuse group.

In the light of this finding the inevitable questions arise concerning firstly, how then may abuse be prevented from occurring initially and secondly, how then can it be prevented from occurring again.

To answer these questions, it seems imperative to have more detailed information about cultural norms regarding attitudes and methods of discipline and cultural definitions of "abuse." It seems really that child abuse is likely to be an area in which generalisations are difficult to make. A solution to the second question above is to make a formulation of each individual case and to devise a treatment programme accordingly while taking into consideration factors such as the influence of a subculture on the family.

Some researchers devise individual treatment programmes (Hutchings and Jones 1979, Sandford and Tustin 1973, Reavley and Gilbert 1978, Doctor and Singer 1978). The difficulty with some of these programmes however, is that the therapists are obviously influenced by poor quality literature as in the case of Doctor and Singer (1978) who identified two problems, one teaching effective child management skills, and the other modifying unrealistic parental expectations. As this study suggests, these two problems seem to be related to social class rather than necessarily to abuse.

It is suggested that an applied behavioural analysis which leads to a treatment programme is the way forward to preventing abuse from recurring.

It seems that to answer the first question, how to prevent abuse from occurring initially, it is really necessary to rethink some basic concepts of child abuse. Since 1962 when Kempe coined the term "The Battered Child Syndrome" researchers have assumed that it is likely that there is a cluster of physical and psychological factor associated with child abuse. Many studies have identified such factors (Steele and Pollock 1968 and Green 1973) but as indicated in section 2.0 many such studies are
methodologically unsound. Frude (1980) advises rejection of this "syndrome" framework as this would lead us to be less likely to look for "the cause" or "the causes" of the phenomenon as if we were trying to identify the cause of a disease. It would also encourage us to take a case based approach. Importantly, it would also lead to the cessation that there are four types of people, "abusers" and "non abusers" and the "abused" and the "non abused." The present study indicates that many of the factors which have been highlighted as differentiating these types of people cease to do so when an adequate control group is included.

It appears that in a certain subsection of the population, notably socio-economic groups four and five, abuse is at an extreme end of a continuum of the use of physical punishment and in a subsection of the population where the use of physical punishment is the norm, being designated as being included on the N.A.I. register may be due to no other factors but chance.

If we therefore reject the assumption that a "battered child syndrome" or a "child batterer syndrome" exists but conceptualise certain features as occurring in social classes four and five which reflect one end of a continuum of disciplining, parent child relationship, or parental handling, "abuse" is therefore conceptualised as not being qualitatively different from "non abuse."

This approach would therefore lead us to answer the initial question, that is, how to prevent abuse from occurring initially, with a suggestion that we should focus resources on nurseries, education and other services to social classes four and five.
REFERENCES


Miller, D. S. "Fractures Among Children: Parental Assault as Causative Agent." Minnesota Medicine, 1959. 1209-1214.


Appendix I

Method for Determining Whether or not a Child is to be Included on the N.A.I. Register

The decision to place a child on the register, or to take a child off the register, can only be taken by a case conference. Such a case conference will be attended by:

- Social Worker
- Medical Social Worker
- General Practitioner
- Clinical Medical Officer
- Health Visitor
- Consultant Paediatrician and/or his medical staff
- Nursing Staff
- Police: C.I.D. Superintendent
- N.S.P.C.C.
- Head Teacher
- Education Welfare Officer (when child or siblings)
- School Nurse (or school age)
- School Doctor
- Day Nursery Matron
- Probation Officer
- Voluntary social work agencies
- Anyone else professionally concerned with the child or his family.

A case conference is called for all cases involving actual/suspected child abuse. One of the decisions that the case conference must make is to decide whether the case is to be recorded on the register. This decision is made by determining if the case falls into one of five categories, that is

1. physical injury
2. physical neglect
3. failure to thrive and emotional abuse
4. children in the same household as a person previously involved in child abuse
5. sexual abuse.

These categories are defined as below:

1. **Physical Injury**
   All physically injured children under the age of 17 years where the nature of the injury is not consistent with the account of how it occurred or where there is definite knowledge, or a reasonable suspicion, that the injury was inflicted (or knowingly not prevented) by any person having custody, charge or care of the child. This includes children to whom it is suspected poisonous substances have been administered. Diagnosis of child abuse will normally require both medical examination of the child and social assessment of the family background.

2. **Physical Neglect**
   Children under the age of 17 years who have been persistently or severely neglected physically, for example, by exposure to dangers of different kinds, including cold and starvation.

3. **Failure to Thrive and Emotional Abuse**
   Children under the age of 17 years who have been medically diagnosed as suffering from severe non-organic failure to thrive; or whose behaviour and emotional development have been severely affected; where medical and social assessments find evidence of either parental rejection or persistent or severe neglect.

4. **Children in the same household as a person previously involved in child abuse**
   Children under the age of 17 years who are in a household with a parent or another person who has abused a child and who are considered at risk of abuse.

5. **Sexual Abuse**
   Children under the age of 17 years who are in a household with a parent or another person who has sexually abused a child and who are considered to be at risk. Also
children who are considered to be at risk of sexual abuse from persons outside the household.
APPENDIX 2

Information Sheet

Name of child ...........................................................................................................

Nursery ....................................................................................................................

Length of time in nursery .......................................................................................  

Date of birth .............................................................................................................

Term: full or premature ............................................................................................

Biological Mum in family home Yes or No

Biological Dad in family home Yes or No

Cohab. present in family home Yes or No

Single parent Yes or No

Number of children in family ....................................................................................

Mum's occupation ...................................................................................................

Dad's/Cohab's occupation .......................................................................................  

Area of residence ...................................................................................................

Mum's education to 16, to 18, 18+  

Dad's education to 16, to 18, 18+

Race .......................................................................................................................

Mental retardation ...................................................................................................

Physical handicap ...................................................................................................
**APPENDIX 4**

**Child Scale**

Below are some descriptions of behaviour which are often shown by children. After each statement are five columns. Please place a tick in the appropriate column.

<table>
<thead>
<tr>
<th></th>
<th>More than twice per day</th>
<th>5-10 times per week</th>
<th>2-4 times per week</th>
<th>Once a wk. - 2 times a month</th>
<th>Less than once a month</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Often destroys own or other's belongings</td>
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<td></td>
<td></td>
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<tr>
<td>2.</td>
<td>Fights with other children</td>
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<td></td>
<td></td>
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<tr>
<td>3.</td>
<td>Fights with staff</td>
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<tr>
<td>4.</td>
<td>Argues with other children</td>
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<tr>
<td>5.</td>
<td>Argues with staff</td>
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<tr>
<td>6.</td>
<td>Bullies other children</td>
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<tr>
<td>7.</td>
<td>Temper tantrums</td>
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<tr>
<td>8.</td>
<td>Smiles</td>
<td></td>
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<tr>
<td>9.</td>
<td>Laughs</td>
<td></td>
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<tr>
<td>10.</td>
<td>Asks to be cuddled</td>
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<tr>
<td>11.</td>
<td>Kisses teacher</td>
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<tr>
<td>12.</td>
<td>Kisses other children</td>
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<tr>
<td>13.</td>
<td>Plays with other children</td>
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<tr>
<td>14.</td>
<td>Tends to do things on his own</td>
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<tr>
<td>15.</td>
<td>Often cries and appears unhappy</td>
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<tr>
<td>16.</td>
<td>Often appears to be afraid of things or people</td>
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<tr>
<td>17.</td>
<td>Clings to teacher</td>
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<tr>
<td>18.</td>
<td>Clings to mother</td>
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<tr>
<td>19.</td>
<td>Holds adult hand by choice</td>
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</tbody>
</table>
APPENDIX 5

Child Development Scale

An average child ..............................................................

1. Can sit himself at a table without any help at
2. Can walk upstairs putting one foot on each step without help at
3. Can walk alone by toddling a few steps from one support to another at
4. Can pull himself up by the furniture even though he may not be able to maintain
   this position and may immediately sit down again at
5. Can drink a small amount of liquid from a cup if it is held to his lips at
6. Can hold small pieces of food, bread or biscuit neatly between thumb and
   forefinger at
7. Can pull off his own shoes (if unfastened for him) and also his socks
8. Is dry at night without being taken out of bed at
9. Can say one word clearly, consistently and appropriately at
10. Will show pleasure in a picture book, e.g. by looking at the pictures or turning the
    pages, or pointing or babbling to the pictures at
11. Can shake his head for "No" - this will be a definite shaking of the head to indicate
    refusal and not be just turning away, at
12. Will laugh aloud for the first time at
13. Can give his full name without any encouragement at
14. Can distinguish between the front and back of clothes and puts them on correctly
    at
15. Can unbutton all front and side buttons by pushing buttons through buttonholes at
16. Can hold a spoon, put it into a dish and fill the spoon with food and can put the
    spoon in his mouth - (there may be some spilling of the food), at
17. Can safely cross a street if not too busy without any help at
18. Can lift up and drink from a cup that is half full with little or no spilling at
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<th>MONTHS</th>
<th>MONTHS</th>
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<td>28</td>
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<td>FIVE YEARS</td>
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# APPENDIX 7

Child Development Scale Record Sheet

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<td>18.</td>
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</table>
APPENDIX 8
CHILD PROBLEMS QUESTIONNAIRE

Situation 166
You tell your child that he cannot have any biscuits before tea. He says "I want some" and begins to hit you with his fists.

Situation 2
After telling your child that he can't go out you hear him swearing at you.

Situation 3
Your child comes home from the nursery and gives you a picture he had just drawn.

Situation 4
Looking out of the window you see your child hitting another child.

Situation 5
You put your child to bed and he starts crying immediately and does not stop.

Situation 6
After putting a meal in front of your child he picks it up and throws it on to the floor.

Situation 7
Your child comes to you and gives you a big kiss.

Situation 8
You return home one afternoon having left your child at home with a relative and discover that your child has ripped up a pound note that you had left on the kitchen table.

Situation 9
Whilst playing with building set your child hits his thumb with a hammer and begins to scream and curse loudly.

Situation 10
Your child ignores you when you tell him to go to the toilet and he dirties his pants.
Situation 11
You are watching T.V. and your child asks you if you will look at a picture book with him.

Situation 12
Your child deliberately tears a big hole in the trousers you have just bought for him.

Situation 13
You return home after shopping to find that your kitchen which you had just cleaned was covered in mud and your child was sitting on the floor surrounded by toys.
APPENDIX 9

Child Problems Questionnaire Answer Sheet

Name of Child .................................................................

Nursery .................................................................

Situation 1

Situation 2

Situation 3

Situation 4

Situation 5

Situation 6

Situation 7

Situation 8

Situation 9

Situation 10

Situation 11

Situation 12

Situation 13
**APPENDIX 10**

**Procedure for rating the responses to the Child Problems Questionnaire**

Please read the reply to Situation 1 on the Child Problems Questionnaire Answer Sheet. Then code the reply in terms of the categories below, for example, if the responses to Situation 1 was:

"I would shout at him and smack him hard"

Then the code would be FM

Then write the code on the Child Problems Record Sheet in the appropriate place.

Then read through the replies to the other situations one by one except situation 3, 7 and 11 and classify them in terms of the categories below.

<table>
<thead>
<tr>
<th>Code</th>
<th>Category</th>
<th>Example of Reply</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>Acceptance</td>
<td>&quot;I wouldn't bother because it wouldn't be that bad.&quot;</td>
</tr>
<tr>
<td></td>
<td>e.g. accept because there is</td>
<td></td>
</tr>
<tr>
<td></td>
<td>nothing wrong with the</td>
<td></td>
</tr>
<tr>
<td></td>
<td>behaviour.</td>
<td>&quot;I wouldn't mind because he is only a child.&quot;</td>
</tr>
<tr>
<td></td>
<td>Accept because a child did it.</td>
<td></td>
</tr>
<tr>
<td>B</td>
<td>Explanation or Discussion</td>
<td>&quot;I would tell him it's wrong to throw his dinner on the floor because I would have just made it and that he needs to eat.&quot;</td>
</tr>
<tr>
<td></td>
<td>e.g. explain why the behaviour is wrong.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Ask for an explanation of the behaviour.</td>
<td></td>
</tr>
<tr>
<td>C</td>
<td>Natural Consequences</td>
<td>&quot;I wouldn't do anything because if my child hit another child then that child would hit mine back and it would serve him right.&quot;</td>
</tr>
<tr>
<td></td>
<td>e.g. child will suffer through doing the behaviour.</td>
<td></td>
</tr>
</tbody>
</table>
D Information Giving
    e.g. evaluate behaviour without explanation.  "I'd say that's naughty."
    Let child know that parent was aware of what was done.  "I'd say I saw you hit that child."

E Bribery
    e.g. promise reward for deterring.  "I would tell him that if he stopped being naughty I would buy him some sweets."

F Reprimand
    e.g. scold, argue  "I would shout and tell him he was really naughty."

G Assert Authority
    e.g. order, forbid, demand physically force to stop  "I would say 'don't do that again,' or 'stop that at once.'"
    "I would grab hold of his arms and make him stop hitting me."
    Supervise child more closely  "I would keep my eye on him and make sure he didn't do it again."

H Threat
    e.g. of deprivation  "I would say if he didn't stop I'd tell him he wouldn't have any tea."
    of natural consequences  "If you hit that child again he will hit you back."
    of physical punishment  "If you do that again I will smack you."
    of loss of love  "I would say 'if you do that again I won't love you.'"
I  **Compensation**
e.g. have child ask for forgiveness
have child do extra work

"I would tell him he has to say he is sorry."
"If she threw her dinner on the floor I would make her get a dustpan and brush and clean it up."

J  **Deprivation**
e.g. remove privileges
call him indoors or limit action
ignore the child

"I wouldn't let him have any sweets."
"I would shout to him and make him come indoors and I wouldn't let him go out to play for the rest of the day."
"I wouldn't pay any attention to him."

K  **Physical Punishment**
e.g. smack

"I would smack her hard."

L  **Forced Admission of Error or guilt**

"I would make him say it was wrong to throw his dinner on the floor."

M  **Retribution**
e.g. pay back in kind

"If my child hit me I would hit him back."

N  **Creation of Shame**
e.g. ridicule

"If he dirtied his pants I would tell him he was a baby and he was stupid."
<table>
<thead>
<tr>
<th>O</th>
<th>Create Fear</th>
<th>&quot;I would tell him that a big bogey man would come and get him because he had been naughty.&quot;</th>
</tr>
</thead>
<tbody>
<tr>
<td>P</td>
<td>Asks Child for more Information</td>
<td>e.g. denies possibility of situation &quot;I don't know really, I don't think my child would swear.&quot;</td>
</tr>
<tr>
<td>R</td>
<td>Distract</td>
<td>&quot;I would distract his attention by showing him something.&quot;</td>
</tr>
<tr>
<td>S</td>
<td>Depends on Circumstances</td>
<td>&quot;If he was crying because he wanted to go to the toilet I wouldn't mind but if he was crying in a temper I would hit him.&quot;</td>
</tr>
<tr>
<td>T</td>
<td>Feel Strongly</td>
<td>&quot;I would be furious.&quot;</td>
</tr>
</tbody>
</table>
APPENDIX II

Summary of categories to be used for rating the responses to the Child Problems Questionnaire

A  Acceptance
B  Explanation or discussion
C  Natural consequences
D  Information giving
E  Bribery
F  Reprimand
G  Assert authority
H  Threat
I  Compensation
J  Deprivation
K  Physical punishment
L  Forced admission of error or guilt
M  Retribution
N  Creation of shame
O  Create fear
P  Asks child for more information
Q  Avoids situation
R  Distract
S  Depends on circumstances
T  Feel strongly
APPENDIX 12

Social responses from the Child Problems Questionnaire - to be used for training codes

Situation 1
I'd say if he didn't stop I'd tell him he wouldn't have any tea either and I'd hit him.

Situation 2
I wouldn't react to swearing because if I sounded shocked they would do it again, I would distract her attention.

Situation 4
I would rush out, ask her why she was hitting another child. If the other child had been aggressive first that would be alright, but if she hit the other one first I would bring her in.

Situation 5
I would find out what was wrong and would act accordingly.

Situation 6
I would give her a dustpan and shovel and tell her to pick it up.
I would shout at her as well.

Situation 8
I would tell her it was naughty and I would stop her from having sweets.

Situation 9
Comfort her and tell her to be more careful next time and tell her not to swear again.

Situation 10
I would be very annoyed, I would shout at her and she would end up with a smacked bottom.

Situation 12
I would tell her it's wrong, I would tell her off and smack her.
Situation 13
There's nothing wrong with it, though I would tell her if she had muddy boots to leave them at the door - it's not really naughty.
**APPENDIX 13**

Child Problems Record Sheet - Answers to the sample responses from the Child Problems Questionnaire which are used for training codes

Name of Child ...........................................................................................

Nursery ........................................................................................................

Please write below the code of the replies to the situations from the Child Problems Questionnaire in the appropriate place.

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<td>I.F.</td>
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<td>8</td>
<td>D.J.</td>
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<td>9</td>
<td>G.G.</td>
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<td>10</td>
<td>T.F.K.</td>
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<td>12</td>
<td>D.F.K.</td>
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<td>Q.A.B.</td>
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## APPENDIX 14

Results of One Way Analysis of Variance on the Coded Responses to the Child Problems Questionnaire

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### APPENDIX 15

#### Results of One Way Analysis of Variance of the Accuracy of Answers on The Child Development Scale

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APPENDIX 16

Results of One Way Analysis of Variance of Parental Expectancies of Child Development

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<td>1</td>
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<td>Within Groups</td>
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<td>16</td>
<td>Between Groups</td>
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<td>1</td>
<td>6.103</td>
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</tr>
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<td>Within Groups</td>
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<td>17</td>
<td>Between Groups</td>
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<td>1</td>
<td>1.711</td>
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<td></td>
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<td>123.653</td>
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<td>18</td>
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<td></td>
<td>Within Groups</td>
<td>105.299</td>
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Total Expectancy

<table>
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<tr>
<th>Source</th>
<th>Mean Square</th>
<th>DF</th>
<th>F</th>
<th>Sig. Level</th>
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<tr>
<td>Between Groups</td>
<td>23814.400</td>
<td>1</td>
<td>3.289</td>
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</tr>
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<td>Within Groups</td>
<td>7239.861</td>
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### APPENDIX 17

Results of Analysis of Variance on the Scores on the Child Scale for the Abused and the Non Abused Groups

<table>
<thead>
<tr>
<th>Behaviour</th>
<th>Source</th>
<th>Mean Square</th>
<th>DF</th>
<th>F</th>
<th>Sig. Level</th>
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<tr>
<td>Often destroys own or others belongings</td>
<td>Between Groups</td>
<td>3.025</td>
<td>1</td>
<td>2.407</td>
<td>NS</td>
</tr>
<tr>
<td></td>
<td>Within Groups</td>
<td>1.257</td>
<td>38</td>
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<td></td>
</tr>
<tr>
<td>Fights with other children</td>
<td>Between Groups</td>
<td>0.900</td>
<td>1</td>
<td>0.377</td>
<td>NS</td>
</tr>
<tr>
<td></td>
<td>Within Groups</td>
<td>2.387</td>
<td>38</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fights with staff</td>
<td>Between Groups</td>
<td>0.025</td>
<td>1</td>
<td>0.035</td>
<td>NS</td>
</tr>
<tr>
<td></td>
<td>Within Groups</td>
<td>0.720</td>
<td>38</td>
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<td></td>
</tr>
<tr>
<td>Argues with other children</td>
<td>Between Groups</td>
<td>0.225</td>
<td>1</td>
<td>0.124</td>
<td>NS</td>
</tr>
<tr>
<td></td>
<td>Within Groups</td>
<td>1.809</td>
<td>38</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Argues with staff</td>
<td>Between Groups</td>
<td>0.025</td>
<td>1</td>
<td>0.017</td>
<td>NS</td>
</tr>
<tr>
<td></td>
<td>Within Groups</td>
<td>1.446</td>
<td>38</td>
<td></td>
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<tr>
<td>Bullies other children</td>
<td>Between Groups</td>
<td>4.900</td>
<td>1</td>
<td>2.932</td>
<td>NS</td>
</tr>
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<td></td>
<td>Within Groups</td>
<td>1.671</td>
<td>38</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Temper tantrums</td>
<td>Between Groups</td>
<td>0.100</td>
<td>1</td>
<td>0.053</td>
<td>NS</td>
</tr>
<tr>
<td></td>
<td>Within Groups</td>
<td>1.892</td>
<td>38</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Smiles</td>
<td>Between Groups</td>
<td>0.225</td>
<td>1</td>
<td>0.564</td>
<td>NS</td>
</tr>
<tr>
<td></td>
<td>Within Groups</td>
<td>0.399</td>
<td>38</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Laughs</td>
<td>Between Groups</td>
<td>0.025</td>
<td>1</td>
<td>0.030</td>
<td>NS</td>
</tr>
<tr>
<td></td>
<td>Within Groups</td>
<td>0.836</td>
<td>38</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Asks to be cuddled</td>
<td>Between Groups</td>
<td>1.600</td>
<td>1</td>
<td>0.923</td>
<td>NS</td>
</tr>
<tr>
<td></td>
<td>Within Groups</td>
<td>1.734</td>
<td>38</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kisses teacher</td>
<td>Between Groups</td>
<td>1.225</td>
<td>1</td>
<td>0.492</td>
<td>NS</td>
</tr>
<tr>
<td></td>
<td>Within Groups</td>
<td>2.488</td>
<td>38</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kisses other children</td>
<td>Between Groups</td>
<td>11.025</td>
<td>1</td>
<td>6.276</td>
<td>0.01</td>
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<tr>
<td></td>
<td>Within Groups</td>
<td>1.757</td>
<td>38</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Plays with other children</td>
<td>Between Groups</td>
<td>0.0</td>
<td>1</td>
<td>0.0</td>
<td>NS</td>
</tr>
<tr>
<td></td>
<td>Within Groups</td>
<td>1.503</td>
<td>38</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tends to do things on his own</td>
<td>Between Groups</td>
<td>1.225</td>
<td>1</td>
<td>0.57</td>
<td>NS</td>
</tr>
<tr>
<td></td>
<td>Within Groups</td>
<td>2.120</td>
<td>38</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Often cries and appears unhappy</td>
<td>Between Groups</td>
<td>0.100</td>
<td>1</td>
<td>0.049</td>
<td>NS</td>
</tr>
<tr>
<td></td>
<td>Within Groups</td>
<td>2.047</td>
<td>38</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Often appears to be afraid of things or people</td>
<td>Between Groups</td>
<td>1.600</td>
<td>1</td>
<td>1.013</td>
<td>NS</td>
</tr>
<tr>
<td></td>
<td>Within Groups</td>
<td>1.579</td>
<td>38</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clings to teacher</td>
<td>Between Groups</td>
<td>0.025</td>
<td>1</td>
<td>0.019</td>
<td>NS</td>
</tr>
<tr>
<td></td>
<td>Within Groups</td>
<td>1.341</td>
<td>38</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clings to mother</td>
<td>Between Groups</td>
<td>0.025</td>
<td>1</td>
<td>0.017</td>
<td>NS</td>
</tr>
<tr>
<td></td>
<td>Within Groups</td>
<td>1.499</td>
<td>38</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Holds adult hand by choice</td>
<td>Between Groups</td>
<td>3.025</td>
<td>1</td>
<td>2.311</td>
<td>NS</td>
</tr>
<tr>
<td></td>
<td>Within Groups</td>
<td>1.309</td>
<td>38</td>
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AN EXPLORATION OF FACTORS

WHICH PREDICT CLIENT SATISFACTION
Abstract

A Psychology Department adult mental health client satisfaction questionnaire was devised which included items from the Client Satisfaction Question (Larsen et al 1979) and additional questions which formed scales which were hypothesised to measure the four factors of process, organisation patient characteristics and outcome. Content validity (0.78) and reliability levels (0.87) were obtained.

The questionnaire was administered to clients with adult mental health problems referred to the Clinical Psychology Department in 1994. The results were factor analysed using a principal components analysis.

Four factors extracted with some questions having poor or multiple loadings on the factors. These items were excluded and a subsequent factor analysis was undertaken and four factors again extracted. This was then subjected to a multiple regression analysis to determine which factors would predict satisfaction as measured by the CSQ. Only organisation and process were significant in being able to predict CSQ scores. A further factor analysis of all items relating to process, organisation and the CSQ was conducted. The CSQ and process appeared to be measuring the same aspects and the organisation factor was not clearly delineated.

The factors of process, organisation, patient characteristics and outcome were not factorially distinct. One factor accounted for 57.3% variance and included both process and global satisfaction questions. The hypothesised factors do not predict global satisfaction as they are not factorially distinct from global satisfaction.

Outcome affects satisfaction. Those who rated that they had improved in terms of severity of problems and degree to which their problems interfered with their daily lives were more satisfied than those who had not improved. Those who attributed the change to therapy were also more satisfied than those who did not. Satisfaction was also higher in the group who reported that treatment was better than expected than those who reported that treatment was worse or were uncertain if treatment was better than expected.
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Appendices

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AN EVALUATION OF FACTORS WHICH PREDICT CLIENT SATISFACTION

1.0 INTRODUCTION

Patient satisfaction seems to be measurable as a distinct entity as illustrated by the use of reliable and valid scales such as the Client Satisfaction Questionnaire (Larsen et al 1979) but also seems to be a multidimensional construct made up of a number of factors. The results reported in the literature suggest that four main factors contribute to satisfaction namely:

1. Process
2. Organisational Issues
3. Outcome
4. Patient Characteristics

The value of these factors in predicting satisfaction has not been demonstrated and will provide the major focus for this study. The field of patient satisfaction research is generally characterised by a lack of theoretical framework but some theories have been explored to explain satisfaction.

2.0 THEORIES OF PATIENT SATISFACTION

2.1 Renwick and Harvey 1989 Model of Satisfaction

Renwick & Harvey (1989) constructed a model which assigned a pivotal role for patient satisfaction in assessing quality of care on the grounds that both amenities and many aspects of the interpersonal process (particularly communication between provider and patient) result in increased satisfaction. These in turn lead to more successful conduct of technical care by the provider and more effective co-operation by the patient in its implementation. As a consequence outcomes are better and more likely to meet with the patient's expectation. This increases satisfaction and further improves the interpersonal and technical process of care. It would seem necessary in testing out this model to determine if amenities/organisational aspects and interpersonal processes are independent factors in patient satisfaction. This will be assessed in the present study and the role of these factors in predicting satisfaction will be explored.
The relationship between good outcomes and expectations being met and satisfaction will also be analysed in the present study. This model incorporates many of the features which have been explored in other studies as will become apparent in the literature survey. Expectations, outcomes, the interpersonal process and satisfaction with organisational issues appear to be key factors in patient satisfaction.

2.2 Expectations and Satisfaction

Linder-Pelz (1982a) proposed a value-expectancy model as an initial step in constructing a theory of satisfaction. She defined patient satisfaction as "positive evaluations of distinct dimensions of health care" and hypothesised that the social psychological variables of expectations, values, entitlement, and perceived occurrences would predict three dimensions of satisfaction - physician conduct, convenience, and general satisfaction. She attempted to operationalise these variables, and carried out a study in which expectations were found to be the most important antecedent of patient satisfaction (1982b). Linder Pelz's view therefore was that satisfaction was multidimensional although general satisfaction could also be measured. This is the view taken in the present study and the ability of the factors in predicting general satisfaction will be tested.

Satisfaction has also been considered from the point of view of a fulfilment model which defines satisfaction as a simple difference between rewards desired and those received, and a discrepancy model which considers the difference between expectations and rewards, relative to the amount expected or desired.

When experience fails to meet expectations patients may be dissatisfied (Linder Pelz 1982). This has been confirmed in the literature e.g. Korsch et al (1968) reported that the mothers who expected to learn the cause and nature of their children's illnesses but did not were likely to be dissatisfied. Similarly, Noyes et al (1974) found that if gynaecology patients positive expectations with their physician were fulfilled they were
more likely to be satisfied. The success or failure in meeting expectations has emerged as contributing to patient satisfaction and will be explored in the present study.

Hisieh and Keale (1991) reported that patients' expectations, with their physicians' conduct and convenience of services were the best predictors of their overall level of satisfaction. This ability of factors to predict overall satisfaction is seen as an interesting development.

Larsen & Rootman (1976) explore role theory and predict that the more a physician's role performance meets a patient's expectations, the more satisfied the patient is with the physician's services. These expectations are familiar role formats established from past experience and from cultural assumptions of normal behaviour. Equally patients' attitudes are shaped by emotional orientations towards health care and are fairly undiscriminating with regard to the instrumental outcomes of their encounters with health care. Very little of the instrumental aspects of health care which are central to modern technological medicine ultimately figure in their evaluations. From such research it is possible therefore to predict that client satisfaction would not be as highly related to outcome as to measures of the manner in which care has been given by the health care professional. This suggests that process and outcome are distinct factors. Much of the theory of satisfaction makes the assumption that satisfaction is multidimensional and that some factors are of greater importance than others but this is not yet clear from the research conducted.

2.3 **Six Principle Model of Patient Satisfaction (Strasser et al 1993)**

These principles maintain the following ideas about the patient satisfaction process:

1. It is driven by human perceptions
2. It may lead to both a multifaceted definition of patient satisfaction and summary judgements
3. It is dynamic; it may change over time, between encounters and within specific encounters
4. It results in both attitudinal and behavioural reactance
5. It allows patients to function in two capacities. First, patients are judges of their health care encounters. In this capacity, they serve as a source of information for the dependent variable, patient satisfaction. Second, patients are activists in how they influence their subsequent satisfaction levels
6. It is person-specific due to patients' differences in values, beliefs, expectations, previous health care experiences and socio-demographic factors including the patient's current health care status.
Strasser et al (1993) developed a six principle model of patient satisfaction which is presented in figure 1. Each principle is grounded in either the theoretical literature or empirical research on ways in which human judgements are formed and how these may influence human behaviour.

**Figure 1. Strasser et al's 1993 Model of Patient Satisfaction**

Principle 1: A Perceptual Process
The process of patient satisfaction attitude formation is viewed as being driven by the ways people form perceptions and subsequently act on them. As such, patient satisfaction may or may not have a basis in objective reality.

Principle 2: A Multidimensional Construct and a Single Global Construct
Some evidence suggests that patient satisfaction is a multidimensional construct (Abramowitz, Cote and Berry 1987). Factor analytic studies consistently show the emergence of multiple factor structures rather than a single principle component solution. However, it can not be said that patients do not form unique summary judgements about their inpatient or outpatient experiences as well; the evidence from patient survey responses to single-item summary questions clearly indicates that this does happen. It would seem to be necessary to test out the factors which emerge from
the literature to determine their contribution to satisfaction and to assess whether satisfaction is a multidimensional construct or a single global construct.

Strasser et al (1993) suggests that any model of patient satisfaction must account for the patient satisfaction construct as both a multidimensional construct (e.g. facets of patient satisfaction) and a summary construct since the research conducted to date indicates that patients form both types of judgements.

It is precisely this question which will be addressed in the present study. Patient satisfaction is seen as a summary construct which will be assessed by the use of the CSQ and as a multidimensional construct made up of the factors of process, organisational issues, outcome and patient characteristics. The ability of the factors to predict satisfaction will be assessed.

Principle 3 : A Dynamic Process
Anecdotal evidence suggests that the patient satisfaction process is dynamic - fluid and often changing.

Principle 4 : Patient Satisfaction as Attitudinal Reactance
In the proposed model, patient satisfaction is defined as a form of attitudinal reactance (Wortman & Brehm 1975; Greenberger and Strasser 1986, 1991). It incorporates both the cognitive and affective components of human perception formation (Principle 1).

Specifically in the model patient satisfaction is seen as an attitudinal response to the value judgements that patients form about their health care experience. These attitudes can be expressed either as cognitive ("I dislike my therapist"), or affective ("I feel uncomfortable in the presence of my doctor"), or both.

Principle 5 : The Patient as a Judge, and as an Activist.
To date, the patient satisfaction literature views patients as almost passive judges of events that befall them. The formulation sequence is that events happen to patients, patients judge them, and then the social scientists measure these judgements. Ironically, patients become non participants in the exact process that so directly affects them. Moreover, they are passive judges of events that they may directly influence themselves. It is suggested that this conceptualisation is phenomenologically inaccurate.
Principle 6: The Principle of Individual Differences
The model suggests that the process of patient satisfaction formation is individualised. Specifically, it is suggested, that while there may be a general cognitive framework for this process, the manifestation of this framework can be patient-specific. Three factors contribute to this. First patients possess different personality characteristics, values, beliefs and expectations that influence perception information (Linder-Pelz 1982b). Second, each patient brings to the health care setting a different knowledge base from previous direct or vicarious health care encounters. In addition, patients differ markedly in how they perceive their own acuity when they present. Third, patients differ across such sociodemographic characteristics as age, sex, race, education, income and marital status. Again patient characteristics can be seen as emerging as a distinct factor in contributing to patient satisfaction.

Stimuli
Patients are exposed to an infinite number of stimuli. These might be initially categorised into two sources - human and non human. Human sources are defined as stimuli derived from other people's actions, attitudes and appearances. Examples include the physician's tone of voice or the radiological technicians reassuring touch. Non-human sources are defined as stimuli derived from objects within or related to the health care environment - the admitting room walls, insurance forms to complete or the blue smock worn by the pharmacist. This seems to incorporate both the process and the organisational aspects which were identified in the literature as factors involved in satisfaction.

Screening and Encoding
Patients screen the stimuli (information) to which they are exposed, they attend to some of the information in their environment and ignore the rest.

Value Judgements
Heretofore patients have been exposed to stimuli, encoded some, and ignored others. Placing values on this information is the next stage in the proposed model. Value judgements in the proposed model are defined as the interpretation and the attributions we attach to stimuli (e.g. hot, cold, painful, nice, "he's kind," "she's comforting" and so forth). The distinction between the encoding and value judgement stages of the model are important. Encoded stimuli are pieces of information that patients have symbolically labelled or attached a cognitive representation to. However, while the
event or object has been labelled, patients have not yet moved to the next and perhaps more complex level of analysis: evaluation of (or value judging) the encoded stimulus.

As with screening, individual differences variables - such as previous life experiences and the patient's personality - are seen as major influences on which (if any) value judgements are assigned to specific stimuli. Patient characteristics are again highlighted as having a contribution to patient satisfaction and yet this has not yet been conclusively proved as being a distinct factor which can predict satisfaction.

Internal and external attributions under the conditions of success and failure of medical outcomes or experiences are also seen as affecting the positive or negative direction in which value judgements are formed. Outcome could be hypothesised therefore as a factor in satisfaction. Before such a theory could be accepted it would be necessary to determine if patient characteristics, outcome, human stimuli (process factor) and non human stimuli (organisational issues) are distinct factors in satisfaction and can predict satisfaction.

Attitudinal (First Level) Reactance
Up to now, patients have been exposed to stimuli, encoded some and ignored others and placed value judgements on part of them. At this point in the model, attitudinal or first-level reactance occurs. Attitudinal reactance is defined as the global attitude of satisfaction or dissatisfaction that patients form in response to their value judgements, first-level reactance may be expressed only as a cognition and/or an affect, not a behaviour. Patients may be motivated to take subsequent action (later defined as second-level reactance) to alter the situation in the direction of a desired outcome. It is very clear then that Strasser et al (1993) consider that a global measure of satisfaction can be obtained but equally clear that they view it also as a multidimensional construct.

Second-Level Reactance and Feedback Loop 1
Second-level reactance is defined as patients' actions designed to attain desired outcomes (Greenberger & Strasser 1991, 1986) e.g. a verbal statement of pleasure or pain or verbal requests for assistance.

3.0 FACTORS ASSOCIATED WITH SATISFACTION

A review of the literature suggests that the four factors of process, organisational issues, outcome and patient characteristics contribute to satisfaction. Process and
organisational issues will be considered together as they seem to be jointly highlighted in many studies.

3.1 Process and Organisational Issues
Kelman (1976) states that "recipients of care are more concerned or dissatisfied with the manner and means of the processes of health care delivery than with the outcome of care or competencies of health care personnel". Ben-Sira (1976) reports that the criteria the patient uses for evaluating are those related to the degree of emotional support that accompanies the course of treatment. Thus patients largely judge a doctor by his affective behaviour which is behaviour directed by the physician towards the patient as a person rather than as a case. Lack of medical knowledge is seen as largely precluding the patient from attending to the more instrumental aspects of the doctor's action. It seems therefore that interpersonal factors in the process of therapy may be important factors in determining satisfaction.

Elbeck & Fecteau's (1990) questionnaire results suggested two principal factors in satisfaction, behavioural autonomy loaded with items that reflected the ability to self regulate daily activities and supportive care loaded with items that tap positive interpersonal relationships with staff. The emergence of the factor of interpersonal factors coincides with the result of Gordon et al (1979) who using post discharge interviews found that staff/patient relationships and the preservation of individuality to be the two aspects of hospitalisation felt by patients to need the most improvement. It is interesting that interpersonal relations with staff have been highlighted as a key factor of patient satisfaction. Interpersonal relations seem to be a factor which contributes to global satisfaction and are seen as representing a process factor.

Feletti et al's (1985) results confirm this view. They reported that five factors accounted for 40% of the variance in ratings. The first factor related to communications, care and reassurance. These data were consistent with other research into patient satisfaction with an individual consultation (Wolf et al 1978, Ware et al 1977) which related to patients perceptions of the physician's professional conduct and their willingness to discuss the patient's illness. The second factor related to the professional's attitude and behaviour. The third factor reflected the apparent mutual respect between physician and patient on a personal level. This included tackling emotional problems as well as physicians advising the patients about what is the treatment. The fourth factor involved the perceived technical competence of the physician and diagnosis management and patient education. The fifth factor related to
the general confidence patients have in their physicians in being able to discuss emotional problems and not being apologetic for one's illness.

Four of the five factors are clearly related to process issues concerning the relationship between therapist and patient and it could be seen that being satisfied with the therapist and the therapeutic relationship contributes to much of the variance in satisfaction. However results from other studies suggest that other factors are important in global satisfaction.

Wyszewianaski (1988) distinguished three general components of care. These relate to (1) the technical competence of the provider (2) the interpersonal aspects of the provider/patient relationship, (3) the amenities aspect which refers to how appealing, comfortable and private the facilities are where care is provided. He argues that it is not necessarily true that high quality in one area implies high quality in other areas as well. Satisfaction is therefore seen as multidimensional and being composed of at least three factors.

In a factor analysis of 111 studies on consumer satisfaction with medical care, Hall & Dorman (1988) ranked satisfaction with 10 aspects of medical care, the results of which are reported below.

<table>
<thead>
<tr>
<th>Aspects</th>
<th>Rank</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall quality</td>
<td>1</td>
</tr>
<tr>
<td>Humanness</td>
<td>2</td>
</tr>
<tr>
<td>Competence</td>
<td>3</td>
</tr>
<tr>
<td>Outcome facilities</td>
<td>4</td>
</tr>
<tr>
<td>Continuity of care</td>
<td>5</td>
</tr>
<tr>
<td>Access</td>
<td>6</td>
</tr>
<tr>
<td>Informativeness</td>
<td>7</td>
</tr>
<tr>
<td>Cost</td>
<td>8</td>
</tr>
<tr>
<td>Bureaucracy</td>
<td>9</td>
</tr>
<tr>
<td>Attention to psycho-social problems</td>
<td>10</td>
</tr>
</tbody>
</table>

It is interesting to notice that humanness, technical and overall quality were ranked near the top. The bottom ranks were occupied by aspects representing attention to other non-physical patient needs such as the need for information and aspects involving the patient's relation to the system not the provider such as access, cost and bureaucracy. It would appear from this study that issues such as access, cost and
bureaucracy are less important to patients than overall quality, humanness and competence and outcome. This again reinforces the importance of process issues as being central to contributing to patient satisfaction.

McAuliffe & MacLachan (1992) asked consumers of a Psychology Service to fill in an A4 sheet on describing an instance during the consumers contact with the service which represented an example of good service and an instance when the consumers contact with the services represented an example of poor service. A second A4 sheet was also provided on which the consumer was asked to write his or her suggestions for improvement in the service. The responses of the consumers was subjected to a content analysis. Positive feelings towards staff were by far the largest category as examples of good service and represent interpersonal factors or human stimuli (Strasser et al 1993). Description of poor service related to waiting for the first appointment for the clinical psychology 3%, personal service 33%, smoke in public areas 12%, lack of continuity and treatment and access to service 11%. These are seen as organisational issues or non human stimuli. (Strasser et al 1993). This study reinforces the view that such factors are operating in determining satisfaction and provide support for the theoretical models discussed.

Contradictory results do exist however, Ware et al (1983) reported that access to care and availability of resources, quality of care and continuity of care together account for 72% of variance in satisfaction ratings.

Jones, Lenerman and MacLean (1987) in a review of outpatient surveys reported that broad satisfaction levels are high and satisfaction with the actual consultations in the region of 85-87% but that most discontent with outpatient services concerns waiting times and amenities. It seems that two distinct factors emerge, that is process and organisation issues.

The present study hypothesises that general levels of satisfaction are highly related to issues regarding therapy such as humanness, outcome and organisational issues.

3.2 **Outcome**
Outcome of therapy is also seen as important in determining satisfaction. Fitzpatrick & Hopkins (1983) suggest that patients evaluated both the affective and instrumental aspects of actions by therapists and that judgements of outcome were more important to them than judgements of process. Measures therefore such as if therapy had led to an improvement in the person's problems or to a decrease in the number of problems
the person has experienced could be hypothesised to be highly related to general satisfaction levels. Process and outcome appear to be seen as distinct factors.

Dankat, Pandiani and Gordon (1983) developed a client satisfaction survey for a Psychology Department and analysis revealed a general satisfaction factor and a problem severity factor for both active and terminated clients. The single overall satisfaction factor was loaded highly on respondent's opinions about services; whether the therapy received contributed to change? How pleased with the therapist the client was? Costs of services, whether the services would be recommended to a friend? Whether the centre would be used again if similar services were needed. For both active and terminated clients the second factor included how severely the problem has been interfering with life and whose decision it was to leave treatment. Good outcome would be seen as affecting the patients value judgement which would then affect first level/attitudinal response (satisfaction).

When terminated clients were excluded from this analysis, this no longer loaded on severity of problem but rather on how much improvement had been made. It appears that the questionnaire tapped one general factor which can be termed satisfaction with service and had a less potent factor which may be called problem resolution.

In Canter's (1989) survey of a Psychology Service, a highly significant relationship between perceived helpfulness of therapy, the relationship with the therapist and satisfaction with the service was reported. This indicates that outcome and process variables are of importance. There were several responders who considered the service good even though they themselves had not been helped. Overall satisfaction is therefore a concept distinct from therapeutic outcome. The role of outcome and its relationship with satisfaction will be tested in the present study. Ratings of the various organisational factors were varied. 78% judged the locations good, 91% rated the attitude of staff as very good, 46% rated the physical surroundings as good and 25% judged the open hours as good. The organisational factors were found to be less important contributors to overall satisfaction, but there was some significant relationships with some factors such as staff attitudes and atmosphere and walk-in facility. Results indicated a high relationship between satisfaction and therapeutic outcome as perceived by the client. Again therefore organisational factors, process and outcome emerge as significant contributors to satisfaction.
In his review of consumer satisfaction in mental health treatment, Lebow (1982) suggested that the assessment of consumer satisfaction and assessment of treatment outcome can yield different conclusions. What literature is available in adult behaviour therapy appears to support this contention. A number of studies have found differences in treatment outcome yet fail to find differences with respect to client satisfaction or preferences (Goldfield, Linehan & Smith 1978; Liberman et al 1976; Love et al 1979). Other studies have found differences in consumer satisfaction without obtaining actual outcome differences (Kantorowitz et al 1978 Rosenthal & Rees 1976 & Weissberg 1977) whilst still others appear to show a correspondence between the two measures (Rownal et al 1978, Hall, Loweb, Coyne & Cooper 1981). Thus the relationship between satisfaction and outcome appears to be rather complex and further research into the question is in order.

Aharony and Strasser (1992) recommend that more investigations into the relationship between patient satisfaction attitudes and clinical outcomes need to be conducted, we still do not know if satisfied patients experience better clinical outcomes. This will be tested in the present study.

Squire (1994) reported on client satisfaction in the psychotherapy service provided by the adult and elderly mental health speciality within a Clinical Psychology department. Analysis of variance shows that satisfaction with service contact, therapy relationship and treatment benefit were significantly different from each other so supporting the independence of factors or organisational issues, process and outcome. Spearman tests of split half reliability showed the internal consistency of the therapy relationship and treatment benefit scales to be acceptable (r = 0.74 and 0.73 respectively). The reliability of the service contact scale by contrast was quite low (r = 0.12). The total scales for perception of treatment benefit could be predicted from satisfaction with therapy relationship.

Process seems to be related to outcome but not to how pleased people were with their contact with the service. Organisational issues seem unrelated to outcome. Client satisfaction with the therapy relationship is only related partly to those aspects of service contact that have to do with understanding the reason for referral and having the opportunity to get back in touch. Otherwise being pleased with the therapy relationship appears to be related to the quality of the relationship offered by the psychologist involved. The importance of a therapy relationship in predicting treatment benefits is consistent with the large bulk of the psychotherapy outcome literature. Process and outcome may exist as separate factors or may be related. At
present, the research results are confusing regarding this issue and will be explored in the present study.

3.3 **Patient Characteristics**

The relationship of client diagnostic, psychological, and treatment history variables to satisfaction appears more promising than the relationship between demographic characteristics and satisfaction. In these studies, as can be seen in Table 1 below, a trend appears to emerge of greater satisfaction in less disturbed clientele.

**Table 1: The relationship of client diagnostic, psychological and treatment history variables to satisfaction as reported in the literature.**

<table>
<thead>
<tr>
<th>Study</th>
<th>Relationship</th>
</tr>
</thead>
<tbody>
<tr>
<td>Getz, Fujita &amp; Allen 1975</td>
<td>Satisfaction lower in psychotics and drug abusers than in depressed clients.</td>
</tr>
<tr>
<td>Ciarlo 1979</td>
<td>Satisfaction lower in antisocial and psychosomatic clients than those with emotional distress problems or alcoholism.</td>
</tr>
<tr>
<td>Distefano et al 1980a</td>
<td>Satisfaction lower in drug abusers than other outpatients.</td>
</tr>
<tr>
<td>Richman &amp; Charles 1976</td>
<td>Satisfaction lower in suicidal than non suicidal clients.</td>
</tr>
<tr>
<td>LeVois et al 1981</td>
<td>Satisfaction lower in more disturbed than less disturbed.</td>
</tr>
<tr>
<td>Slater et al 1981</td>
<td>Satisfaction lower in those with a greater number of hospitalisations and less time since the last in-patient treatment.</td>
</tr>
<tr>
<td>Woodward et al 1978</td>
<td>Satisfaction lower in those with a poor prognoses in outpatient family therapy.</td>
</tr>
<tr>
<td>Spensley et al 1980</td>
<td>Satisfaction lower in involuntary rather than voluntary hospitalised patients.</td>
</tr>
</tbody>
</table>

However, other studies have failed to find significant relationships between diagnostic and history variables and satisfaction. Inpatient studies have found no difference in satisfaction across diagnosis (Distefano et al 1980b; Pryer et al 1982), time in hospital (Distefano et al 1980b), history of hospitalisation (Distefano et al 1980b); prior treatment (Distefano et al 1981) and voluntary versus involuntary status (Grove & Fain 1977). Outpatient studies have failed to detect a difference across the type of problem (Stevens 1972), diagnosis (Danner & Halprin 1974b), and prior history (Kirchner 1981). Therefore, although diagnostic and history variables emerge as more promising than demographic variables as predictors of satisfaction, the pattern of findings remains insufficiently consistent to allow for the drawing of conclusions at this time.
Lebow (1983) comments that few consistent trends are evident linking the degree of satisfaction to particular client or treatment characteristics; the relevant research has basically yet to be done. Client demographic characteristics have emerged from the limited research available as particularly poor predictors. More promising predictors are client expectations and level of aspiration, client diagnostic and history variables, length of treatment, manner of termination, and the degree to which the treatment is experienced as supportive.

Age is the one factor consistently associated with satisfaction; older patients tending, as in other studies, to report more favourably. Social class and other personal variables are generally not significantly associated (Lebow 1979).

4.0 Satisfaction as a Uni Dimensional or Multi Dimensional Construct

Lebow (1988) comments that several of the better methodological efforts in consumer satisfaction research have examined the dimensionality of satisfaction responses, testing whether respondents distinguish between aspects of the service delivery process and its content. The results of these studies, however, have not been entirely consistent. A wide range of scales have been utilised, there has been no consistency in measures so making comparisons between studies difficult.

Nine factor-analytic studies have concluded that satisfaction responses are multidimensional. Brown (1979) identified seven factors; satisfaction with (a) the therapist; (b) outcome; (c) clinic service; (d) felt importance; (e) access; (f) confidentiality; and (g) therapist intent. Love et al (1979) also identified seven factors in a CMHC outpatient sample including satisfaction with: (a) overall care; (b) staff responsiveness; (c) staff behaviour and skill; (d) center accountability; (e) meeting needs; (f) medicines; and (g) access. Essex et al (1980) in another mental health center sample, found four factors: (a) satisfaction with services; (b) acceptability of the clinician; (c) impact of services (outcome); and (d) dignity of treatment. Slater et al (1981) uncovered four factors in an outpatient sample: (a) general satisfaction; (b) satisfaction with the therapeutic relationship; (c) satisfaction with explanations and preventative care; and (d) satisfaction with access to care. Murphy (1980) found three factors in an outpatient sample: satisfaction with (a) improvement; (b) advice given; and (c) the therapeutic relationship. Although the specific factors vary across these studies, the similarity is striking, given the differences in items, samples, and methods.

Three studies have found multidimensional structures with shorter scales. In an outpatient sample, Fiester and Fort (1978) found two factors, satisfaction with
outcome and satisfaction with availability and access, plus a number of single item factors. In aftercare samples, Grob et al (1978) found factors assessing outcome and general satisfaction, and Tessier (1975) found factors assessing help with problem solving and closeness. These studies are not comparable to those using longer scales but also suggest multidimensionality.

It would appear to be useful to factor analyse scales which could measure aspects such as process, outcome, organisational issues and patient characteristics to determine if they do exist as separate factors or if satisfaction is indeed a unidimensional construct.

Some results do suggest a unidimensional construct. A general or global satisfaction factor emerged using the CSQ which accounted for 75% of the common variance. The second factor accounted for less than 7% of the total variance (Larsen et al 1979). It was thought that clients integrate many contributing factors into an overall impression about a program's services rather than differentiate this impression into distinct dimensions. This occurs despite the fact that many specific factors, in addition to program quality, have been suggested by researchers as potential contributors to satisfaction ratings.

De Brey (1983) reported the use of the CSQ 8 in a Dutch population and his results indicated the existence of one primary factor which accounted for 57% of the variance whereas other factors were below 10% which is reported as evidence for the CSQ measuring one salient factor. All eight of the scale items loaded heavily on this general factor (loadings were 0.71 or higher).

Further, it can be argued that even in several of the studies that conclude that responses were multidimensional (e.g., Brown, 1979; Love et al., 1979), large initial factors account for much of the total variance.

The conflicting findings have important implications: if satisfaction responses are multidimensional, longer scales addressing specifics of service delivery are to be preferred; if not, then short scales are preferable. Further, if responses are multidimensional, satisfaction data are also likely to more useful in generating specific suggestions for improving care. It would be useful to be able to determine which factors of a service predict satisfaction.

The use of global evaluations alone are problematical in that the level of satisfaction expressed may vary with different aspects of care. Global evaluations could mask
these differentials. Global evaluations tend not to take account of specific instances of dissatisfaction and bias the satisfaction. A greater limitation of global evaluations is that they give no indication of how a service would have to be changed to increase patient satisfaction. If consumer satisfaction studies are to have a function at the level of the provision of services as well as in the formulation of policy, more specific information is required which would allow the identification of which factors in a service lead to satisfaction. For this reason, it seems necessary to identify the factors contributing to satisfaction and to determine which factors predict satisfaction. This will be the focus of the present study.

The present study assumes that a global satisfaction factor exists but also that satisfaction is multidimensional. One implication of multidimensionality is that more satisfaction with some aspects of care will be expressed than with others. To ascertain such differences would be a useful goal because of the relevance of patient satisfaction to an understanding of the importance of the performance of health care systems.

The present study considers that patient characteristics, organisational features, process and outcome variables are major factors in determining global satisfaction. These are seen as distinct factors and satisfaction is seen as being multidimensional although recognising that it is possible to obtain a global rating of satisfaction.

5.0 METHODOLOGICAL AND RESEARCH RELATED PROBLEMS
Researchers conducting consumer satisfaction studies have been insufficiently concerned with methodology (Lebow 1982). Several significant methodological problems can be noted.

5.1 Reported Levels of Satisfaction
Perhaps the most widely acknowledged findings in all consumer satisfaction research is that clients report generally high levels of satisfaction with services provided (Dobell 1982). While these findings may reflect actual levels of satisfaction, methodologically they also may reflect bias, distortion, response set reactivity, social desirability and other uncontrolled influences. This problem is made all the more salient given that few studies reviewed actually specified that the rating questionnaires were completed anonymously. Clearly this is to be considered when planning a satisfaction survey. Statistical analyses may become spurious because of a lack of variability. Measures should be taken to maximise variability for example using scales that inquire about specific aspects of satisfaction and that feature multiple response alternatives denoting levels of satisfaction (Lebow 1979). This has been included in the present study.
Lebow (1982, 1983a, 1983b) reports that satisfaction is not universal and reports of its lack of variability are greatly exaggerated. Studies of consumer satisfaction with mental health services generally report a small group of dissidents - approximately 10% of the cases report dissatisfaction. Further, when finer levels of satisfaction are solicited, only 49% of clients rate themselves as highly satisfied.

Research in the U.S.A. has shown however that small differences, even in the upper end of the scale, have important implications on patients subsequent behaviour with respect to health and health care. In one study, an eight point difference in patient satisfaction with care at the upper end of the scale ranging from 1 to 100 was associated with a ten fold increase in the probability of patients disenrollment from the health care plan (Kaplan & Ware 1989).

5.2 Social Psychological Factors In Satisfaction Research

Expressions of satisfaction or dissatisfaction with public services are likely to be sensitive to a large number of social-psychological factors. These factors include: Social Desirability Response Bias; Ingratiating Responses; The Hawthorne Effect; Experimenter Effects; Economic self-interest and Cognitive Consistency.

1. Social desirability response bias (Edwards 1957) may colour client's statements concerning their feelings about a program. In other words, clients may report greater satisfaction than they actually feel because they believe that positive remarks about a program are more acceptable to social service program administrators than are negative comments.

2. Clients may perceive satisfaction assessment as an opportunity to ingratiate themselves with program sponsors or staff. This is especially likely if the client does not believe that his or her responses are anonymous or even confidential. Such disbelief is reinforced when a client is identified by name on the measuring instrument or if his or her signature is requested for informed consent purposes.

3. Client evaluations of services are likely to reflect a sensitivity to the "Hawthorne effect" (Roethlisberger & Dickson 1939). Reactivity to the additional attention implicit in the data collection process and to the apparent concern of the program sponsors about one's level of satisfaction is likely to lead to a positive perception of the program, and consequently, to positive ratings. An option open to evaluators is to take advantage of this serendipitous
aspect of measuring client satisfaction. By regularly involving clients in satisfaction assessment it is possible that clients will become more satisfied as a result.

4. Experimenter bias may inflate client satisfaction ratings. The evaluator's expectation of favourable ratings could influence his or her perceptions, choice of instruments and data recording and analysis strategies (Rosenthal 1966). Or the evaluator may provide clients with unintentional cues which influence them to report high satisfaction (Friedman 1967). Gordon and Morse (1975) sampled 93 published service outcome evaluations that appeared in the *Sociological Abstracts* between 1969 and 1973. They found that evaluators who were affiliated with the program being evaluated were much more likely to report program success (58%) than were non-affiliated researchers (14%). Nearly all client satisfaction research is done by affiliated evaluators, leaving open to question the effect of evaluator expectations and cues in client satisfaction assessment.

5. From a behavioural contingency perspective, most social programs provide clients with a variety of rewards (e.g. additional resources, money, help, companionship, hope, even social power in democratic or community governed programs). Whether one takes the economic view that individuals seek to maximise their own self-interest, or the social exchange perspective that behaviour is governed by an exchange of activities and reinforcers within one's social environment (Homans 1974), clients are likely to perceive that their expressions of satisfaction will contribute to the continuation of the personally rewarding program serving them.

6. Finally, positive client satisfaction ratings can also be predicted from cognitive consistency theory (Festinger & Carlsmith 1959). According to this theory, when clients are free to drop out of a service program but continue to participate instead, they are likely to report that they are satisfied as a way of justifying their own investment of time and effort. In particular, clients who continue in the face of adverse program or personal conditions are the most likely to be influenced by this type of bias. Evidence consistent with this proposition is found in Larsen's study where length of stay in a program was positively correlated with expressed satisfaction (Larsen et al 1979).
Many studies have not taken these social psychological variables into consideration and the argument could be put forward that the satisfaction ratings do not reflect true satisfaction but are a result of bias. Many of the findings relating to evidence of factors contributing to global satisfaction may not therefore be valid and previous findings can not be accepted where researchers have not limited the effects of such bias. It appears necessary to conduct a study which considers methods of reducing the effect of social psychological factors while measuring the effect of the factors identified by an analysis of the literature as contributing to global satisfaction.

5.3 Reliability
The lack of information about reliability is a problem with this research. The few satisfaction studies reporting reliability (usually internal consistency) have generally and found adequate-to-high reliability (Larsen, Attkisson, Hargreaves & Nguyen, 1979 Love, Caid & Davis 1979), but generalisation about reliability from this sample may be inappropriate. In any study it will be necessary to assess reliability for the population to be studied.

Lebow (1983a) has noted that in patient satisfaction studies, reliability is seldom assessed. Ware, Snyder, Wright and Davies (1983) reported that reliability estimates are rarely published for studies of satisfaction with medical care, and even more rarely do estimates of test-retest or temporal stability reliability appear in the literature. In their review they found that only in 11 of 81 empirical studies were reliability coefficients reported, and this information was provided in none of the 51 publications that described analyses of single-item scales. The reliability coefficients which were reported ranged from 0.52 to 0.90. While some of the scales in the field of mental health (Lebow 1983a) and primary health care (Pascoe and Atkinson 1983) appear to have satisfactory reliability (Helmstader 1964; Nunally 1967) many scales have not been assessed for psychometric characteristics.

5.4 Validity
There have been few attempts to validate the instruments used in consumer satisfaction surveys or to assess the validity of the data obtained. The most prominent threats to validity are explored below.

Sampling. Two sources of sampling bias threaten validity in the research; selection in the clients contacted and selection in the clients responding. Selection of clients to contact appears to be only a minor problem. Occasionally consumers who are believed to be unable to respond (e.g. psychotic or illiterate clients) or those whose treatments
are atypical (e.g. early terminations) are excluded from assessments (e.g. Powell, Shaw & O'Neal, 1971), but the number of these instances appears to be small.

A greater problem arises from the failure of clients to respond to these surveys. Mental health centre directors have reported that an average of only 54% of consumers respond to surveys (Sorenson et al., 1979). Although this is not a poor rate of return, it is limited enough for differential response among consumers to influence results. Moreover, in the published studies, where more careful reporting of return rates is likely, response rates are even lower. Of the studies on consumer satisfaction reviewed by Lebow (1982), 31 indicated return rates; of these 10 reported return rates between 21% and 40%, 8 between 41% and 60%, 7 between 61% and 80%, and 6 between 81% and 100%.

Differences emerge in treatment related characteristics. Outpatients who respond more frequently to surveys have the following characteristics: mutual terminations (Denner & Halpin 1974a, 1974b, Frank, Salzman & Fergus 1977; McWilliams, Lewis, Balch & Ireland 1979; Speer & Zold 1971), longer treatments (Grob et al 1978; Schainblatt, 1980; Strupp et al 1969; Strupp et al 1964; Speer & Zold 1971), better related outcomes (Speer & Zold 1971), higher fees (Speer & Zold 1971), and better ratings as patients by therapists (Speer & Zold 1971; Strupp et al 1964). Similarly, inpatients who respond more frequently to surveys are more likely to have planned discharges (Eisen & Grob 1982), shorter treatments (Bene-Kociemba, Cotton & Fortgang 1982), fewer prior hospitalisations (Bene-Kociemba et al 1982), longer treatments (Eisen & Grob 1982) and better rated outcomes (Eisen & Grob 1982; Grob et al 1978).

A few studies have failed to detect a relationship between treatment-related characteristics and the likelihood of responding (e.g. length of treatment: Silver et al 1975, outcome: Ellsworth 1979, Laporte, McClelland, Erdlan & Parante, 1981; multiple treatment characteristics: Birnbaum & Suits 1979). A few studies also have found similar levels of satisfaction among respondents and initial non-respondents contacted through extensive and atypical follow-up procedure (Ellsworth, 1979; Frank et al 1977; Silverman & Beech 1979). However, the large body of findings of the differences between respondents and non-respondents suggest the taking of a conservative stance in which differences in satisfaction between the sample and those not responding are presumed until the comparability of these groups is demonstrated.
Comparison of Overall Patient Ratings with Other Validation Standards.

Three strategies have been used to assess the validity of patients' ratings: (1) comparison of patient ratings to experimentally manipulated features of care, (2) comparison of patient ratings to ratings of care from other sources, and (3) comparison of patient ratings to other theoretically related patient perceptions, attitudes or behaviours concerning the hospital stay (e.g. construct validation) (Rubin 1989). Content validity refers to whether the items on a questionnaire measure what it is purported to measure. Barker Bausell (1986) consider content validity to be of extreme importance and states that the assurance of content validity precedes reliability. Content validity has been considered in some studies e.g. Ngugen et al (1983) when developing the CSQ used mental health professionals to rank items to determine how well each item reflected the dimension in question.

Other Patient Perceptions, Attitudes, or Behaviour

Albeit rarely, some investigators have used more than one type of measure of how patients feel about or experience their hospital care. Houston and Pasanen (1972), Strasser and Davis (1991), Strasser et al (1992), and Doering (1983) confirm a strong association between patient satisfaction with hospital care and willingness to return to the hospital or recommend it to family and friends. In contrast, Abramowitz, Cote and Berry (1987) failed to find an association between patient satisfaction and intention to return to the hospital, but did find overall patient satisfaction and satisfaction with nursing care highly related to intentions to recommend the hospital. Houston and Pasanen (1972), Fleming (1981), and Carmel (1985) reported higher overall satisfaction when patients perceive that their health improved in the hospital.

5.5 Survey Methods of Satisfaction

Survey methods of measuring consumer satisfaction have been and will continue to be the most commonly used evaluation methods employed. While being potentially reactive they are direct and practical. Bornstein & Ricktarik (1983) suggest that when survey methods are employed, the Larsen, Attkisson, Hargreaves and Nguyen (1979) Client Satisfaction Questionnaire (CSQ) should be the measure of choice. The CSQ provides a general measure of client satisfaction that can be used in a wide variety of settings. It is a simple scale to administer with sound psychometric properties and requires approximately 5 minutes for completion. In addition to providing inter-programme comparisons the CSQ can also potentially yield significant information within agencies by supplementing the form with additional questions of special interest to the particular facility and so invaluable qualitative and quantitative evaluation information may be derived.
There is difficulty in identifying areas for service improvements on the basis of global statements of satisfaction and dissatisfaction. Clearly more specific information needs to be obtained. It seems appropriate to use highly reliable and valid questionnaires such as the Client Satisfaction Questionnaire but to supplement it with additional questions which consider specific aspects of the service. The CSQ can be seen as providing a measure of global satisfaction.

6.0 THE CLIENT SATISFACTION QUESTIONNAIRE (CSQ)
The CSQ was developed as a general measure of client satisfaction. Attkisson and Zwick (1982) reported that internal consistency of the CSQ was .93 and was highly correlated with being in therapy at one month after intake (.57). This finding corroborates that of Larsen et al (1979). Correlations between the CSQ and five measures of psychotherapy outcome were examined.

1. Change on client checklist, the self report symptom checklist composed of items from the CSL 90 (Derogatis, Lipman and Covi 1973).
2. Change on the out patient rating scale (published as the Brief Patient Out Patient Psychopathology Scale by Freer and Ovenall 1977) a symptom rating scale completed by the therapist.
4. Client self rating scale single item rating of improvement produced by the client.
5. Therapist global rating scale a measure and analogous to 4 produced by the therapist.

Greater satisfaction was associated with greater symptom reduction (r =-.40 for the CSQ). However, satisfaction ratings were not correlated with concurrent ratings of symptom level. This suggests that the CSQ ratings were not simply the result of client satisfaction resulting from low symptom levels. Clients who reported a greater degree of discomfort at intake tended to be more pleased with the services provided.

Larsen et al (1979) reported that the CSQ was not related to change on therapists' ratings of symptom level or global functioning, but correlated with change in self reported symptoms as measured by the client checklist. The fact that client satisfaction ratings were not correlated with their concurrent ratings of symptom level suggests that the relationship between symptom reduction and satisfaction was not merely the result of a global satisfaction factor or halo effect. The association between symptom...
reduction and satisfaction was not due solely to the correlation of each of these variables with initial symptom level. Examination of the relationships between satisfaction and the remaining therapy outcome measures revealed that the CSQ 8 was correlated with client and therapist global ratings of improvement as assessed by the clients self rating scale and therapist global rating scale. Despite the brevity of the follow up period satisfaction with services was related to three of the five measures of improvement in therapy.

Erroll (1982) examined client satisfaction evaluation methodology by assessing client satisfaction using the CSQ at a large out patient mental health clinic. The subjects were 502 consecutive terminations who were over 21 and had attended three sessions or more. A factor analysis yielded two interpretable factors, overall client satisfaction and client satisfaction with the therapist. The overall client satisfaction was positively correlated with treatment time, therapist evaluation of outcome and number of consecutive therapists. Although clients did not discriminate between treatment outcome and overall satisfaction they did discriminate between overall satisfaction and satisfaction with their therapist.

Therapists were asked to rate their satisfaction with their work on the client. This rating correlated .42 (p=.01) with the client satisfaction ratings. Finally, therapists' estimates of how satisfied they believed the client to be were correlated .56 (p=.01) with the actual client rating on the CSQ. The latter finding provides some evidence of the scale's concurrent validity.

Hank De Brey (1983) used the Client Satisfaction Questionnaire (CSQ) (Larsen et al 1979) and reported that clients who decided to stop therapy on their own were less satisfied than other clients. Clients who made a common decision with their therapist or let him or her make that decision were more satisfied than clients who stopped by themselves. Higher satisfaction and high degrees of problem resolution and change credited to the services received are obtained from clients when termination is mutually agreed by therapist and client (Denner & Halpin 1974(a) & 1974(b)).

In summary, the CSQ appears to be a useful measure of general satisfaction with services. It possesses a high degree of internal consistency and correlates with therapists' estimates of client satisfaction. A modified form of the CSQ is used in the present study as a measure of general satisfaction.
Consumer satisfaction research suffers from a number of methodological problems, the most pressing of these is clearly related to psychometric considerations. Data reactivity is the prime consideration in most currently employed consumer satisfaction methods. Given that this distortion is a problem inherent to all direct forms of assessment a number of recommendations are offered. (a) Such research should be presented by independent evaluators, (b) clients must be assured of anonymity (c) appropriate rationales should be provided and (d) explanations offered as to how data will be used in future programme planning so that it is evident that the results will not be used for information regarding the client but for the development of a service. Regarding timing and sampling difficulties it is suggested that clients be sampled cross sectionally. That is a particular period of time should be chosen and all clients receiving service during that period should provide data as regard to their level of satisfaction. These considerations will receive attention in the present study.

7.0 SUMMARY

It appears that global satisfaction can be measured but that different factors contribute to satisfaction. The role of these factors in predicting satisfaction has not been determined.

It seems possible to measure global satisfaction and as the CSQ has been identified as a reliable and valid measure of global satisfaction, this will be employed in the present study. The literature indicates that there is support for four factors which may contribute to satisfaction i.e. process, organisational issues, outcome and patient characteristics. Scales will be devised to determine whether these factors exist as distinct factors in satisfaction. The ability of these factors to predict global satisfaction will be explored as particular aspects of the service which lead to satisfaction. It is only when these aspects can be identified that measures can be undertaken to change the service with the aim of increasing consumer satisfaction.

In addition it is clear that many of the theories relating to satisfaction encompass expectations. It would be useful to determine if clients attending the Psychology Service consider that their expectations have been met and if this is related to satisfaction. Clearly if this is the case then it would inform us of the necessity to elicit
client's expectations and explore these with the client to determine if these are realistic or unrealistic and to address this as an issue.

As was evident from the literature, the relationship between outcome and satisfaction is far from clear. It would appear that there are mediating factors. The present study will determine firstly if good clinical outcome leads to greater satisfaction. Secondly, following on from the Strasser et al (1993) model of patient satisfaction, the role of client's attributions will be investigated. It is hypothesised that when the client attributes change to therapy, satisfaction would be higher.

Some of the methodological issues discussed earlier will be addressed in an attempt to ensure that the study is as free of bias as is possible.

The hypotheses which will be tested in the present study are listed below.

**HYPOTHESES**

**Major Hypotheses**
1. Four factors; process, organisational issues, outcome and patient characteristics contribute to and will predict global satisfaction.

**Minor Hypotheses**
1. Satisfaction would be higher if treatment matched or was better than expected.
2. Good clinical outcome would lead to greater satisfaction.
3. When clients attribute change to therapy, satisfaction would be higher.
9.0 METHODOLOGY

9.1 Subjects
The subjects were clients who had been referred to the Clinical Psychology Department in Mid Surrey Health Authority between 1st January 1994 and 31st December 1994. The clients were referred as having adult mental health problems. A total of 388 clients were referred. Two clients were excluded as they had stated that no post was to be sent to their home address due to a desire for confidentiality.

The Clinical Psychology Department
Consists of eight psychologists whose work is detailed below:

<table>
<thead>
<tr>
<th>Psychologist</th>
<th>5 sessions Community Mental Health Team</th>
<th>5 sessions Rehabilitation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychologist 2</td>
<td>5 sessions</td>
<td>5 sessions Neuropsychology &amp; Elderly</td>
</tr>
<tr>
<td>Psychologist 3</td>
<td>5 sessions</td>
<td>5 sessions Alcohol &amp; Drug Abuse</td>
</tr>
<tr>
<td>Psychologist 4</td>
<td>5 sessions</td>
<td>2 sessions General Community Work</td>
</tr>
<tr>
<td>Psychologist 5</td>
<td>5 sessions</td>
<td>5 sessions General Community Work</td>
</tr>
<tr>
<td>Psychologist 6</td>
<td>5 sessions CMHT</td>
<td></td>
</tr>
<tr>
<td>Psychologist 7</td>
<td>1 session CMHT</td>
<td></td>
</tr>
<tr>
<td>Psychologist 8</td>
<td>6 sessions 6 months placement. Mixture of CMHT work, Rehab &amp; Alcohol &amp; Drug abuse.</td>
<td></td>
</tr>
</tbody>
</table>

Table 1: The Psychologists Work Commitments To Various Specialities

A range of psychological approaches are utilised within the department and include a range of cognitive behavioural therapy and psychotherapy approaches. Neuropsychological assessments and more general psychological assessments are also undertaken.

9.2 Initial Questionnaire Development
The first step in developing the Psychology Department adult mental health client satisfaction questionnaire (see Appendix 1) was to conduct a literature review to determine the factors which could be seen as contributing to global satisfaction. A psychometrically well validated measure of global satisfaction, the Client Satisfaction Questionnaire (CSQ) (Larsen et al 1979) was identified and included in the Psychology Department adult mental health client satisfaction questionnaire.

The first section incorporates The Client Satisfaction Questionnaire (CSQ-8) of Larsen et al (1979) which has been widely used as a global measure of satisfaction and has
good psychometric properties (Lebow 1983). The CSQ-8 has a high degree of internal consistency indicated by an alpha coefficient of 0.93. The CSQ was to be used as a global measure of satisfaction. The CSQ was modified slightly to specifically ask about the Psychology Service rather than any service.

9.3 **Content Validity**

Four Clinical Psychologists were then asked to rate each item of the questionnaire excluding those of the CSQ as to which of the four dimensions hypothesised to be determinants of satisfaction the item related to, i.e. organisational issues, client characteristics, process and outcome variables. The average Cohen's Kappa was 0.784 which indicates that there was an acceptable level of inter-rater agreement. The Cohen's Kappa values obtained by comparing psychologists ratings are presented in Appendix 2.

9.4 **Question Type**

Regarding the question type used in the questionnaire, various formats were considered which included simple Yes/No answers which was discarded as lacking in sensitivity, and a rating scale for each question resulted in the questionnaire appearing extremely long. It was considered clearer to ask clients to fill in their answers in boxes but to use a 4 or 5 point scale to determine their responses to certain questions. A statement is presented, which typically has 5 responses, from for example "strongly agree" to "strongly disagree" which is given a numerical score and this is then entered in a box. Some simple answer boxes were also included.

9.5 **Pilot Study**

Questionnaires with stamped and addressed envelopes were posted to the last 55 clients from July 1995 who had been discharged by the Mid Surrey Clinical Psychology Service. An accompanying letter (see Appendix 3) explained that the information which would be gained from the survey would be used to improve the service so that future clients would benefit. In addition, clients were assured of confidentiality in that a researcher would process individual questionnaires and that individual psychologists would not be able to identify individual's questionnaires and that information from the questionnaires would not be linked to patient's case notes.

A second questionnaire was mailed a month later in order for test re-test reliability to be analysed (see Appendix 4 for accompanying letter).
A response rate of 34.5%, N=19 was achieved for the first set of questionnaires and N=15 for the second set, (27.27% response rate). The average reliability for the whole scale is 0.87, and for individual items as presented in Appendix 5. No items were excluded from the scale on the grounds of poor test retest reliability. The wording of several questions was changed as it was apparent that a lack of clarity existed, as several clients indicated that they were unsure of the meaning or how to respond to these questions.

9.6 Main Study
Questionnaires with stamped and addressed return envelopes were posted to all clients who had been referred to the Psychology Service and received appointments between 1st January 1994 and 31st December 1994. The accompanying letter is to be found as Appendix 6. Two patients were excluded as patients had asked that no post was to be sent to the home address due to a desire for confidentiality.

If a response was not received within two weeks of this initial mailing, then a second questionnaire was mailed. In all mailings it was guaranteed that responses would be confidential and only the Psychology Service Secretary and the research assistant would have access to an individual client's response. To assure this confidentiality questionnaires were identified by a code number.

10.0 RESULTS

10.1 Responders/Non Responders
114 questionnaires were returned which represents a response rate of 29.38%. Respondents were not significantly different from non respondents in terms of age. The mean age for the respondents was 41.79, and for non respondents 41.12. No difference in terms of sex was found (x² = 1.19, df= 1, p= 0.27).

A comparison of the type of problem for which referred between respondents and non respondents is presented in appendix 7.

Anxiety is the most frequent reason for referral with depression being the second most common, alcoholism and drug abuse being the third most frequent referral and neurological problems being the fourth most commonly referred. Those with agoraphobia, anxiety and eating disorders responded twice as frequently in comparison with the total number responding than the non responders. Non responders were more than twice as highly represented in those with health problems, sexual problems, relationship problems, where diagnosis was questioned, where forensic reports were
requested, in cases of schizophrenia, bereavement or non attenders. However, the numbers involved in some of these categories e.g. Schizophrenia (N=3), bereavement (N=2) is quite low. It does suggest however that there is a different rate of response for certain types of referral problems. This could represent a source of bias in the results in that the responders appear to have different problem types than non responders.

A comparison between responders and non responders in terms of therapy received is presented in appendix 8.

A higher proportion of those receiving counselling failed to respond, as did those who failed to attend for treatment.

The type of therapy received was significantly different between the responders and non responders [Pearson's Chi Square = 27.29, df=9.1 p=0.001]. Appendix 8 summarises this data.

10.2 Responses to Satisfaction Items
Examination of Appendices 9 and 10 suggest that although satisfaction is reasonably high with 74% indicating that the quality of the service received was excellent or good or fair, a wide spread of responses was obtained.

22% stated that they would not use the Psychology service again if they were to seek help and 33% stated that the Psychology service either did not help or seemed to make things worse. 67% stated that they were generally satisfied with the service received.

The wide range of responses obtained is atypical of a satisfaction survey and may be seen as indicating that the methodology which included anonymity of responses, the use of an independent researcher and the expressed aim of the survey as being to improve services, increased the incidence of negative responses. Certainly, the responses argue against the operation of response bias. It could also be argued that dissatisfaction with the psychology service is higher than that found in other services, where satisfaction is reported as higher and examination of responses to more specific questions is necessary to identify sources of dissatisfaction.

10.3 Factor Analysis
The responses to the questionnaire items, excluding the CSQ items, were factor analysed as it was hypothesised that four discreet factors would exist. A principal
components analysis using a direct oblimin rotation was used. Values of less than 0.3 were suppressed. Four factors were extracted. The pattern matrix is presented in Table below.

**Pattern Matrix A**

<table>
<thead>
<tr>
<th>Question Number</th>
<th>Scale</th>
<th>Process Factor 1</th>
<th>Patient Characteristics Factor 2</th>
<th>Organisation Factor 3</th>
<th>Outcome Factor 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q.27</td>
<td>Process</td>
<td>.91228</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q.33</td>
<td>Process</td>
<td>.84408</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q.29</td>
<td>Process</td>
<td>.83466</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q.26</td>
<td>Process</td>
<td>.83466</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q.25</td>
<td>Process</td>
<td>.80377</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q.30</td>
<td>Process</td>
<td>.78014</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q.24</td>
<td>Process</td>
<td>.69191</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q.28</td>
<td>Process</td>
<td>.64852</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q.32</td>
<td>Process</td>
<td>.64816</td>
<td></td>
<td></td>
<td>.32745</td>
</tr>
<tr>
<td>Q.3</td>
<td>Organisation</td>
<td>.56536</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q.21</td>
<td>Patient Charact.</td>
<td></td>
<td>.82903</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q.19</td>
<td>Patient Charact.</td>
<td></td>
<td>.80849</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q.17</td>
<td>Organisation</td>
<td>.42841</td>
<td>.46132</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q.20</td>
<td>Outcome</td>
<td>-.32030</td>
<td>.40112</td>
<td>-.33513</td>
<td>-.30079</td>
</tr>
<tr>
<td>Q.16</td>
<td>Organisation</td>
<td>.66743</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q.9</td>
<td>Organisation</td>
<td>.64697</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q.15</td>
<td>Organisation</td>
<td>.30064</td>
<td>.62306</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q.6</td>
<td>Organisation</td>
<td>.43713</td>
<td>.51814</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q.5</td>
<td>Organisation</td>
<td>.49656</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q.22</td>
<td>Outcome</td>
<td></td>
<td></td>
<td></td>
<td>.87175</td>
</tr>
<tr>
<td>Q.31</td>
<td>Outcome</td>
<td></td>
<td></td>
<td></td>
<td>.78360</td>
</tr>
</tbody>
</table>

Values of less than 0.3 were suppressed.

It was hypothesised that the four factors of process, patient characteristics, organisational issues and outcome would be evident and from the pattern matrix. This did not emerge clearly.

Two questions which loaded on patient characteristics (Questions 17 and 20) were not hypothesised measures of patient characteristics and had low correlations with the factor. They were multiply loaded on other factors and so do not achieve simple structure and so were excluded from the patient characteristics scale. Question 3
loaded on the process factor but the content validity analysis suggested that it was part of the organisational issues factor and was therefore excluded from the scale. These three questions were excluded when constructing the scales to measure these factors and then from the subsequent factor analysis. A second analysis was conducted whereby the questions which were unrelated to the factors were excluded.

**Pattern Matrix B** represents the second factor analysis and is presented below.

<table>
<thead>
<tr>
<th>Question Number</th>
<th>Scale</th>
<th>Process Factor 1 38.4% variance</th>
<th>Patient Characteristics Factor 2 10.8% variance</th>
<th>Outcome Factor 3 7.5% variance</th>
<th>Organisational Issues Factor 4 6.8% variance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q.27</td>
<td>Process</td>
<td>0.91984</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q.29</td>
<td>Process</td>
<td>0.88308</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q.30</td>
<td>Process</td>
<td>0.85235</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q.33</td>
<td>Process</td>
<td>0.84888</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q.26</td>
<td>Process</td>
<td>0.79482</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q.25</td>
<td>Process</td>
<td>0.73796</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q.32</td>
<td>Process</td>
<td>0.73350</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q.28</td>
<td>Process</td>
<td>0.72108</td>
<td>0.31249</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q.24</td>
<td>Process</td>
<td>0.69581</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q.21</td>
<td>Patient Characteristics</td>
<td></td>
<td>0.89089</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q.19</td>
<td>Patient Characteristics</td>
<td></td>
<td>0.86572</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q.22</td>
<td>Outcome</td>
<td></td>
<td>0.75544</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q.31</td>
<td>Outcome</td>
<td>0.40889</td>
<td>0.70292</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q.15</td>
<td>Organisation</td>
<td></td>
<td></td>
<td>0.80413</td>
<td></td>
</tr>
<tr>
<td>Q.16</td>
<td>Organisation</td>
<td></td>
<td></td>
<td>0.69364</td>
<td></td>
</tr>
<tr>
<td>Q.9</td>
<td>Organisation</td>
<td></td>
<td></td>
<td>0.59687</td>
<td></td>
</tr>
<tr>
<td>Q.5</td>
<td>Organisation</td>
<td></td>
<td></td>
<td>0.50553</td>
<td></td>
</tr>
<tr>
<td>Q.6</td>
<td>Organisation</td>
<td>0.39927</td>
<td></td>
<td></td>
<td>0.46537</td>
</tr>
</tbody>
</table>

The inter factor correlations are illustrated below.

**Factor Correlation Matrix of the Hypothesised Factors of Process, Patient Characteristics, Outcome And Organisational Issues**

<table>
<thead>
<tr>
<th></th>
<th>Factor 1</th>
<th>Factor 2</th>
<th>Factor 3</th>
<th>Factor 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Factor 1</td>
<td>1.00</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Factor 2</td>
<td>-0.10</td>
<td>1.00</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Three items load on more than one factor.

These relate to the coping strategies learned through therapy which load on both process and patient characteristics. Clearly, although therapists distinguish clearly on this item and consider it to be measuring process as indicated by the content validity exercise, clients are less clear. This item loaded at a level of 0.72 on process and 0.31 on patient characteristics (Q.28)

Another item which loads on two factors relates to the client's understanding of their problems after therapy which loaded on both the process and the outcome factors (0.40 on process and 0.70 on outcome) (Q31). This item loaded more heavily on outcome. The other item loading on two factors related to length of appointment satisfaction which appears in the process (0.39) and in the organisational (0.46) factors (Q6)

In summary therefore, four factors emerged.

1. **Factor 1** which accounts for 42.2% variance and represents process.
   The correlation in the pattern matrix range from 0.69 to 0.91. This factor is made up of the following items:
   - Q24. Was treatment better, or worse than you expected?
   - Q25. Talking about my problem during therapy was helpful.
   - Q26. The personal attention I received from the Psychologist during therapy was helpful.
   - Q27. The Psychologist's understanding of my problem during therapy was helpful.
   - Q28. The coping strategies I learnt during therapy were helpful.
   - Q29. The explanation I was given of my treatment was helpful.
   - Q30. The Psychologist understood me and the problems I was experiencing.
   - Q32. Treatment contributed to the improvement in my problems.
   - Q33. The Psychologist who was involved in my care or assessment was satisfactory.

2. **Factor 2** which accounts for 10.4% of variance and represents patient characteristics.
This factor is made up of the questionnaire items below. The correlations range from 0.3 to 0.89

Q19. At the time you were referred to the Psychologist would you rate your problem as severe.
Q21. How much was your problem interfering with your daily life before treatment with the Psychologist?

3. **Factor 3** which accounts for 8.3% variance and represents outcome and is made up of the following items.

Q22. The problem is seriously interfering with my daily life now
Q31. I feel that I understand my problems more now:

4. **Factor 4** which accounts for 7.3% variance and represents the organisational factor and is made up of the questionnaire items below.

Q5. The waiting time for the start of my appointment was satisfactory.
Q6. The length of appointment was satisfactory
Q9. The frequency of appointments was satisfactory
Q15. Whilst waiting to see the Clinical Psychologist staff were satisfactory.
Q16. The environment where the appointment was held was satisfactory

**Reliability Analysis**

A reliability analysis was conducted on the items which were seen in the factor analysis to contribute to each factor. The alpha for the process scale being 0.948. This represents a good level of reliability for the scale.

The reliability for the patient characteristics scale was 0.80.

The alpha score of 0.761 for the organisational issues scale.

The outcome scale has an overall alpha of 0.8177. The scales can be seen to be offering acceptable levels of reliability.

10.4 **Multiple Regression**

A multiple regression was conducted on the four factors, patient characteristics, organisation, outcome and process to determine whether these factors could predict CSQ scores. The main aim of the study was to determine which factors could predict global satisfaction. It would then be possible to change components of the service
which could be seen as having a direct influence on global satisfaction. The adjusted R square was 0.72 which is a high score, \( F= 43.67, \text{ df}= 4,60, p< 0.0 \) The details of the analysis are presented in table 2 below.

### Table 2 Details of The Multiple Regression Analysis On The Four Factors and Their Ability to Predict CSQ Scores

<table>
<thead>
<tr>
<th>Variable</th>
<th>B</th>
<th>SE B</th>
<th>Beta</th>
<th>T</th>
<th>Sig T</th>
</tr>
</thead>
<tbody>
<tr>
<td>Organisation</td>
<td>.431270</td>
<td>.145872</td>
<td>.237341</td>
<td>2.956</td>
<td>.0044</td>
</tr>
<tr>
<td>Outcome</td>
<td>.302917</td>
<td>.205007</td>
<td>.108450</td>
<td>1.478</td>
<td>.1447</td>
</tr>
<tr>
<td>Process</td>
<td>.439435</td>
<td>.058107</td>
<td>.650192</td>
<td>7.563</td>
<td>.0000</td>
</tr>
<tr>
<td>Patient Characteristics (Constant)</td>
<td>-.029527</td>
<td>.218659</td>
<td>-.008987</td>
<td>-0135</td>
<td>.8930</td>
</tr>
</tbody>
</table>

It can be seen that two factors, organisation and process were significant in being able to predict CSQ scores. The highly significant contribution that the process factor makes to CSQ scores raises the possibility that the CSQ is actually a measure of satisfaction with process aspects of therapy. The outcome and patient characteristics factors seem unrelated to patient satisfaction.

### 10.5 Factor Analysis of Process, Organisation and CSQ

A further analysis was conducted of all the items relating to process, organisation and the CSQ. This was undertaken because although process and organisation emerged as being factors which could predict CSQ scores, it was necessary to ascertain that process, organisation and CSQ were distinct factors and that the scales were not measuring the same aspects. Patient characteristics and outcome items were excluded as they had been shown to have no significance in being able to predict CSQ scores.

The items hypothesised as relating to process, organisation and CSQ were entered. Then the factor analysis was run to extract three factors which were hypothesised to represent the factors of process, organisation and CSQ. A principal components analysis using a direct oblimin rotation was used.

Table 4 reports the pattern matrix of all the process, organisation and CSQ items and illustrates clearly the CSQ and process seem to be measuring the same aspect of satisfaction. The organisation factor does not seem to be clearly delineated.
Factor 2 consists of items 15 and 16 which are part of the previous organisation factor relating to place of appointment and clinic staff. Factor 3 also consists of previous organisation factor items of waiting time for the start of the appointment and frequency of appointment.

Table 3: Pattern Matrix of all items of process, organisation and CSQ

<table>
<thead>
<tr>
<th>Previous Factor Question related to</th>
<th>Question Number</th>
<th>Factor 1 57.3% variance</th>
<th>Factor 2 6.9% variance</th>
<th>Factor 3 5.7% variance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Process</td>
<td>27</td>
<td>.92308</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Process</td>
<td>32</td>
<td>.90097</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Process</td>
<td>29</td>
<td>.88728</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Process</td>
<td>30</td>
<td>.86639</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Process</td>
<td>28</td>
<td>.85497</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Process</td>
<td>33</td>
<td>.83576</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Satisfaction (CSQ)</td>
<td>8</td>
<td>.81232</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Satisfaction (CSQ)</td>
<td>4</td>
<td>.77351</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Satisfaction (CSQ)</td>
<td>3</td>
<td>.77173</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Satisfaction (CSQ)</td>
<td>7</td>
<td>.76696</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Satisfaction (CSQ)</td>
<td>2</td>
<td>.76514</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Process</td>
<td>26</td>
<td>.74904</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Satisfaction (CSQ)</td>
<td>1</td>
<td>.73699</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Process</td>
<td>25</td>
<td>.70798</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Process</td>
<td>24</td>
<td>.69193</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Satisfaction (CSQ)</td>
<td>6</td>
<td>.66430</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Satisfaction (CSQ)</td>
<td>5</td>
<td>.63316</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Organisation</td>
<td>15</td>
<td>.90381</td>
<td></td>
<td></td>
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<tr>
<td>Organisation</td>
<td>16</td>
<td>.82516</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Organisation</td>
<td>5</td>
<td>.85597</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Organisation</td>
<td>6</td>
<td>.75251</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Organisation</td>
<td>9</td>
<td>.46510</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Values of less than 0.3 were supressed.

The inter correlations of the factor are displayed below.
Factor Correlation Matrix For Process, Organisational Issues and CSQ as Three Factors

<table>
<thead>
<tr>
<th></th>
<th>Factor 1</th>
<th>Factor 2</th>
<th>Factor 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Factor 1</td>
<td>1.00</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Factor 2</td>
<td>0.32</td>
<td>1.00</td>
<td></td>
</tr>
<tr>
<td>Factor 3</td>
<td>0.46</td>
<td>0.21</td>
<td>1.00</td>
</tr>
</tbody>
</table>

The factor correlation matrix for process, organisation and CSQ indicates that not only does factor 1 represent a large proportion of the variance but also correlates highly with the other factors so suggesting that the factors are not very different. Factor 3 and factor 1 for example share over 20% of the variance. In addition the adjusted R square was 0.72 which is a high score and again suggests that the factors are measuring the same thing.

These results suggest that despite the content validity exercise, the scales are not factorially distinct. It appears that one factor accounts for the process and global satisfaction questions and which accounts for 57.3% of the variance. The organisational issues items do not form a distinct factor as they are divided into two factors, the first of which accounts for 6.9% of the variance and the second which accounts for 5.7% of the variance. It seems that a global measure of satisfaction has emerged with a major contribution from the process items. The hypothesised factors do not predict global satisfaction as they are not factorially distinct from global satisfaction.

Expectations and CSQ Scores

Much of the literature utilises expectations in models of satisfaction (Linder Pelz 1982), and in Strasser et al's (1993) model, expectations are seen as part of the individual differences which determine how stimuli are encoded by the patient to form value judgements which are then translated by the individual into the attitudinal response of satisfaction. For such a model to receive support, it would be necessary to gain results which would confirm the hypothesis that expectations are related to satisfaction.

The results confirmed this hypothesis. A significant difference in satisfaction scores was obtained between those who rated that treatment was better than expected and
those who rated treatment was worse or were uncertain if treatment was better than expected ($t=-8.37$, $df=71$, $p=0.0$)

**Outcome**

A significant difference was obtained between those that rated that they had no improvement ($N=25$) and those that had improved in terms of severity of problems ($N=59$) and CSQ scores ($t=-5.58$, $df=34.38$, $p=0.0$).

A significant difference was obtained between those that rated that there had been an improvement with the rating of their problems interfering with daily life and CSQ scores ($t=-3.38$, $df=73.3$, $p=0.001$).

A significant difference was obtained between those that stated that they attributed the change to therapy and those who did not and CSQ scores ($t=-10.97$, $df=64.09$, $p=0.0$).

### 10.9 Overall Satisfaction Scores

Psychometric properties of the CSQ-8 (Nguyen et al 1988) are presented in Table 4 below and the CSQ properties as used in the present study are presented in table 6.

**Table 4: Psychometric Properties of the CSQ 8 (Nguyen et al 1983)**

<table>
<thead>
<tr>
<th>Scale Attributes</th>
<th>CSQ 8</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Score Average</td>
<td>27.09</td>
</tr>
<tr>
<td>Total Score Standard Deviation</td>
<td>4.01</td>
</tr>
<tr>
<td>Mean of Item Measures</td>
<td>3.39</td>
</tr>
<tr>
<td>Mean of Item Variances</td>
<td>0.48</td>
</tr>
</tbody>
</table>

**Table 5: Scores on the CSQ as used in the present study**

<table>
<thead>
<tr>
<th>Scale Attributes</th>
<th>CSQ 8</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Score Average</td>
<td>23.08</td>
</tr>
<tr>
<td>Total Score Standard Deviation</td>
<td>6.71</td>
</tr>
<tr>
<td>Mean of Item Measures</td>
<td>2.87</td>
</tr>
<tr>
<td>Mean of Item Variances</td>
<td>0.884</td>
</tr>
</tbody>
</table>

The average score in the present study is lower than that reported by Nguyen et al (1983) which suggests that either satisfaction with the Psychology Service is lower or that the response biases are operating to a lower degree in the present study. It could
be hypothesised that different client groups could account for the differences. The client type of the two studies was slightly dissimilar. In the Nguyen et al (1983) study, clients were drawn from 21 different community mental health centres, public health centres and mental health clinics. This included psychiatric inpatient settings, residential settings and outpatient clinics. Clearly some clients, from public health centres did not have psychiatric/psychological problems as their main reason for referral to the centre as was the case in the present study. However, many of the clients in the Nguyen et al (1983) sample did have such problems and so similarities do exist between the two samples.

11.0 DISCUSSION

The hypothesis that satisfaction is multidimensional and composed of the four factors identified in the literature has not been confirmed. Questions thought to be pertaining to these factors were devised and content validity using professionals confirmed that the questions seemed to be assessing these factors. The initial factor analysis largely confirmed the existence of these categories as factors. Three of the questions which professionals thought of as pertaining to specific factors were not confirmed as being related to clients views. These questions were then excluded and a second factor analysis conducted.

A multiple regression was conducted to assess the ability of the factors to predict global satisfaction but only two factors, organisation and process emerged as determining satisfaction. The Beta values for process was 0.65 and for organisation was 0.24. The high level of the Beta value for process raises the possibility that the CSQ score and the process factor are measuring the same thing. The high R² is also seen as being very high for questionnaire research and again supports the view that the same thing is being measured. It could be that the CSQ measures primarily process aspects. This would also receive support from the huge body of literature which suggests that satisfaction is significantly related to interpersonal features of consultations. Outcome and patient characteristics do not emerge as significant factors in their own right.

When items relating to process and organisation and the CSQ items were factor analysed to determine the distinctiveness of the factors, factor 1 emerged as incorporating all the CSQ items and the process items and accounted for 57.3% of the variance, so suggesting that the CSQ is indeed measuring process aspects. The factor
analysis seemed to confirm the existence of a global representation of patient satisfaction.

Organisation items emerged as the second and third factors but only accounted for 6.9% and 5.7% of the variance respectively.

Strong support for the unidimensionality of satisfaction has been provided. Satisfaction appears to be highly related to process items which could be expected from the literature which frequently reports the importance of interpersonal aspects of a service as being linked to satisfaction. Interpersonal processes have repeatedly emerged as a factor but the present study suggests that this is actually similar to that measured by a global measure of satisfaction such as the CSQ.

Distinct factors did not emerge and so the aim of being able to isolate aspects of the service which could predict satisfaction and which could provide a focus for change to improve a service was not achieved.

It is interesting that so many studies in the literature report the emergence of a number of factors and indeed in the present study, four factors did emerge although not clearly. But when their ability to predict satisfaction was considered and the factor structure again analysed, the distinctiveness of the factors disappeared.

The factors reported in the literature therefore may also have little predictive value of satisfaction. Models such as that of Renwick and Harvey (1989) suggest that aspects of the interpersonal process and amenities/organisational issues will tend to increase satisfaction. However, crucially, the factor analysis revealed the lack of distinctiveness of these factors. Certainly process issues seem synonymous with satisfaction and organisational issues account for only a small percentage of the variance. The ability of these factors in leading to satisfaction as suggested in the Renwick and Harvey (1989) and the Strasser et al (1993) models receives little support.

The work of Linder Pelz (1982) who developed the value- expectancy model of satisfaction also receives little support from the present study in that she hypothesised that satisfaction was multidimensional- a proposal which has received little support from this study.

Strasser et al's (1993) model considered that the patient satisfaction process would lead to both a multifaceted definition of patient satisfaction and a summary constant
but this is not supported by the present study. Strasser et al's model suggest that individual differences, defined in the present study as patient characteristics, human stimuli defined in this study as organisational issues would affect satisfaction. They could be hypothesised as being predictors of satisfaction - this is not borne out by the present study.

Obtaining factors such as process or organisational issues has been reported frequently in the literature but the present study suggests that their ability to predict satisfaction is poor. This suggests therefore that manipulating variables such as an organisational feature may have little effect on satisfaction. Satisfaction appears to be more highly related to process features than any other aspect. Indeed process and satisfaction could be seen as being synonymous. Regarding the major hypothesis of the study, a global measure of satisfaction was obtained, however, the assumption of multidimensionality of satisfaction was questioned. The ability of the four factors to predict satisfaction was disproved.

Regarding the minor hypotheses, satisfaction was found to be higher if treatment matched or was better than expected. This is what would be expected from theories of satisfaction. However, from the first part of the study, which suggests that factors which had previously received much support in the literature were not factorally distinct, it would seem relatively unlikely that expectations would have such a predictive value and would affect satisfaction to a large extent. Satisfaction seems to be much more of a global concept. Aharony and Strasser (1992) recommended a study into satisfaction and outcome, as it still was not known if satisfied patients experience better clinical outcomes. It had therefore been hypothesised that good clinical outcome is associated with greater satisfaction. This received support. This is consistent with the findings of Dankat et al (1983). This is also consistent with the Strasser et al model of satisfaction in that good outcome would be seen as affecting patients value judgements which would then affect satisfaction. The Renwick and Harvey model also suggested that good outcome would lead to increased satisfaction.

Interestingly, when clients attributed change to therapy, satisfaction was found to be higher. The final hypothesis was therefore confirmed. This is support for the Strasser et al (1993) model which suggests that patients are exposed to stimuli, encode some and ignore others and then place value judgements on them. It is suggested by Strasser et al (1993) that internal and external attributions of medical outcome may affect the positive or negative direction in which value judgements are formed. This is supported by the present study.
Client's improvement as a consequence of psychological therapy in terms of a decrease in the severity of their problems and in terms of the degree to which their problems interfered with their lives was evident. It was those who improved who had higher satisfaction scores so it seemed that positive outcome in its own right affects satisfaction scores.

Strasser et al (1993) discussed that internal and external attributions under the conditions of success and failure of medical outcomes may affect the direction on which value judgements are formed.

The present study's result that positive outcome led to higher CSQ scores suggests that although attributions may play a role, positive outcome alone can lead to higher CSQ scores.

Those clients who considered that treatment contributed to an improvement in the client's problems were more satisfied than those who did not attribute change to therapy. This supports Strasser et al's (1993) model which suggests that attributions do affect satisfaction.

It would seem that rather than focusing research on factors in satisfaction, it would be of more interest to determine the process by which clients make evaluations and judgements which lead to satisfaction. The situation is more complex than gross factors leading to satisfaction, but appears to involve mediating variables such as attributions or degree of improvement.

Regarding the measurement of satisfaction, the satisfaction questionnaire utilised in the present study incorporated a modified form of the CSQ-8 and items which related to process, organisational issues, patient characteristics and outcome. The questionnaire had good psychometric qualities (content validity 0.78 and reliability of 0.87). Attempts to reduce bias were made by ensuring anonymity and by using an independent researcher.

The responses to satisfaction items displayed a wide range of responses which argues against response bias operating. It would be interesting to study the dissatisfied group directly to ascertain the sources of their dissatisfaction.
The overall satisfaction score on the CSQ as used in the present study was 23.08. This is lower than levels reported by Nguyen et al (1983) of 27.09.

An attempt had been made to reduce the effect of bias and validity problems.

1. Two sources of sampling bias threaten validity in this area (a) selection of clients - all clients in a period of a year were selected (b) failure of clients to respond - it is necessary to know if respondents are similar to non respondents. This was considered and differences emerged. It is necessary to acknowledge this source of bias and this will be explored further. A study is currently being planned to interview non responders and responders to determine if satisfaction is indeed different between responders and non responders and factors affecting this.

2. Social desirability and reactivity can inflate ratings. Anonymity, explaining that the assessment was linked to evaluate a service, an emphasis that the analysis will focus on group not individual data, and using an independent researcher can reduce problems stemming from reactivity and social desirability (Lebow 1982). These features were included in the present study.

A major problem in using satisfaction measures is the finding that service recipients report high levels of satisfaction. At one extreme these findings can be viewed as arising from demand characteristics of the rating situation or at the other extreme, the observed data are taken as "proof" of the effectiveness of the program (Nguyen et al 1983). Both of these positions are short sighted as one can use such data while acknowledging its limitations. It is necessary to gain a basis for comparison so that the level of satisfaction can be more meaningful. For this reason, the survey may be repeated at intervals with Psychology referrals or may be utilised in an adapted way by other professionals in the community mental health team. The questionnaire may also be utilised with particular client groups or for the work of particular Psychologists as now a basis has been created for comparison. Nguyen et al (1983) report that a key issue in research is the enhancement of our capacity to detect dissatisfied customers.

The content validity exercise illustrates that professionals can distinguish between process, organisational issues, patient characteristics and outcome, but the subsequent analyses illustrated that these are not factorially distinct.

No difference between responders and non responders in terms of age or sex was apparent. However, a difference in terms of problems for which referred was obtained.
Those referred for agoraphobia, anxiety and eating disorders are over represented in the responders and those referred for sexual problems, relationship problems and forensic problems were under represented in the responders. This could have biased the results. Clients receiving counselling tended to be non responders. Clearly treatment type was significantly different between responders and non responders and could have introduced bias into the results. Many studies do not consider problems for which referred or therapy type and do not even present summary information regarding their samples on these variables. This information seems to be necessary to collate in satisfaction studies and the differences between responders and non responders explored further.

In addition, given that there do appear to be some differences between responders and non responders in terms of problem type and therapy, it would be interesting to conduct a study exploring if there is a difference between the groups of responders and non responders in terms of satisfaction.

Many lessons have been learned through conducting this research.

Patient satisfaction is now included in many evaluative studies as an outcome of care but in view of the results of the present study which suggests that satisfaction is unidimensional and that factors involved in patient satisfaction have little predictive value, it is considered that it would be more valuable to utilise other outcome measures such as the uptake of services, the drop out rate or failure to return to services as a measure of satisfaction than questionnaires. Another more subtle method of detecting satisfaction which would be utilised in a future study would be gap analysis which would, for example, question what the clinic environment is like now and how the client would like it to be and to examine the differences between the responses.

Multidimensional scales do exist, it seems patients can rate different features of care as is shown by numerous factor analytic studies, but the present study shows that these have little predictive value and so have limited value. Future research which I would consider would compare patient ratings of these features of care to independent ratings as it is not yet apparent if the clients are making valid discriminations. Independent measure of satisfaction such as re-use of a service and satisfaction levels need to be compared.

It is considered that it would be more helpful in future research to use a general scale and then to conduct an interview with those who are dissatisfied. Such a qualitative
research could use content analysis to explore the issues. The relationship between satisfaction and behavioural reactance also needs to be explored to determine what behaviours are evident if patients are satisfied or not.

The present study was also interesting in that it appeared that while clinicians agreed about the factors which questionnaire items were measuring the public did not demonstrate this agreement as shown in the factor analysis. In hindsight, it would have been more useful to conduct the construct validity exercise using the public to rate the items. This would however, also have been biased as the people who would have agreed to participate in such a study would perhaps have been a special collection of people.

Much has also been learned about questionnaire design. The questionnaire utilised in the present study had overlapping categories, the mid point in the scale rather than "uncertain" should have been "neither agree or disagree". Questions were also phrased with a bias towards satisfaction, e.g. "the environment where the appointment was held was satisfactory" and "whilst waiting to see the Clinical Psychologist staff were satisfactory". Rather than using "satisfactory" for all the items, "dissatisfactory" should also have been used. Several question types using boxes or rating scales were used. With hindsight an attempt to use the same format throughout the questionnaire where possible would be made.

A study focusing on the dissatisfied group would have perhaps produced some interesting results. It is considered that it is likely that this group would be different from the satisfied group in terms of satisfaction levels. It is hypothesised that the non responders would be less satisfied than the responders and future studies would focus on this group to allow an exploration of what service changes may be necessary.

A whole range of evaluation methods are possible of which patient satisfaction is one. It is now considered to be more valuable to utilise several methods of evaluating a service. Evaluation can assess if the service is reaching the target population, can assess service implementation, effectiveness by the use of service records and information systems as well as surveys and can assess outcome. User satisfaction can be included as otherwise the providers view can be over-represented but user satisfaction could be better used as one assessment in a multiple instrument assessment of outcome.
12.0 CONCLUSION

Satisfaction is seen as a global concept. The four proposed factors of process, organisational issues, patient characteristics and outcome were not factorially distinct and were not able to unambiguously predict satisfaction. The assumption that satisfaction is multidimensional received little support.

Outcome affects satisfaction. Those who rated that they had improved in terms of severity of problems and degree to which their problems interfered with their daily lives were more satisfied than those who had not improved. Those who attributed the change to therapy were also more satisfied than those who did not. Satisfaction was also higher in the group who reported that treatment was better than expected than those who reported that treatment was worse or were uncertain if treatment was better than expected.

It is proposed that looking at the process of satisfaction formation including the variables such as expectations, outcome and attribution of change to therapy will be more productive.
Missing pages are unavailable
This questionnaire is designed to obtain your views about the psychology service which you have received. It will take a few minutes of your time, but it is important for the planning and development of the service and will be used to improve the service for people who will be using the Psychology department in the future.

SECTION 1
The Client Satisfaction Questionnaire (CSQ)

Please help us to improve the psychology service by answering some questions about the services you have received. We are interested in your honest opinions, whether they are positive or negative. Please answer all of the questions. If you feel a question does not apply to you please write N/A (not applicable) next to the question. We also welcome your comments and suggestions. Thank you very much, we appreciate your help.

PLEASE CIRCLE YOUR ANSWER

1. How would you rate the quality of service received?
   4 Excellent  3 Good  2 Fair  1 Poor

2. Did you get the kind of service you wanted?
   4 No definitely not  3 No not really  2 Yes generally  1 Yes definitely

3. To what extent has the psychology service met your needs?
   4 Almost all of my needs have been met  3 Most of my needs have been met  2 Only a few of my needs have been met  1 None of my needs have been met

4. If a friend were in need of similar help, would you recommend the psychology service to him/her?
   4 No definitely not  3 No I don't think so  2 Yes, I think so  1 Yes, definitely

5. How satisfied are you with the amount of help you received?
   4 Quite satisfied  3 Indifferent or mildly dissatisfied  2 Mostly satisfied  1 Very satisfied
6. Have the services you received helped you to deal more effectively with your problems?

<table>
<thead>
<tr>
<th>4</th>
<th>3</th>
<th>2</th>
<th>1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes they helped a great deal</td>
<td>Yes they helped somewhat</td>
<td>No they really didn't help</td>
<td>No they seemed to make things worse</td>
</tr>
</tbody>
</table>

7. In an overall general sense, how satisfied are you with the service you received?

<table>
<thead>
<tr>
<th>4</th>
<th>3</th>
<th>2</th>
<th>1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very satisfied</td>
<td>Mostly satisfied</td>
<td>Indifferent or mildly dissatisfied</td>
<td>Quite dissatisfied</td>
</tr>
</tbody>
</table>

8. If you were to seek help again, would you come back to the Psychology Services?

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td>No definitely not</td>
<td>No I don't think so</td>
<td>Yes I think so</td>
<td>Yes definitely</td>
</tr>
</tbody>
</table>

WRITE COMMENTS BELOW:-

_________________________________________________________________
_________________________________________________________________
_________________________________________________________________
_________________________________________________________________
_________________________________________________________________
_________________________________________________________________
_________________________________________________________________
_________________________________________________________________
_________________________________________________________________
_________________________________________________________________
_________________________________________________________________
## SECTION 2

Below are some questions about the Psychology Service. There are also some statements about the Psychology service. You may agree with some whilst disagreeing or being uncertain about others. Please read each statement and put the number which corresponds to your view in the appropriate box.

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Strongly Agree</td>
<td>Uncertain</td>
<td>Disagree</td>
<td>Strongly Agree</td>
<td>Disagree</td>
</tr>
</tbody>
</table>

**Appointment Satisfaction**

1. **What the approximate date of your last appointment?**

2. **How long did you have to wait to get an appointment with the Clinical Psychologist after you have been referred?**
   - Less than 2 weeks
   - 3 - 5 weeks
   - 6 - 8 weeks
   - 9 - 12 weeks
   - 13 - 16 weeks
   - More than 16 weeks
   (Please tick one box)

3. **In your opinion was this:**
   - Much too long
   - Quite a long time
   - Not long
   - Reasonably short
   - Very short time

4. **Generally, how long did you have to wait after the expected time of your appointment?**
   - No waiting
   - Less than 5 minutes
   - 5-15 minutes
   - 15-30 minutes
   - More than 30 minutes
   (Please tick one box)

5. **The waiting time for the start of my appointment was satisfactory.**
   (Using the scale at the top of the page please put the number which corresponds to your view).

6. **The length of the appointment was satisfactory**
   (Using the scale at the top of the page please put the number which corresponds to your view).

7. **Generally, how long were your appointments?**
   - Less than 30 minutes
   - 30-45 minutes
   - 45-60 minutes
   - More than 60 minutes
   (Please tick one box)

8. **Generally, how frequent were your appointments?**
   - Weekly
   - Fortnightly
   - Monthly
   - Less than monthly
   - Frequency varied
   (Please tick one box)
<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Strong Agree</td>
<td>Uncertain</td>
<td>Disagree</td>
<td>Strongly Disagree</td>
<td></td>
</tr>
</tbody>
</table>

9a. The frequency of appointments was satisfactory
(Using the scale at the top of the page please put the number which corresponds to your view).

9b. How many appointments did you have with the Psychologist?

10. Was the number of appointments your received
(Please tick one box)

<table>
<thead>
<tr>
<th>Your decision</th>
</tr>
</thead>
<tbody>
<tr>
<td>Your decision</td>
</tr>
<tr>
<td>The psychologist's decision</td>
</tr>
<tr>
<td>A joint decision between you and the psychologist</td>
</tr>
<tr>
<td>Any other decision: e.g. GP, Court, Parents</td>
</tr>
</tbody>
</table>

11. Were you satisfied with the total number of appointments you received?
(Please tick one box)

   | Yes |
   | No |

12. If 'No' would you have like:
(Please tick one box)

   | More |
   | Fewer |

13. Where were you seen for your appointment? (Please tick one box)

   | West Park Hospital |
   | Dept. of Psychiatry, Epsom General Hospital |
   | Community Mental Health Team Base |
   | Local Clinic |
   | Your GP's Surgery |
   | Other - Please specify |

14. Where would you prefer to have your appointment? (Please tick one box)

   | West Park Hospital |
   | Dept. of Psychiatry, Epsom General Hospital |
   | Community Mental Health Team Base |
   | Local Clinic |
   | Your GP's Surgery |
   | Other - Please specify |
15. Whilst waiting to see the Clinical Psychologist staff were satisfactory.
(Using the scale at the top of the page please put the number which corresponds to your view).

16. The environment where the appointment was held was satisfactory.
(Using the scale at the top of the page please put the number which corresponds with your view).

17. The referral to a Psychologist was appropriate.
(Using the scale at the top of the page please put the number which corresponds with your view).

18. Were you seen for assessment only.
(Please tick one box) Yes 

If 'Yes' please go to question 34.
If you received treatment/therapy please answer all the questions below.

SECTION 3.
GENERAL THERAPY SATISFACTION

Below are some statements. Would you please put a circle around the number which reflects your views. If 'moderately severe' reflected your views you would put a circle around 3 as shown.

19. At the time you were referred to the Psychologist, would you rate your problem as:

20. After treatment with the Psychologist would you rate your problem as:
21. How much was your problem interfering with your daily life before treatment with the psychologist?

<table>
<thead>
<tr>
<th>5</th>
<th>4</th>
<th>3</th>
<th>2</th>
<th>1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very seriously</td>
<td>Seriously</td>
<td>Moderately</td>
<td>Mildly</td>
<td>Not at all</td>
</tr>
</tbody>
</table>

22. How much is your problem interfering with your daily life now?

<table>
<thead>
<tr>
<th>5</th>
<th>4</th>
<th>3</th>
<th>2</th>
<th>1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very seriously</td>
<td>Seriously</td>
<td>Moderately</td>
<td>Mildly</td>
<td>Not at all</td>
</tr>
</tbody>
</table>

23. What was your major difficulty or problem?

________________________

24. Was treatment better, or worse than you expected?

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Better</td>
<td>As expected</td>
<td>Worse</td>
</tr>
</tbody>
</table>

25. Talking about my problem during therapy was helpful. [ ]

26. The personal attention I received from the Psychologist during therapy was helpful [ ]

27. The Psychologist's understanding of my problem during therapy was helpful. [ ]

28. The coping strategies I learnt during therapy were helpful. [ ]

29. The explanation I was given of my treatment was helpful. [ ]

30. The Psychologist understood me and the problems I was experiencing. [ ]

31. I feel that I understand my problems more now. [ ]

32. Treatment contributed to the improvement in my problems. [ ]
33. The Psychologist who was involved in my care or assessment was satisfactory

34. Have you any suggestions for improvements which could be made to the service: Is there anything else you would like to tell us?

Thank you very much for completing this questionnaire. We really appreciate that you have helped us. We will find it very useful in helping us to develop the Psychology Service for people who will be referred to us in the future.
APPENDIX 2

Table showing the Cohen's Kappa values obtained by comparing psychologists content validity ratings.

<table>
<thead>
<tr>
<th>Psychologists</th>
<th>Cohen's Kappa Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 and 2</td>
<td>0.705</td>
</tr>
<tr>
<td>1 and 3</td>
<td>0.676</td>
</tr>
<tr>
<td>1 and 4</td>
<td>0.828</td>
</tr>
<tr>
<td>2 and 3</td>
<td>0.79</td>
</tr>
<tr>
<td>2 and 4</td>
<td>0.871</td>
</tr>
<tr>
<td>3 and 4</td>
<td>0.834</td>
</tr>
<tr>
<td>Average Kappa value</td>
<td>0.784</td>
</tr>
</tbody>
</table>
Appendix 3

Letter accompanying Satisfaction Questionnaire as part of the Pilot Study

AD/SG/001
September 1995

Dear Client

PSYCHOLOGY DEPARTMENT - CLIENT SATISFACTION SURVEY

We are presently conducting a survey to assess the quality of the psychology service. We hope that you will be willing to help us by answering some questions for us.

Enclosed is a questionnaire which is asking you about your views about the psychology service which you have received. We would appreciate it if you could complete the questionnaire and return it to the Secretary at the Psychology Department.

Individual Psychologists will not see the returned questionnaires, these will be dealt with by a research assistant who is now part of the Psychology Department. The psychologists will get information about all the returned questionnaires but this will be in terms of how all the past clients have answered the questions, no information on any individual client will be presented. No questionnaires will be placed in case notes. This means that your answers are confidential and we would appreciate your honesty about the care which you have received and your suggestions for improvements will be considered very carefully. It is important for this study that we are able to ask past clients to fill in the questionnaire twice, the second time will be approximately a month after the first questionnaire has been sent out. We do appreciate that this will take your time but we will find it extremely helpful if you would be prepared to fill in the questionnaires. It is important for us to get some good information about psychology services as we are involved in planning and developing the service and we would like your feedback so that we can develop a service which will be helpful and fulfil the needs of future clients. Yours views are therefore of extreme importance to us.

I do hope that you will feel able to complete this questionnaire and that you will complete the second questionnaire which will be sent in one month’s time. We thank you very much for reading this letter and hopefully filling in the questionnaires for us.

With best wishes.

Yours sincerely

Angela Devon
Principal Clinical Psychologist
& Specialist in Community Psychology
A Psychology Department Client Satisfaction Questionnaire was sent to you two weeks ago. If you have completed the questionnaire and returned it to us we would like to thank you as the information will be very helpful to us in ensuring that your views are used in planning and developing the Psychology Service.

If you have not yet returned the questionnaire would you consider doing so as we really need your views. If you would like another copy of the Questionnaire, please telephone the number at the top of the letter and we will send another to you.

Thank you once again.

Yours sincerely

Angela Devon
Principal Clinical Psychologist
& Specialist in Community Psychology
APPENDIX 5

The levels of reliability between each test-re-test correlation's

<table>
<thead>
<tr>
<th>Reliability</th>
<th>Alpha Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q.1</td>
<td>0.8913</td>
</tr>
<tr>
<td>Q.2</td>
<td>0.9433</td>
</tr>
<tr>
<td>Q.3</td>
<td>0.8892</td>
</tr>
<tr>
<td>Q.4</td>
<td>0.9513</td>
</tr>
<tr>
<td>Q.5</td>
<td>0.8661</td>
</tr>
<tr>
<td>Q.6</td>
<td>0.9737</td>
</tr>
<tr>
<td>Q.7</td>
<td>1</td>
</tr>
<tr>
<td>Q.8</td>
<td>0.9026</td>
</tr>
<tr>
<td>B1</td>
<td>0.9896</td>
</tr>
<tr>
<td>B2</td>
<td>0.9701</td>
</tr>
<tr>
<td>B3</td>
<td>0.8399</td>
</tr>
<tr>
<td>B4</td>
<td>0.7690</td>
</tr>
<tr>
<td>B5</td>
<td>0.9228</td>
</tr>
<tr>
<td>B6</td>
<td>0.8808</td>
</tr>
<tr>
<td>B7</td>
<td>0.8007</td>
</tr>
<tr>
<td>B8</td>
<td>0.7083</td>
</tr>
<tr>
<td>B9</td>
<td>0.9332</td>
</tr>
<tr>
<td>B10</td>
<td>0.9871</td>
</tr>
<tr>
<td>B11</td>
<td>0.7947</td>
</tr>
<tr>
<td>B12</td>
<td>0.8528</td>
</tr>
<tr>
<td>B13</td>
<td>1</td>
</tr>
<tr>
<td>B14</td>
<td>0.7594</td>
</tr>
<tr>
<td>B15</td>
<td>0.8295</td>
</tr>
<tr>
<td>B16</td>
<td>0.8143</td>
</tr>
<tr>
<td>B17</td>
<td>0.9155</td>
</tr>
<tr>
<td>B18</td>
<td>0.8435</td>
</tr>
<tr>
<td>B19</td>
<td>1</td>
</tr>
<tr>
<td>B20</td>
<td>0.6008</td>
</tr>
<tr>
<td>B21</td>
<td>0.8087</td>
</tr>
<tr>
<td>B22</td>
<td>0.7071</td>
</tr>
<tr>
<td>B23</td>
<td>0.8381</td>
</tr>
<tr>
<td>B24</td>
<td>1</td>
</tr>
<tr>
<td>B25</td>
<td>1</td>
</tr>
<tr>
<td>B26</td>
<td>0.8152</td>
</tr>
<tr>
<td>B27</td>
<td>0.9690</td>
</tr>
<tr>
<td>B28</td>
<td>0.8171</td>
</tr>
<tr>
<td>B29</td>
<td>0.7904</td>
</tr>
<tr>
<td>B30</td>
<td>0.8671</td>
</tr>
<tr>
<td>B31</td>
<td>0.7358</td>
</tr>
<tr>
<td>B32</td>
<td>0.8484</td>
</tr>
<tr>
<td>B33</td>
<td>0.9112</td>
</tr>
<tr>
<td>B34</td>
<td>0.8093</td>
</tr>
</tbody>
</table>
Appendix 6

September 1995

Dear Client

PSYCHOLOGY DEPARTMENT - CLIENT SATISFACTION SURVEY

We are presently conducting a survey to assess the quality of the psychology service. We hope that you will be willing to help us by answering some questions for us.

Enclosed is a questionnaire which is asking you about your views about the psychology service which you have received. We would appreciate it if you could complete the questionnaire and return to the Secretary at the Psychology Department.

Individual Psychologists will not see the returned questionnaires, these will be dealt with by a research assistant. The psychologists will get information about all the returned questionnaires but this will be in terms of how all the past clients have answered the questions. No information on any individual client will be presented. No questionnaires will be placed in case notes. This means that your answers are confidential and we would appreciate your honesty about the care which you have received and your suggestions for improvements will be considered very carefully. We do appreciate that this will take your time but we will find it extremely helpful if you would be prepared to fill in the questionnaires. It is important for us to get some good information about psychology services as we are involved in planning and developing the service and we would like your feedback so that we can develop a service which will be helpful and fulfil the needs of future clients. Yours views are therefore of extreme importance to us.

I do hope that you will feel able to complete this questionnaire. Thank you very much for reading this letter and hopefully filling in the questionnaires for us.

Yours sincerely

Angela Devon
Principal Clinical Psychologist
& Specialist in Community Psychology
## APPENDIX 7

Types of problems in groups of responders and non responders to the questionnaire

<table>
<thead>
<tr>
<th>PROBLEM</th>
<th>RESPONDERS</th>
<th>NON RESPONDERS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agoraphobia</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>2.6%</td>
<td>8%</td>
</tr>
<tr>
<td>Health Problems</td>
<td>2</td>
<td>12</td>
</tr>
<tr>
<td></td>
<td>1.8%</td>
<td>4.7%</td>
</tr>
<tr>
<td>Personality Problems</td>
<td>5</td>
<td>15</td>
</tr>
<tr>
<td></td>
<td>4.4%</td>
<td>5.9%</td>
</tr>
<tr>
<td>Obsessional Compulsive Disorder</td>
<td>6</td>
<td>11</td>
</tr>
<tr>
<td></td>
<td>5.3%</td>
<td>4.3%</td>
</tr>
<tr>
<td>Anxiety</td>
<td>36</td>
<td>49</td>
</tr>
<tr>
<td></td>
<td>31.6%</td>
<td>19.2%</td>
</tr>
<tr>
<td>Depression</td>
<td>14</td>
<td>32</td>
</tr>
<tr>
<td></td>
<td>12.3%</td>
<td>12.5%</td>
</tr>
<tr>
<td>Other Phobias</td>
<td>7</td>
<td>15</td>
</tr>
<tr>
<td></td>
<td>6.1%</td>
<td>5.9%</td>
</tr>
<tr>
<td>Neurological Problems</td>
<td>11</td>
<td>21</td>
</tr>
<tr>
<td></td>
<td>9.6%</td>
<td>8.2%</td>
</tr>
<tr>
<td>Behavioural Problems</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>.9%</td>
<td>1.2%</td>
</tr>
<tr>
<td>Eating Disorder</td>
<td>6</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>5.3%</td>
<td>2.4%</td>
</tr>
<tr>
<td>Alcoholism/Drug Abuse</td>
<td>9</td>
<td>33</td>
</tr>
<tr>
<td></td>
<td>7.9%</td>
<td>12.9%</td>
</tr>
<tr>
<td>Post Traumatic Stress Disorder</td>
<td>4</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>3.5%</td>
<td>2.4%</td>
</tr>
<tr>
<td>Stress Headaches</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>.9%</td>
<td>.0%</td>
</tr>
<tr>
<td>Confidence Problems</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>.9%</td>
<td>.4%</td>
</tr>
<tr>
<td>Temper/Anger/Aggression</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>2.6%</td>
<td>.8%</td>
</tr>
<tr>
<td>Sexual Problems</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>.9%</td>
<td>1.6%</td>
</tr>
<tr>
<td>Relationship Problems</td>
<td>3</td>
<td>16</td>
</tr>
<tr>
<td></td>
<td>2.6%</td>
<td>6.3%</td>
</tr>
<tr>
<td>Sexual Abuse</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>.9%</td>
<td>.0%</td>
</tr>
<tr>
<td>Query Diagnosis</td>
<td>0</td>
<td>8</td>
</tr>
<tr>
<td></td>
<td>.0%</td>
<td>3.1%</td>
</tr>
<tr>
<td>Forensic Report</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>.0%</td>
<td>.8%</td>
</tr>
<tr>
<td>Did not attend</td>
<td>0</td>
<td>12</td>
</tr>
<tr>
<td></td>
<td>.0%</td>
<td>4.7%</td>
</tr>
<tr>
<td>Schizophrenia</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>.0%</td>
<td>1.2%</td>
</tr>
<tr>
<td>Bereavement</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>.0%</td>
<td>.8%</td>
</tr>
</tbody>
</table>
### APPENDIX 8

Types of therapy received in groups of responders versus non-responders to questionnaire

<table>
<thead>
<tr>
<th>Therapy</th>
<th>Responders</th>
<th>Non-Responders</th>
</tr>
</thead>
<tbody>
<tr>
<td>Behavioural &amp; Cognitive Therapy</td>
<td>68</td>
<td>137</td>
</tr>
<tr>
<td>Neuropsychological &amp; Psychometric Assessments</td>
<td>18</td>
<td>18</td>
</tr>
<tr>
<td>Counselling</td>
<td>2</td>
<td>24</td>
</tr>
<tr>
<td>Individual Psychotherapy</td>
<td>5</td>
<td>7</td>
</tr>
<tr>
<td>Assessment</td>
<td>22</td>
<td>57</td>
</tr>
<tr>
<td>Support</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Liaison with other medics</td>
<td>1</td>
<td>11</td>
</tr>
<tr>
<td>Did not attend for treatment</td>
<td>0</td>
<td>15</td>
</tr>
<tr>
<td>Couple therapy</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Relapse prevention</td>
<td>0</td>
<td>3</td>
</tr>
</tbody>
</table>
## APPENDIX 9

### Showing the responses to satisfaction items

<table>
<thead>
<tr>
<th>Have the services you received helped you to deal more effectively with your problem?</th>
<th>Yes they helped a great deal</th>
<th>Yes they helped somewhat</th>
<th>No they really didn't help</th>
<th>No they seemed to make things worse</th>
</tr>
</thead>
<tbody>
<tr>
<td>Frequency of response</td>
<td>35</td>
<td>39</td>
<td>31</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>31.50%</td>
<td>35.10%</td>
<td>27.90%</td>
<td>5.40%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>In an overall general sense, how satisfied are you with the service you received?</th>
<th>Very satisfied</th>
<th>Mostly satisfied</th>
<th>Indifferent of mildly dissatisfied</th>
<th>Quite dissatisfied</th>
</tr>
</thead>
<tbody>
<tr>
<td>Frequency of response</td>
<td>34</td>
<td>42</td>
<td>26</td>
<td>11</td>
</tr>
<tr>
<td></td>
<td>30.10%</td>
<td>37.20%</td>
<td>23.00%</td>
<td>9.70%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>If you were to seek help again, would you come back to the psychology service?</th>
<th>Yes definitely</th>
<th>Yes I think so</th>
<th>No I don't think so</th>
<th>No definitely not</th>
</tr>
</thead>
<tbody>
<tr>
<td>Frequency of response</td>
<td>42</td>
<td>45</td>
<td>16</td>
<td>9</td>
</tr>
<tr>
<td></td>
<td>37.50%</td>
<td>40.20%</td>
<td>14.30%</td>
<td>8.00%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Total Satisfaction scores:</th>
<th>Score 8</th>
<th>Score 9-15</th>
<th>Score 16-24</th>
<th>Score 25-32</th>
</tr>
</thead>
<tbody>
<tr>
<td>No. of clients</td>
<td>3</td>
<td>13</td>
<td>40</td>
<td>51</td>
</tr>
<tr>
<td></td>
<td>2.80%</td>
<td>12.15%</td>
<td>37.38%</td>
<td>47.67%</td>
</tr>
</tbody>
</table>
### APPENDIX 10

**Showing the responses to satisfaction items**

<table>
<thead>
<tr>
<th>How would you rate the quality of service you received?</th>
<th>Excellent</th>
<th>Good</th>
<th>Fair</th>
<th>Poor</th>
</tr>
</thead>
<tbody>
<tr>
<td>Frequency of response</td>
<td>27.40%</td>
<td>40.70%</td>
<td>6.40%</td>
<td>9.70%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Did you get the kind of service you wanted?</th>
<th>Yes definitely</th>
<th>Yes generally</th>
<th>No not really</th>
<th>No definitely not</th>
</tr>
</thead>
<tbody>
<tr>
<td>Frequency of response</td>
<td>22.80%</td>
<td>46.50%</td>
<td>22.80%</td>
<td>7.90%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>To what extent has the psychology service met your needs?</th>
<th>Almost all my needs have been met</th>
<th>Most of my needs have been met</th>
<th>Only a few of my needs have been met</th>
<th>None of my needs have been met</th>
</tr>
</thead>
<tbody>
<tr>
<td>Frequency of response</td>
<td>19.60%</td>
<td>30.75%</td>
<td>25.90%</td>
<td>18.80%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>If friend were in need of similar help, would you recommend the psychology service to him/her?</th>
<th>Yes definitely</th>
<th>Yes I think so</th>
<th>No I don't think so</th>
<th>No definitely not</th>
</tr>
</thead>
<tbody>
<tr>
<td>Frequency of response</td>
<td>41.10%</td>
<td>33.90%</td>
<td>14.30%</td>
<td>10.70%</td>
</tr>
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<thead>
<tr>
<th>How satisfied were you with the amount of help you received?</th>
<th>Very satisfied</th>
<th>Mostly satisfied</th>
<th>Indifferent or mildly dissatisfied</th>
<th>Quite dissatisfied</th>
</tr>
</thead>
<tbody>
<tr>
<td>Frequency of response</td>
<td>24.80%</td>
<td>38.90%</td>
<td>26.50%</td>
<td>9.70%</td>
</tr>
</tbody>
</table>


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SECTION 5

5.1 Psychological Training Undertaken

5.2 Value of Undertaking the Psych.D. in Clinical Conversion Programme
6.1 PSYCHOLOGY TRAINING UNDERTAKEN


2. 1979 - 1980 Psychology Assistant - Princess Marina Hospital, Northampton.
   Learning Disability.

   Accredited by B.P.S.
   Courses
   Interviewing
   Issues and Approaches
   Psychometrics
   Formulation
   Psychotherapy
   Behaviour Modification
   Child Development
   Ageing
   Psychopharmacology
   Learning Disability
   Abnormal Behaviour of Adults
   Abnormal Behaviour of Children
   Neurology
   Neuropsychology
   Psychiatry
   General Medicine

   Placements
   Adult
   Child
   Learning Disability
   Primary Care
   Psychotherapy - Adult

   Specialist Experience
   2 year Psychotherapy Supervision
Research Dissertation
A Controlled Investigation into some Factors in Non-Accidental Injury

4. Post Qualification Training
Participation in 2 year Basic Grade Training Programme - Mersey Regional Health Authority.

3 year Psychotherapy Supervision.

Workshops and courses covering wide range of clinically relevant topics focusing on Adult Mental Health, Psychotherapy and Primary Care.

WAIS update - Neuropsychological Testing (CCPPD course)
Brief Psychotherapy
Supervisors Workshops - University of Surrey
Community Care and New Patterns of Working : The Psychologists Role in Committing to the Changes : Tavistock University. 10th November 1992
Media Workshop 15th November 1994
VALUE OF UNDERTAKING THE PSYCH.D. COURSE
FOR ME

Undertaking the Psych.D. Conversion Course has been very valuable for me. Training was established as a priority and participation in a wide range of lectures, conferences and workshops was possible. This has resulted in an updating of my knowledge and skills base. In addition, the training courses have stimulated me to undertake a more academic approach to my work and focused me to integrate theory and practice.

The academic reviews provided the stimulus for a detailed academic consideration of three areas in which I have had an interest and a desire to learn more. Knowledge had been gained in an experiential manner but the opportunity to approach the subjects from a more academic standpoint has been very rewarding. It has enabled me to be more informed and to be able to participate with an increased knowledge base in, for example, meetings and to have evidence to support my views and opinions. It has increased my supervision skills as I can link theory to practice much more effectively. In addition my clinical skills in brief psychotherapy, the subject of one of my reviews, have increased.

The research part of the Psych.D. was the most challenging and has promoted change in me. Having participated in very little research since qualification, my research skills were very poor. The undertaking of a literature review in an area which was necessary for me in relation to my work needs was valuable. An increased knowledge in patient satisfaction surveys has been extremely valuable as I have been able to act in a consultative capacity to Audit and Quality Assurance Groups in my N.H.S. Trust. The research part of the study was valuable in that I have become reacquainted with experimental design and methodology. I have never been involved in questionnaire design and concepts such as reliability and validity and issues relating to question type, bias etc. were seen as remote issues. I would now feel skilled to be able to help other professionals and to be able to devise questionnaires for my own use. My computer skills were non existent before the course and are now more developed and have provided me with the impetus to organise a course for me to develop these skills further in 1996. The involvement in research has provided me with skills which I had lost and have enabled me to see that it is possible, and extremely valuable, to undertake research in one's clinical work. A different attitude is created, one in which academic knowledge and investigative skills are more integrated into one's work.
The clinical part of the Psych.D. represented a report on service development and was useful in that it created the opportunity of drawing together several pieces of work but was difficult in that lower standards of data collection can be achieved. A greater understanding of the issues and practicalities in organising and conducting such work has been aided.

In summary, my knowledge base has increased enormously throughout the past year which enhances my clinical work, my ability as a supervisor and as a member of my Psychology Department. The integration of theory and practice has been enhanced due to an increase in my theoretical and academic knowledge. My computer and research skills have also been increased and has led to a desire to improve these skills further. The Psych.D. has caused a change in my attitude and approach to psychology in that it has refocused me on to a greater appreciation of the need for academic knowledge and research skills in my work.