Beliefs Held In Counselling Psychology Regarding Secondary Mental Health Care Provision: Reflections From 1998

by

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Declaration of authorship

Annie Maillard designed the research tool and planned the research.
Annie Maillard collected and analysed the data and wrote the DPsych thesis.
Dr Don Rawson and Dr Jacqui Farrants supervised the research process. Dr Don Rawson gave suggestion in the design stage of the research while Dr Jacqui Farrants gave suggestions and feedback on the research in progress, read and made comments on written sections of the thesis and provided valuable mentoring throughout the study.

SECTION A

INTRODUCTION TO THE PORTFOLIO

1 Overview

The thesis is an historical record of the beliefs held within the division of counselling psychology at the time of the data collection in November 1998. The broad area of interest is the provision of psychological services by counselling psychologists to individuals who have enduring mental health problems. This research topic was chosen for its personal relevance to the researcher, who at the time was employed as the sole psychologist within a CMHT. The researcher provided psychological therapy to individuals with enduring mental health problems as well as indirect psychological services to other members of the CMHT – supervision, training and liaison with other professionals providing care to service users. The following sections, and the items within them were included because of their relevance to, and association with, the research topic. They also provide the context for understanding the social, political and professional dimensions of the research findings.

2 The research component

The objective of the main body of the research was to compare the beliefs held by applied psychologists when working with individuals who have enduring mental health problems.

There has been no previous published national study comparing the beliefs held by clinical and all registered counselling psychologist's in the UK about their role as a psychologist when working with people who have enduring mental health problems. The research was an attempt to address the total absence of material on this topic and the paucity of literature on the psychological interventions that counselling psychologists can and do provide this particular client group (James, 2005).

This research is being published at a time of far-ranging proposed changes to the delivery of mental health care (SCMH, 2006) and to the regulation of psychology. The Department of Health (DoH), The British Psychological Society (BPS) and the Health Professions Council (HPC) are currently discussing the potential move to regulate all applied psychologists who provide a service to the public (Bellamy, 2005b; Van Scoyoc, 2005a) and discussing the vision presented in The Sainsbury

Centre for Mental Health's policy paper of the paradigm shift poised to take place in the mental health service sector.

In line with this move towards an integrated applied psychology profession is the very controversial suggestion of generic training for applied psychologists (Bellamy, 2005a; James, 2005; Kinderman, 2005; Lane & Corrie, 2006; Miller, 2006; Van Scoyoc, 2005b; Van Scoyoc & Bellamy, 2005).

In light of these possible developments, it seems timely that the beliefs of applied psychologists working with this complex client group are explored, in particular those held by counselling psychologists. As this specialisation is relatively new in the NHS (Fellows, 1996; Golsworthy & Wilkinson, 1997; James, 1996; Milton, 2004; Milton, 2006; Willoughby & Ashdown, 2003; Woolfe, 2006) it lacks a clearly defined role (Bor, 2006) and practitioners are accorded a lower status than those from other divisions (Bor, 2006; Miller, 2006; Van Scoyoc & Bellamy, 2005). As a result of this, counselling psychologist's often lack confidence in their abilities (Bor, 2006; Rowden, 2005), especially when working with individuals who have enduring mental health problems, as they are perceived as lacking the skills to work with this client group (James, 2005; Van Scoyoc, 2005b).

However, when the underlying humanistic[1] therapeutic framework for counselling psychology is considered (Bellamy, 2005a; Bor, 2006; Howard, 1992; Lewis & Bor, 1998; Strawbridge, 2006; Van Scoyoc, 2005b), and their core skills – especially that of establishing effective therapeutic alliances with clients – are examined, it becomes obvious that counselling psychologist's should be employed more frequently to provide psychological therapy to this client group.

This is particularly true when considering the fundamental role therapeutic alliance plays in delivering positive outcomes for psychological treatment (Finfgeld, 2004; Fitzgerald et al, 2005; Golsworthy, 2004; James, 2005; McWilliams, 2005; Milton, 2001; Ploszajski, 2004). This dynamic has been cited frequently in the literature as the most powerful aspect of therapy with all client groups, irrespective of the client's complexity (Vogel, 2005).

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[1] Humanistic framework throughout the thesis refers to holding the individual's experience central to the therapeutic process. It does not exclusively refer to the Rogerian therapeutic model of counselling unless specified.

There were three main aims to the research, with each aim having a separate hypothesis. These were:

- **Aim 1:** Comparison between clinical and counselling psychologists.
  Hypothesis 1: Clinical psychologists responses to the *Psychologist Role Definition Instrument* will be significantly different from the responses of the counselling psychologists.

- **Aim 2:** Comparison between student counselling psychologists and clinical psychologists.
  Hypothesis 2: Student counselling psychologists responses to the *Psychologist Role Definition Instrument* will be significantly different from the responses of the clinical psychologists.

- **Aim 3:** Comparison between student counselling and counselling psychologists.
  Hypothesis 3: Student counselling psychologists responses to the *Psychologist Role Definition Instrument* will be significantly different to the responses of the counselling psychologists.

The research was conducted by means of a postal questionnaire sent out nationally to all registered counselling psychologists, a sample of registered clinical psychologists and a student group. As no suitable research tool existed to compare the beliefs of the three groups, these were extrapolated using the *Psychologist Role Definition Instrument,* which was specifically developed by the researcher for this research.

When the results for the 294 respondents (39.73% response rate) were compared, it was found that despite the underlying different theoretical paradigms on which the disciplines are based (Corrie & Callahan, 2000; Milton, 2005b), an overwhelmingly strong similarity of beliefs emerged between the three groups. This appears to support the reported convergence of the applied psychology specialisations of clinical and counselling psychology (Bor, 2006; Gournay, 1995; Guernina, 1995a; Hall, 1993; Humphreys, 1996; Miller, 2006). This issue is the source of grave concern for the future of counselling psychology in particular (Van Scoyoc, 2005b; Walsh, 2005), as

many commentators believe it will be subsumed by other more established disciplines.

3 Professional practice: client study component

The theme of examining the role of counselling psychologists in the provision of psychological therapy to individuals who have enduring mental health problems is considered through two case studies. These case studies explore the practical aspects (competencies, therapeutic skills and teamwork abilities) of being a counselling psychologist within a CMHT that serviced a large multicultural population within the city of Coventry. Both individuals discussed in the case studies were considered to have 'enduring mental health problems' by their psychiatrists, hence their referral to the local CMHT, and subsequently to the psychologist within the team. As the case studies were completed some seven years ago, their content and the interventions used are reflected on, and more recent techniques that might be considered appropriate are retrospectively examined as alternative interventions.

The first case study reflects on the provision of therapy to a man presenting with long standing bulimia nervosa and reactive depression. He had a long history of inpatient psychiatric treatment for morbid obesity, obsessive ruminations, voice hearing and self-harm behaviour.

The second case study examines a female survivor of childhood sexual abuse who had a history of inpatient treatment as a result of suicide attempts and a history of self-harm behaviour. The referral was to work on issues of anxiety; this was believed to be an appropriate referral to the CMHT given her psychiatric history.

4 The literature review

The main forum for the delivery of secondary mental health care is through CMHTs. For counselling psychologists it is important to be aware of the context for the delivery of secondary mental health care especially for the client. The importance of context has been highlighted in current academic literature, in particular the political and social context (Milton, 2005a; Milton, 2005c; Milton, 2006; Van Scoyoc & Bellamy, 2005; Van Scoyoc, 2005b).

Counselling psychologist's are encouraged to 'think outside the box', as well as to consider what they can contribute to society outside of the consulting room (Milton,

2005a). It is with this sentiment in mind that the topic of community mental health teams and the literature pertaining to them was critically reviewed. The consideration of the context for the delivery of secondary mental health care pulls the portfolio together in a meaningful way.

Section D examines CMHTs, their genesis from conception in the 1960s to 2006 (Bugge et al, 1997; Gauntlett et al, 1996; Mind, 2006; Thornicroft & Tansella, 2004). The political nature of their existence is explored, and the role of psychology within them is given special consideration.

5 Personal statement

The researcher believes that counselling psychologists have much to offer individuals who have severe and enduring mental health problems despite suggestions that counselling psychologists have neither the skills nor experience to provide a psychological service to this particular client group. The researcher hopes that the examination of this subject area in the portfolio will present material that repudiates these suggestions.

References

Bellamy, A. (2005a). Letter from the outgoing Chair. *Counselling Psychology Review,* 20, 2: 34-35.

Bellamy, A. (2005b). Health Professions Council (HPC) consultation response from the DCoP. A response to the DH consultation 'Enhancing public protection: proposal for the statutory regulation of applied psychologists'. *Counselling Psychology Review,* 20, 2: 67-69.

Bor, R. (2006). A brief reflection on counselling psychology. *Counselling Psychology Review*, 21, 1: (in press).

Bugge, C., Smith, L. & Shanley, E. (1997). A descriptive study of multidisciplinary mental health staff moving to the community: the demographic and educational issues. *Journal of Psychiatric and Mental Health Nursing*, 4: 45-54.

Corrie, S., & Callahan, M. (2000). A review of the scientist-practitioner model: reflections on its potential contribution to counselling psychology within the context of current health care trends. *British Journal of Medical Psychology,* 73, 3: 413-427.

Fellows, R. (1996). The role of counselling psychologists. *The Counselling Psychology Review*, 11, 4: 27-33.

Finfgeld, D. L. (2004). Empowerment of individuals with enduring mental health problems: results from concept analyses and qualitative investigations. *Advances in Nursing Science*, 27, 1: 44-49.

Fitzgerald, J., Calvert, S., Thornburn, J., Collie, R., & March, J. (2005). Counselling psychology in New Zealand and the use of bi-focal lenses: a reply to Gibson, Stanley and Manthei's article. *The Bulletin*, 104: 23-25.

Gauntlett, N., Ford, R. & Muijen, M. (1996). *Teamwork: models of outreach in an urban multi-cultural setting*. Sainsbury Centre for Mental Health.

Golsworthy, R. & Wilkinson, J. D. (1997). Perceptions of training. *Counselling Psychology Review*, 12, 3: 123-126.

Golsworthy, R. (2004). Counselling psychology and psychiatric classification: clash or co-existence? *Counselling Psychology Review*, 19, 3: 23-28.

Gournay, K. (1995). What clinical psychology trainees should know about psychiatric rehabilitation. *Clinical Psychology Forum*, 82: 21-26.

Hall, J. (1993). Clinical psychology in context. *Clinical Psychology Forum*, 61: 3-10.

Howard, G. S. (1992). Behold our creation! What counselling psychology has become and might yet become. *Journal of Counselling Psychology*, 39. 4: 419-442.

Humphreys, K. (1996). Clinical psychologists as psychotherapists. *American Psychologist*, 51, 3: 190-197.

James, P. (1996). Meanings of prevention and cure for the counselling psychologist. *Counselling Psychology Review*, 11, 2: 12-16.

James, P. (2005). Group dynamics in a professional setting: the challenge for

applied psychologists. Reflections after the NIMHE/BPS conference in Birmingham, February 2005. *Counselling Psychology Review*, 20, 2: 52-55.

Kinderman, P. (2005). The applied psychology revolution. *The Psychologist*, 18, 12: 744- 746.

Lane, D. & Corrie, S. (2006). Counselling psychology: its influences and future. *Counselling Psychology Review*, 21, 1 (in press).

Lewis, S., & Bor, R. (1998). How counselling psychologists are perceived by NHS clinical psychologists. *Counselling Psychology Quarterly*, 11, 4: 427-437.

McWilliams, N. (2005). Preserving our humanity as therapists. *Psychotherapy: Theory, Research, Practice, Training,* 42, 2: 139–151.

Miller, R. (2006). A long time in (counselling) psychology: memoirs of a BPS junkie. *Counselling Psychology Review*, 21, (in press).

Milton, M. (2001). Recent research on suicide: issues for British counselling psychologists. *Counselling Psychology Review*, 16, 3: 28-33.

Milton, M. (2004). Talking point: If you swim...You get wet. *Counselling Psychology Review*, 19, 4: 56-57.

Milton, M. (2005a). Letter from the incoming Chair. *Counselling Psychology Review*, 20, 2: 36-37.

Milton, M. (2005b). Letters to the Editor. *Counselling Psychology Review*, 20, 3: 20-21.

Milton, M. (2005c). Letter from the Chair. *Counselling Psychology Review*, 20, 4: 2-3.

Milton, M. (2006). Reflections on the past: thoughts about the future...*Counselling Psychology Review*, 21, 1: (in Press).

Ploszajski, J. (2004). Using psychometrics in an NHS addictions service. *Counselling Psychology Review*, 19, 4: 9-17.

Rowden, J. (2005) (scribe). Workshop discussing relationships with other subsystems. *Counselling Psychology Review*, 20, 2: 45-46.

Thornicroft, G. & Tansella, M. (2004). Components of a modern mental health service: a pragmatic balance of community and hospital care. *The British Journal of Psychiatry*, 185: 283-290.

Strawbridge, S. (2006). Thoughts on becoming, being and developing as a counselling psychologist. *Counselling Psychology Review*, 21, 1: (in press).

Van Scoyoc, S. (2005a). Statutory regulation: implications for counselling psychologists. *Counselling Psychology Review,* 20, 1: 36-37.

Van Scoyoc, S. (2005b). The future of our profession: time to remember our history. *Counselling Psychology Review,* 20, 2: 49-51.

Van Scoyoc, S. & Bellamy, A. (2005). Talking point. 'hot issues' for counselling psychologists: a conversation between the Chair-Elect, Susan Van Scoyoc and the Past-Chair, Alan Bellamy. *Counselling Psychology Review,* 20, 3: 22-24.

Vogel, S. (2005). Going counselling: aspects of the therapeutic relationship in

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young people's experiences of their counselling at a drop-in centre. *Counselling Psychology Review,* 20, 2: 2-11.

Willoughby, R. & Ashdown, L. (2003). Adult community psychology services: tiering and its seams. *Counselling Psychology Review*, 18, 4: 11-16.

Woolfe, R. (2006). Journey from infancy to adulthood: the story of counselling psychology. *Counselling Psychology Review*, 21, 1 (in press).

Walsh, Y. (2003). Third Response – Testing the way the wind blows: innovation and a sound theoretical basis. *Counselling Psychology Review*, 18, 3: 29-33.

SECTION B

RESEARCH

A comparison of beliefs: what applied psychologists think about their role when working with people who have enduring mental health problems

Abstract

This study examined the beliefs held by registered clinical and counselling psychologists in the UK regarding their role as a psychologist when working with people who have enduring mental health problems. The undertaking of the research was an attempt to address the lack of any previous published national study comparing the beliefs of these applied psychologists.

The data was gathered through a postal questionnaire sent out nationally to all registered counselling psychologists, and a selected sample of registered clinical psychologists and student counselling psychologist's. The beliefs were extrapolated using the *Psychologist Role Definition Instrument*, a research tool specifically developed for the purpose of this research.

Data from the 294 respondents (39.73% response rate) was analysed. It was found that despite the underlying different theoretical paradigms on which the disciplines are based (Corrie & Callahan, 2000; Milton, 2005c) an overwhelmingly strong similarity of beliefs emerged between the three groups.

When the beliefs held regarding the role of psychologists working with individuals who have enduring mental health problems are examined, the findings support the increasingly widely reported convergence of the applied psychology specialisations of clinical and counselling psychology.

As the data was collected in 1998 the thesis reflects the state of the division at the time the data was gathered.

CHAPTER 1: Background literature

1.1 Overview

There is no known historic record which compares the beliefs held by clinical and counselling psychologists about their role as a psychologist when working with people who have enduring mental health problems. This comparison has not been made perhaps because of the lack of explicit acknowledgement of the role of counselling psychologists in providing psychological therapy to this particular group. While it could be assumed that counselling psychologists and clinical psychologists would hold different beliefs about the role of a psychologist when working with this client group — for example, views on psychopathology or formulation — the complete lack of relevant studies does not permit any conclusions to be drawn.

This chapter examines the origins of counselling psychology training and the scope of practice, as well as comparing them with similar aspects of clinical psychology. This is done to illustrate the skills and training counselling psychologists have in order to work with people who have enduring mental health problems.

The provision of psychological services to individuals with enduring mental health problems will also be explored in relation to the present study and counselling psychology in particular, as recent developments in the literature raise the importance of issues such as therapeutic alliance and empowerment when working with this client group (DOH, 2001; Finfgeld, 2004; Golsworthy, 2004).

1.2 Overview of the roles of clinical and counselling psychologists

An investigation of articles in appropriate international medical, psychological and social academic journals for the years 1991 to 2006 was conducted, and a manual search made through related conference proceedings, abstracts, journals, published books and websites. Professional bodies were also consulted regarding relevant works in progress in this and related areas. (See Appendix One for a list of the

databases searched and the search strategy). Papers were identified that directly or indirectly addressed the research aim: 'A comparison of beliefs held by clinical and counselling psychologists about their role as a psychologist when working with people who have enduring mental health problems'.

There is a body of research relating to the role of psychologists in the National Health Service (NHS) who work with individuals who have enduring mental health problems (Quarry & Burbach, 1998). This literature often identifies only clinical psychologists as the providers of psychology in secondary mental health care settings and does not recognise the contribution of counselling psychology in this area; nor does it examine the beliefs about the psychologist's role when working with this client group. The absence of an evidence base for the use of counselling psychologists in secondary mental health care settings may be due to the infancy of the profession (Bor, 2006).

1.3 Counselling psychology

Counselling psychology existed as a field of practice in the UK for four years at the time of data collection in 1998 and since the early 1950s in the United States of America (USA) (Munley et al, 2004). Internationally the term counselling psychology can mean slightly different things. As a discipline it is composed of slightly different elements and is unique to its particular cultural context. Yet despite the cultural differences from country to country, it overwhelmingly shares similar characteristics across the Western world (Pelling, 2004). The history of counselling psychology and its origins within the USA are explored to provide an international dimension to the thesis and also because it developed earlier there. The section concludes with an account of its current status before focusing on the origins of both clinical and counselling psychology within the UK.

1.3.1 Origins of counselling psychology in the USA

According to Munley et al (2004), 1951 is considered to be the date that counselling psychology came into being in the USA. Its genesis occurred at a time of social and political change following the end World War II, during which time the Veterans Administration (VA) provided a service to returning veterans, which over time moved away from the medical and psychoanalytical approaches to one that considered the individual, their particular needs and using their personal strengths in therapy.

Several years earlier the American Association of Applied Psychology (AAAP) and the American Psychological Association (APA) merged, creating a single professional organisation. At about the same time the VA was instrumental in promoting the move to funded doctoral level training for clinical psychologists and again in 1952 influenced the move for universities to offer doctoral training in counselling psychology.

The 1950s saw a name change for Division 17 from "Counseling and Guidance" to the "Division of Counseling Psychology" and the establishment of the "Journal of Counseling Psychology". These changes were not without problems, notably a critical report comparing the established profession of clinical psychology with the emerging discipline of counselling psychology. The report rated counselling psychology unfavourably, which negatively impacted the identity of counselling psychology and resulted in the Greyston Conference of 1964. During the conference the role of counselling psychology and issues surrounding identity were discussed, with delegates concluding diversity was a source of strength and not a weakness.

During the 1970s and 1980s counselling psychologists became recognised as health service providers in psychology and the number of accredited training courses grew rapidly as mental health in the USA was increasingly embraced as an important element of health care, increasing from 27 in 1980 to 59 in 1990. By 2003 this had grown to 72 accredited training courses (Munley et al, 2004).

The 1980s also saw counselling psychologists advocating for the recognition of increasingly diverse research paradigms as well as for practitioners to be more responsive to the vast variety of cultural and social influences impacting on clients and the profession.

The 1990s was a period of significant change in the USA health care marketplace, with counselling psychology being influenced by these economic and social forces at a time when it was rapidly becoming a far more complex, larger and more broadly defined specialty. This trend was reinforced in 2003 when Division 17 officially changed its title to "The Society of Counseling Psychology", reflecting greater autonomy and what Munley et al (2004) have referred to as "identity affirmation".

As we move deeper into the first decade of the new millennium, counselling psychology in the USA is beginning to recognise that diversity is not limited to

addressing ethnic diversity issues within the USA but that it applies equally to bridging international boundaries so that cross-cultural practice can flourish. As we will see in the following section, the recurring theme of diversity is mirrored in the development of counselling psychology in the UK.

1.3.2 Counselling psychology in the UK

The researcher will present a brief history of counselling psychology in the UK in order to place into context its emergence as a provider of psychological treatment.

1982 The BPS established a counselling psychology section
1989 A counselling psychology special group was formed
1992 Counselling psychology becomes the third largest special group in the BPS
1992 A Diploma in Counselling Psychology was developed through the BPS for psychologists studying to obtain chartered status in counselling psychology
1994 The Division of Counselling Psychology was created for psychologists who either held the Diploma or Statements of Equivalence and who were then able to use the title 'Chartered Counselling Psychologist'.
2005 The Division of Counselling Psychology is the second largest division in the BPS. (BPS website accessed 3rd January, 2006 (a))

Counselling psychology is now the second largest division in the BPS (BPS, 2006a) and its rapid development has been well documented (Bor, 1995; Clark, 1994; Crawford-Wright & Hart, 1997; Guernina, 1998; Lewis & Bor, 1998; Miller, 2006; Nelson-Jones, 1999; Pugh & Coyle 2000; Tholstrup, 1999; Woolfe, 1996; Woolfe, 2006; Woolfe & Dryden (eds) 1996).

1.3.3 Philosophical underpinnings of counselling psychology

As suggested by the title counselling psychology, this field of professional psychological practice is influenced by human science research and is based on the principals of psychotherapeutic traditions (Frankland & Walsh, 2006; Smallwood, 2002; Woolfe, 1996).

There has been a mutually challenging relationship within mainstream psychology, as counselling psychology has drawn on phenomenological models that are at odds with dominant thinking in applied psychology (Hart, 2005, Lane & Corrie, 2006; Strawbridge, 2006).

Counselling psychology is now recognised as a speciality within applied psychology (Bor, 2006), with its members practising as 'scientist-practitioners' by providing evidence-based psychological therapy (Corrie & Callahan, 2000; Hart, 2005; Lane & Corrie, 2006; Pelling, 2000; Strawbridge, 2006; Wilkinson et al, 1997). The Division is developing models of practice and research based on the fundamental role of the therapeutic relationship and which meet the demand for scientific enquiry (Lane & Corrie, 2006; O'Brien, 1997; Strawbridge, 2006).

The underlying framework of counselling psychology is client-centred, placing people with enduring mental health problems at the centre of the therapeutic intervention (Bellamy, 2005b; Bor, 2006; Howard, 1992; Lewis & Bor, 1998; Strawbridge & Woolfe, cited in Woolfe, & Dryden (eds) 1996; Strawbridge, 2006; Woolfe, 1996; Van Scoyoc, 2005b; Van Scoyoc & Douglas, 2006).

The humanistic framework allows counselling psychologists to concentrate on empowering clients to move forward by focusing on their strengths and encouraging them to overcome their difficulties. This is in contrast to the traditional approach of clinical psychology, which is to attempt to assist individuals by working with the pathology and with the diagnosis that the individual is given (Knight, 1995; Smallwood, 2002; Stanley & Manthei, 2004; Stanley et al, 2005; Strawbridge, 2006; Van Scoyoc & Douglas, 2006). The difference has been described by Ryder & Shillito-Clarke as "*the continual process of being with rather than the doing to*" (Ryder & Shillito-Clarke, 1999, p.13).

Counselling psychologists are trained to apply interventions as skilled practitioners using the competency framework (Walsh et al, 2004); this provides them with the skills to help individuals address their problems in a flexible way. This reflective person-centred therapeutic approach delivered by practitioners who have experienced their own personal development, most commonly through therapy, results in interventions that are empowering and both culturally and socially sensitive (Lane & Corrie, 2006; Palmer, 1999, Strawbridge, 2006).

Because of their training, counselling psychologists are recognised as having a good understanding of therapeutic dynamics and a high degree of self-awareness (Crawford-Wright & Hart, 1997; Donati & Watts, 2000; Grimmer & Tribe, 2001; Lane & Corrie, 2006; Lewis & Bor, 1998; Quinn, 2005; Ryder & Shillito-Clarke, 1999; Shillito-Clarke, 1996; Van Scoyoc & Bellamy, 2005; Wilkinson et al, 1997; Williams et

al, 1999). These are essential skills for therapists working with individuals who have enduring mental health problems (Golsworthy, 2004), many of whom experience intractable psychological problems (Willoughby & Ashdown, 2003).

While there are no known studies to support the belief that experience of personal development through therapy makes you a more effective psychologist, there is a body of literature in counselling psychology extolling the value of being a reflective practitioner (Lane & Corrie, 2006; Woolfe, 2006).

1.3.4 Counselling psychologists' professional competencies

The training counselling psychologists undertake equips them with the abilities to provide effective psychological interventions for people with enduring mental health problems. Counselling psychologists work in a field of practice therapeutically with individuals who present a broad range of issues, including effects from childhood, relationship breakdown, systemic issues and major life events(Bor & Achilleoudes, 1999; Ryder & Shillito-Clarke, 1999).

In addition to working therapeutically with individuals on these issues, any of which could result in enduring mental health problems, counselling psychologists also work with the symptoms of psychological disorders that can manifest because of these experiences. Counselling psychologists can work individually with clients or facilitate group work, can provide family therapy, or can offer collaborative relationships with other mental health professionals (Smallwood, 2002).

These competencies are maintained through regular supervision (Elton-Wilson, 1995; Fortune & Watts, 2000; Green, 1995; Hammersley, 2004; Lane & Corrie, 2006; Miller, 2006) and continuing professional development (CPD) (Bellamy, 2004; Bartram et al, 1995; Cohen, 1995; Lane & Corrie, 2006; Lindley & Bromley, 1995; Lindley, 1998; Purcell, 2004, Strawbridge, 2006). Traditionally regarded as an important element of determining psychological treatment for this client group, these competencies can be summarised as:

- Assessments, including mental health needs and risk; psychometric testing (Farrants, 2005; James, 2005b; Ploszajski, 2004; Raspin & Kanellakis, 2004; Sequeira and Van Scoyoc, 2004; Williams & Irving, 1997)
- Formulation, which is a comprehensive history; maintaining factors of the presenting psychological problem (Ploszajski, 2004)

- Planning and implementation of therapy
- Research and development, report writing and record keeping
- Providing supervision, and training applied psychologists and related professionals
- Multidisciplinary team work and team facilitation
- Audit and evaluation of the effectiveness of therapy and service (Lane & Corrie, 2006; Strawbridge, 2006)

Despite counselling psychologists undertaking similar duties at the same level of competence and status (Miller, 2006) as their clinical counterparts, the issue of parity of pay and funded placements in the NHS has yet to be practically resolved (Barlett, 1997; Bellamy, 2004; Bellamy, 2005d; Bor et al, 1997; Bor, 2006; Clarkson, 1998; Frankland & Walsh, 2005; Hart, 2005; James, 2004; James, 2005a; Kinderman, 2005; Miller, 1997; Miller, 2006; Milton, 2006; Sequeira, 2005b; Smallwood, 1996; Smuts & Mackay, 2004; Thomas et al, 1999; Van Scoyoc & Bellamy, 2005).

1.4 Clinical psychology

Clinical psychology owes much of its development in the UK to the work of the psychologist Eysenck (Corrie & Callahan, 2000). His vision was for clinical psychologists to be diagnostician-researchers, and he regarded "therapy as alien to psychologists working in health care settings" (Corrie & Callahan, 2000, pp. 415). It was within this medical model background that clinical psychology developed, and in its simplest form it can be viewed as a relationship between diagnosis, treatment and cure (Fitzgerald et al, 2005; Strawbridge, 2006).

1.4.1 Clinical psychology in the UK

Clinical psychology emerged after the Second World War and its theoretical origin is "*largely derivative from experimental psychology, rather than firstly addressing the phenomena of personal distress*" (Hall, 1993, p. 4). Unlike counselling psychology, which focuses on the individual experiences as central to the therapeutic process, clinical psychology has traditionally focused on pathology and its diagnosis to treat the individual. It is this fundamental difference that distinguishes it from counselling psychology (Corrie & Callahan, 2000; Lane & Corrie, 2006; Smallwood, 2002).

Employment for most clinical psychologists towards the end of the 1960s was within adult mental health services (Hughes & Budd, 1996; Newnes, 1995). At the time, this was predominately psychiatric hospitals, and involved generally working with patients who had acute problems. The emphasis was on testing and results (Milton, 2005c), with little or no consideration given to cultural or social issues (Smith et al, 1993). Hall noted that by the 1990's clinical psychologists recognised the need for understanding the context of an individual's mental health; at about the same time the Division of Counselling Psychology came into being.

There has been a philosophical shift then in terms of the development of the Counselling Psychology Division and a corresponding move within the body of clinical psychology to be more holistic (Bor, 2006; Gournay, 1995; Guernina, 1995a; Humphreys, 1996; Miller, 2006).

At about this time, Bellamy observed that clinical psychologists were being required to move increasingly towards the provision of secondary care, creating opportunities for counselling psychologists at the primary care level (Bellamy, 2000, pp 5). This fits with the traditional picture of the secondary or enduring mental health care system being the main employment arena for clinical psychology (Alexander, 1995; Bor & Achilleoudes, 1999), and contributes to the belief that counselling psychologists do not work in secondary mental health care settings.

Other historical factors may also provide insight into why counselling psychology has not been recognised as a provider of secondary mental health care within the NHS. Webster and Al-Bassam (1997) examined the reluctance shown by clinical psychologists to consider themselves part of the allied health care system within the NHS. Al-Bassam postulated that they feared being overlooked and subsumed by larger professional bodies and that they struck an independent path in an effort to prevent this from occurring.

It was the combination of this history of independence and self-promotion, along with clinical psychology having been the only form of psychological treatment in the NHS since the late 1960s that has made it hard for members of this professional area to embrace practitioners who use a different theoretical paradigm (Hall, 1993).

More recently, commentators have noted several factors that are making clinical psychologists more receptive to working alongside their counselling psychology

counterparts. These include a worldwide shortfall in the numbers of trained clinical psychologists (Ashcroft & Turpin, 1994; Collins & Murray, 1995; James, 2005a; Leiper, 2002; Miller, 2006; Stanley et al, 2005; Turpin, 2005) and an appreciation by clinical psychologists the importance of context for the individual in therapy (Bor, 2006) as well as of the subjective and personal aspects of psychology (Butler, 2006). Leary and Maddux predicted this convergence as far back as 1987, in an article on progress towards a viable interface between different divisions of psychologists.

One recent development that illustrates this merging of the two applied psychology divisions is the establishment in 2003 of the Register for Psychologists Specialising in Psychotherapy, which has attracted counselling and clinical psychologists alike (Lane & Corrie, 2006; Milton, 2006; Strawbridge, 2006; Van Scoyoc, 2005b; Van Scoyoc & Bellamy, 2005).

1.4.2 Philosophical underpinnings of clinical psychology

Given that clinical psychology is rooted in the medical model (Corrie & Callahan, 2000; Milton, 2005c), it is unsurprising that the subject of personal therapy for clinical psychologists is a controversial matter (Allen et al, 1994; Leiper & Casares, 2000; Macran & Shapiro, 1998).

Morgan (1993), a clinical psychologist, questions why personal therapy is not an integral part of clinical psychology training and considers that it would be important in developing self-awareness. She also believes that studying therapeutic frameworks in isolation is not the best mode in which to understand the application of these interventions.

A US study showed that by 1996 the majority (75% of a returned sample of 500) of clinical psychology students were entering treatment voluntarily rather than as a programmatic requirement (Holzman et al, 1996). A UK study also found that a surprisingly high number (44%) of clinical psychologists had undertaken personal therapy despite it generally not being considered a core aspect of training (Garrett & Davis, 1995).

1.4.3 Clinical psychologists' professional competencies

A clinical psychologist may deal with a wide range of psychologically distressing issues. Treatment often begins with a psychological assessment that may include the

use of psychometric tests (Milton, 2005c), interviews, consultations with other professionals or family, and possibly behaviour observation or neuropsychological testing. This assessment process results in a formulation and diagnosis of the problem. Evidence-based treatment is then provided to alleviate the individual's psychological disorder (Fitzgerald et al, 2005; Kinderman & Lobban, 2000).

Clinical psychologists are required to undertake regular CPD (Cohen, 1995; Davies, 2004; Devonshire, 1997; Green, 1995; Knight & Devonshire, 1996; Lane & Corrie, 2006; Lindley, 1995; Lindley, 1996; Lindsay, 1996; Philcox et al, 1994) and supervision (Lane & Corrie, 2006; Napier, 1993) in order to develop their skills and keep their practice informed by the latest research.

Clinical psychologists are largely involved in providing secondary mental health care to individuals experiencing complex psychological difficulties (Kinderman & Lobban, 2000). Cushion (1997) examined the views of CMHT regarding the role of the clinical psychologist in the teams and found that they perceived clinical psychologists to be best placed to conduct a range of client-centred assessments and interventions as well as indirect client tasks such as research, supervision, service evaluation and consultation. They made no mention of the possibility of counselling psychologists providing these services.

1.5 The beliefs of applied psychologists

Knight (1995) infers that counselling psychology is best suited to primary care, as the profession is in its infancy and because role clarity within the profession is limited. However, over the past 12 years, increasing numbers of counselling psychologists have moved into secondary mental health care provision in the UK (Bor & Achilleoudes, 1999), indicating that it has a wider role than first envisaged.

Fellows examined 'perceptions' held by clinical and counselling psychologists of the role of counselling psychologists working within NHS psychology departments. He found there was a marked difference in the perceptions held by the two groups, with clinical psychologists doubting whether counselling psychologists had the core competencies to undertake work with all NHS client groups and whether they had the skills to provide supervision to clinical psychologists (Fellows, 1996). In another

study Golsworthy & Wilkinson (1997) found that clinical psychologists held similar perceptions of counselling psychologists.

A paper by Ellis (1990) explored beliefs — both rational and irrational — and how these result in certain cognitions, behaviours and emotions, suggesting, "*active-directive cognitive restructuring*" (Ellis, 1990, p.221) as a way to modify irrational beliefs. The researcher considers it important for the profession of counselling psychology to actively explore the beliefs that counselling psychologists hold about working with individuals who have enduring mental health problems. This is required to dispel any assumptions (Irving & Williams, 1995) or irrational beliefs that may be held about the profession in terms of working with this client group by applied psychologists, the NHS and policy makers. It is only with a growing evidence base that cognitive restructuring can occur and assumptions be challenged.

1.6 The importance of role clarity

Roles are positions that people hold within organisations, and are formed by the organisation itself and professional and regulatory bodies (Tavris & Wade, 1995). Haynes (2000) says that role clarity leads to a decrease in stress levels among health professionals and enables team members to be more effective in their respective roles (Carpenter et al, 2003; Corwin, 1960; Hammer, 1993; Geczy & Sultenfuss, 1994). Moreover, being a team member also leads to a better understanding of expectations and a more supportive work environment: *"...teams helped people to cope better and to experience less stress by providing role clarity"* (Haynes, 2000, p. 128).

As counselling psychology is still a relatively new profession it has no historically defined role in the UK (Fellows, 1996; Golsworthy & Wilkinson, 1997; James, 1996; Milton, 2004; Milton, 2006; Willoughby & Ashdown, 2003; Woolfe, 2006). Despite the list of professional competencies and areas of practice referred to earlier, it is still little understood by many employers and the public (Milton, 2006). As noted by Lewis and Bor: *"The perceived breadth of role that is possible in counselling psychology has been considered both a weakness and a strength" (Lewis & Bor, 1998, p 429).* This lack of certainty about their skills and role could erode their sense of self-confidence, potentially leading to high levels of stress (Bor & Achilleoudes, 1999).

1.7 Scientist-practitioners

The combination of being both researcher and practitioner underpins the work of clinical and counselling psychologists alike and is essential for determining evidence-based, appropriate therapeutic interventions for individuals with enduring mental health problems. The scientist-practitioner approach is identified as being at the heart of applied psychology practice by the BPS (Lane & Corrie, 2006).

Both disciplines practice as scientist-practitioners (Beech, 1986; B.P.S, 2005; Corrie, 2003; Corrie & Callahan, 2000; Corrie & Callahan, 2001; Cowie & Glachan, 2000; Kenney & Rohrbaugh, 1997; Lane & Corrie, 2006; Miller, 2006; Pelling, 2000; Roth & Fonagy, 1996; Ryder & Shillito-Clarke, 1999; Strawbridge, 1997; Strawbridge, 2002; Van Scoyoc, 2004; Walsh, 2003), but the perception of what this means for the two professions can at times be fundamentally different (Hart & Hogan, 2003), with counselling psychologists perhaps being more comfortable with the term 'reflective practitioner' (Woolfe, 2006).

It was believed that counselling psychologists were reluctant to integrate research into therapeutic practice, with practitioners preferring to rely on therapist 'intuition' (Pelling, 2000; Spinelli, 2001; Williams & Irving, 1996). However, acceptance of qualitative and quantitative research in providing a valid 'evidence base' for therapeutic practice has dispelled this myth (Cowie & Salm, 1996; Gupta, 1998; Hart, 2005; Lane & Corrie, 2006; McWilliams, 2005; Pugh, 1998; Pelling, 2000; Strawbridge, 2006).

Corrie and Callahan suggest that the scientist-practitioner model has played an important role in the emergence of new psychological professions: *"By appealing to its scientific status, clinical psychology could not only justify itself as a social institution but also procure the prestige necessary for its survival"* (Corrie & Callahan, 2000, p 416).

In contrast to focusing on quantitative research, counselling psychology, holding the client central in the therapeutic process, has focused on phenomenological investigations, where it can be enlightening and empowering. (Corrie & Callahan, 2000; Pelling, 2000). As noted in Pelling, even though it may appear that these two approaches to the scientist-practitioner model are at opposite ends of the spectrum, it

is more helpful and realistic to see them as complementary to each other *"together providing a more comprehensive and accurate view of any phenomena"* (Pelling, 2000, p.6).

1.8 Enduring mental health problems

A substantial body of evidence supports the effectiveness of psychological therapies in treating a variety of mental health difficulties (DOH, 2001; Layard, 2005; Levant et al, 2001; SCMH, 2006; Turpin, 2005). However, the provision of psychological services by counselling psychologists to this client group is seen as a controversial issue, with questions being raised about the skills and training counselling psychologists have to equip them to undertake this type of work (Van Scoyoc, 2005b; James, 2005a).

James notes that in terms of therapeutic interventions for individuals with enduring mental health problems, the most important aspects are for therapy to be founded on an appropriately informed assessment and formulation; placing the individual's needs central to the therapeutic process, with consideration for the context in which they exist; and using well developed interpersonal therapeutic skills and the therapeutic alliance through which to empower the individual to make changes (Finfgeld, 2004; Fitzgerald, 2005; Golsworthy, 2004; McWilliams, 2005; Milton, 2001b; Ploszajski, 2004). Counselling psychologists have these competencies as part of their core training (James, 2005a).

James goes on to note the "*mental health needs of service users are complex, varied and need the most flexible approach possible*" (James, 2005a, p. 53). Flexibility is about a skilled therapist providing the best support possible for the consumer, rather than focusing on the provider or the orientation of that support (DOH, 2001; Miller, 2006; Norcross, 2005).

Studies looking at the importance of the therapeutic alliance for people who have enduring mental health problems have not been systematic or widely investigated (Catty, 2004). Often these individuals, who are long-term consumers of psychiatric services, experience a rapid turnover of staff who care for them (Catty, 2004; Kai &

Crosland, 2002), possibly due to the high levels of stress and anxiety associated with the job (Goodwin & Gore, 2000, Shillito-Clark & Tholstrup, 2006).

A study by Paley and Shapiro (2002) examined the type of therapeutic interventions used with individuals with schizophrenia, just one type of enduring mental health problem. They concluded that the over-reporting of cognitive behaviour therapy (CBT) -based interventions by researchers who often had a bias towards the positive outcome of CBT therapy, could have a negative impact on the therapeutic treatments available to this client group. The implication is that this problem is associated not just with schizophrenia but also with other enduring mental health problems, resulting in a reduction of the range of therapeutic interventions offered to this client group (Paley & Shapiro, 2002).

It is of concern that a client group that most needs someone who can engage with them, and develop a therapeutic alliance and empower them, is instead being offered CBT techniques from clinicians who are not as highly skilled therapists as counselling psychologists (McWilliams, 2005).

1.9 Statutory regulation of applied psychology and proposed developments

The Department of Health, the British Psychological Society, and the Health Professions Council have all been advancing towards establishing applied psychology as a regulated profession. (Bellamy, 2005a; D.O.H; 2005; Palmer, 1996; Powell, 2006; Van Scoyoc, 2005a).

A consultation document was circulated in March 2005 to various bodies who had an interest in the draft legislation, proposing that the HPC should regulate all *"Applied Psychologists who provide services to the public*". (Van Scoyoc, 2005a, p.36). The proposal caused much debate about regulation by the HPC, with the BPS expressing concern over several issues related to the protection of the public from regulated practitioners (Bellamy, 2005c). Van Scoyoc comments in her article that becoming a registered psychologist may reduce switching between specialisations, but the DoH may be politically motivated to homogenise the applied psychologies via HPC for administrative simplicity (Van Scoyoc, 2005a).

Van Scoyoc is concerned that while HPC registration might establish psychologists as duly registered, it fails to establish their scope of practice. Thus the public would still need to refer to the BPS to ascertain from their records what area of training a particular psychologist has had.

One of the positive aspects of being registered with the HPC, according to Van Scoyoc, is that it may "*lessen the friction between specialisations*" (Van Scoyoc, 2005a, p.37) by according them equal status. This in turn could open the way for counselling psychologists to provide the professional delivery of therapeutic interventions to individuals with enduring mental health problems.

Kinderman has proposed a controversial method of making it easier for the public, policy makers, employers and other psychologists to understand what skills and competencies a particular psychologist has (Bellamy, 2005b; Miller, 2006; Van Scoyoc, 2005b; Van Scoyoc & Bellamy, 2005). He suggests a "*single three-year doctoral training programme in applied psychology*" (Kinderman, 2005, p. 744), a move that would clearly affect all aspects of applied psychology training, from content to funding to placements.

While the suggestion of merging training pathways is not new, it begets a number of strategic and philosophical concerns that will take some effort and energy to overcome should this proposal ever come to fruition (James, 2005a; Kinderman, 2005; Van Scoyoc, 2005b; Van Scoyoc, 2006; Van Scoyoc & Bellamy, 2005; Van Scoyoc & Douglas, 2006).

The lack of trained psychologists is a concern noted by Layard (2005), and would be a very real barrier to implementing the changes in mental health care as boldly proposed in the policy paper 'The future of mental health: a vision for 2015' (SCMH, 2006). A radical philosophical shift from one of mental 'illness' to mental 'wellbeing' is suggested: this would involve a holistic approach to care, with 'talking therapies' being the first recommendation as treatment for mental health problems.

The research to be described below was conducted to examine the beliefs clinical and counselling psychologists hold about working with individuals who have enduring mental health problems. The next chapter describes the research process.

CHAPTER 2: Development of the research instrument

2.1 Overview

As highlighted in the Literature Review Chapter, it was necessary to develop a research instrument suitable for gathering appropriate information about psychologists 'beliefs' about their 'role as a psychologist' when working with people who have enduring mental health problems.

This chapter describes the development of the *Psychologist Role Definition Instrument* research tool. This development involved several stages that will be presented sequentially below. The steps taken were similar to those undertaken when constructing an attitude questionnaire, as beliefs are considered to be the cognitive component of attitudes, according to Oppenheim (1998). Beliefs combine with feelings, values and judgements to determine an attitude, which is a "tendency to respond in a certain manner when confronted with certain stimuli" (Oppenheim, 1998, p. 174).

Table 2.1.1 Flow chart of research tool development

Literature review

↓

Depth interviews

↓

Overview

↓

Design

↓

Interviewees

↓

Procedure

↓

Item pool clustering

↓

Development of Likert Scale

↓

Participants in development of Likert Scale

↓

Instructions

↓

Psychologist Role Definition Instrument

↓

Weighting for the scale

↓

Recording responses

↓

Item analysis

↓

Verification of questionnaire through consultation

↓

Selection of demographic questions

↓

Peer review of draft questionnaires

2.2 Literature review

The first stage of research for the development of the *Psychologist Role Definition Instrument* involved considering current relevant literature on the professional development of clinical and counselling psychology over the last ten years, as well as examining existing questionnaires on 'roles'. In reviewing the literature it became apparent that there were several dimensions that had to be investigated, including:

- Current changes in the development of counselling psychology
- Therapeutic and ethical issues facing mental health workers
- Working in multidisciplinary teams with other mental health professionals (Becoming 'generic' when in these teams, for example, a psychologist undertaking tasks normally associated with a social worker)
- Specialist therapeutic skills

These items were reduced to five themes:

- Professional training
- Therapeutic skills
- Team work
- Mentoring role (educational or supervisory)
- Organisational requirements

These themes were the basis for depth interviews covering professional and therapeutic issues, and were drawn from the sources mentioned earlier (review of current literature as well as existing mental health and attitude questionnaires).

The literature review Table 2.2 is presented below.

Table 2.2: Literature review

Authors	Type	Main findings	Conclusions and notes
Bechtoldt et al (2001) USA	Questionnaire (n=1,389)	Comparison of clinical and counselling psychologists' theoretical orientations and employment settings. Only modest differences and greater commonality found.	Greater convergence between the disciplines in respect of orientation and employment; still trend for clinical psychologists towards behavioural and counselling psychologists towards humanistic traditions.
Bellamy (2000)	Control and treatment groups (n=70)	Clinical effectiveness of a counselling psychology service in primary care.	Statistical significance achieved for some measures, reduction in GP visits noted and improvements in treatment group.
Benanti (2002)	Questionnaire counselling psychologists (n=20).	Counselling psychologists in NHS, employed in primary care, rarely in severe and enduring mental health, children, neuropsychology, older adults or learning disabilities services.	A review of clinical and counselling psychology training required to assess appropriate skills and roles for NHS; training courses need to change. Clinical heads of services more receptive to counselling psychology and some will fund training.
Crawford-Wright & Hart (1997)	Autobiographical	Developing training course for counselling psychology complicated because of role confusion.	Issue of identity crucial to development of the profession.
Corrie & Callahan (2000)	Literature review	Scientist-practitioner model may mean different things to different professions.	Scientist-practitioner has a place in the current health-care system.

Fellows (1996)	Questionnaire (n=200)	Potential role of counselling psychologists in the NHS.	Role of counselling psychologists in the NHS perceived differently by clinical and counselling psychologists.
Golsworthy & Wilkinson (1997)	Semi-structured interviews	Two main themes from interviews with clinical psychologists about perceptions they have of counselling psychology.	Confusion about roles of counselling psychologists, their suitability to work with all client groups and the therapeutic interventions they are skilled to use.
Green & Geldhill (1993)	Delphi panel questionnaire	Professional competencies of trainee clinical psychologists.	The social and systemic context of practice needs to be considered.
Hall (1993)	Literature review	Historical background of clinical psychology in UK.	Moving towards an understanding of the cultural and social contexts of an individual's mental health.
Haynes (2000)	Longitudinal study (medical students), and teamwork study	Working in clearly defined teams reduces stress levels. Early cognitive interventions related to self-criticism could prevent depression later in career. Self-criticism part of NHS accountability/auditing.	Role clarity in teams leads to a reduction in stress as experienced by healthcare professionals in stressful jobs.
Levant et al (2001) USA	APA taskforce	Exploration of the new roles that psychology could adopt.	Psychology has much to offer in many roles including serious mental health.
Lewis & Bor (1998)	Questionnaire survey of clinical psychologists	Clinical psychology heads of NHS psychology departments did not understand counselling psychology training.	Subject of identity is a fundamental issue for clinical and counselling psychologists. Proactive approach needed by counselling psychologists.

Ryder & Shillito-Clarke (1999)	Review of literature	Exploration and definition of counselling psychology.	Misunderstanding of counselling psychology competencies and roles.
Smallwood (1996)	Questionnaire	Comparison of results of a satisfaction survey of patients in a psychology department.	Each clinical psychologist had their own concept of the role of a counselling psychologist and of which patients to refer for therapy.
Smallwood (2002)	Article	Examination of counselling psychology in the NHS.	Looks at the best 'fit' between client and therapist, why a client is more or less suitable for a clinical or counselling psychologist.
Stanley & Manthei (2004)	Review of counselling psychology (NZ)	Description of the struggle endured by counselling psychology to develop a role in New Zealand (NZ).	Difficulty in establishing a clear identity.
Thomas, Tholstrup & Jordan (1999)	Working party (Interviews, letters, workshop)	Disparity of pay between clinical and counselling psychologists in the NHS.	Grading document equivalent to clinical psychology drawn up, union representation, briefing paper to Minister. Role of counselling psychologists promoted.

2.3 Depth interviews

2.3.1 Overview

Following the literature review it was important to consult with practitioners and academics in the fields of clinical and counselling psychology about the themes that had emerged. The process of consultation was through a number of depth interviews, which are a type of exploratory interview (Oppenheim, 1998).

The depth interview process was used for three reasons. Firstly the objective was to explore perceptions about '*the role of a psychologist working with people who have enduring mental health problems'* in order to understand the different conceptualisations of this role and which ones to measure in the research study.

The second objective was to obtain 'sayings', as illustrated by Oppenheim (1998), when gathering 'attitude' statements. The 'sayings' were provided by the interviewees on their beliefs regarding the research area and would later be used as statements in the questionnaire.

The third objective was to establish a systematic method of exploring the same belief related to the research aim rather than risk looking at an arbitrary set of statements.

2.3.2 Design

The depth interviews were semi-structured, informal and conversational. This type of interview was used to give a freedom to the narrative, allowing a richer source of material to be elicited (Oppenheim, 1998).

2.3.3 Interviewees

Interviews were held with nine psychologists: five were chartered clinical and two were chartered counselling psychologists, with the remaining two being third year trainee counselling psychologists. Of the five chartered clinical psychologists, three were either heads or former heads of Adult Psychological Services in the National Health Service (NHS) and two were 'B' grade psychologists.

The psychologists interviewed were personally known to the researcher through professional connections and were practitioners with clients who had enduring mental health problems. They were slightly senior in grade and mental health

experience to the sample population, but this was deemed advantageous in terms of accessing their professional knowledge of this client group.

2.3.4 Procedure

The face-to-face depth interviews were conducted and each lasted approximately sixty minutes. The interview commenced with an introduction to the research subject, with each of the interviewees being informed that they were being taped but that any identifying comments would be removed from the transcripts to preserve their anonymity.

The researcher invited the interviewees to talk about beliefs regarding "*The role of a psychologist working with people who have enduring mental health problems*".
In addition to the researcher introducing the research title, the five specific themes described earlier were also introduced. These were:

- Professional training
- Therapeutic skills
- Team work
- Mentoring role (educational or supervisory)
- Organisational requirements

The interviewees were presented at the start of the interview with a sheet of paper with the five themes printed on it (see Appendix Two) to serve as a prompt throughout the conversation, and were invited to comment on the five areas in relation to the research question. The interview ended with the researcher formally thanking the interviewees for their time and contribution. The tapes were transcribed and the transcriptions printed.

2.4 Item pool clustering

The next stage of the development of the research tool was the compilation of the item pool drawn from the depth interviews.

The printed transcripts were cut up and sorted into interviewee responses. To group the responses a clustering process described by Robson (1997) was used. Using the

technique the responses were placed in piles by the researcher and two other chartered psychologists. Similar items were pooled together and six distinct sub-areas emerged. These pools of items were then displayed by pasting the comments or 'sayings' from interviewees on to big sheets of coloured card. The six sub-areas consisted of:

- Teamwork - pink card
- Therapeutic skills - white card
- Professionalism - green card
- Further organizational requirements - white card
- Continuing professional development (CPD) - pink card
- Methods of research - blue card.

The sheets of card with comments attached to them were then studied and discussed by the researcher and two counselling psychologists in training. Comments that were felt not to fit comfortably into the sub-areas were removed from the sheets. This brainstorming resulted in clarification of the item pools, and a level of agreement about the material was reached.

The content of the item pools on the sheets of card were then used as the 'sayings' for the statements or questions. Discussion took place during the researchers psychology department 'professional development' meeting to establish if the belief statements were 'positive' or 'negative' items. Obtaining peer review was a technique used by Robson (1997) to verify statements.

Eventually a total of seventy-seven statements were drawn from this material, of which approximately half were positive and half negative: this gave a reasonably balanced item pool.

The items were considered by the psychologists to be thought-provoking as well as interesting. They were also seen as appropriate statements for exploring beliefs relating to the research aims.

2.5 Development of Likert Scale

The next stage of the development of the research tool was the construction of a Likert Scale (Likert, 1932, cited in Robson, 1997), which was considered by Robson (1997), to be a systematic way of measuring respondent attitudes.

A sampling of the item pool was required to reduce the large number of belief statements to an amount that could effectively be used in the questionnaire. Care was taken to retain a balanced item pool that would reflect the wide range of beliefs held, without being too rigid, and to incorporate at least some element of each of the sub-areas of the beliefs.

2.5.1 Participants in development of Likert Scale

The researcher was able to recruit participants for this stage of the study by attending meetings at local NHS psychology departments in addition to approaching acquaintances that were chartered psychologists. Twenty-five psychologists took part, thirteen of whom were chartered clinical psychologists and twelve of whom were chartered counselling psychologists. The respondents were a similar sample to the population who would participate in the final study.

2.5.2 Instructions

The respondents were given the seventy-seven belief statements, which had been pasted onto individual cards. These were placed in a envelope and randomly chosen by the respondent. The respondent was asked to place the statement on a board[1]. The board had a Likert Scale drawn out on it, with five response categories as shown in Table 2.5.2.

Table 2.5.2: Psychologist role definition instrument

Their role as psychologist when working with people who have enduring mental health problems				
Very strongly	Fairly strongly	Neutral	Fairly weak	Very weak

[1] The researcher had observed similar selection and scoring methods employed in children's board games and chose to use the idea in the research.

Respondents were instructed to place the statements/questions on to the board in whichever of the response categories they felt best fitted their belief about the statement when thinking of a psychologist working with people who have enduring mental health problems.

2.5.3 Weighting for the scale

The five categories were given a scoring or 'weight' (as cited in Robson, 1997, p. 258), of 5, 4, 3, 2 and 1. The order of the weights was varied according to whether the statement was valued as positive or negative. Thus a weight of 5 would be attached to 'very strongly' for a positive statement, and a weight of 5 would be attached to 'very weak' for a negative statement. The relative weights for each statement stayed consistent for each respondent.

2.5.4 Recording responses

As the respondents placed the statements onto the board the researcher recorded a letter – A, B, C, D or E – onto the back of the card. The letters were consistent with the weighting of the statements, so that for a positive statement 'very strongly' was denoted as an 'A', where as for a negative statement 'very weak' was assigned an 'A' rating. Letters were used to record the responses so that participants would not be influenced to place their statements in a particular category on the board if they saw the back of the statement.

When all respondents had finished rating the statements, the researcher scored each statement by writing down the appropriate weighting assigned to the letter recorded on the back of the statement. For example, A, A, B, C, D, C, B, would be 5, 5, 4, 3, 2, 3, 4, as this was a positively weighted statement.

2.5.5 Item analysis

An item analysis of all of the statements was conducted to select appropriate ones for inclusion in the final questionnaire, as described by Oppenheim (1998). This was done to screen out statements that did not 'fit' – statements that had the greatest variation in their scoring totals.

The process of 'cleaning up' the statements, i.e. by removing the odd ones out, helped to establish reliability through internal consistency. An additional reason for establishing this internal consistency was because no external criteria existed against

which to correlate the statements. The discriminative power (DP) for each statement was then calculated.

There are a variety of ways of achieving internal consistency: for example, the correlation coefficient method. However, the discriminative power method was selected for its applicability of use with Likert Scales. The calculation of the DP involved adding the score for each participant response then ranking the statements by the total score attained.

The DP allows participant responses to be compared so that the statements included in the final questionnaire have the highest discriminative power to the total score. Statements from the lower quartile (25%) – that is the ones that did not 'fit' – were removed from the sample. Following this process thirty-five items were selected to be included in the first draft of the questionnaire.

2.6 Verification of questions through consultation

The draft questionnaire, comprising 35 statements, was taken back to the original seven psychologists who had been initially interviewed face-to-face for the research. As a result of the consultation process, three of the statements were rejected as being too similar to other questions in the item pool. The process of consultation occurred continuously, both formally in psychology department development meetings where the researcher practised, and informally during the researcher's supervision time.

The statements were reduced to thirty items that made up the final main body of the questionnaire. All of the items retained for the questionnaire had a high level of discriminative power to the total score, as suggested by Robson (1997) p. 258.

2.6.1 Selection of demographic questions

Questions to gather demographic information, information about chartering, therapeutic orientation, time in practice and income were selected for inclusion in the final questionnaire. A literature search, consideration of questionnaires and peer review again occurred to select the appropriate questions for the study.

2.7 Peer review of draft questionnaires

The peer review panel comprised psychologists within the department where the researcher practised. These individuals were asked to comment on draft copies of the research questionnaire, and the researcher incorporated their suggestions into the questionnaire design.

Changes made to the questionnaire were factors such as the design of the front cover (four with borders or graphics), the font used and the line spacing. Tick boxes were found to be the preferred method of recording responses for the Likert Scale statements, and ticks for indicating demographic information.

The final questionnaire was again taken back to the original seven psychologists for their comments. There was a general consensus that the questionnaire covered the main areas that had arisen during the initial depth interviews, and it was approved for use.

The next chapter explores how this instrument was used to examine beliefs and the methodology employed to do this.

CHAPTER 3: Methodology

3.1 Overview

This chapter explains the genesis of the research question from the literature review and the consultations that were involved in the development of the research tool. The methodology is described, and includes sample selection, recruitment, procedure, incentives, questionnaire and statistical analysis.

3.2 Research objective

As described in Chapter One, there is a body of research about the role of psychologists in the NHS who work with individuals who have enduring mental health problems. This literature often describes psychology in secondary mental health care settings as being provided by clinical psychologists. The lack of explicit acknowledgement of the role of counselling psychologists in these environments led to the development of the research question.

This research project was an opportunity to explore the beliefs psychologists held about their role as a psychologist when working with this client group. The views held by psychologists of differing disciplines could at times be fundamentally similar when thinking about professional issues and at other times vastly different when considering other aspects of their role; the aim of the research design was to draw out these beliefs. By comparing the beliefs of clinical and counselling psychologists, one is objectively addressing the issue, with no preconceptions as to whether beliefs are going to be the same or different.

There is greater pressure on counselling psychology as a professional body to explain its abilities and core competencies as well as how it differs from clinical psychology. The need to inform through a body of research the beliefs held by clinical and counselling psychologists was deemed to be useful in the debate regarding the future development of the profession of counselling psychology, particularly within the NHS.

The research was designed to bring together the lessons learnt from the depth-interviews, consultation processes and the researcher's personal experiences as well as from the literature review to compare the beliefs held by clinical and counselling psychologists.

3.3 The research hypothesis

The purpose of the research study was to examine the three main aims and the hypothesis for each of these aims, which were drawn from the literature review and from consultation processes focusing on the beliefs held by clinical and counselling psychologists and student counselling psychologists. The beliefs examined were about their role as a psychologist when working with people who have enduring mental health problems.

3.3.1 Aim 1: Comparison between clinical and counselling psychologists

The first and main aim is the comparison of beliefs held by clinical and counselling psychologists about their role as psychologist when working with people who have enduring mental health problems.

Hypothesis 1: The responses of clinical psychologist to the *Psychologist Role Definition Instrument* will be significantly different from those of counselling psychologists.

3.3.2 Aim 2: Comparison between student counselling psychologists and clinical psychologists

The second aim is the comparison between student counselling psychologists and clinical psychologists in terms of their beliefs about their role as psychologist when working with people who have enduring mental health problems.

Hypothesis 2: The responses of student counselling psychologists to the *Psychologist Role Definition Instrument* will be significantly different from those of clinical psychologists.

3.3.3 Aim 3: Comparison between student counselling and counselling psychologists

The third aim is to compare student counselling and counselling psychologists beliefs about their role as psychologist when working with people who have enduring mental health problems.

Hypothesis 3: The responses of student counselling psychologists to the *Psychologist Role Definition Instrument* will be significantly different from those of counselling psychologists.

3.3.4 Demographic questions

Demographic questions were explored in addition to the three main aims of the study. The therapeutic orientation of the psychologists in the study, their place of practice and years of being chartered were all examined, as was their income. These questions were included to provide context by looking at how psychologists practised, who they were, where they were employed and how much they were paid. These questions were considered to be useful so that a comparison could be made between the two main groups in the study, not only in terms of their beliefs related to the *Psychologist Role Definition Instrument* but also the more practical aspects of the different professions.

3.4 Methodology overview

A sample of 340 chartered counselling psychologists – the total number of all chartered counselling psychologists – was compared with chartered clinical psychologists. The groups were matched through gender, and both groups were

recruited through the BPS database. A third group comprising 60 student counselling psychologists from City University London was included.

3.4.1 Sample size

The sample size related to the total number of counselling psychologists meeting the criteria for being chartered and being registered at the time on the BPS database in the UK. The study was a national one and the sample size reflected this. The group was compared with the same number of chartered clinical psychologists. A third group of 60 students was also included in the research study.

3.4.2 Inclusion criteria

Chartered counselling psychologist who were registered on the BPS database. Criteria for registering as a chartered counselling psychologist at the time of the study included:

- Having successfully completed part 1 and part 2 of the BPS requirements for chartering
- Completed a minimum of 450 hours of supervised practice
- A minimum of three years to have passed since registering for the MSc (part 1 of the BPS requirements) in Counselling Psychology
- Chartered clinical psychologist registered on the BPS database. Criteria for registering as a chartered clinical psychologist at the time of the study included having successfully completed a BPS recognised and validated three-year full-time Diploma in Clinical Psychology

Student participants to be registered (part time or full time) on the MSC or Post MSc Counselling Psychology Programme at City University.

3.4.3 Exclusion criteria

Counselling and clinical psychologists not residing in the UK – included Scotland and Northern Ireland – were excluded from the study.

3.4.4 Sample recruitment and selection

All chartered counselling psychologists registered with the BPS and living in the UK were sent a questionnaire. This group was matched with the chartered clinical psychologist group through gender to try reduce any variance in the samples that

might influence the results. The third group, comprising student counselling psychologists, was contacted through the City University MSc and Post MSc Counselling Psychology Programmes.

3.4.5 Selection variables of samples

Questionnaires were sent to 340 accredited members of the Division of Counselling Psychology, 340 full members of the Division of Clinical Psychology and 60 counselling psychology students drawn from City University, London, on MSc and Post MSc Counselling Psychology courses. This gave a sample size of 740 participants. The clinical psychology group was selected by alphabetical order to try minimise selection bias.

3.4.5.1 Matching on doctoral status

Where there were several potential matches with a chartered counselling psychologist doctor, a clinical match was selected from psychologists whose name began with the same letter. Where there was a Dr title and no indication of gender, then a Dr was also drawn from the directory with their surname starting with a letter as near as possible in the alphabet. These were selected against the counselling psychology group for the clinical psychology group.

Geographical area was also used as a semi-random means of allocation to the clinical psychology group. For example, if there was a Dr B Simpson, Warwickshire, in the counselling psychology group, then a Dr was located in the directory for chartered clinical psychologists whose surname started with 'S' who also lived in Warwickshire. If there was not a Dr 'S' in Warwickshire then Dr 'S' in counties bordering Warwickshire were located; the first Dr 'S' located who fitted the criteria was selected.

3.4.6 Potential participants who did not take part in the study

As mentioned earlier, any participants who were registered as living overseas were not included in the study. This was for several reasons:

- The validity of the study depended on the beliefs of the participants involved in the study being related to experience of secondary mental health care within the UK

- Demographic questions used to put the respondents' answers to the *Psychologist Role Definition Instrument* into context could potentially skew the data

Any psychologist selected from the chartered clinical psychology list who was found to also be a chartered counselling psychologist was screened out. The reason for excluding them was because inclusion of participants belonging to both groups might obscure potential differences or even similarities between the two groups.

3.5 Design

An independent variable between subject design was used to explore the research hypotheses. The aim of the research was the comparison of the beliefs held by the three groups about their role as a psychologist when working with people who have enduring mental health problems.

3.6 Incentives

Incentives to return questionnaires were used in the form of a raffle of £80 worth of book vouchers (see Appendix Three, I-III).

3.7 Covering letters

Covering letters accompanied the questionnaires. These letters were 'tailored for the audience', Robson (1997). The covering letters varied slightly depending on the subject group. The letters to the chartered counselling psychology (see Appendix Four), and student counselling psychology groups (see Appendix Five) emphasised the importance of returning completed questionnaires for the useful information that it could provide the division of counselling psychology. The letter to the clinical psychology participants did not mention this aspect of the study (see Appendix Six).

- The letters explained that the questionnaire would take approximately ten minutes to complete

- There was an emphasis on the importance of completing the questionnaire, as it might be useful to the professional development of psychology, hence a reply was strongly encouraged
- The opportunity to win £80 worth of book vouchers was emphasised, the repetition of the incentive was to try and increase the response rate
- Participants were instructed to use the stamped addressed envelope provided to return their completed questionnaire

3.8 Questionnaire

A self-administered questionnaire designed to maximise the response rate was used. The main part of the questionnaire was the *Psychologist Role Definition Instrument*, which used a Likert Scale designed for the purpose of the study.

3.8.1 Structure of the Questionnaire

The questionnaire (see Appendix Seven) consisted of eight pages of cut paper. The first page was the title page, 'The role of chartered psychologists working with people who have enduring mental health problems – a questionnaire study'.

The second page contained information that provided some background about the researcher, the researcher's interest in the study area, the research topic relationship to the development of counselling psychology, and the relevance of the study to that process.

The researcher's membership of the Division of Counselling Psychology Committee for Science and Practice was declared, to increase transparency regarding professional and personal interest in the research, and to address the phenomenon of investigator allegiance (Paley & Shapiro, 2002).

The research title was again repeated and the scene was set for the study by the inclusion of some information about the roles of psychologists. It was explained that it was helpful to see role behaviour as a combination of organisational requirements and individual interests. It was again repeated that the questionnaire would attempt to begin the exploration of the role of psychologists who work with people who have enduring mental health problems.

The information page contained further explanation about the aims of the study, as above, as well as the need for clinical psychologists – who were often employers of counselling psychologists – to be aware of these perceptions. It also highlighted the relevance of developing an understanding of the value of counselling psychology in this area.

The opportunity to win £80 worth of book vouchers for participants who fully responded to the survey was again mentioned at the bottom of the second page, with an explanation of how the participants with the winning numbers would be notified in a later edition of *The Psychologist*.

The final comments on the information page were that the questionnaire was entirely confidential and that any information held relating to the raffle tickets would be erased once the prizes were distributed.

3.8.2 Part one of the questionnaire

The third page of the questionnaire contained Part one of the study. This section asked questions about demographical and professional information. Questions included:

- Age
- Gender
- Chartering; if no, the question went on to ask:
- Were they a student full time or part time;
- If they answered yes to the chartering question, then they were requested to say what sort they were and how many types of chartered psychologist they were.
- The setting that they practised in; if this was more then one, they were asked to indicate this.
- Therapeutic orientation.
- How long they had practised as a therapist.
- Annual pro-rata income.

3.8.3 Part two of the questionnaire

The second part of the questionnaire was the *Psychologist Role Definition Instrument*. The research title and instructions on how to complete this section were

repeated ahead of the questions. This part of the questionnaire contained thirty items in a Likert Scale to measure respondents' beliefs. The question to compare respondents' beliefs about role was *How strongly do you feel that a psychologist should or should not do the following things when working with people who have enduring mental health problems?*

There were three pages (4, 5 and 6) with a total of thirty statements. The statements were randomly ordered, as it was not wanted that the ordering of the statements influence the participants' responses to them. The instructions were repeated at the top of each page to avoid confusion and to aid the respondents in completing the questionnaire.

On page seven, following the thirty statements in the *Psychologist Role Definition Instrument,* there was an open question where respondents had the opportunity to comment on the questions or their responses to them. This page ended with the researcher thanking the participants for taking the time to complete the questionnaire. The researcher's contact details were included for participants who wanted more information about the study. The final page, which was the eighth, consisted of an acknowledgement of sources.

3.9 Mailing out

The BPS sent out the questionnaire in October 1998 on behalf of the researcher. This service was supported and paid for by Coventry Health Care NHS Trust, Adult Psychological Services, Psychological Therapies Team, Sage Ward, Gulson Hospital, Gulson Road, Coventry. The letter to the BPS outlined how the questionnaire was to be sent out. A list of membership numbers and surnames of the psychologists who were to be sent questionnaires was included. The questionnaire was to be sent to the three groups:

- All chartered counselling psychologists on the BPS database
- Chartered clinical psychologists (membership numbers and names were included with the letter)
- Students from City University, London, enrolled on the MSc and Post MSc in Counselling Psychology

The questionnaires for students were sent in one package to the course administrator. The administrator put the separate envelopes containing the questionnaire, cover letter and BPS literature into student pigeonholes. The name and address and other contact details for the course administrator was included in the letter.

The BPS was instructed that cover letters of a particular colour should accompany questionnaires that had a top sheet of the same colour. The reason for the different coloured front sheets was so that the researcher could easily identify the different research groups for analysis purposes. The different coloured front sheets were:

- Counselling psychologists – blue
- Clinical psychologists – green
- Students – pink

The questionnaires were sent out in a BPS franked envelope, which contained the questionnaire, cover letter, a self-addressed franked envelope and a flyer for BPS books. The questionnaires were posted out in late October 1998. The completed questionnaires were returned to the BPS office in Leicester throughout November and returned to the researcher at the end of December 1998.

3.10 Data collection

In all, two hundred and ninety-one completed questionnaires were returned and then numbered by the researcher, yielding a response rate of 39.73%. Three questionnaires were randomly selected, raffle tickets removed and book vouchers sent out (see Appendix Three I-III). The questionnaires were sorted into three piles by the colour of their front sheet and numbered for processing. The database used to store the results was Windows Excel, but a coding system had to be devised before the qualitative data from the questionnaires could be entered into the database.

Different columns were assigned to each question. Nominal data such as *age* or *length of time in practice* could be input as raw data but questions such as *sex* or *type of chartered psychologist* needed to have codes created for the answers so that nominal representative results could be input (see Appendix Eight). In order to code

two of the questions – number 6, '*what type of setting do you practise in?'* and number 7, '*what is your therapeutic orientation?'* – the researcher consulted with two peers to consider the main employment settings and the main therapeutic frameworks psychologists used in their practices. The inclusion of *'+ other'* categories allowed the results to be most appropriately input.

For Part two of the questionnaire, transparent templates were created to go over the appropriate questions. The templates had the questions printed on them and in the tick boxes the weight for each answer was hand-drawn. As described earlier, the five answers for each question were given a scoring system or 'weight' of 5, 4, 3, 2 and 1. The transparencies were used to expedite the data inputting by giving an immediate visible template of the weights for each item.

3.11 Data analysis

The quantitative data from the study was analysed. After consultation with statisticians the recommendation was to compare the median scores for students, counselling psychologists and clinical psychologists using the Mann Whitney U Test, as the independent variable was at the ordinal level of measurement and the data was from two independent samples.

The Mann Whitney U Test (see Appendix Nine) was chosen in preference to the independent t-Test, as the data was not normally distributed. (The Mann Whitney U Test is the non-parametric analogue of the independent t-Test). The significance level for the analysis was set at 0.05. However, multiple tests were used as there is an increased potential for Type 1 errors: this is controlled by adjusting the significance value using Bonferroni's method (i.e., 0.05 / number of tests undertaken). As there were 30 tests undertaken in a set, the required significance level is 0.05 / 30 = 0.00166. The hypothesis was two-tailed, as no direction for the difference in the results for each of the hypotheses was predicted.

The demographic questions such as gender, therapeutic orientation and practice setting were compared using the means. The findings for the data analysis are presented in the next chapter.

CHAPTER 4: Results

4.1 Overview

The chapter is presented in six sections. The first section introduces the study participants, how they were selected, how many were involved in the research and how many responded from each group. The second section presents descriptive information about the samples in the study, including age, gender, income and therapeutic orientation.

Sections three to five examine the results for the main body of the questionnaire, the *Psychologist Role Definition Instrument.* The Instrument comprised 30 Likert statements, which respondents rated, as a means of examining the beliefs held by the different groups about their role as psychologist when working with people who have enduring mental health problems.

Each of Sections three to five explores one of three aims, with its corresponding hypothesis. The hypotheses are two-tailed, as a difference is predicted between the results of the two groups being compared, though the direction of that difference is not indicated. The respondents' results were analysed using the Mann Whitney U test (see Appendix Nine for all quantative data and analysis), as advised by statistical experts.

For each of the hypotheses, qualitative comments relating to the statistically different test results are presented (see Appendix Ten for all qualitative comments).
The third section examines the first aim, which is the comparison of beliefs held by clinical and counselling psychologists about their role as psychologist when working with people who have enduring mental health problems.

In section four the second aim is the comparison of beliefs held by clinical and student counselling psychologists about their role as psychologist when working with people who have enduring mental health problems.

Section five examines the third aim. This is the comparison of beliefs held by counselling and student counselling psychologists about their role as a psychologist when working with people who have enduring mental health problems.

The researcher provides an overall summary of the results for the *Psychologist Role Definition Instrumen*t in the sixth section.

4.2 Section one

4.2.1 Description of the groups

4.2.1.1 Selection variables

As described in Chapter Three, participants were selected from the BPS database for chartered psychologists in the UK. All chartered clinical psychologists and all chartered counselling psychologists were sent questionnaires and matched through gender to reduce any variance in the samples that might influence the results. Other selection variables that were used to select participants in an unbiased way were alphabetical order of name and geographical location. The third group comprised student counselling psychologists, who were contacted through City University MSc and Post MSc Counselling Psychology Programmes.

Table 4.2: Response rate for return of questionnaire

Questionnaires sent out	*N*	Questionnaires returned	*N*
Clinical psychologists	340	Clinical psychologists	97 (33%)
Counselling psychologists	340	Counselling psychologists	130 (44.2%)
Students	60	Students	39 (13.3%)
		Respondents chartered in clinical and counselling psychology removed from data set	28 (9.5%)
Total	740	294 returned (39.73% of total sent out)	294 (100%)

The overall response rate for the study is 39.73% (Table 4.2). The percentage score relates to the sample size of the group in the final study: for example, 13% of the total number of respondents (100%) are students.

As can be seen counselling psychologists returned the largest proportion of completed questionnaires, followed by clinical psychologists, with the student group returning the smallest number.

Dual chartered psychologists – practitioners chartered as both counselling and clinical psychologists – made up 9.5% (28) of the total number of respondents. These participants were not compared as a separate group or included in either the clinical or counselling psychology groups for two reasons. First, inclusion of the dual chartered group may have obscured potential differences or similarities between clinical and counselling psychologist groups. Second, while it may have been interesting to see if there were any defining features for this group, the low numbers (28) did not provide significant information to the study. As the 28 psychologists who were chartered in both divisions were not included in the analysis, the overall number of respondents for the study whose results were analysed was 266.

The analysis therefore focused on three distinct groups: clinical, counselling and student counselling psychologists, and the results for these were compared.

4.3 Section two

4.3.1 Means of age for each group

Table 4.3.1 shows the age range for the three groups, the number of respondents, standard deviation of the ages and the maximum and minimum ages for each group. The three groups vary, with a mean for students being 35 years of age, clinical psychologists being 44 years of age and counselling psychologists being 49 years of age.

Table 4.3.1: Means of age for each group

Types	Mean	N	Std. Deviation	Minimum	Maximum
Clinical	44.27	97	9.11	27.00	74.00
Counselling	49.84	130	9.57	27.00	76.00
Student	35.37	38	9.44	23.00	54.00
Total	47.22	265	10.20	23.00	76.00

4.3.2 Gender of subjects

Table 4.3.2 shows the gender of respondents for each of the groups. The missing data is also noted. There are proportionately more females to males for each of the groups. Three clinical psychology respondents did not supply information about their gender as did five counselling psychology respondents.

Table 4.3.2: Gender of subjects

Gender	Group			*N*
	Clinical	Counselling	Student	
Female	55	77	33	165
Male	39	48	6	93
Missing data	3	5	0	8
Total	97	130	39	266

4.3.3 Therapeutic orientation

The percentage scores in Table 4.3.3 relate to the groups and the percentage for the different therapeutic orientations within each of those groups. For example, 20.9% of counselling psychologists report that their therapeutic orientation is primarily CBT. As can be seen in Table 4.3.3, most clinical psychologists reported that they used a CBT approach for their therapeutic work while the majority of the counselling psychologists reported an integrative approach as their therapeutic orientation.

Table 4.3.3: Therapeutic orientation

Therapeutic orientation		Group			Total
		Clinical	Counselling	Student	
CBT	*(N)*	53	27	10	90
	% within groups	54.6%	20.9%	40.0%	35.9%
Dynamic	*(N)*	15	28	0	43
	% within groups	15.5%	21.7%	.0%	17.1%
Humanistic	*(N)*	1	21	10	32
	% within groups	1.0%	16.3%	40.0%	12.7%
Systemic	*(N)*	9	8	1	18
	% within groups	9.3%	6.2%	4.0%	7.2%
Integrative	*(N)*	19	45	4	68
	% within groups	19.6%	34.9%	16.0%	27.1%
Total	*(N)*	97	129	25	251
	% within groups	100.0%	100.0%	100.0%	100.0%

4.3.4 Length of time in years of being chartered and in therapeutic practice

As expected, none of the student respondents reported being chartered. The clinical psychologist group reported that their mean length of time being chartered was double the length of time generally reported by the counselling psychology group (10 years compared to 5 years). The clinical psychologists' time in practise in comparison to the counselling psychologists' reported time in practice varied by less than three years, with 15 years for the clinical group and 12.59 years for the counselling group.

Table 4.3.4: Length of time in years of being chartered and in therapeutic practice

Group		Length of time in years chartered	Time in practice in years
Clinical	(*N*)	90	96
	Range	24	34
	Mean	10.21	15.19
Counselling	(*N*)	124	130
	Range	18	37
	Mean	5.37	12.59
Student	(*N*)	0	17
	Range	0	3
	Mean	0	1.88
Total	(*N*)	214	243
	Range	24	39
	Mean	7.41	12.87

4.3.5 Setting for practice

The percentage scores relate to the groups and the setting for practice reported within each of the groups. For example, 34.4% of counselling psychologists report that they practise within the NHS. The results in Table 4.3.5 show that the majority of clinical psychologists as well as students reported practising in the NHS. The majority of counselling psychologists, however, reported practising in private practice, while a large proportion of participants 34% also reported practising in the NHS.

Table 4.3.5: Setting for practice

Setting for practice		Group			Total
		Clinical	Counselling	Student	
NHS	(*N*)	73	44	12	129
	% within groups	78.5%	34.4%	60.0%	53.5%
Private practice	(*N*)	6	61	1	68
	% within groups	6.5%	47.7%	5.0%	28.2%
Other	(*N*)	14	23	7	44
	% within groups	15.1%	18.0%	35.0%	18.3%
Total	(*N*)	93	128	20	241
	% within groups	100.0%	100.0%	100.0%	100.0%

4.3.6 Annual income

The percentage scores in Table 4.3.6 relate to the groups and their pro rata level of income within those groups. As indicated in the table, the student group report earning the lowest income, the majority of the group saying between £0.00 and £9,999. Counselling psychologists are mainly spread around the middle-income brackets, between £20k range and £29,999. The annual income for the clinical psychologists, in contrast to the student and counselling psychologist group, is reported to be mainly in the highest income bracket, with 36% earning £40k plus.

Table 4.3.6: Annual income (pro rata)

Income		Group			*N*
		Clinical	Counselling	Student	
£0.00 - £9,999	*N*	14	2	5	21
	% within groups	35.9%	2.1%	3.8%	7.9%
£10k - £14,999	*N*	5	1	5	11
	% within groups	12.8%	1.0%	3.8%	4.1%
£15k - £19,999	*N*	4	2	12	18
	% within groups	10.3%	2.1%	9.2%	6.8%
£20k - £24,999	*N*	1	15	30	46
	% within groups	2.6%	15.5%	23.1%	17.3%
£25k - £29,999	*N*	1	12	26	39
	% within groups	2.6%	12.4%	20.0%	14.7%
£30k - £34,999	*N*	0	12	13	25
	% within groups	.0%	12.4%	10.0%	9.4%
£35k - £39,999	*N*	0	17	16	33
	% within groups	.0%	17.5%	12.3%	12.4%
£40k plus	*N*	0	35	20	55
	% within groups	.0%	36.1%	15.4%	20.7%
	Missing data	14	1	3	18
	% within groups	35.9%	1.0%	2.3%	6.8%
Total	(*N*)	39	97	130	266
	% within groups	100.0%	100.0%	100.0%	100.0%

4.4 Section three

Aim 1: Comparison of beliefs held by clinical and counselling psychologists about their role as a psychologist when working with people who have enduring mental health problems.

Hypothesis: The responses of clinical psychologists to the *Psychologist Role Definition Instrument* will be significantly different from those of counselling psychologists.

As explained earlier in this chapter, the main body of the questionnaire comprised 30 Likert statements that the respondents were asked to rate. These statements were the *Psychologist Role Definition Instrument.* Tables 4.4.1 (I) to (III) present the median, range and Mann-Whitney U Test (Z scores) results for the clinical and counselling groups. As mentioned earlier in the Methodology chapter, the Bonferroni correction was used to protect against Type 1 errors; it was also used because the hypothesis was tested using 30 tests. The 0.05 significance level is therefore adjusted to 0.00166 using the Bonferroni correction. The hypothesis is two-tailed as a difference is being predicted, though the direction of that difference is not indicated.

Tables 4.4.1. (I) to (III) present the range and median scores for the clinical and counselling psychologist groups. The hypothesis is accepted for 11 out of 30 tests (1, 3, 5, 10, 11, 13, 17, 19, 22, 25, and 30). The results clearly show that the two groups are significantly different, scoring less than 0.00166 (P= 0.05 is adjusted to P= 0.00166 using the Bonferroni correction, as previously described). This hypothesis is rejected for 19 of the 30 tests. Overall the hypothesis is rejected.

4.4.1 A comparison of clinical and counselling psychologist's on The *Psychologist Role Definition Instrument* using the Mann-Whitney U Test (Z).

4.4.1. (I)

Psychologist Role Definition Instrument	Group	Median	Range	Z	p
Have had personal therapy	Clinical	3.00	2-5	- 8.15	<0.000*
	Counselling	5.00	2-5		
Draw on a basic knowledge of psychopathology	Clinical	5.00	3-5	- 2.53	=0.011
	Counselling	5.00	2-5		
Undertake to study the use of psychometric tests if not included in initial training	Clinical	4.00	2-5	- 5.32	<0.000*
	Counselling	3.00	1-5		
Have further training in therapeutic skills following professional psychology training	Clinical	5.00	3-5	- 0.98	=0.327
	Counselling	5.00	3-5		
Employ the principles of a 'scientist practitioner'	Clinical	4.00	2-5	- 3.18	<0.001*
	Counselling	4.00	2-5		
Conduct research	Clinical	4.00	1-5	- 1.76	=0.078
	Counselling	4.00	3-5		
Take responsibility for own lack of knowledge or skill and address this through further training	Clinical	5.00	4-5	- 0.57	=0.563
	Counselling	5.00	3-5		
Keep up to date with the progress of their professional psychological division	Clinical	5.00	3-5	- 1.84	=0.066
	Counselling	4.00	3-5		
Liaise with other professionals by speaking the 'same' language	Clinical	4.00	3-5	- 2.00	=0.046
	Counselling	4.00	3-5		
Work in multidisciplinary teams	Clinical	4.00	2-5	- 4.01	<0.000*
	Counselling	3.00	3-5		

* Significant at the adjusted probability level 0.00166

4.4.1. (II)

Psychologist Role Definition Instrument	Group	Median	Range	Z	p
Work in a consultancy role to other professionals	Clinical	4.00	3-5	- 5.04	<0.000*
	Counselling	3.00	3-5		
Supervise other professionals	Clinical	4.00	3-5	- 2.32	=0.020
	Counselling	3.00	2-5		
Train other professionals	Clinical	4.00	3-5	- 3.63	<0.000*
	Counselling	3.00	3-5		
Prescribe medication	Clinical	5.00	2-5	- 0.90	=0.368
	Counselling	4.00	1-5		
Train in the 'therapeutic' use of assessment tests	Clinical	4.00	2-5	- 2.37	=0.017
	Counselling	3.00	2-5		
Establish skills for recognising psychotic episodes for clients, so that they can be understood and coped with in a helpful way	Clinical	5.00	3-5	- 0.04	=0.967
	Counselling	5.00	3-5		
Provide clinical supervision on cases to trainee clinical psychologists	Clinical	4.00	3-5	- 6.09	<0.000*
	Counselling	3.00	1-5		
Work with a client despite misdiagnosis from a psychiatrist	Clinical	3.00	2-5	- 2.97	=0.003
	Counselling	3.00	1-5		
Discuss with a referrer your assessment of an individual	Clinical	4.00	3-5	- 6.50	<0.000*
	Counselling	3.00	1-5		
Have inadequate experience of secondary mental health care	Clinical	4.00	1-5	- 1.90	=0.057
	Counselling	4.00	1-5		

* Significant at the adjusted probability level 0.00166

4.4.1. (III)

Psychologist Role Definition Instrument	Group	Median	Range	Z	p
Become a friend of a client	Clinical	5.00	1-5	-1.88	=0.060
	Counselling	5.00	1-5		
Co-work with other professionals	Clinical	4.00	3-5	- 3.18	<0.001*
	Counselling	4.00	3-5		
Shout at a client in therapy	Clinical	5.00	3-5	-1.77	=0.076
	Counselling	5.00	2-5		
Have limited formulation regarding therapy following an assessment session with a client	Clinical	3.00	1-5	-0.52	=0.600
	Counselling	3.00	1-5		
See a client for therapy who arrives outside of their appointment session	Clinical	3.00	1-5	- 3.94	<0.000*
	Counselling	4.00	2-5		
Be able to section a client	Clinical	4.00	1-5	- 0.09	=0.926
	Counselling	4.00	1-5		
Provide clinical supervision to trainee counselling psychologists	Clinical	3.00	2-5	- 2.58	=0.010
	Counselling	4.00	2-5		
Recommend a particular type of medication for a client	Clinical	3.00	1-5	- 3.04	=0.002
	Counselling	4.00	2-5		
Without a client's consent, inform their family about their mental health problems	Clinical	4.00	2-5	- 6.89	=0.005
	Counselling	5.00	3-5		
Work with more than one member of the same family for individual therapy	Clinical	4.00	1-5	- 3.24	<0.001*
	Counselling	4.00	2-5		

As thirty statistical tests are applied to the *Psychologist Role Definition Instrument* (30 tests as indicated in Table 4.3.1 (I-III)) the 0.05 significance level is adjusted to 0.00166 using the Bonferroni correction.

* Significant at the adjusted probability level 0.00166

4.4.2 Analysis of questions where statistically significant differences were found

The questions that show a significant difference between the two groups are listed below, with supportive qualitative comments to illustrate the differences.

Question 1. Have had personal therapy

The results indicate that clinical psychologists believe that 'you may or may not' have had personal therapy, but in contrast counselling psychologists believe that 'you absolutely must' have had personal therapy. This indicates that clinical psychologists do not see personal therapy as an essential element in the role of a psychologist working with individuals who have enduring mental health problems. Two qualitative comments by clinical psychologists illustrate this:

- "*Personal choice*"
- "*Should of some kind, but not long-term psychotherapy particularly*"

Counselling psychology group participants made no qualitative comments for this question.

Question 3. Undertake to study the use of psychometric tests if not included in initial training

The results suggest that clinical psychologists believe 'you preferably should' undertake to study the use of psychometric tests; in contrast counselling psychologists believed that 'you may or may not'. This indicates that clinical psychologists believe undertaking to study the use of psychometric tests, if not included in initial training, is a more important element in the role of a psychologist working with individuals who have enduring mental health problems than do counselling psychologists. A comment from a counselling psychology group participant reflects the 'may or may not' result:

- "*Although I ticked 'preferably should', I feel that there may always be another psychologist who is experienced and could undertake this instead, if required*"

Question 5. Employ the principles of a 'scientist practitioner'

The results indicate that clinical and counselling psychologists believe 'you preferably should' employ the principles of a scientist practitioner. As the median scores for this

test were both four and the range for both between two and five, the beliefs are similar but still statistically different. This indicates that clinical psychologists and counselling psychologists believe employing the principles of a scientist practitioner is an important element in their role as psychologist when working with individuals who have enduring mental health problems. One comment related to this question came from the clinical group:

- "*I'm sick of this phrase*"

There were no other strong beliefs being recorded by either group for this question.

Question 10. Work in multidisciplinary teams

The results reveal clinical psychologists believe 'you preferably should' work in multidisciplinary teams, while counselling psychologists believe that 'you may or may not'. This indicates a difference between the two groups relating to their beliefs about the relevance of working in multidisciplinary teams as a psychologist when treating this client group, with counselling psychologists not believing it to be as important an aspect of a psychologist's role as do clinical psychologists. Comments reinforcing this response came from clinical psychology group participants about liaising with other disciplines. The counselling psychology group offered two comments, one similar to the clinical group about liasing with other disciplines. The other was:

- "*Depends on setting – private practice Vs NHS*"

This illustrates the 'may or may not' response to the question for many counselling psychologists.

Question 11. Work in a consultancy role to other professionals

The results indicate clinical psychologists believe 'you preferably should' work in a consultancy role to other professionals, while counselling psychologists believe that 'you may or may not'. This suggests a difference between the two groups relating to their beliefs about the importance of working in a consultancy role to other professionals in the role of a psychologist working with individuals who have enduring mental health problems. This indicates counselling psychologists do not believe it to be as important an aspect of a psychologist's role as do clinical psychologists. One respondent from the clinical group made a comment that one must on occasions

work in a consultancy role. One counselling psychologist made a similar comment but said it depended on grade. Two comments reinforcing this response came from clinical psychology group participants, both about liasing with other disciplines.

Question 13. Train other professionals

The results suggest clinical psychologists believe 'you preferably should' train other professionals. In contrast, counselling psychologists believe 'you may or may not'. This indicates clinical psychologists believe that to train other professionals is a more important element of their role as a psychologist working with individuals who have enduring mental health problems than do counselling psychologists. Neither groups offered any comments for this question.

Question 17. Provide clinical supervision on cases to trainee clinical psychologists

The results reveal clinical psychologists believe 'you preferably should' provide clinical supervision on cases to student clinical psychologists. In contrast, counselling psychologists believe 'you may or may not'. This indicates counselling psychologists do not believe it to be as important an aspect of a psychologist's role as do clinical psychologists. Two comments illustrate these results, with one comment from the clinical group being *'you must and should take on trainees'*. Two comments made by counselling psychology participants were:

- "*Having been trained in supervision and partaking of supervision*"
- "*If a clinical psychologist*"

Question 19. Discuss with a referrer your assessment of an individual

The results suggest that clinical psychologists believe 'you preferably should' discuss with a referrer your assessment of an individual while counselling psychologists believe 'you may or may not'. This indicates clinical psychologists believe that to discuss with a referrer your assessment of an individual is a more important aspect in the role of a psychologist working with individuals who have enduring mental health problems than do counselling psychologists.

Five comments came from the clinical group: three suggested written feedback, confidentiality was mentioned by one respondent, and another respondent commented on a response within an agreed time frame for quality standards. Nine comments were made by counselling psychology respondents: three of these were

similar to the clinical group in suggesting discussion by letter or report; two suggested it depended on the 'contract' with the referrer; one on who the referrer was; and one commented on the context that one was in. Other comments were about level of client risk or confidentiality, for example:

- "*Would depend on various factors. If doing assessment I found a client might harm self/others I would obviously discuss with referrer. It also depends on level of risk/disturbance*"

The comments support the result of 'may or may not' discuss with a referrer your assessment of an individual, dependent on your 'contract', perception of risk or working context.

Question 22. Co-work with other professionals

The results indicate that both clinical and counselling psychologists believe 'you preferably should' co-work with other professionals. The equal median scores and the same ranges for the two groups – from three to five 'may or may not' to 'preferably should' – indicate clinical psychologists and counselling psychologists believe it is important to co-work with other professionals when working with individuals who have enduring mental health problems. Despite there being no comments from the clinical psychology group three comments from the counselling psychology respondents support the 'preferably should' results, one stating that you would co-work with professionals in the NHS, another said that you absolutely must, even post qualification. The other comment was: "*But links should be there or permission to liase as necessary*".

Question 25. See a client for therapy who arrives outside of their appointment session

The results reveal clinical psychologists believe 'you may or may not' 'see a client for therapy who arrives outside of their appointment session'. In contrast, counselling psychologists believe that 'you preferably should'. This indicates that counselling psychologists believe to see a client outside of their appointment time to be a more important part of a psychologist's role than do clinical psychologists. The most common response from participants was that it "*depended on the circumstances*" (three clinical psychologists and four counselling psychologists). If it is possible "*To see briefly, to reschedule or to establish what has happened*", was commented on by

two clinical respondents and six counselling psychologists; one such comment by a counselling psychologist was:

- "*If a client turned up outside of their normal time, I'd see them briefly (5-10 mins.) to ascertain the situation, alternative support systems and how able they are to continue to the next scheduled session. I'd also compliment them for seeking appropriate help if they are distressed. I'd do all this when I had free time, if I had any. Even 3 mins might help*"

Proportionately more comments about seeing clients came from the counselling psychology group, all supporting the 'preferably should' results.

Question 30. Work with more than one member of the same family for individual therapy

The results indicate clinical and counselling psychologists alike believe 'you preferably should not' work with more than one member of the same family for individual therapy. The median scores for this test were both four, indicating that clinical psychologists and counselling psychologists alike believe that to work with more than one member of the same family for individual therapy is not an important element in the role of a psychologist working with individuals who have enduring mental health problems. The range for the clinical psychology group was one to five and for the counselling psychology group two to five, suggesting the clinical psychology group was on occasion more likely to believe that the role of psychologist could involve working with more than one member of the same family for individually therapy than did the counselling psychology group. Representative of the belief held by the counselling psychology group regarding 'preferably should not' was a suggestion by two practitioners in this group that if a psychologist were to work with more than one member of the same family then this should not occur concurrently:

- "*Should not – but at different points in time, it may happen*"

A similar comment made by respondents from the counselling and clinical groups was that you should not "*unless in family therapy*".

4.5 Section four

Aim 2: Comparison of beliefs held by clinical and student counselling psychologists about their role as a psychologist when working with people who have enduring mental health problems.

Hypothesis: The responses of student counselling psychologists to the *Psychologist role definition instrument* will be significantly different from those of clinical psychologists.

As explained earlier in the chapter the main body of the questionnaire comprised 30 Likert statements that respondents were asked to rate. These statements were the *Psychologist Role Definition Instrument.* Table's 4.5.1 (I) to (III) present the median, range and Mann-Whitney U Test (Z scores) results for the two groups. The Bonferroni correction was used to protect against Type 1 errors and was also used because the hypothesis was tested using 30 tests. The 0.05 significance level is therefore adjusted to 0.00166 using the Bonferroni correction.

Tables 4.5.1 (I) to (III) present the range and median scores for the student counselling psychologist and clinical psychologist groups. The results show the hypothesis for the second aim is accepted for six out of 30 tests (1, 2, 17, 19, 24, and 25,), but rejected for 24 tests out of the 30 tests. The results clearly show that the two groups are significantly different, being less than 0.00166 (P= 0.05 is adjusted to P= 0.00166 using the Bonferroni correction, as previously described). Hypothesis 2 is rejected overall by 24 tests out of 30, and the null hypothesis is therefore accepted.

4.5.1 A comparison of clinical and student counselling psychologist's on *The Psychologist Role Definition Instrument* using the Mann-Whitney U Test (Z).

4.5.1. (I)

Psychologist Role Definition Instrument	Group	Median	Range	Z	p
Have had personal therapy	Clinical	3.00	2-5	-6.89	<0.000*
	Student	5.00	4-5		
Draw on a basic knowledge of psychopathology	Clinical	5.00	3-5	-4.22	<0.000*
	Student	5.00	3-5		
Undertake to study the use of psychometric tests if not included in initial training	Clinical	4.00	2-5	-3.00	=0.003
	Student	4.00	2-5		
Have further training in therapeutic skills following professional psychology training	Clinical	5.00	3-5	-0.01	=0.987
	Student	5.00	3-5		
Employ the principles of a 'scientist practitioner'	Clinical	4.00	2-5	-1.76	=0.078
	Student	4.00	2-5		
Conduct research	Clinical	4.00	1-5	- 0.49	=0.619
	Student	4.00	3-5		
Take responsibility for own lack of knowledge or skill and address this through further training	Clinical	5.00	4-5	-0.08	=0.934
	Student	5.00	4-5		
Keep up to date with the progress of their professional psychological division	Clinical	5.00	3-5	-0.39	=0.697
	Student	5.00	4-5		
Liaise with other professionals by speaking the 'same' language	Clinical	4.00	3-5	-0.88	=0.376
	Student	4.00	2-5		
Work in multidisciplinary teams	Clinical	4.00	2-5	-0.98	=0.326
	Student	4.00	3-5		

* Significant at the adjusted probability level 0.00166

4.5.1. (II)

Psychologist Role Definition Instrument	Group	Median	Range	Z	p
Work in a consultancy role to other professionals	Clinical	4.00	3-5	-2.87	=0.004
	Student	3.00	3-5		
Supervise other professionals	Clinical	4.00	3-5	-3.00	=0.003
	Student	3.00	2-4		
Train other professionals	Clinical	4.00	3-5	-2.56	=0.010
	Student	3.00	2-5		
Prescribe medication	Clinical	5.00	2-5	-1.23	=0.218
	Student	4.00	2-5		
Train in the 'therapeutic' use of assessment tests	Clinical	4.00	2-5	-2.48	=0.013
	Student	3.00	2-5		
Establish skills for recognising psychotic episodes for clients, so that they can be understood and coped with in a helpful way	Clinical	5.00	3-5	-0.24	=0.810
	Student	5.00	3-5		
Provide clinical supervision on cases to trainee clinical psychologists	Clinical	4.00	3-5	-3.48	<0.000*
	Student	4.00	2-5		
Work with a client despite misdiagnosis from a psychiatrist	Clinical	3.00	2-5	-1.55	=0.121
	Student	3.00	1-5		
Discuss with a referrer your assessment of an individual	Clinical	4.00	3-5	-3.46	<0.001*
	Student	4.00	1-5		
Have inadequate experience of secondary mental health care	Clinical	4.00	1-5	-2.42	=0.015
	Student	4.00	1-5		

* Significant at the adjusted probability level 0.00166

4.5.1. (III)

Psychologist Role Definition Instrument	Group	Median	Range	Z	p
Become a friend of a client	Clinical	5.00	1-5	-0.41	=0.678
	Student	5.00	1-5		
Co-work with other professionals	Clinical	4.00	3-5	-0.95	=0.338
	Student	4.00	3-5		
Shout at a client in therapy	Clinical	5.00	3-5	-0.56	=0.574
	Student	5.00	3-5		
Have limited formulation regarding therapy following an assessment session with a client	Clinical	3.00	1-5	-3.76	<0.000*
	Student	4.00	1-5		
See a client for therapy who arrives outside of their appointment session	Clinical	3.00	1-5	-4.50	<0.000*
	Student	4.00	2-5		
Be able to section a client	Clinical	4.00	1-5	-2.21	=0.027
	Student	3.00	1-5		
Provide clinical supervision to trainee counselling psychologists	Clinical	3.00	2-5	-2.27	=0.023
	Student	4.00	1-5		
Recommend a particular type of medication for a client	Clinical	3.00	1-5	-1.84	=0.065
	Student	4.00	2-5		
Without a client's consent, inform their family about their mental health problems	Clinical	4.00	2-5	-2.55	=0.011
	Student	5.00	3-5		
Work with more than one member of the same family for individual therapy	Clinical	4.00	1-5	-1.88	=0.059
	Student	4.00	2-5		

As thirty statistical tests are applied to the Psychologist Role Definition Instrument (30 tests as indicated in Table 4.5.1 (I-III), the 0.05 significance level is adjusted to 0.00166 using the Bonferroni correction. * Significant at the adjusted probability level 0.00166

4.5.2 Analysis of questions where statistically significant differences were found

The questions that show a significant difference between the two groups are listed below, with supportive qualitative comments to illustrate the differences.

Question 1. Have had personal therapy

The results to this test indicate clinical psychologists believe 'you may or may not' have had personal therapy; student counselling psychologists believe 'you absolutely must have had personal therapy, indicating that clinical psychologists do not see personal therapy as an essential element in the role of psychologist working with individuals who have enduring mental health problems. Two qualitative comments by clinical psychologists that illustrate this are:

- "*Personal choice*"
- "*Should of some kind, but not long-term psychotherapy particularly*" (sic)

Question 2. Draw on a basic knowledge of psychopathology

The results indicate that both groups believe 'you absolutely must' draw on a basic knowledge of psychopathology. The medians and range were similar for the two groups. There were no comments from the student group and only one comment came from the clinical psychology sample:

- "*Depends which knowledge base*"

Question 17. Provide clinical supervision on cases to trainee clinical psychologists

The results indicate that clinical and student counselling psychologists believe 'you preferably should' provide clinical supervision on cases to student clinical psychologists. Both groups believe that to provide clinical supervision on cases to student clinical psychologists is an important element in the role of a psychologist working with individuals who have enduring mental health problems, as indicated by the identical median scores in this test. The range showed a difference with the student groups ranging across the scale from two to five, and the clinical psychology group having a narrower range of three to five. This indicates that some of the students believe that 'you may or may not' provide clinical supervision on cases to trainee clinical psychologists. One comment supporting the quantitative results came

from the clinical group: this was that you must and should take on trainee clinical psychologists. There were no comments from the student group.

Question 19. Discuss with a referrer your assessment of an individual

The results reveal clinical and student counselling psychologists believe 'you preferably should' discuss with a referrer your assessment of an individual. The median scores suggest that clinical psychologists and student counselling psychologists believe that discussing with a referrer your assessment of an individual is an important aspect in the role of a psychologist working with this client group. The range differed for the two groups, with the clinical psychology group having a narrower range – three to five, from 'may or may not' through to 'preferably should' – while the range for the student counselling psychologists went from one end of the spectrum to the other. Comments that support the results from the clinical group were "*suggested written feedback*", "*a response within an agreed time frame for quality standard*" and another suggesting discussion by letter or report. There was one comment from the student group:

- "*To explain continued care*"

Question 24. Have limited formulation regarding therapy following an assessment session with a client

This question indicates a difference. While student counselling psychologists believed 'you preferably should not' have limited formulation regarding therapy following an assessment session with a client, the clinical psychology group believed that 'you may or may not' have limited formulation regarding therapy following an assessment session with a client. This indicates clinical psychologists believe it may not always be possible to have a formulation following an assessment session with a client. While there were no qualitative comments from the student group for this question, a comment from the counselling psychology group that supports the 'may or may not have limited formulation regarding therapy following an assessment session with a client' response is:

- "*Sometimes, depending on experience of therapist and complexity of client may not have clear formulation after first appointment, but should be aiming for this as soon as possible*"

Question 25. See a client for therapy who arrives outside of their appointment session

The results reveal that clinical psychologists believe 'you may or may not' 'see a client for therapy who arrives outside of their appointment session' in contrast to student counselling psychologists who believe 'you preferably should'. This indicates that student counselling psychologists believe it to be a more important part of a psychologists role than do clinical psychologists. Reflecting the 'may or may not' response recorded in the results, one clinical psychologist commented:

- "*Unless contract negotiates for client contact*"

4.6 Section five

Aim 3: Comparison of beliefs held by counselling and student counselling psychologists about their role as a psychologist when working with people who have enduring mental health problems.

Hypothesis: The responses of student counselling psychologists to the *Psychologist Role Definition Instrument* will be significantly different from those of counselling psychologists.

Tables 4.6.1 (I) to (III) present the median, range and Mann-Whitney U Test (Z scores) results for the two groups. As mentioned earlier in the methodology chapter, the Bonferroni correction was used to protect against Type 1 errors; it was also used because the hypothesis was tested using 30 tests. The 0.05 significance level is therefore adjusted to 0.00166 using the Bonferroni correction.

Tables 4.6.1 (I) to (III) present the range and median scores for the counselling and student counselling psychologist groups for the *Psychologist Role Definition Instrument.* The hypothesis is rejected for 29 of the 30 tests and the results clearly show that the two groups are not significantly different. The results for the one dissenting test (Question 24) clearly show that the two groups have significantly different beliefs at less than 0.00166 (P= 0.05 is adjusted to P= 0.00166 using the Bonferroni correction, as previously described) but the hypothesis is rejected overall by 29 out of 30 tests.

4.6.1 A comparison of counselling and student counselling psychologists on *The Psychologist Role Definition Instrument* using the Mann-Whitney U Test (Z).

4.6.1. (I)

Psychologist Role Definition Instrument	Group	Median	Range	Z	p
Have had personal therapy	Counselling	5.00	2-5	-0.81	=0.417
	Student	5.00	4-5		
Draw on a basic knowledge of psychopathology	Counselling	5.00	2-5	-2.27	=0.023
	Student	5.00	3-5		
Undertake to study the use of psychometric tests if not included in initial training	Counselling	3.00	1-5	-1.03	=0.299
	Student	4.00	2-5		
Have further training in therapeutic skills following professional psychology training	Counselling	5.00	3-5	-0.68	=0.491
	Student	5.00	3-5		
Employ the principles of a 'scientist practitioner'	Counselling	4.00	2-5	-0.49	=0.619
	Student	4.00	2-5		
Conduct research	Counselling	4.00	3-5	-0.83	=0.406
	Student	4.00	3-5		
Take responsibility for own lack of knowledge or skill and address this through further training	Counselling	5.00	3-5	-0.50	=0.616
	Student	5.00	4-5		
Keep up to date with the progress of their professional psychological division	Counselling	4.00	3-5	-1.82	=0.068
	Student	5.00	4-5		
Liaise with other professionals by speaking the 'same' language	Counselling	4.00	2-5	-0.62	=0.534
	Student	4.00	2-5		
Work in multidisciplinary teams	Counselling	3.00	2-5	-2.12	=0.034
	Student	4.00	3-5		

* Significant at the adjusted probability level 0.00166

4.6.1. (II)

Psychologist Role Definition Instrument	Group	Median	Range	Z	p
Work in a consultancy role to other professionals	Counselling	3.00	3-5	-0.55	=0.580
	Student	3.00	3-5		
Supervise other professionals	Counselling	3.00	2-5	-1.50	=0.132
	Student	3.00	2-4		
Train other professionals	Counselling	3.00	2-5	-0.12	=0.903
	Student	3.00	2-5		
Prescribe medication	Counselling	4.00	1-5	-0.58	=0.561
	Student	4.00	2-5		
Train in the 'therapeutic' use of assessment tests	Counselling	3.00	2-5	-0.89	=0.370
	Student	3.00	2-5		
Establish skills for recognising psychotic episodes for clients, so that they can be understood and coped with in a helpful way	Counselling	5.00	3-5	-0.21	=0.828
	Student	5.00	3-5		
Provide clinical supervision on cases to trainee clinical psychologists	Counselling	3.00	1-5	-0.66	=0.507
	Student	4.00	2-5		
Work with a client despite misdiagnosis from a psychiatrist	Counselling	3.00	1-5	-0.47	=0.636
	Student	3.00	1-5		
Discuss with a referrer your assessment of an individual	Counselling	3.00	1-5	-1.10	=0.269
	Student	4.00	1-5		
Have inadequate experience of secondary mental health care	Counselling	4.00	1-5	-1.37	=0.169
	Student	4.00	1-5		

* Significant at the adjusted probability level 0.00166

4.6.1. (III)

Psychologist Role Definition Instrument	Group	Median	Range	Z	p
Become a friend of a client	Counselling	5.00	1-5	-1.89	=0.058
	Student	5.00	1-5		
Co-work with other professionals	Counselling	4.00	3-5	-1.70	=0.089
	Student	4.00	3-5		
Shout at a client in therapy	Counselling	5.00	2-5	- 0.77	=0.439
	Student	5.00	3-5		
Have limited formulation regarding therapy following an assessment session with a client	Counselling	3.00	1-5	- 3.80	<0.000*
	Student	4.00	1-5		
See a client for therapy who arrives outside of their appointment session	Counselling	4.00	1-5	-2.10	=0.035
	Student	4.00	2-5		
Be able to section a client	Counselling	4.00	1-5	-2.39	=0.017
	Student	3.00	1-5		
Provide clinical supervision to trainee counselling psychologists	Counselling	4.00	1-5	- 0.57	=0.568
	Student	4.00	1-5		
Recommend a particular type of medication for a client	Counselling	4.00	1-5	- 0.09	=0.922
	Student	4.00	2-5		
Without a client's consent, inform their family about their mental health problems	Counselling	5.00	2-5	- 0.63	=0.523
	Student	5.00	3-5		
Work with more than one member of the same family for individual therapy	Counselling	4.00	1-5	-0.51	=0.610
	Student	4.00	2-5		

As thirty statistical tests are applied to the Psychologist Role Definition Instrument (30 tests as indicated in Table 4.6.1 (I-III), the 0.05 significance level is adjusted to 0.00166 using the Bonferroni correction. * Significant at the adjusted probability level 0.00166

4.6.2 Analysis of questions where statistically significant differences were found

The results for Question 24 have added importance, as it is the only question in the comparison between these two groups to yield a statistically significant difference between the two groups.

Question 24. Have limited formulation regarding therapy following an assessment session with a client

Student counselling psychologists believe 'you preferably should not' have limited formulation regarding therapy following an assessment session with a client. The counselling psychology group believed that 'you may or may not' have limited formulation regarding therapy following an assessment session with a client. This indicates that counselling psychologists believe it may not always be possible to have a formulation, limited or otherwise, following an assessment session with a client. While there were no qualitative comments from the student group for this question, one comment from the counselling psychology group that supports the 'may or may not' response is:

- "*There may be a situation where a psychiatrist or previous psychologist had made a full report and then one would only need to make a linked formulation if one agreed with the previous formulation*"

4.7 Section six

4.7.1 Summary of the overall results for the respondents' scores on the *Psychologist Role Definition Instrument*

The examination of the results as a whole reveals a statistically significant differences between the three groups for some of the questions, but overall the three hypotheses are rejected and the null hypotheses are accepted.

The *Psychologist Role Definition Instrument* revealed the counselling and student counselling psychology groups held a similar set of beliefs in contrast to the clinical psychology group. Only one question differentiated the counselling and student counselling psychology groups, while six responses to questions indicated

differences between the clinical and student counselling psychology group. Also, responses to 11 questions were found to be different between the clinical and counselling psychology groups.

There is seen to be a difference in the beliefs held about the role of a psychologist working with individuals who have enduring mental health problems between the counselling and student counselling psychology groups in comparison to the clinical psychology group. As the results indicate a high level of agreement rather than difference among the three groups, the hypotheses have to be rejected and the null hypotheses accepted. The reasons and possible explanations for this will be explored in the Discussion Chapter.

CHAPTER 5: Discussion

5.1 Overview

The objectives of Chapter Five are to discuss the findings of the main study, to link these findings (see Appendix Eleven for a summary) to counselling psychology research in the wider field and to examine what kind of 'differences' emerge. Findings relating to the three main hypotheses in the study are discussed, i.e. 1. The comparison of the beliefs held by clinical and counselling psychologists to the *Psychologist Role Definition Instrument*, 2. The comparison of clinical and student counselling psychologists and 3. The comparison of counselling and student counselling psychologists (5.1). Findings related to the demographic questions are also examined (5.2).

The findings suggest clinical and counselling psychology groups do hold different beliefs regarding their role as psychologist working with individuals who have enduring mental health problems, but reveal a greater overall similarity rather than divergent views. The exploratory analyses indicate the possibility that some differences in the beliefs held by the three groups may be reflective of specific aspects of the psychologist's role, such as multi-disciplinary teamwork or supervising other professionals. Only one difference was noted between the counselling and student counselling psychology groups: the need for formulation following an assessment.

5.2 *Psychologist Role Definition Instrument*

5.2.1 Similarities and differences of beliefs held as measured on the *Psychologist Role Definition Instrument*

The *Psychologist Role Definition Instrument* was used to test the three main hypotheses, all of which posit that the three groups would have different responses to the research instrument. The analysis of the responses of the participants largely rejected these hypotheses, indicating a greater convergence than disagreement of beliefs.

- Hypothesis one: Clinical and counselling psychologists will have significantly different responses to the *Psychologist Role Definition Instrument*

- Hypothesis two: Clinical and student counselling psychologists will have significantly different responses to the *Psychologist Role Definition Instrument*

- Hypothesis three: Counselling and student counselling psychologists will have significantly different responses to the *Psychologist Role Definition Instrument*

5.2.2 Teamwork

Psychologist's involved in the care of individuals who have enduring mental health problems are often required to work in teams. Primarily within the NHS this teamwork may be in a CMHT, where there is immediate contact with other professionals (Benanti, 2002).

Five questions examined teamwork or team-related issues:

- Liaise with other professionals by speaking the 'same' language
- Work in multidisciplinary teams (significant difference between the clinical and counselling psychology groups)
- Work in a consultancy role to other professionals (significant difference between the clinical and counselling psychology groups)
- Train other professionals (significant difference between the clinical and counselling psychology groups)
- Co-work with other professionals (significant difference between the clinical and counselling psychology groups)

Four of the five questions produced significantly different results between the clinical and counselling psychology groups. All of these questions may be seen as representing the interactive aspects of multidisciplinary teamwork in a psychologist's role when working with this client group and with other professionals involved in their care.

All the above differences are between the clinical and counselling psychology groups and account for a third of the statistically significant results in the total study, indicating that this is an area of distinct variation between the two groups.

5.2.2.1 Underlying paradigm

This variation of beliefs could be due to the underlying diverse nature of the two disciplines (Hart, 2005, Knight, 1995; Lane & Corrie, 2006; Smallwood, 2002; Stanley & Manthei, 2004; Stanley et al, 2005, Strawbridge, 2006), as clinical psychologists have traditionally received training that inevitably prepares them to work with other mental health care professionals as part of a team (Hughes & Budd, 1996; Newnes, 1995), while the traditional theoretical orientation of counselling psychologists is client-centered, with the focus being on the individual (Bellamy, 2005b; Howard, 1992; Lewis & Bor, 1998; Milton, 2006; Strawbridge & Woolfe, 1996, cited in Woolfe, & Dryden (eds); Strawbridge, 2006; Woolfe, 1996; Van Scoyoc, 2005b). Working within a team may therefore not necessarily be a natural mode of practice for counselling psychologists.

5.2.2.2 Identification with a therapeutic orientation

While the historical paradigm for counselling psychology is identified as being humanistic (Bor, 2006; Strawbridge, 2006; Van Scoyoc, 2005b), what is noted in this study is that a significant proportion of counselling psychologist's (34%) identify their therapeutic orientation as being integrative. This might appear to negate the above line of reasoning, given that one speculation explaining the difference in findings is theoretical orientation.

Perhaps it is possible that the historical orientation of counselling psychology (Frankland & Walsh, 2006; Smallwood, 2002; Woolfe, 1996) has a greater influence on the beliefs counselling psychologist's hold regarding teamwork than does their primary identification with a therapeutic orientation. This however is not supported by the results for the comparison between the clinical and student counselling psychologists.

Although it is possible that the integrative framework may well be predominantly humanistic, the data does not allow the extraction of this information. The nature of the Integrative framework is certainly an area worthy of examination in future studies.

5.2.2.3 Lack of role clarity

A further line of reasoning that might offer an explanation for these findings is the lack of clarity of role in counselling psychology, which as referred to in Chapter One is a relatively new discipline (Bor, 2006; Fellows, 1996; Golsworthy & Wilkinson, 1997; James, 1996; Knight, 1995; Milton, 2004; Milton, 2006; Willoughby & Ashdown, 2003). Moreover, counselling psychology has limited pre-existing relationships with other mental health disciplines and unlike clinical psychology it did not come into existence from within the NHS (Corrie & Callahan, 2000).

5.2.2.4 Setting for practice

The findings suggest counselling psychologists believe that teamwork is a less important aspect of a psychologist's role when working with individuals who have enduring mental health problems than do clinical psychologists. Supportive comments from counselling psychology respondents indicate the results are influenced by the setting one practises in, for example, private practice or NHS. However, the data reveals that more counselling psychologists work outside private practice settings (52%) than within them (48%), which would appear to contradict the qualitative comments on the importance of setting.

In realistic terms the lack of current practical teamwork experience may well have had a bearing on the findings for the counselling psychology group when compared to the clinical psychology group. The percentage of counselling psychologists working in private practice (48%) as opposed to in the NHS (34%) almost certainly would have this effect.

5.2.2.5 Student's beliefs

No difference was noted in the results for the comparison between clinical psychologists and student counselling psychologists. It is tempting to suggest that this similarity is due to the student's greater awareness of counselling psychology's role in the provision of secondary mental health care. This could be partly due to increased confidence in their ability to contribute as applied psychologists to this specialist area because of having undertaken internships within the NHS (Milton, 2001). This view is supported by a student counselling psychology respondent in the open response section, saying that they "*Usually would anyway*" (work in a multidisciplinary team). What can be interpreted from the data is that student

counselling psychologists believe teamwork to be important when working with this client group.

5.2.2.6 Potential area of concern

The issue of teamwork is potentially an area of concern for counselling psychologists, as multi-disciplinary work is an important aspect of working with this client group in the NHS (Lane & Corrie, 2006).

Findings in Benanti's (2002) study of potential employers (B grade clinical psychologists) indicated that "*One hundred per cent of the sample said they would like counselling psychologists to know more about multi-disciplinary working*" (Benanti, 2002, p. 31).

The research findings suggest that given their prevailing beliefs counselling psychologists may benefit from thought-provoking examination of the importance of teamwork. As this is an area of potential employment for counselling psychologists (Bor, 2006), training courses and the syllabus for the independent route would better serve their trainees' needs by placing greater emphasis on this aspect of applied psychology training.

5.2.3 Therapeutic boundary issues

Psychologists working with this client group need to be conscious that they often do not work in isolation but are possibly part of a package of care provided by a larger multidisciplinary team (Benanti, 2002; Hughes & Budd, 1996; Newnes, 1995). With this in mind the issue of therapeutic boundaries was examined through six questions:

- Discuss with a referrer your assessment of an individual (significant differences between clinical and counselling psychology groups and clinical and student counselling psychology groups)
- Become a friend of a client
- Shout at a client in therapy
- See a client for therapy who arrives outside of their appointment session (significant differences between clinical and counselling psychology groups and clinical and student counselling psychology groups)
- Without a client's consent, inform their family about their mental health problems

- Work with more than one member of the same family for individual therapy (significant differences between clinical and counselling psychology groups)

The six questions elicited a significant difference for three items when the clinical and counselling psychologist groups were compared, representing a quarter of the statistically significant results for the whole study. Importantly, two of these differences were also apparent in the findings for the comparison between the clinical psychology and student counselling psychology groups, and represented a third of the statistically significant findings for the student group. These two questions were, 'Discuss with a referrer your assessment of an individual' and 'See a client for therapy who arrives outside of their appointment session'.

5.2.3.1 Practical and ethical issues

Of the two questions outlined above the first question addressed the issue of confidentiality and the second one focused on the practical and ethical issues related to good practice. Although the qualitative comments section did not yield any insight into the underlying reasons for these different beliefs, one student counselling psychology respondent commented on the question 'Discuss with a referrer your assessment of an individual', saying they would do this *"To explain continued care"*. This suggested that a limited amount of information would be disclosed to the referrer only. Similarly, a clinical psychologist respondent reflected on the issue of confidentiality with the comment "*Whilst respecting confidentiality*". Despite a significant difference being indicated between the beliefs of the groups in the quantative results the qualitative comments reflect a similarity of beliefs.

5.2.3.2 Confidentiality within a context

Qualitative responses indicate that the clinical psychology respondents seemed to be more interested in the mode of communication than in the actual act of communication itself. This may indicate an expectation of the need to communicate with a referrer when working with individuals who have enduring mental health problems. The acceptance of open communications with referrers is associated with both a 'shared care approach' that is part of multi-disciplinary work, as well as with safety issues for clients who frequently have complex psychological and social needs (Benanti, 2002; Hughes & Budd, 1996; Newnes, 1995). Curiously, the median scores for the clinical and student counselling psychology groups were both 4 ('preferably

should'), perhaps indicating they actually held a very similar belief to the clinical psychology group despite the statistically significant difference.

5.2.3.3 Providing therapy to individuals from the same family

'Work with more than one member of the same family for individual therapy' produced a statistically significant difference in results for the comparison between the clinical and counselling psychology groups. The median scores were 4 ('preferably should not') for the two groups, indicating that in practice they both endorsed similar beliefs regarding the question despite a statistically significant difference being found.

Generally the qualitative comments were very similar from the two groups, reflecting the view that the only time it is appropriate to work with more than one member of the same family for individual therapy is in 'family therapy settings' or when doing preparatory work for 'couple therapy'. The median scores and comments show a realistic similarity between the beliefs of the three groups regarding the role of a psychologist when working with this client group, despite the fact that a statistically significant difference was found. In real world terms this might mean that for an individual client working with a psychologist from either discipline they might appear to be similar in their approach (Lane & Corrie, 2006; Miller, 2006), yet when examined as a group they are significantly different.

5.2.3.4 Similarity of beliefs held regarding boundary issues

The remaining three questions within this section indicate a similarity of beliefs held between the three groups. These are 'Become a friend of a client', 'Shout at a client in therapy' and 'Without a client's consent, inform their family about their mental health problems'.

These three questions generated a high number of comments from the groups, with respondents having strong beliefs about these issues. The exception throughout the study was the student counselling psychology group, which tended not to make additional qualitative comments. This could be because they might have believed they did not have enough experiential knowledge to add to the research as they were new to the profession.

All of the responses suggested similar beliefs being held on the topic of good therapeutic practice with this client group.

5.2.3.5 Breaching confidentiality

The final question concerning therapeutic boundary issues was 'Without a client's consent, inform their family about their mental health problems'. Given the earlier significantly different result when discussion of a client's assessment with the referrer was posited, it might have been speculated that a significant difference would be apparent here too. However, the three groups held similar beliefs about this boundary issue, regarding the act of informing a client's family as inappropriate. This issue yielded many comments from all the groups. Predictably, the reasons given for breaching confidentiality were to do with a client's mental incapacity and safety.

5.2.4 Professional issues

The beliefs regarding professional psychology matters held by the three groups did not vary significantly. Questions that explored this aspect of a psychologist's role were:

- Keep up to date with the progress of their professional psychological division
- Prescribe medication
- Work with a client despite misdiagnosis from a psychiatrist
- Be able to section a client
- Recommend a particular type of medication for a client

Two of the questions explored beliefs regarding some procedures that are not currently possible for registered psychologists within the UK, 'Prescribe medication' and 'Be able to section a client'. The three groups had similar responses despite the hypothetical nature of these questions. It could be argued that as it is not legal in the UK for psychologists to perform these two functions, the results would undoubtedly be similar.

However, the Likert Scale provides a range of scores and so a significant difference could have been indicated in the findings (Oppenheim, 1998). Although a range of beliefs was indeed expressed through the qualitative comments the quantitative results indicate similar beliefs among the three groups regarding professional issues.

5.2.5 Supervision

Supervision is recognised as an important requirement for applied psychologists in order to foster knowledge acquisition (DoH, 2004; Fortune & Watts, 2000; Lane & Corrie, 2006; Miller, 2006; Napier, 1993). Three questions focused on the topic of supervision:

- Supervise other professionals
- Provide clinical supervision on cases to trainee clinical psychologists (a significant difference between the clinical and counselling psychology group and between the clinical and student counselling psychology group)
- Provide clinical supervision to trainee counselling psychologists

5.2.5.1 Professional competencies

No significant difference was found between the three groups for the first question, and all three groups believed it was appropriate for applied psychologists to supervise other professionals when working with people who have enduring mental health problems. The term 'other professionals' referred to community psychiatric nurses (CPNs), social workers and occupational therapists as these mental health workers are commonly represented in CMHTs. Counselling psychologists commented on requiring specific training prior to supervising other professionals.

5.2.5.2 Difference in beliefs

When the question 'provide clinical supervision on cases to trainee clinical psychologists' was asked the responses indicated significant differences between the two counselling psychology groups on the one hand and the clinical psychology group on the other, with the counselling psychology groups believing it was not an essential element of a psychologist's role when working with this client group.

It is possible that counselling psychologists believe they do not have the appropriate skills to supervise trainee clinical psychologists – one respondent suggested the need for specific training in supervision – or they believe their professional training has not adequately prepared them for this role, resulting in a lack of confidence (Bor, 2006; Rowden, 2005). One qualitative comment made by a counselling psychologist reflected a view cited in other literature (Bor & Achilleoudes, 1999; DCoP, 2005b; Irving & Williams, 1995; James, 2005a; Rowden, 2005), that only clinical psychologists could supervise trainee clinical psychologists.

As was noted in Chapter One, an essential aspect of working with this client group is the therapist's ability to establish a therapeutic alliance with the client (Lane & Corrie, 2006; McWilliams, 2005; Strawbridge, 2002; Strawbridge, 2006). Despite this skill being associated with positive therapeutic outcomes (Finfgeld, 2004; Golsworthy, 2004; James, 2005a; McWilliams, 2005; Strawbridge, 2006), counselling psychologists do not believe it is part of their role to offer supervision to trainee clinical psychologists who work with individuals who have enduring mental health problems. This indifference to transferring the skills required to establish a therapeutic alliance appears inconsistent with counselling psychologists' appreciation of the role this dynamic plays in positive therapeutic outcomes.

Furthermore it fails to correspond with the DCoP draft strategic plan for 2005-2006, Section 17, which states: "*To promote our knowledge and skills with respect to clinical supervision, and specifically to 'market' the competency of clinical supervision as central to the practice of counselling psychology*" (BPS, 2005, p.1).

5.2.5.3 Appropriateness of training

When the supervision of counselling psychologist's is considered, the results for this question indicate that there is no significant difference between the three groups.

For counselling psychologist's working within the NHS there has often been little choice but to receive supervision from clinical psychologist's due to the low numbers of registered counselling psychologists (Milton, 2001a). Only one counselling psychology group respondent mentioned that supervisors '*preferably need to be a counselling psychologist themselves at least*'. It may then be seen as common for trainee counselling psychologists working in the NHS to have clinical psychologists as supervisors.

From the results in the study clinical psychologists appear to believe it is part of their role as a psychologist when working with people who have enduring mental health problems to provide clinical supervision to trainee counselling psychologists.

It might be considered unusual that the result did not indicate that clinical psychologist's might question the appropriateness of providing supervision to counselling psychologists. One reason for this might be because they have an established and accepted knowledge of enduring mental health problems and may therefore be perceived as the psychological experts in this area (Alexander, 1995),

with their training being embedded in the psychopathology/ illness model (Corrie & Callahan, 2000; Fitzgerald et al, 2005; Lane & Corrie, 2006; Strawbridge, 2006).

This background may engender a belief among clinical psychologists that endorses them to supervise other applied psychologists. However, clinical psychology training appears to place less emphasis on the reflective aspect of therapeutic work (Knight, 1995; Smallwood, 2002; Stanley & Manthei, 2004; Stanley et al, 2005, Strawbridge, 2006) – the processing of emotion and empowerment of the individual – even though this is associated with successfully working with this client group (DoH, 2004; Finfgeld, 2004).

The practice of holding the clients experiences as central to the therapeutic process may at times be difficult for clinical psychologists, given their training (Lane & Corrie, 2006; Strawbridge, 2006). This could lead to the trainee counselling psychologist feeling de-skilled, disempowered or confused (Rowden, 2005) – ironically perhaps paralleling their clients experiences.

There is some concern, as reflected by Milton, that the supervised placement often within the NHS *"is the forum where trainees get their first experiences of what it is like to be a therapist; where they develop confidence in their aptitude for this role, where they are able to develop a professional identity"* (Milton, 2001a, p.4). It is therefore important that these values are encouraged and nurtured during trainee development. There is, as suggested by Milton (2001a), every opportunity for each profession to gain from the experience of working with the other.

A further observation is that this similarity may be indicative of the increasing convergence of the two orientations towards a unified applied psychology way of working, where each specialisation gains from the experience of working with the other (Kinderman, 2005; Miller, 2006; Lane & Corrie, 2006).

A tentative speculation as to why the student counselling psychologists and clinical psychologists indicated similar beliefs is because they are echoing the beliefs of their supervisors. A future study might yield different results, because there are increasing opportunities for supervision by counselling psychologists (Bor, 2006).

5.2.6 Therapeutic issues

The differences in the philosophical underpinnings and value placed on reflective practice by clinical and counselling psychologists (Lane & Corrie, 2006; Leiper & Casares, 2000; Stanley & Manthei, 2004; Strawbridge, 2006; Van Scoyoc, 2005b) suggest that their beliefs regarding therapeutic issues when working with this particular client group might be different. Two questions examined this issue:

- Have had personal therapy
- Have further training in therapeutic skills following professional psychology training

5.2.6.1 Different perspectives

There was a significant difference between clinical and counselling psychologists and clinical and student counselling psychologists when considering beliefs about the importance of having had personal therapy. It might be considered interesting that the range of scores went from 5 ('absolutely must') through to 1 ('preferably should not') for both groups. This was unexpected, as some aspect of personal development through personal therapy is a fundamental requirement of training in counselling psychology (Crawford-Wright & Hart, 1997; Grimmer & Tribe, 2001), yet not for clinical psychology (Corrie & Callahan, 2000; Garrett & Davies, 1995; Morgan, 1993).

The clinical psychology group responded with a median of 3, while the median for the counselling psychology group was 4. This result was repeated when the clinical and student counselling psychology groups were compared. The 3, ('may or may not') result for the clinical psychology group would seem to suggest that approximately half of the respondents considered it important in the role of a psychologist working with this client group to undertake personal therapy.

This belief appears to correlate with the Garret and Davis (1995) study, which found that 44% of clinical psychologist respondents had independently undertaken personal therapy. A qualitative comment that seems to be reflective of this is, *'should of some kind, but not long term psychotherapy particularly'* (sic).

Despite the result being significantly different for the clinical group when compared with the two counselling psychology ones, the difference is not as extreme as could have been originally predicted and may be a reflection of the change that has taken

place in the profession of clinical psychology (Bor, 2006; Butler, 2006; Hall, 1993), with the two applied psychology professions potentially becoming closer both regarding this at times 'controversial' issue (Leiper & Casares, 2000; Miller, 2006; Macran & Shapiro, 1998).

5.2.6.2 Issue of self-confidence

There was no significant difference between the three groups to the question 'have further training in therapeutic skills following professional psychology training'. Once again this was unusual, particularly as clinical psychology training is not traditionally embedded in the practice of therapy, unlike counselling psychology (Corrie & Callahan, 2000; Hall, 1993; Smallwood, 2002; Ryder & Shillito-Clarke, 1999).

In terms of explaining this result perhaps one might again look at the issue of self-confidence that clinical psychology training seems to instil in its graduates. When applied psychologists graduate in clinical psychology they appear to do so with the belief that they are competently equipped with proficient therapeutic skills to work with individuals who have enduring mental health problems, which may be due to the legacy of working in the NHS.

The suggestion that there is a relative lack of confidence in ability held by the counselling psychology (Bor, 2006) and student counselling psychology group (Rowden, 2005) is tentatively postulated, as they also believed they 'absolutely must' have further training in therapeutic skills.

It might reasonably be considered that counselling psychologists have acquired in their training a high level of competency in the use of therapeutic skills. The 'absolutely must' response selection of may be interpreted as counselling psychologists perceiving their therapeutic skills training as inadequately equipping them to offer psychological therapy to this client group, potentially suggesting that counselling psychology training does not equip practitioners with confidence in their professional abilities.

The student counselling psychology group's responses were similar to the other two groups, possibly reflecting their status as trainees who appropriately recognise the need for further training. However, as the question is phrased 'Have further training in therapeutic skills following professional psychology training' this result could be

interpreted as a further indication of the lack of confidence or self-effacing aspect of counselling psychology that leads counselling psychologists to underestimate their own professional abilities in their core skills (Rowden, 2005). An alternative, positive, interpretation is that it reflects recognition of the importance of updating professional therapeutic competencies through CPD (Lane & Corrie, 2006).

5.2.7 Psychometric and assessment testing

The issue of psychometric testing has been perceived as controversial for counselling psychologists (James, 2005b; Sequeira & Van Scoyoc, 2004), not always sitting comfortably with the humanistic philosophy of this theoretical orientation (James, 2005b; Bellamy, 2005b; Lewis & Bor, 1998; Van Scoyoc, 2005b), yet being a core component of clinical psychology training (Corrie & Callahan, 2000). Two questions examined this topic in the study, and these were:

- Undertake to study the use of psychometric tests if not included in initial training
- Train in the 'therapeutic' use of assessment tests.

A significant difference was found between the clinical and counselling psychology groups for the question 'Undertake to study the use of psychometric tests if not included in initial training'. Given the philosophical differences spoken of earlier, this may come as no surprise. The median for the clinical psychology group was 4 ('preferably should'), indicating that the group believed this to be an important aspect of a psychologist's role.

A qualitative comment made by a clinical psychology group respondent stated: '*But this is included in all basic training of clinical psychologists. It would not be necessary for counselling*'. This statement *may* represent a view held by some clinical psychologist's that as counselling psychologist's performed a 'therapeutic' role it was neither necessary nor appropriate for them to use psychometric tests.

The counselling psychology group had a median score of 3 ('may or may not'). This could have been anticipated, as counselling psychologists might be expected to hold a belief that undertaking psychometric testing was a less important role for psychologists working with individuals with enduring mental health problems than therapeutic practice. One qualitative comment was: '*Although I ticked "preferably*

should", I felt that there may always be another psychologist who is experienced and could undertake this instead, if required'. This reflects the notion that psychometric testing is relevant in certain situations, echoing comments by James, (2005b); it also reveals the belief that psychologists with appropriate experience would be better placed to offer this service.

No significant difference was found between the clinical and student counselling psychology groups, once again possibly indicating the influence of clinical psychology values on student counselling psychologist's within the NHS.

In contrast to the previous question no significant difference was found between the three group's scores for the statement 'Train in the "therapeutic" use of assessment tests'. This result is surprising, implying a similarity in beliefs held by the applied psychologists irrespective of theoretical orientation and indicating a convergence of beliefs.

5.2.8 The role of research

The training of both applied psychology specialisations equips their practitioners to conduct research in order to provide an evidence base from which to offer effective interventions (Corrie, 2003; Lane & Corrie, 2006; Strawbridge, 2006). As reflected throughout the study, the differing underlying philosophical nature of the two applied training routes can at times result in 'research' and 'scientist-practitioner' being potentially interpreted very differently by the two groups (Corrie & Callahan, 2000; Hart & Hogan, 2003; Lane & Corrie, 2006; Pelling, 2000; Strawbridge, 2006; Walsh, 2003). Two statements explored this aspect of a psychologist's role when working with this particular client group:

- Employ the principles of a scientist-practitioner
- Conduct research

5.2.8.1 Different interpretations of scientist-practitioner

The results indicated a statistically significant difference, although the median scores for both groups were 4 ('preferably should') and both endorsed a full range of scores to the statement 'Employ the principles of a scientist-practitioner'. The significant difference found in these results may be reflective of the different understanding of what it is to be a 'scientist-practitioner', as illustrated by two comments from

counselling psychologists: "*Practitioners should not be hostile to the notion of scientist-practitioner, as some social constructionists seem to be", and "It depends whose definition is used*".

The results for the comparison between the clinical psychology and the student counselling psychology groups for this question do not correspond with the significant difference found earlier. Considering the results and comments above, this could be seen as surprising, but it may once again be related to student counselling psychologists serving their internships within the NHS where the norm is to be 'scientist-practitioners' through auditing and clinical evaluation (Hart & Hogan, 2003). Additionally, the students were in current training in an academic institute where the use of the term 'scientist-practitioner' would be in regular use with its meaning spanning all modalities of research practice. Either or both of these explanations could have influenced the results.

No significant difference was found between the three groups when 'conduct research' was considered. It could be postulated that it was interpreted as being unrelated to a particular theoretical framework, hence all the groups felt equally comfortable in believing that this was an important aspect of a psychologist's role when working with this client group. This result may then appear to run contrary to historical and popularly held beliefs that counselling psychologists are averse to research (Pelling, 2000; Spinelli, 2001).

Despite a difference in range, with counselling psychologists having a narrower range, no significant difference was found between the three groups beliefs regarding the question. The findings lead to a tentative speculation of a similarity emerging between the three groups in their beliefs regarding the importance of research.

5.2.8.2 Importance of science

The issues of 'research' and 'scientist-practitioner' are fundamentally important to both of the applied psychology disciplines. As observed by Corrie, (2003) "*It is difficult to challenge the principle of using research to inform our practice-related endeavours, given the profession's official endorsement of and allegiance to the scientist-practitioner model*" (Woolfe, 1996, in Corrie, 2003, p.6).

This statement leads one to query the difference noted in the findings of the 'scientist-practitioner' question. The medians and ranges were the same for the

clinical and counselling psychology respondents, indicating that any differences are minor in actuality and probably related to differing interpretations of the term from divergent phenomenological perspectives. Another factor is the large response rate that potentially could be picking up slight differences of understanding and resulting in these being seen as statistically significant.

It would be a major area of concern for the future of counselling psychology if this finding reflected an underlying belief among counselling psychologists that the 'scientist-practitioner model' is unimportant or irrelevant. Perhaps this attitude may reflect a belief that it is impossible to successfully combine the roles of a scientist with those of a practitioner, as put forward by Williams & Irving (1996) and explored by Lane and Corrie (2006).

5.2.9 Enduring mental health issues

The commonly held belief that counselling psychologists have neither the skills nor training to conduct psychological therapy with this client group (Van Scoyoc, 2005b; James, 2005a) was to some extent examined with these statements:

- Draw on a basic knowledge of psychopathology
- Have inadequate experience of secondary mental health care

In contrast to many of the previously reviewed results there was a significant difference between the clinical and student counselling psychology groups when the question 'draw on a basic knowledge of psychopathology' was examined. Despite the difference, the median scores (5, 'absolutely must') were identical for both groups.

5.2.9.1 Time in practice

In terms of length of time in practice, the students' lack of experience as practitioners *may* be a deciding factor in the significantly different results. The clinical psychology group had on average practised for just over 15 years whereas the student counselling psychology group had practised for just 18 months. If length of time in practice were a deciding factor, these findings would also have been expected when the counselling psychology group, who had practised on an average for 12-and-a-half years, are compared with the student group. This, however, was not found to be the case.

5.2.9.2 Therapeutic orientation

In terms of therapeutic orientation both the clinical psychology and student counselling psychology group respondents identified themselves primarily as cognitive behavioural therapists – almost 55% of clinical psychologists and 40% of student counselling psychologists – with the student group jointly endorsing humanistic at 40% as their primary orientation. This surprising similarity only further suggests that the two groups are actually overall very similar despite the result indicating a statistically significant difference for the question on psychopathology; differing fundamentally though in their practical experience with this client group.

5.2.9.2 Surprising similarities

With the result and tentative causes examined for the difference in beliefs held between clinical and student counselling psychologists, it seems curious that no difference has been recorded for the comparison between the clinical and counselling psychology groups. If the deciding factor for the statistically significant difference in results examined earlier for the clinical and student counselling psychology groups is the practical experience of working with this client group, then for there to be no difference reported between the clinical and counselling psychology groups leads to the assumption that counselling psychologists are also experienced in working with this client group.

This result may be considered all the more surprising given the group's primary places of practice, with 78% of clinical psychologists indicating the NHS and 47% of counselling psychologists private practice, where arguably they would have reduced contact with this client group.

The lack of difference is worth noting when the contextual background for the two applied psychology professions is considered (Bellamy, 2005b; Hart, 2005; Lewis & Bor, 1998; Van Scoyoc, 2005b). This result would appear to run contrary to views commonly held that counselling psychologists do not have the skills or training to work with individuals who have enduring mental health problems; the results appear to indicate they believe they have the competencies to undertake this work.

5.2.10 Differences and similarities in beliefs held between the counselling and student counselling psychology groups

There have been concerns about the implications of working within the NHS for the future of counselling psychology (Walsh, 2005). Reference has been made to the issue of having psychometric testing competencies: that is how this negates some criticism about lack of pertinent skills from 'competitors' (Milton, 2005c), but possibly comes at the cost of counselling psychologists having a 'potential divorce from our roots' (Walsh, 2005).

This study reveals that student counselling psychologists hold the same beliefs about their role as a psychologist working with individuals who have enduring mental health problems as registered counselling psychologists, all of whom had generally been practising for an average of 12-and-a-half years. There was one exception, 'Having limited formulation regarding therapy following an assessment session with a client': counselling psychologists believed that you 'may or may not' whereas student counselling psychologists believed that you 'preferably should' in response to this statement. With the additional information regarding the length of time in practice that the counselling psychology group had in contrast to the student group, the result could be understood in terms of clinical experience and the acknowledgement that this particular client group has complex needs (Willoughby & Ashdown, 2003) that take time to assess.

Qualitative comments that did seem to support the rationale for this opinion were "*If not would need a longer assessment period*" or "*I think one should have a rough idea what they intend to do in terms of therapy and desired outcomes, and a lot of this can often be done after initial assessment (which in my practice, can take 2-4 hourly sessions)*" (sic).

The acknowledgement that the assessment process sometimes takes several sessions often comes with experience and practice. The only question that differentiates the two groups is based on time in practice as a psychologist rather than being based on a philosophical difference or 'divorce' from the roots of counselling psychology training.

Despite there being only one difference between counselling and student counselling psychologists, it is also noted from the findings that the student counselling

psychology group were more similar in the beliefs they held when compared to clinical psychologists than counselling psychologists were.

This similarity between clinical psychologists and student counselling psychologists about working with this client group could be interpreted as a convergence of beliefs. Possible reasons for this result are:

- Clinical psychologists as internship supervisors and role models
- Internships within the NHS
- Greater understanding of enduring mental health problems due to NHS internships
- Particular structure of the City University course that produces students with these types of beliefs
- Therapeutic orientation being strongly identified as CBT

Taking into consideration the caveats above, the findings suggest a greater similarity emerging between clinical psychologists and student counselling psychologists.

5.3 Demographic results

The demographic results will be discussed sequentially, in the order that they were presented in the questionnaire.

5.3.1 Rationale for the age of respondents

The mean age of the counselling psychology group was higher than that of the clinical group, at 49 years of age and 44 years of age respectively. A possible explanation is that many counselling psychologists self-fund their own training (Bor, 2006; Kinderman, 2005; Van Scoyoc & Bellamy, 2005), possibly taking longer to complete their training and resulting in the older average age of respondents. When the length of time in years of being chartered (registered) and in therapeutic practice are considered, clinical psychologist's report that they have been in practice longest, with a mean of 15 years despite the higher mean age of counselling psychologists, who recorded a mean practice period of 12 years. The higher age but lower practice time may reflect time spent in other occupations by counselling psychologists before becoming chartered later in life, possibly due to the financial burden placed on them to pay for their training.

5.3.2 Rationale for the disparity in time to charter

Related to the above is the length of time respondents had been chartered – a mean of 10 years for clinical psychologists and five years for counselling psychologists. This again could be suggestive of the impact of self-funded training on the findings but is more likely to be an artefact arising from counselling psychology's infancy in the UK at the time the data was gathered. It is worth considering the historic context within which counselling psychology developed: when the division initially formed there were no accredited counselling psychology courses so most counselling psychologists at the time would have obtained chartership through the grandparenting route.

Another possible explanation is that given the length of time counselling psychologists had been in practice compared to their length of time as registered practitioners, it *may* be that some of the respondents had trained through the independent route and practised prior to registration. Most likely the bulk of the sample would have been grandparented.

5.3.3 Income

Clinical psychologists earn substantially more than counselling psychologists despite on average being younger. The highest percentage of clinical psychologists (36%) earned £40,000 plus, while the highest percentage of counselling psychologists (23%) earned almost half the amount of their clinical colleagues, in the £20,000 to £24,999 income bracket. The possible reasons for this discrepancy have been outlined above in regard to factors such as time in practice or being chartered. However, the mean time for being chartered was over five years – an important finding, as within the NHS five years of practice is often associated with a high spine point 'A' grade or even a 'B' grade posting, which attracts a higher income. This is not shown in the results, which appear to reflect a lack of parity of pay for counselling psychologists, an issue that has and continues to raise concerns for the discipline (Bellamy, 2004; Bor et al, 1997; Bor, 2006; Hart, 2005; James, 2004; James, 2005a; Kinderman, 2005; Miller, 2006; Thomas et al, 1999; Van Scoyoc & Bellamy, 2005).

CHAPTER 6: Limitations and strengths of the study

6.1 Overview

The present study reveals the similarities between clinical and counselling psychologists using the *Psychologist Role Definition Instrument* to examine beliefs held regarding the role of a psychologist working with individuals who have enduring mental health problems. Although it has attempted to overcome the complete lack of published work in the field, limitations also exist. A comprehensive discussion of both the limitations and strengths of the current work will contribute toward future research in this area.

6.2 Limitations of the study

Limitations of the current study are organised into the following categories: questionnaire design, distribution of the questionnaire, response rate, sample and statistics.

6.2.1 Limitations of the questionnaire design

The use of a questionnaire is generally associated with lower response rates than other research methods, with a lack of opportunity for respondents to ask questions, an inability to determine who fills in the questionnaire or under what circumstances (Bor & Achilleodes, 1999). This study, however, attracted a relatively high response rate of 39.73%, compared to the 34% for Bor & Achilleodes (1999) survey and similar responses for Street & Rivett (1996) and Doherty & Simmon (1996) as cited in Bor & Achilleodes (1999).

6.2.2 Analysis of items used in the questionnaire

For the purpose of the study the items selected in the final questionnaire were chosen through a calculation of their discriminative power.

A potential criticism of the method of selecting statements for the final questionnaire could be the choice of technique used for the '*item analysis*'. An alternative might have been a measurement of the statements' correlation coefficients, which would have involved calculating the total score for the questionnaire with the score for the item in the question subtracted from that. This may have resulted in a slightly different ranking of the questions selected but it is unlikely to have resulted in a very different selection of questions being chosen for the final questionnaire. The decisive factor for choosing discriminative power over the correlation coefficient was its recorded applicability with Likert Scale questions (Robson, 1997).

6.2.3 Scaling categories for responding to the *Psychologist Role Definition instrument*

The choice of the five-point Likert Response Scale was felt to be open to possible improvement. Comprising 'Absolutely must', 'Preferably should', 'May or may not', 'Preferably should not', and 'Absolutely must not', the scale could be considered too inflexible. One clinical psychologist made reference to the scaling with the comment: "*I don't believe in absolutes – there are far too many individual differences involved in anything like this and most of the Q's depend on personal choice!...*". One counselling psychologist commented: *"Don't like the word 'absolute' – too dogmatic - 'feel strongly' might be better*"; and a student counselling psychologist made reference to the scaling with: "*some questions depend on individual circumstances of the case, unsure how to answer them. Also I did not like 'must' and 'should's' neither would Albert Ellis!*"

Overall it would appear that respondents generally found the scaling system useable but that a theme of opinion regarding the 'absolute' nature of the scale is clearly expressed by a small number of them. An alternative suggestion for the wording might be a five-point scale consisting of the phrases 'Strongly agree' through to 'Strongly disagree'.

6.2.4 Potential risk of 'response sets'

The potential risk that respondents would respond to the questions in the 'response sets' described by Oppenheim (1998), was limited by the anonymity of the questionnaire. This should have moderated the 'social desirability' and the 'acquiescence' type of response sets which arise when respondents wish to be seen

in a certain way, causing them to agree to statements that they perceive to reflect professionally desirable beliefs rather than answering honestly.
The acquiescence set refers to the tendency to agree to 'generally plausible' statements like 'Keep up to date with the progress of their professional psychological division'. Screening all potential items that could fall into the 'acquiescence' response set out of a questionnaire is very difficult, and there is always the risk that respondents will reply to questions in a socially desirable way.

Clearly, research into why certain respondents feel compelled to respond in a certain way to particular questions is needed, as considered by Oppenheim (1998). It could be hypothesised that issues such as age, self-confidence or even professional identity might potentially have an impact on this type of response behaviour. Understanding this issue would be of value, particularly as factors such as self-confidence and lack of role clarity have been raised as possibly impacting on the findings of the study.

6.2.5 Structure of questions

Two of the questions used in the *Psychologist Role Definition Instrument* could be deemed by respondents to be 'double-barrelled' (Oppenheim, 1998), which may have made responding to them difficult. These questions were number 7 – 'Take responsibility for own lack of knowledge or skill and address this through further training' – and question number 16 – 'Establish skills for recognising psychotic episodes for clients, so that they can be understood and coped with in a helpful way'. None of the respondents raised concern about the possible ambiguity in the qualitative comments section.

In terms of the phrasing of questions, number 20 – 'Have inadequate experience of secondary mental health care' – included an item with a negative meaning to present a question that was 'weighted' in the opposite direction to many of the other statements, so that a balanced research instrument was attained as well as to test participants' concentration in order to ensure that responses were not automatically given.

As a result of the wording of the statement, one clinical and one counselling psychologist questioned if there had been a '*misprint*' and wondered if the intention of the researcher had been to use the word '*adequate*'. In contrast to this reaction, other respondents replied with comments, such as '*We need to have experience of*

secondary mental health care' (made by a clinical psychologist). Two comments by counselling psychologists were '*Psychologist's preferably should have experience of secondary mental health care*' and '*Everyone has to start somewhere*'. These three comments appear to show that the question has been correctly understood.

It is important to recognise that despite the potential methodological limitations identified in the phrasing of the questions, respondents still diligently completed the questionnaires fully and that just 1% of all respondents took issue with the construction of the questions.

6.2.6 Terminology

The study examined the role of psychologists working with individuals who have enduring mental health problems. The definition of 'role' was provided in the questionnaire to reduce any ambiguity regarding interpretation of the term, but it was assumed that respondents would be familiar with the term 'enduring mental health problems' hence a definition of the term was not included in the questionnaire. Comments were made by three counselling psychologists (again 1% of the total number of respondents) about the definition of the term 'enduring mental health problems'. These were:

- *"I had some problems defining enduring mental health problems…"*
- *"I had problems understanding what you meant by enduring mental health problems"*
- *"I would have appreciated a detailed definition of enduring mental health problems. My experience is that as a counselling psychologist I have a very different perception of what these are than many clinical psychologists"*

Despite the small number of comments a theme is being articulated, and a sentence defining the term would evidently be helpful in future research.

6.2.7 Topics not included in the questionnaire

While the research was complete at the time it was conducted, recent developments in the profession of counselling psychology would require additional statements, but it is not always feasible to incorporate these retrospectively as they were not researched through appropriate questions at the time. It is possible sometimes to

make an inference from certain information to other associated areas, but not all the time, and it would be naïve as a researcher to suggest that this was always possible. Recent developments have taken place around issues such as doctoral level training (Bellamy, 2005a; Frankland & Walsh, 2005; Martin, 2005), the BPS Register for Psychologists Specialising in Psychotherapy (Lane & Corrie, 2006; Milton, 2006; Strawbridge, 2006; Van Scoyoc, 2005b; Van Scoyoc & Bellamy, 2005) and proposals for changes to mental health services, from mental *'illness'* to mental '*health*' (Layard, 2005; SCMH, 2006). Statutory regulation through the HPC (Bellamy, 2005b; Sequeira, 2005a; Van Scoyoc & Bellamy, 2005) is one area that has been referred to in the background literature but not actually examined in the questionnaire. All four issues would have been interesting to explore, but including them in the study might not have yielded pertinent information to enlighten the debate about the similarity or difference of beliefs held regarding the role of psychologists working with individuals who have enduring mental health problems.

6.2.8 Investigator bias

The researcher attempted to address the phenomenon of 'investigator allegiance' (Paley & Shapiro, 2002) through a declaration of interest in the introduction section of the questionnaire (see Appendix Seven). It was hoped that using transparency might allow the reader to see any bias in the interpretation for themselves. The researcher acknowledges however the difficulty in remaining entirely neutral when the subject has meaning both personally and professionally. It can be noted that despite the researcher's best efforts to remain neutral, there may be investigator bias that might potentially limit the objective stance taken in the presentation of the material in the study.

6.2.9 Distribution of the questionnaire

The questionnaire could have been considered as a 'corporate' or 'institutional' piece of research, particularly as a BPS book catalogue was enclosed in the envelope with the questionnaire. This could have caused confusion for some respondents who may have thought the research was being conducted by the BPS, but this does not appear to have impacted negatively on the study response rate.

Different-coloured front sheets were used for each of the subject groups when the questionnaires were sent out so they could be identified easily for analysis purposes. This procedure was, however, unnecessary as subjects were identifiable from their

response to the question 'what type of chartered psychologist are you?" and the author would not repeat this in future research studies as it did not save time, aid the coding of information or reduce costs.

6.2.10 Response rate

There was a relatively high response rate for the questionnaire (39.73%; 294 out of 740) resulting in a very large sample size. When large samples are analysed, even relatively small or 'clinically insignificant' differences can be *statistically* significant. (Statpac, 2006).

6.2.11 Student sample

The researcher was uncertain about including the data from the student group in the study. The rationale for this was:

- Relatively small response rate, at 13.3%
- Limited ability to generalise the results due to the student respondents being drawn from one academic institution, giving a narrow sample pool
- Results mirrored the registered counselling psychology group with the exception of one question (covered in more detail in Chapter Six, section 5.1.7.3). The students' results added little additional information to the study when a comparison is drawn with counselling psychologists.

6.2.12 Statistics

In addition to providing transparency (see 6.1.8), the data was analysed after consultation with an independent statistician using a conservative method of analysis. Furthermore, the Bonferroni correction/adjustment procedure was used to maintain methodological rigour. However, the use of the procedure might result in the findings being interpreted too conservatively with respect to uncovering different beliefs between the three groups. The use of the Bonferroni correction is contentious, with one view being that it is necessary when more than one statistical test is conducted in order to maintain methodological rigor. Moreover, some statisticians reason that because of the associated increase in risk of Type II errors its use could at times be superfluous or even harmful in some studies (Perneger, 1998).

6.3 Strengths of the study

Despite the limitations discussed above, the thesis provides a snapshot of the state of the counselling psychology division in the closing years of the 1990s. It also addresses the complete lack of previous work by providing the first examination of beliefs held between clinical and counselling psychologists regarding the role of a psychologist when working with individuals who have enduring mental health problems. The current study's strengths are addressed in the following sections: study design, strengths of Likert Scale, sample, distribution of the questionnaire, measures, validity of the study and respondent report.

6.3.1 Study design

6.3.1.1 Strengths of the questionnaire design

The structure of the main body of the study was a postal questionnaire. Recognised advantages for this mode of research are (Bor & Achilleoudes, 1999; Robson, 1997):

- Access to respondents is unhindered by geographical location or time
- Economical means of gathering information, both financially and with regard to time
- As the research was a national study of counselling psychologists compared with clinical psychologists, a large sample was involved, and the use of the questionnaire allowed minimisation of the time spent processing paperwork and results
- The structure of the questionnaire reduced 'investigator bias' through the use of transparency, and interviewer bias was not raised by any of the respondents as an issue

6.3.1.2 Strengths of the Likert Scale

The main body of the questionnaire used a Likert Scale for several reasons:

- It gave a "*systematic procedure so that we can demonstrate that the different items are related to the same attitude*" (Robson, 1997, p. 256). There was a risk of assuming that because the respondents were applied psychologists or psychologists in training that they would share similar beliefs. The Likert

Scale is able to separate people in the same group, which was important for the research

- As no suitable pre-designed research instrument that would measure the key areas necessary existed one had to be developed. A Likert Scale, with its ease of design, aided the development of the questionnaire
- An increased response rate through using this type of questionnaire was anticipated, Robson (1997), reported that Likert Scales are generally found to hold the attention of the respondents better, which tends to generate more thoughtful answers rather than perfunctory ones
- They are considered to be more pleasing to the eye and familiar to respondents as they are often used in magazines and newspapers for quizzes
- They are generally found to be reliable due mainly to the fact that there is a large range of answers the respondents can choose from (Oppenheim, 1998)

The use of the scale was considered to be partly responsible for the relatively high return rate for the study.

6.3.2 Sample

This is the first national study that compares the beliefs held by clinical and all registered counselling psychologists in the UK about their role as a psychologist when working with people who have enduring mental health problems.

The sample group included 38% of all the registered counselling psychologists in the UK at the time of the study being undertaken. The resulting beliefs are therefore likely to be fairly representative of the population of counselling psychologists in the UK.

In addition to the national survey of counselling psychologists, a student group was also examined, the resulting trend in the similarity emerging between the 'applied psychologies' regarding their beliefs seems to be supportive of recent discussions concerning the interrelationship emerging from the different divisions of 'applied psychologists' (Bellamy, 2005b; Bellamy & Van Scoyoc, 2005; Bor, 2006; Lane & Corrie, 2006; Miller, 2006; Van Scoyoc, 2005b). The inclusion of the student sample enabled this trend to be documented.

6.3.3 Distribution of the questionnaire

The questionnaire was sent out by the BPS. Overall, this was a positive decision and may have contributed to the relatively high response rate of returns at 39.73%, almost 6% higher than rates reported in other postal studies (Bor & Achilleoudes, 1999). Another possible reason for the high response rate could be attributed to an incentive being offered in the form of the £80 worth of book vouchers.

The content of the cover letter was intended to interest each of the subject groups by increasing their feelings of *'social responsibility'* for their particular professional psychological group membership. The *'altruistic'* rationale of completing the questionnaire for the greater good of the development of the Division of Counselling Psychology for the Counselling Psychology participants could additionally have been interpreted as an 'incentive' by these respondents.

6.3.4 Validity of the study

The use of the Likert Scale as discussed above increased the validity of the study. The fact that the findings are as a result of a national poll implies that the beliefs reflect a large portion of the registered counselling psychologist's views at the time of the study (see Section 6.2.2). Preliminary work undertaken to increase the validity of the study:

- Rigorous pilot study that included consultations with senior experienced psychologists involved in the provision of psychological services to clients with enduring mental health problems
- Conservative methodologies employed for statistical analysis based on advice from expert statisticians
- Literature referred to in the study was published in recognised peer-reviewed journals of high academic standing

In terms of the validity of the *Psychologist Role Definition Instrument,* all of the questions used following item analysis had a high level of discriminative power to the total score and were a good 'fit' (Oppenheim, 1998; Robson, 1997). The beliefs under examination through comparison of the applied psychology groups were deemed appropriate and relevant, and appeared to have been considered so by the respondents in the final study.

6.3.5 Respondents' comments

The qualitative comments regarding the research topic indicated that a chord was struck with the respondents. Comments from the clinical and particularly the counselling psychology group applauded the relevance of the research. Some examples of comments were:

- "*I am very pleased to see this work happening…*" (clinical)
- "*Only minor niggles in a worthwhile research project…*" (clinical)
- "*Thank you for your work in preparing this useful and important piece of research*" (counselling)
- "*As a chartered counselling psychologist who applied (successfully) for a clinical psychology vacancy, your ?'s touch on many issues I deal with/question re my role. Therefore your research is very interesting, I think, and will provide much needed information*" (counselling)

The respondent groups articulated a clear theme that is a strength of the research, in that this area needs to be examined not only for the future of applied psychology but also for the implication that this has on client care.

The next chapter explores the implications of the findings and suggests possible developments.

CHAPTER 7: Implications and future developments

7.1 Overview

The central theme supported by both the quantative findings and qualitative comments is that clinical and counselling psychologists are more similar than different in their beliefs about their role as psychologist when working with individuals who have enduring mental health problems. This preliminary investigation has raised several questions for further exploration, which have been highlighted in the Discussion and Limitations Chapters.

7.2 Philosophical underpinnings and similarities

The notion that applied psychologists are tied inextricably to the roots of their profession is both disturbing and encouraging disturbing if the interpretation is too prescriptive, encouraging if the 'essence' of professional genesis endures. Hall (1993) comments on values shared by the two divisions that are allowing convergence to occur: "*the concept of mutualism between disciplines can further release us from the restraints acquired early in our academic background*" (Still & Good, (1992). In Hall, 1993. p.5). Current discussions regarding joint training paths for applied psychologists (Kinderman, 2005; Miller, 2006; Van Scoyoc & Bellamy, 2005; Van Scoyoc & Douglas, 2006), would seem timely when the similarity of the results are considered in the wider context of psychological therapy provision and proposals for applied psychology training.

A theme noted by Bechtoldt et al, (2001), regarding similarity between the two disciplines was "*only modest differentiation and considerable commonality*" (Bechtoldt et al, 2001, p. 6). This USA study of clinical and counselling psychology discovered that convergence of the two disciplines was taking place and that they were not growing further apart. Future research is needed in the UK to determine whether this trend is occurring here as well.

It is hoped this study contributes to the body of applied psychology knowledge, with regard to the complex dynamic process of the beliefs held by applied psychologist's when working with individuals who have enduring mental health problems.

7.3 Wider systems

Applied psychologists need to be aware of the wider system within which they operate, both for themselves as a profession and also for the clients that they work with (Milton, 2005a; Milton, 2006). In order to help individuals overcome difficulties, it is important that psychologists keep an eye on the internal and external factors such as social and political ones, that affect individuals both professionally and therapeutically (Van Scoyoc, 2005b). This theme is echoed by Bellamy, (2005a: "*Perhaps we need to do the same with respect to applied psychology, both for the health of the profession and for the benefit of the wider society*" (Bellamy, 2005a, p. 35).

The recent policy paper *'The future of mental health: a vision for 2015'* (SCMH, 2006) potentially has major implications for applied psychology in particular, as it proposes fundamental changes to mental health from an illness model to one of wellbeing:

> *"The focus of public services will be on mental wellbeing rather than on mental ill health. The balance of power will no longer be so much with the system, but instead there will be more of an equal partnership between services and the individual who uses, or even chooses, them."*
>
> (SCMH, 2006, p. 1)

This proposed philosophical shift to mental health care in all public services could move the treatment of people with enduring mental health problems closer to the traditional counselling psychology approach. Van Scoyoc's (2005b) advice of the need for counselling psychologists to become more socially and politically aware seems all the more pressing against the background of the SCMH paper.

7.4 Multidisciplinary teamwork

Beliefs regarding teamwork emerged as the main difference in the findings of the study between the clinical and counselling psychology groups. The importance of having experience and knowledge of multi-disciplinary teamwork is accepted as an essential need (Benanti, 2002) when working within the NHS with this client group. Benanti (2002) recognised this was an issue when 'B' grade clinical psychologists raised concerns about counselling psychologists' perceived lack of experience of teamwork.

'Lack of experience and knowledge of multi-disciplinary teamwork is viewed as a shortcoming that could perhaps hold back counselling psychologists from future employment opportunities as applied psychologists within the NHS. This may be particularly important when it is considered that approximately half of all registered counselling psychologists are employed in the NHS (Van Scoyoc & Bellamy, 2005). Furthermore, Layard (2005) estimated, in a paper he delivered at the Sainsbury Centre for Mental Health (SCMH) entitled *Therapy for all on the NHS,* that 10,000 more therapists were needed within the NHS to meet the psychological needs of individuals suffering from mental health problems. If counselling psychologist's are to be included in this number then multi-disciplinary teamwork should be incorporated as a topic in training course curricula. This could be done without impacting on the underlying theoretical philosophies of counselling psychology.

While Milton (2005c) has questioned the possibility of incorporating any other information into a already 'packed' curricula, this issue is arguably too important not to be included in the training of counselling psychologists as it influences not only employment opportunities for counselling psychologists but potentially the client group that multidisciplinary teams serve. In order to provide competent therapeutic interventions, counselling psychologists need to be aware of the wider context (Milton, 2005b; Milton, 2006; Mytton, 2005) within which this client group's mental health needs are generally provided.

As counselling psychology aims to work with individuals in a holistic way it would seem fitting that practitioners in this division have an understanding of the services and systems that provide the psychological therapies to this client group.

Overall, the findings suggest a stronger similarity than difference among applied psychologists in their beliefs about working with individuals who have enduring mental health problems.

Interestingly, of the student counselling psychologist and counselling psychologist groups, the students registered beliefs most similar to clinical psychologists. This result suggests an interesting future for counselling psychology as it may indicate convergence is already occurring in the beliefs the groups hold. This convergence may be beneficial, as aspects of counselling psychology training such as empowerment, reflective practice and the therapeutic alliance, are vital to the effective psychological treatment of this client group (Finfgeld, 2004; Golsworthy, 2004; Lane & Corrie, 2006; McWilliams, 2005). These factors may have a greater onus placed on them due to this melding of practice and to changes indicated in government policy regarding mental health care (SCMH, 2006).

Yet, although student counselling psychologists are identifying with the majority of clinical psychology beliefs, the findings also indicate they are not 'divorcing' themselves from their philosophical roots (Walsh, 2005).

7.5 The reflective practitioner

Several lines of future investigation *may* be warranted given the underlying differing paradigms on which the professions are based and the differences that emerged in the findings of this investigation regarding reflective practice. These include researching the role of personal development through individual therapy and its possible impact on a psychologist's ability to provide effective and empowering therapy to individuals who have enduring mental health problems.

The reflective aspect of a counselling psychologist's training is one of the defining factors that separate it from other applied psychology disciplines (Lane & Corrie, 2006). Understanding reflective practice is probably best suited to qualitative investigation, as dynamics such as empowerment, the therapeutic alliance or personal meaning cannot be easily quantified (Strawbridge, 2006). This is particularly true of this client group, for whom these dimensions play an important role in the

positive outcome of therapy (Finfgeld, 2004; Golsworthy, 2004; McWilliams, 2005; Vogel, 2005).

7.6 Accredited training courses

At the time of writing 37 accredited training courses in counselling psychology exist in the UK in addition to the independent training route, and 65 accredited training courses for clinical psychology (BPS web site accessed 3rd January 2006b).

There are 3,745 chartered clinical psychologists currently employed in the NHS compared to 517 chartered counselling psychologists (DoH, 2005), with the Division of Counselling Psychology claiming over 1000 members (Frankland & Walsh, 2005). These figures suggest that approximately half of the registered counselling psychologists in the UK are employed in the NHS (Van Scoyoc & Bellamy, 2005), an increase of over 15% in the seven years since the results for this research were collated.

The growth in the number of accredited counselling psychology courses means the number of qualified counselling psychologists entering the profession will increase considerably each year. With this in mind it would appear prudent for counselling psychology to establish both a sense of competency when working with individuals who have enduring mental health problems and an evidence base from which to promote their discipline.

It seems reasonable to suggest that *if* counselling psychology advances towards being established as an applied psychology body regulated through the HPC (Van Scoyoc, 2005a), it *may* lead to increased numbers of accredited counselling psychology training courses (BPS web site accessed 30/08/05) and the potential increase in numbers of registered counselling psychologists working with individuals who have enduring mental health problems in the NHS. This will all potentially impact on the beliefs and attitudes held by the counselling psychology division.

Another area worthy of future attention would be to 'partial out' the training route that the counselling psychologist had undertaken. It may be of value to examine if registering through the independent route as compared to taught courses results in

different beliefs being held by the psychologist. There are potentially 'real life' implications for the development of the division and for the provision of psychological care to this client group.

7.7 Supervision

As reported in the Discussion chapter, supervision is believed to be appropriate depending on who the recipient is. What is beyond question is the importance of supervision for applied psychologists' (Lane & Corrie, 2006) with counselling psychology particularly holding it central to its professional practice (BPS, 2005).

A supervisor's professional identity may well have an impact on a trainee's development, so not only do counselling psychology training courses need to equip their trainees with appropriate knowledge and experience of multidisciplinary work and NHS practice, but also ideally with experience of a counselling psychologist as a supervisor and role model in this environment.

It is increasingly likely that counselling psychologists acting, as supervisors will become a reality, as Bor, (2006), reports they are now *"employed in almost every NHS Trust in the country"* (Bor, 2006).

Exploring the professional identity of the student counselling psychologists' supervisors may well have shed light on some of the results found in the study. Supervision would seem the ideal forum for cross-pollination within the applied psychology disciplines but for this to occur counselling psychologists will first need to change the beliefs they hold about the importance of providing supervision to trainee clinical psychologists when working with this client group. Similarly, the views held within the NHS regarding the ability of counselling psychologists to supervise (Rowden, 2005) will also need to be modified.

7.8 Promoting professional relationships

In the words of Martin Milton (2005d):

> *"The work of counselling psychologists is again tougher and more complex than the soft and fluffy stereotype would have people believe. In fact, I think that this is often used to diminish the reality of what a counselling psychologist does."*
>
> (Martin Milton (2005d, p. 2)

It is the researcher's aim to present through this research the similarity of beliefs held by clinical and counselling psychologist's about working with individuals who have enduring mental health problems. It is hoped the research will contribute to illuminating the tougher and more complex side of counselling psychology rather than the 'soft and fluffy'. It seems that self-promotion as a theme is still of paramount importance to counselling psychology and has been commented on by several authors (Guernina, 1995a; Guernina, 1995b; James, 1995; Lloyd-Elliott, 1995; Sequeira, 2005b). There would appear to be a need for counselling psychology to promote itself as a competent provider of secondary mental health care.

This need is perhaps best summed up by a comment from a counselling psychologist reported by Sequeira (2005b, p. 1): *"We are very good at listening but we have to start speaking"*. The division risks becoming marginalised if it remains silent about its beliefs, abilities and professional capabilities. It is hoped this study will contribute to the development of the evidence base that is required for counselling psychologists to be seen as well as heard as practitioners skilled to work with individuals who have enduring mental health problems.

Milton (2006), has cautioned that perhaps we need to be careful of what our wishes are as they might just become reality. It would be disturbing if counselling psychologists were employed to work with individuals who have enduring mental health problems simply because they were seen as a cheaper alternative to clinical psychologists. It is hoped that this study will stimulate further research in this area, as counselling psychology begins to mature beyond its infancy years into its second decade of existence as a division within the BPS (Frankland & Walsh, 2005; Sequeira, 2005c; Miller, 2006; Woolfe, 2006).

Now would appear to be the time for counselling psychology to move beyond inward speculation and to focus instead on the abilities and skills they can offer as applied psychologist's working with this client group. Counselling psychology is now of an age to assertively and appropriately claim its place as an applied psychology discipline of equal standing alongside clinical psychology. It still has much to aspire to, however, in terms of parity of pay, funded placements and career advancement (Miller, 2006; Milton, 2006).

Furthermore, a growing evidence base of counselling psychology's appropriateness of providing care for this client group will instil greater confidence in the profession about its abilities. This will in turn empower members of this division to assert themselves to gain equitable treatment.

While the study was completed in 1998 it seems that it has 'come of age' in terms of mirroring current issues and beliefs. For example, the impact of teamwork, the relevance of being a reflective practitioner and the importance of supervision are at present vigorously debated in the area of counselling psychology and the broader family of applied psychology (DCoP, 2005; Kinderman, 2005; Lane & Corrie, 2006; Layard, 2005). Moreover, the core skills that counselling psychologists possess are now being promoted within policy papers (SCMH, 2006) as the way forward for the treatment of mental health problems rather than focusing on the 'illness' model.

7.9 Suggestions for further research

Given that seven years have passed since the questionnaires for this study were sent out, replication of the research with updated pertinent 'belief' questions would add to the much-needed evidence-base for this research area and for the development of applied psychology and counselling psychology particularly.

A key finding from the study is the closer similarity in beliefs found between the clinical psychology and student counselling psychology groups, especially regarding psychometric testing and being a scientist-practitioner, when compared to the observed similarity between the clinical and counselling psychology groups. Expansion of the subject groups through inclusion of students from different academic institutions and the independent route would be advisable in order to be

able to generalise the results from the student group to all student counselling psychologist's.

The increased similarity between the applied psychology disciplines clearly has implications for the future of psychology in general and counselling psychology in particular. Future research ought to address these and other important questions. Furthermore, it would seem appropriate that applied psychology development is user-led and based on client needs rather than on what different disciplines regard as being important (Miller, 2006).

Other aspects that warrant further attention are the effectiveness of interventions offered by applied psychologists to this client group; what clients find helpful; and how this might be provided differently or similarly by the two applied psychology groups. In view of the proposals contained in the SCMH policy paper regarding user-lead services, it would seem pertinent to ask individuals with enduring mental health problems about their experiences of the similarities and differences in practice between the two applied psychology divisions. Qualitative research into what this client group finds useful and empowering might be a powerful and 'real' means of examining the different skills and strengths developed during the training of clinical and counselling psychologists.

While this research is a record of the state of the division in 1998, current literature indicates that some of the more contentious issues are still being debated in applied psychology circles both in the UK and abroad (Pelling, 2004; Munley et al, 2004; Walsh et al, 2004).

On the basis of the beliefs examined in this study, the future for counselling psychology indicates favourably towards joining assertively with it's nearest applied psychology relative – clinical psychology – and doing so on an equitable yet distinct basis within the family of applied psychology.

REFERENCES

Alexander, P. (1995). Adult mental health psychology services: a declining future? *Clinical Psychology Forum,* 78: 18-23.

Allen, C., Austin, S., Palmer, S. & Street, E. (1994). Recognising the developmental process of clinical psychology training: clues from the South Wales course developmental tutor system. *Clinical Psychology Forum*, 70: 19-22.

Ashcroft, J. & Turpin, G. (1994). Clinical psychology postgraduate training: meeting the shortfall. *Health Manpower Management*, 20, 2: 35-36.

Bartlett, S. (1997). How to convince prince charming that the shoe fits: or (some of) the struggles to become a counselling psychologist. *Counselling Psychology Review*, 12, 1: 37-38.

Bartram, D., Lindley, P. & James, I. (1995). National Vocational Qualifications, continuing professional development and the future practice of applied psychology. *Counselling Psychology Review*, 10, 3: 20-24.

Bechtoldt, H; Norcross, J. Wyckoff, L. & Pokrywa, M. (2001). Theoretical orientations and employment settings of clinical and counselling psychologists: a comparative study. *The Clinical Psychologist.* 54, 1: 3-6.

Beech, J. R. (1986). Clinical psychology and the medical model. *Psychological Reports,* 59: 75-78.

Bellamy, A. (2000). An evaluation of the clinical effectiveness of a counselling psychology service in primary care. *Counselling Psychology Review,* 15, 2: 4-12.

Bellamy, A. (2004). The British Psychological Society: The 2004 Annual Report: *Division of Counselling Psychology (DCoP).* Leicester. British Psychological Society: 30-31.

Bellamy, A. (2005a). Letter from the Chair. *Counselling Psychology Review,* 20, 1: 35.

Bellamy, A. (2005b). Letter from the outgoing Chair. *Counselling Psychology Review,* 20, 2: 34-35.

Bellamy, A. (2005c). Health Professions Council (HPC) consultation response from the DCoP. A response to the DH consultation. 'Enhancing public protection: Proposal for the statutory regulation of applied psychologists'. *Counselling Psychology Review,* 20, 2: 67-69.

Bellamy, A. (2005d). *Division of Counselling Psychology: Twelfth Annual General Meeting, Agenda.* Leicester. British Psychological Society.

Benanti, J. (2002). Are counselling psychologists experiencing 'a clinical apartheid' within the NHS? *Counselling Psychology Review*, 17, 1: 28-33

Bor, R. (1995). Division of Counselling Psychology, Standing Committee for Scientific Affairs. *Counselling Psychology Review*, 10, 4: 22-23.

Bor, R. (2006). A brief reflection on counselling psychology. *Counselling Psychology Review*, 21, 1: (In press).

Bor, R., & Achilleoudes, H. (1999). Survey of BPS Division of Counselling Psychology members; 1999. *Counselling Psychology Review*, 14, 4: 35-45.

Bor, R., Watts, M. & Parker, J. (1997). Financial and practical implications of counselling psychology training: a student survey. *Counselling Psychology Quarterly*, 10: 69-76.

British Psychological Society. (2005). *Division of Counselling Psychology Draft Strategic Plan for 2005-2006.* Leicester. British Psychological Society.

British Psychological Society. (2006a). DCoP: The Division of Counselling Psychology. Leicester: British Psychological Society. Online available HTTP: www.bps.org.uk/dcop/about.cfm

British Psychological Society. (2006b). Careers :areas: counselling: Leicester: British Psychological Society. Online available HTTP: www.bps.org.uk/careers/areas/areas_home.cfm (accessed 3rd January 2006).

Butler, C. (2006). Psychology students – This time it's personal. *The Psychologist*, 19, 1: 45.

Carpenter, J., Schneider, J., Brandon, T. & Wooff, D. (2003). Working in multidisciplinary community mental health teams: The impact on social workers and health professionals of integrated mental health care. *British Journal of Social Work,* 33, 8: 1081-1103.

Catty, J. (2004). 'The vehicle of success': Theoretical and empirical perspectives on the therapeutic alliance in psychotherapy and psychiatry. *Psychology and Psychotherapy: Theory, Research and Practice*, 77, 2: 255-272.

Clark, H. (1994). Professional training in psychology. *The Psychologist*, 7, 10: 462-463.

Clarkson, P. (1998). News and views from the chair of the society counselling psychology diploma examinations board. *Counselling Psychology Review*, 13, 1: 42-44.

Cohen, L. (1995). Continuing professional development for clinical psychologists: carrot, stick or cattle prod? *Clinical Psychology Forum*, 76: 31-40.

Collins, S. & Murray, A. (1995). A pilot project employing counselling psychologists within an adult mental health clinical psychology service. C*linical Psychology Forum*, 78: 8-12.

Corrie, S. (2003). Keynote paper – Information, innovation and the quest for legitimate knowledge. *Counselling Psychology Review*, 18, 3: 5-13.

Corrie, S., & Callahan, M. (2000). A review of the scientist-practitioner model: reflections on its potential contribution to counselling psychology within the context of current health care trends. *British Journal of Medical Psychology,* 73, 3: 413-427.

Corrie, S., & Callahan, M. (2001). Therapists' beliefs about research and the scientist-practitioner model in an evidence-based health care climate: A qualitative study. *British Journal of Medical Psychology,* 74, 2:135-149.

Corwin, R. G. (1960). The professional employee: A study of conflict in nursing roles. *The American Journal of Sociology*, 66: 604-615.

Cowie, H. & Glachan, M. (2000). Designing and disseminating research in counselling psychology. *Counselling Psychology Review,* 15, 3: 27-30.

Cowie, H. & Salm, A. (1996). Research issues in counselling psychology: introduction. *Counselling Psychology Review*, 11, 1: 4-5.

Crawford-Wright, A. & Hart, N. (1997). Developing a training course. *Counselling Psychology Review*, 12, 3: 117-121.

Cushion, B. (1997). Clinical psychology in community mental health teams: a sample of the views of team managers and members. *Clinical Psychology Forum*, 102: 27-29.

Davies, F. (2004). The British Psychological Society: The 2004 Annual Report: *Division of Clinical Psychology (DcP).* Leicester. British psychological society: 30.

Department of Health. (2001). *Treatment choice in psychological therapies & counselling: Evidence Based Clinical Practice Guideline.* London: HMSO.

Department of Health, (2004). *Organising and delivering psychological therapies.* London. HMSO.

Department of Health. (2005). *Applied psychology: Enhancing public protection: Proposals for the statutory regulation of applied psychologists.* London: HMSO.

Devonshire, P. (1997). Continuing professional development. *Clinical Psychology Forum*, 99: 12-16.

Division Committee, (2005). What you said: Hot topics: your profession, your future, your opinions needed. *Counselling Psychology Review,* 20, 3: 26-27.

Doherty, W. Simmons, D. (1996). In Bor, R., & Achilleoudes, H. (1999). Survey of BPS Division of Counselling Psychology Members; 1999. *Counselling Psychology Review*, 14, 4: 35-45.

Donati, M. & Watts, M. (2000). Personal development in counselling psychology training: the case for further research. *Counselling Psychology Review,* 15, 1: 12-21.

Ellis, A. (1990). Rational and irrational beliefs in counselling psychology. *Journal of Rational-Emotive & Cognitive-Behaviour Therapy,* 8, 4: 221-233.

Elton-Willson, J. (1995). Current trends in counselling psychology. *The Psychologist*, 8, 11: 499-502.

Farrants, J. (2005). Training course news update: what's new at City. *Counselling Psychology Review*, 20, 4: 61-62.

Fellows, R. (1996). The role of counselling psychologists. *The Counselling Psychology Review*, 11, 4: 27-33.

Finfgeld, D. L. (2004). Empowerment of individuals with enduring mental health problems: results from concept analyses and qualitative investigations. *Advances in Nursing Science*, 27, 1: 44-49.

Fitzgerald, J., Calvert, S., Thornburn, J., Collie, R., & March, J. (2005). Counselling psychology in New Zealand and the use of bi-focal lenses: a reply to Gibson, Stanley and Manthei's article. *The Bulletin*, 104: 23-25.

Fortune, L. & Watts, M. (2000). Examining supervision: comparing the beliefs of those who deliver and those who receive. *Counselling Psychology Review,* 15, 3: 5-15.

Frankland, A. & Walsh, Y. (2005). Talking point: Division of Counselling Psychology 10th Anniversary. *Counselling Psychology Review*, 20, 4: 45-47.

Frankland, A. & Walsh, Y. (2006). Editorial for the special edition. *Counselling Psychology Review*, 21, 1: (In press).

Garrett, T. & Davis, J. (1995). So who are we anyway? *Clinical Psychology Forum*, 78: 2-4.

Geczy, B. & Sultenfuss, J. F. (1994). Contributions of psychologists to inpatient care of persons with chronic mental illness. *Hospital and Community Psychiatry*, 45, 1: 54-56.

Golsworthy, R. & Wilkinson, J. (1997). Perceptions of training. *Counselling Psychology Review*, 12, 3: 123-126.

Golsworthy, R. (2004). Counselling psychology and psychiatric classification: clash or co-existence? *Counselling Psychology Review*, 19, 3: 23-28.

Goodwin, A. & Gore, V. (2000). Managing the stresses of nursing people with severe and enduring mental illness: A psychodynamic observation study of a long-stay psychiatric ward. *British Journal of Medical Psychology,* 73, 3: 311-325.

Gournay, K. (1995). What clinical psychology trainees should know about psychiatric rehabilitation. *Clinical Psychology Forum*, 82: 21-26.

Green, D. (1995). Carry on learning. *Clinical Psychology Forum*, 76: 37-40.

Green, D. & Gledhill, K. (1993). What ought qualified clinical psychologist be able to do? Consulting the oracle. *Clinical Psychology Forum*, 60: 7-11.

Grimmer, A., & Tribe, R. (2001). Counselling psychologists' perceptions of the impact of mandatory personal therapy on professional development: an exploratory study. *Counselling Psychology Quarterly,* 14, 4: 287-301.

Guernina, Z. (1995a). Special issue editorial: who knows about counselling psychology? PR For '95. *Counselling Psychology Review*, 10, 2: 3.

Guernina, Z. (1995b). The cohesive corporate identity in counselling psychology: Public Relations In Action. *Counselling Psychology Review*, 10, 2: 4-5.

Guernina, Z. (1998). The interface between counselling psychology, psychotherapy and counselling. *Counselling Psychology Review*, 13, 1: 39-41.

Gupta, A. (1998). Training in the use of the 'counselling style' interview in qualitative research. *Counselling Psychology Review*, 13, 3: 13-19.

Hall, J. (1993). Clinical psychology in context. *Clinical Psychology Forum*, 61: 3-10.

Hammersley, D. (2004). Divisional News: The BPS Qualification In Counselling Psychology - a major revision. *Counselling Psychology Review*, 19, 1: 43-45.

Hart, N. (2005). News from the Wolverhampton course. *Counselling Psychology Review*, 20, 2: 63-64.

Hart, N. & Hogan, K. (2003). Second response – training counselling psychologists: what role for evidence-based practice? *Counselling Psychology Review*, 18, 3: 21-27.

Haynes, C. (2000). Stress in health professionals. *The Psychologist*, 13, 3:128-129.

Holzman, L., Searight, R. & Hughes, H. (1996). Clinical psychology graduate students and personal psychotherapy: Results of an exploratory survey. *Professional Psychology: Research and Practice*, 27, 1: 98-101.

Howard, G. (1992). Behold our creation! What counselling psychology has become and might yet become. *Journal of Counselling Psychology*, 39. 4: 419-442.

Hughes, I. & Budd, R. (1996). Roles for clinical psychologists in psychosis? *Clinical Psychology Forum*, 98: 23-25.

Humphreys, K. (1996). Clinical psychologists as psychotherapists. *American Psychologist*, 51, 3: 190-197.

Irving, J. & Williams, D. I. (1995). Reflective practice: a cognitive task. *Counselling Psychology Review*, 10, 2: 31-33.

James, I. (1995). Who knows about us? A PR strategy for DCoP. *Counselling Psychology Review*, 10, 2: 9-10.

James, P. (1996). Meanings of prevention and cure for the counselling psychologist. *Counselling Psychology Review*, 11, 2: 12-16.

James, P. (2004). Divisional News: on the road to funded training for counselling psychologists. *Counselling Psychology Review*, 19, 3: 32-35.

James, P. (2005a). Group dynamics in a professional setting: The challenge for applied psychologists. Reflections after the NIMHE/BPS Conference in Birmingham, February 2005. *Counselling Psychology Review*, 20, 2: 52-55.

James, P. (2005b). Letters to the Editor. *Counselling Psychology Review*, 20, 4: 49-50.

Kai, J. & Crosland, A. (2002). People with enduring mental health problems described the importance of communication, continuity of care, and stigma. *Evidence-Based Nursing*, 5, 3: 93-94.

Kenney, J. & Rohrbaugh, C. (1997). Scientist and practitioner role preferences: the undergraduate dilemma. *Counselling Psychology Quarterly*, 10, 4: 439-448.

Kinderman, P. (2005). The applied psychology revolution. *The Psychologist*, 18, 12: 744-746.

Kinderman, P. & Lobban, F. (2000). Evolving formulations: sharing complex information with clients. *Behavioural and Cognitive Psychotherapy*,28: 307-310.

Knight, L. (1995). Explaining what counselling psychology is and what it can offer to GPs in Primary Health Care settings. *Counselling Psychology Review*, 10, 4: 2-45.

Knight, T. & Devonshire, P. (1996). A survey of the needs for CPD in a group of clinical psychologists in the South Thames (West) region. *Clinical Psychology Forum*, 87: 40-42.

Lane, D. & Corrie, S. (2006). Counselling psychology its influences and future. *Counselling Psychology Review*, 21, 1 (in press).

Layard, R. (2005). *Sainsbury Centre lecture: Therapy for all on the NHS.* (12th September, 2005). Accessed HTTP Web Site: http://www.babcp.com.

Leary, M. & Maddux, J. (1987). Progress towards a viable interface between social and clinical-counselling psychology. *American Psychologist*, 42, 10: 904-911.

Leiper, R. (2002). Assessing needs for psychological therapies in the context of the National Service Framework for Mental Health. *Counselling Psychology Review*, 17, 4: 11-19.

Leiper, R. & Casares, P. (2000). An investigation of the attachment organization of clinical psychologists and its relationship to clinical practice. *British Journal of Medical Psychology*. 73, 4: 449-464.

Levant, R., Reed, G., Ragusea, S., DiCowden. M., Murphy, M, Sullivan, F., Craig, P. & Stout, C. (2001). Envisioning and accessing new roles for professional psychology. *Professional Psychology: Research and Practice,* 32, 1: 79-87.

Lewis, S., & Bor, R. (1998). How counselling psychologists are perceived by NHS clinical Psychologists. *Counselling Psychology Quarterly*, 11, 4: 427-437.

Likert, (1932). In Robson, C. (1997). *Real world research: a resource for social scientists and practitioner-researchers*. Oxford: Blackwell Publishers. Ltd.

Lindley, P. (1995). Looking towards the future for continuing professional development for psychologists. *Clinical Psychology Forum*, 81: 38.

Lindley, P. (1996). Continuing professional development and statutory registration I. *Clinical Psychology Forum*, 89: 44.

Lindley, P. (1998). Continuing professional development – The needs of the professional and the professional body. *Counselling Psychology Review*, 13, 1: 31-34.

Lindley, P. & Bromley, D. (1995). Continuing professional development. *The Psychologist*, 8, 5: 215-218.

Lindsay, G. (1996). Continuing professional development and statutory registration II. *Clinical Psychology Forum*, 89: 44-46.

Lloyd-Elliott, M. (1995). The counselling psychologist and the media. *Counselling Psychology Review*, 10, 2: 6-8.

Macran, S. & Shapiro, D. (1998). The role of personal therapy for therapists: A review. *British Journal of Medical Psychology*, 71, 1: 1-11.

Martin, P. (2005). Division of Counselling Psychology Annual Conference. *Counselling Psychology Review,* 20, 2: 38-41.

McWilliams, N. (2005). Preserving our humanity as therapists. *Psychotherapy: Theory, Research, Practice, Training,* 42, 2: 139–151.

Miller, R. (1997). Division of Counselling Psychology. *Clinical Psychology Forum*, 105: 46.

Miller, R. (2006). A long time in (counselling) psychology: memoirs of a BPS junkie. *Counselling Psychology Review*, 21, (in press).

Milton, M. (2001a). Counselling psychology placements: Reflections from the Health Service. *Counselling Psychology Review*, 16, 2: 4-10.

Milton, M. (2001b). Recent research on suicide: Issues for British counselling psychologists. *Counselling Psychology Review*, 16, 3: 28-33.

Milton, M. (2004). Talking Point: if you swim...You get wet. *Counselling Psychology Review*, 19, 4: 56-57.

Milton, M. (2005a). The process of transformation: a fighter's perspective. *Counselling Psychology Review*, 20, 1: 2-9.

Milton, M. (2005b). Letter from the incoming Chair. *Counselling Psychology Review*, 20, 2: 36-37.

Milton, M. (2005c). Letters to the Editor. *Counselling Psychology Review*, 20, 3: 20-21.

Milton, M. (2005d). Letter from the Chair. *Counselling Psychology Review*, 20, 4: 2-3.

Milton, M. (2006). Reflections on the past: Thoughts about the future... *Counselling Psychology Review*, 21, 1: In Press.

Morgan, S. (1993). Trainees in therapy: why not? *Clinical Psychology Forum*, 59: 32-33.

Munley, P., Duncan, L., McDonnell, K. & Sauer, E. (2004). Counseling psychology in the United States of America. *Counselling Psychology Quarterly*, 17, 3: 247-271

Mytton, J. (2005). Report from the Sub-Committee for Conferences. *Counselling Psychology Review*, 20, 3: 40.

Napier, B. (1993). Striving towards the ethical practice of clinical psychology. *Clinical Psychology Forum*, 54: 20-23.

Nelson-Jones, R. (1999). On becoming counselling psychology in the society: Establishing the Counselling Psychology section. *Counselling Psychology Review*, 14, 3: 30-37.

Newnes, C. (1995). The development of clincal psychology and its values. *Clinical Psychology Forum*, 95: 29-34.

Norcross, J. (2005). Lose Not Our Moorings: Commentary on McWilliams (2005). *Psychotherapy: Theory, Research, Practice, Training*, 42, 2: 52–155.

O'Brien, M. (1997). Training in higher education. *Counselling Psychology Review*, 12, 3: 127-132.

Oppenheim, A. (1998). *Questionnaire design, interviewing and attitude measurement.* London: Pinter.

Paley, G., & Shapiro, D. A. (2002). Lessons from psychotherapy research for psychological interventions for people with schizophrenia. *Psychology and Psychotherapy: Theory, Research and Practice*, 75, 1: 5-17.

Palmer, S. (1996). Journal interview: Past, present and future. *Counselling Psychology Quarterly*, 9, 4: 333-341.

Palmer, S. (1999). Letting the baby out with the bathwater: reflections on counselling, counselling psychology and psychotherapy in Britain. *Counselling Psychology Quarterly*, 12, 2: 159-168.

Pelling, N. (2000). Scientists versus practitioners: a growing dichotomy in need of integration. *Counselling Psychology Review*, 15, 4: 3-7.

Pelling, N. (2004). Counselling psychology: diversity and commonalities across the Western World. *Counselling Psychology Quarterly*, 17, 3: 239-245.

Perneger, T. (1998). What is wrong with Bonferroni adjustments. *British Medical Journal*, 136. 1236-1238.

Philcox, L., Bradley, R., Gamsu, D., & Godsi, E. (1994). A regional survey: grading, supervision and continuing professional development for recently qualified clinical psychologists. *Clinical Psychology Forum*, 69: 16-18.

Ploszajski, J. (2004). Using psychometrics in an NHS addictions service. *Counselling Psychology Review*, 19, 4: 9-17.

Powell, G. (2006). President's column: discussions. *The Psychologist,* 19, 1: 3.

Pugh, D. (1998). The use of the qualitative case study approach as a way of integrating research and practice in counselling psychology. *Counselling Psychology Quarterly,* 11, 3: 2895-263.

Pugh, D. & Coyle, A. (2000). The construction of counselling psychology in Britian: a discourse analysis of counselling psychology texts. *Counselling Psychology Quarterly,* 13, 1: 85-98.

Purcell, V. (2004). Divisional News: continuing professional development (CPD) – new society requirements. *Counselling Psychology Review*, 19, 4: 50-53.

.

Quarry, A. & Burbach, F. (1998). Clinical consultancy in adult mental health: integrating whole team training and supervision. *Clinical Psychology Forum,* 120: 14-28.

Quinn, F. (2005). 'The good life is hanging in the balance. *Counselling Psychology Review,* 20, 1: 44-45.

Raspin, C. & Kanellakis, P. (2004). Embracing psychometric assessment: enhancing a cognitive-behavioural eating disorders practice through the qualitative use of self-report measures. *Counselling Psychology Review*, 19, 4: 19-24.

Robson, C. (1997). *Real world research: a resource for social scientists and practitioner-researchers.* Oxford: Blackwell Publishers. Ltd.

Roth, A & Fonagy, P. (1996). *What works for whom? A critical review of psychotherapy research.* New York: Guilford Press.

Rowden, J. (2005) (scribe for the workshop). Workshop discussing relationships with other subsystems. *Counselling Psychology Review,* 20, 2: 45-46.

Ryder, J. & Shillito-Clarke, C. (1999). Counselling psychologists: upstarts, competitors or colleagues? *Counselling Psychology Review,* 14, 1: 12-15.

Sainsbury Centre for Mental Health. (2006). *Policy Paper: the future of mental health: a vision for 2015.* London: Sainsbury Centre for Mental Health.

Sequeira, H. (2005a). Editorial. *Counselling Psychology Review,* 20, 2: 1.

Sequeira, H. (2005b). Editorial. *Counselling Psychology Review,* 20, 3: 1.

Sequeira, H. (2005c). Editorial. *Counselling Psychology Review,* 20, 4: 1

Sequeira, H. and Van Scoyoc, S. (2004). Discussion paper on psychological testing. *Counselling Psychology Review,* 19, 2: 37-40.

Shillito-Clarke, C. (1996). The distinguishing features of counselling psychology: A personal reflection. *Counselling Psychology Review*, 11, 3: 33-35.

Shillito-Clarke, C. & Tholstrup, M. (2006) (In Press). What!? Life after counselling psychology: isn't retirement the end of the affair??. *Counselling Psychology Review*, 21, 1: In Press.

Smallwood, J. (1996). A year in the life of a trainee Counselling Psychologist in the NHS. *Counselling Psychology Review*, 11, 4: 19-25.

Smallwood, J. (2002). Counselling psychology and the NHS: An individual perspective. *Counselling Psychology Review*, 17, 1: 16-20.

Smith, G., Schwebel, A., Dunn, R. & McIver, S. (1993). The role of psychologists in the treatment, management, and prevention of chronic mental illness. *American Psychologist*, 48, 9: 966-971.

Smuts, P. & Mackay, T. (2004). Use of agreed AfC generic profile of all applied psychologists in health. *Reps Direct; amicus*, 334.

Spinelli, E. (2001). Counselling psychology: A hesitant hybrid or a tantalising innovation? *Counselling Psychology Review*, 16, 3: 3-12.

Stanley, P., & Manthei, R. (2004). Counselling psychology in New Zealand: the quest for identity & recognition. *Counselling Psychology Quarterly,* 17, 3: 301-315.

Stanley, P., Manthei, R., & Gibson, K. (2005). The case for counselling psychology as an additional psychological speciality: a response to Fitzgerald and others. *The Bulletin*, 104: 26-28.

Statpac. (2006). *Survey Software Online Surveys & Paper Questionnaires: Statistical Significance*. Http web site (accessed 9th January 2006: www.statpac.com/surveys/statistical-significance.htm,)

Still & Good. (1992). In Hall, J. (1993). Clinical psychology in context. *Clinical Psychology Forum*, 61: 3-10.

Strawbridge, S. (1997). Reflective practice and the Diploma in Counselling Psychology. *Counselling Psychology Review*, 12, 2: 74-78.

Strawbridge, S. (2002). 'McDonaldisation' or 'fast-food therapy'. *Counselling Psychology Review*, 17, 4: 20-24.

Strawbridge, S. (2006). Thoughts on becoming, being and developing as a counselling psychologist. *Counselling Psychology Review*, 21, 1 (In press).

Strawbridge, S. & Woolfe, R. (1996). 'Counselling psychology: a sociological perspective'. In Woolfe, R. & Dryden, W. (eds) *Handbook of counselling psychology.* London: Sage.

Street, E. & Rivett, M. (1996). In Bor, R., & Achilleoudes, H. (1999). Survey of BPS Division of Counselling Psychology members; 1999. *Counselling Psychology Review*, 14, 4: 35-45.

Tavris, C. & Wade, C. (1995). *Psychology in perspective*. New York. HarperCollins.

Tholstrup, M. (1999). Professional registration: a contentious debate. *Counselling psychology Review,* 14, 2: 15-20.

Thomas, A., Tholstrup, M., & Jordan, R. (1999). Parity of pay and conditions for counselling psychologists: a report from the Working Party. *Counselling psychology Review,* 14, 4: 22-26.

Turpin,G. (2005). New ways of shaping and delivering psychology services. Reflections after the NIMHE/BPS Conference in Birmingham, February 2005. *Counselling Psychology Review*, 20, 2: 56-57.

Van Scoyoc, S. (2004). The personal (psychologist) Is political. *Counselling Psychology Review*, 19, 3: 42-44.

Van Scoyoc, S. (2005a). Statutory regulation: implications for counselling psychologists. *Counselling Psychology Review,* 20, 1: 36-37.

Van Scoyoc, S. (2005b). The future of our profession: time to remember our history. *Counselling Psychology Review,* 20, 2: 49-51.

Van Scoyoc, S. & Bellamy, A. (2005). Talking Point. 'Hot issues' for counselling psychologists: a conversation between the Chair-Elect, Susan Van Scoyoc and the Past-Chair, Alan Bellamy. *Counselling Psychology Review,* 20, 3: 22-24.

Van Scoyoc, S. & Douglas, B., (2006). Letters. *The Psychologist*, 19, 2: 76.

Vogel, S. (2005). Going Counselling: aspects of the therapeutic relationship in young people's experiences of their counselling at a drop-in centre. *Counselling Psychology Review*, 20, 2: 2-11.

Walsh, Y. (2003). Third response –testing the way the wind blows: innovation and a sound theoretical basis. *Counselling Psychology Review*, 18, 3: 29-34.

Walsh, Y., Frankland, A. & Cross, M. (2004). Qualifying and working as a counselling psychologist in the United Kingdom. *Counselling Psychology Quarterly*, 17, 3: 317-328.

Walsh, Y. (2005). Letters to the Editor. *Counselling Psychology Review*, 20, 3: 21.

Webster, R. & Al-Bassam, S. (1997). Clinical psychology: winning friends and gaining influence. *Clinical Psychology Forum*, 104: 13-15.

Wilkinson, J., Campbell, E. Coyle, A., Jordan, R. & Milton, M. (1997). Trials, tribulations and tentative triumphs. *Counselling Psychology Review*, 12, 2: 79- 89.

Williams, D. I. & Irving, J. A. (1996). Counselling psychology: a conflation of paradigms. *Counselling Psychology Review*, 11, 2: 4-6.

Williams, D. I. & Irving, J. A. (1997). Assessment of trainee counsellors. *Counselling Psychology Review*, 12, 3: 133-137.

Williams, F., Coyle, A., & Lyons, E. (1999). How counselling psychologists view their personal therapy. *British Journal of Medical Psychology*, 72, 4: 544-555.

Willoughby, R. & Ashdown, L. (2003). Adult community psychology services: tiering and its seams. *Counselling Psychology Review*, 18, 4: 11-16.

Woolfe, R. (1996). Counselling psychology in Britain: past, present and future. *Counselling Psychology Review*, 11, 4: 7-18.

Woolfe, R. (2006). Journey from infancy to adulthood: the story of counselling psychology. *Counselling Psychology Review*, 21, 1 (in press).

Woolfe, R. & Dryden, W. (eds.) (1996). *Handbook of counselling psychology.* London: Sage.

SECTION C

PROFESSIONAL PRACTICE:

CLIENT STUDY COMPONENT

Part one

A case study of psychological therapy for bulimia nervosa and reactive depression in a man with a psychiatric history of morbid obesity, Pickwickian syndrome, obsessive ruminations, voice hearing and self-harm behaviour

1 Overview

This case study was conducted while I was employed as a counselling psychologist in a CMHT. It is included in the portfolio because it is an example of a counselling psychologist providing psychological therapy to an individual who has been diagnosed as having severe and enduring mental health problems. The case study demonstrates that counselling psychologists do provide therapy to this complex client group and are employed in secondary mental health care settings contrary to popularly held beliefs.

2 The referral and context

Charlie[1] was referred to the CMHT by his GP for psychological treatment and mental health monitoring. Due to the severe and enduring nature of Charlie's psychiatric history his GP did not consider him to be suitable for counselling within the primary care team – in line with the national service framework (DoH, 1999). He was also not an appropriate referral for the psychology department due to their long waiting list – currently running at nine months.

Following the referral by the GP an initial assessment was conducted by one of the team members, a community psychiatric nurse (CPN). Charlie's file was then taken to the weekly allocation meeting where it was decided that he would be referred to me, the psychologist within the team, for psychological therapy. I was also allocated as his key worker.

3 The assessment session

3.1 First impressions: appearance and behaviour

Charlie presented as a quiet pleasant twenty-eight year old. He had fairly short sandy coloured hair, curling at the back. He came from work neatly dressed in jeans and a shirt. He seemed very unsure of where to seat himself, standing in the corner of the room until invited to sit down. Charlie was about five feet eight inches tall and large-

[1] To preserve confidentiality any identifying information has been altered

boned: he stooped when walking and sitting, almost as though he wanted to hide inside himself. Charlie's face was haggard, caused by the excess skin that remained since he lost twenty-six stone in weight, dropping from forty stone in 1992 to his present weight of fourteen and a half stone. The folds of skin gave him a weathered and worn-out appearance.

When Charlie sat, it was on the edge of the chair, with his elbows on his knees and his head hanging, his arms either wrapped around himself or held out in front of him with his hands clasped, it looked as though in supplication.

Charlie was able to make eye contact on occasions though his head was often hanging down. He appeared to make eye contact to emphasise a particularly hard issue for him, or in an almost imploring way for help. Charlie was an articulate man and his speech tone and speed were normal, though on occasions he was hesitant and needed some prompting.

3.2 Biographical information and family history

Charlie was a 28-year-old, English-born caucasian male. His closest relationship was with his fiancée Sue. They had plans to marry in the summer and lived in a house that they had recently bought together.

Charlie's family comprised his fifty-one year old mother and sixty-nine year old father. He had one sister, Claire, who was twenty-seven years old. He said that when he was a child his mother was always feeding him, explaining that if he hurt himself she would give him something to eat as opposed to giving a hug or showing love. Charlie described himself as an overweight child in a family with a history of obesity: his maternal and paternal grandmothers, his parents and sister were all obese. He had a history of morbid obesity with Pickwickian syndrome (http://www.gpnotebook.co.uk, accessed 06.02.06) – a group of symptoms that generally accompany massive obesity such as sleep apnea and shortness of breath – and a psychiatric diagnosis of reactive depression with obsessive ruminations, stress-related voices and a history of self-harm.

Charlie was assigned dieticians to work with him to lose weight at the age of eight. He said his mother did not follow any of the recommendations they gave her, instead feeding him even more food. Given the family history of obesity described by Charlie, it was considered that a predisposition towards eating disorders might be in part

inherited (Benninghoven et al, 2003; Cooper 1995; Troop et al, 2003), with family members sharing the same environment: "*it could be this common experience that explains why eating disorders run in families*" (Cooper 1995, p 30). A tendency to be overweight can make an individual vulnerable to the development of bulimia nervosa and binge eating (Cooper 1995; Fairburn & Cooper, in Hawton et al, 1995 eds), both conditions which Charlie suffered from. Feelings of perceived low social rank – low self-esteem, lack of self-worth and shame – are also associated with an increased incidence of eating disorders (Troop et al, 2003). Commonly it is seen that there is a connection between body image dissatisfaction and low self-esteem, which correlates with the development and maintenance of eating disorders (Freeman et al, 1985). Poor body image was another identified issue for Charlie.

Charlie attended the local school, which he enjoyed, and described himself as an average child who lacked confidence and was teased though never bullied because of his size. He explained that he had some friends though no close friendships and that he got on with his peers mainly through making them laugh. Charlie felt that as he was fat as a child he was expected to be happy; he explained that he acted the part as he believed he had to "*put a face on*". This was a strong theme in later sessions, along with the dichotomous thinking of "*to be fat is to be happy*", which was a core belief for Charlie. On losing weight this core belief was challenged, causing an increase in anxiety whenever he was happy (Greenberger & Padesky, 1995).

Charlie left school and completed an apprenticeship as a mechanic at a local transport company, staying with them for five years before changing employers. In June of 1991 he was made redundant following a period of hospitalisation earlier that year for oedema and breathing difficulties due to his gross obesity.

Two months prior to his referral Charlie had been admitted to the local psychiatric hospital because of self-harm, attempted suicide, reactive depression and "*voices*" – auditory hallucinations that appeared to be stress-related obsessive ruminations. Charlie was hospitalised for two months, and self-harmed superficially on a regular basis when prompted by a female voice "*Mary*". He explained a feeling of relief after the self-harm episodes. Charlie improved following inpatient treatment and was thought to be ready for rehabilitation after a period of two months, with his psychiatrist reporting no current psychotic features or delusional paranoid ideas; his auditory hallucinations were considered to have obsessional rumination qualities rather than being indicative of more serious mental health problems.

Following his hospitalisation Charlie was moved to a rehabilitation unit. While an inpatient there he attended a community day centre for anxiety management and social skills group work. He made such swift progress that he was moved into sheltered accommodation for a short time, following which he gained employment as a mechanic and began a relationship with his fiancée, who he met at the rehabilitation unit.

3.3 The client's definition of the problem

Charlie stated that he wanted to control his eating disorder. In particular his goals for therapy were "*to be able to be more normal and have three meals a day, plus to change the way I think about food*". Charlie felt that his bulimia nervosa and past obesity were the reasons for his low self-esteem, lack of confidence and bouts of depression. He constantly questioned the "*meaning of life*" and "*reality*". He believed his failure to come to terms with his past obesity prevented him from being content with himself now and possibly in the future.

3.4 The psychologist's definition of the problem

My formulation following the first session was that the primary presenting problem was the long-standing eating disorder, which now presented as bulimia nervosa, meeting the DSM-IV (APA, 1996), criteria for diagnosis of bulimia nervosa – recurrent episodes of binge eating within a discrete period of time, accompanied by feelings of lack of control about the binge, having at least two bingeing sessions a week for a duration of no less than three months with inappropriate compensatory behaviours such as vomiting DSM-IV (APA, 1996). In addition he presented with a lack of confidence, low self-esteem and reactive depression, with occasional stress-related auditory hallucinations. There had been a previous diagnosis of major depressive disorder, severe with psychotic features DSM-IV (APA, 1996). This was considered by the psychiatrist to be in full remission. He was not on any medication, not wishing to take the Prozac that had been suggested by his GP; he had been on anti-psychotic medication while in hospital and now wanted to be free of medication.

My understanding of why he was presenting for therapy at this time was that he was facing a life-cycle transition of marriage, imminent plastic surgery to his stomach to remove excess skin and a recent house move. These were all stress factors and therefore triggers for the increase in bulimic behaviour (Burnham, 1993). The

presenting issues all affected the quality of his life and caused him anxiety and distress.

Charlie's goals were to live a "*normal*" life despite his history of obesity, to be able to control his eating, having three meals a day without thinking about it. His motivation to work on these issues seemed to be very strong and appropriate to work on psychologically. I felt comfortable with Charlie as a client, and thought that individual therapy might be helpful for him to manage his bulimic behaviours, challenge his dysfunctional cognitions and to reduce his emotional distress. During supervision it was agreed that indeed this seemed to be the case. When the first session came to an end, Charlie expressed a desire to come back and explore these issues further.

3.5 The approach, rationale and goals

3.5.1 The contract and structure of the sessions

We discussed the number of sessions that would be required. I explained that we could work for up to eight sessions but at that stage we would need to review goals and progress with the possibility of renegotiating for more sessions. Weekly sessions of just under an hour at a mutually agreed time were held at the CMHT.

I also explained that it was not unusual for people suffering from bulimia nervosa to need more sessions: twenty sessions of therapy over a five-month period is common (Cooper, 1995). Given his psychiatric history and current dual diagnosis of reactive depression and bulimia nervosa it seemed likely that more sessions would be needed. Research suggests that individuals who evaluate themselves negatively and who have done so for a long period of time (such as Charlie) respond least well to short-term psychological treatments (Cooper 1995; DoH, 2001; Fairburn & Cooper, in Hawton et al, 1995 eds).

3.5.2 Goals

The main goal as identified by Charlie was to focus on his bulimic behaviours, to normalise them and his cognitions related to food. Additionally, it was important to focus on his depression as this was linked to his low self-esteem.

3.5.3 Confidentiality

The subject of confidentiality was discussed and the situations in which confidentiality would need to be broken were highlighted, for example if I felt that he posed a risk either to himself or to a third person. The nature of supervision and information taken to supervision was also explored and he was informed that his GP would be contacted with a brief report following the assessment session, which would include a treatment plan. In a later session the need to contact his dietician and psychiatrist was discussed and he gave permission for this to happen.

3.5.4 Therapeutic approach taken

I used an integrative framework, which included cognitive behaviour therapy (CBT) to address the bulimia nervosa, as the literature indicates that it is the psychological treatment of choice (Brouwers, 1990; Cooper, 1995; DoH, 2001; Fairburn & Cooper, in Hawton et al, 1995 eds). Personal construct psychology (PCP) was used to explore with Charlie his construing (Button, 1995). Additionally, a systemic technique known as genogram was used in the assessment (Bor et al, 1993; Burnham, 1993). At this stage the approach seemed to be appropriate, allowing Charlie to address his bulimic behaviour in a direct and managed way using CBT, while the PCP supported exploration of further issues in a safe, accepting and genuine relationship (Winter, 1992). I worked within the therapeutic frameworks, placing value on his personal and subjective experiences.

The CBT approach as advocated by Brouwers (1990) was the framework used to address the bulimia. This model has six components:

Education: for example, about appetite set points – body programmed to contain a certain amount of fat.
Socio-cultural: exploring how people have tried to change their bodies to fit in with history and culture.
Cognitive component: the negative thoughts about his body needed to be rationalised and self-defeating thoughts uncovered and challenged, such as dichotomous thinking when to be happy meant he had to be fat. Perfectionist thinking was also challenged, as was egocentricity, which manifested for Charlie as a belief that everyone in his town of origin perceived him as a forty stone man even though he was now fourteen and a half stone. Over-generalisation was also to be

addressed, dysfunctional attitudes and beliefs were challenged and rationalised, and a positive attitude towards his body was nurtured.

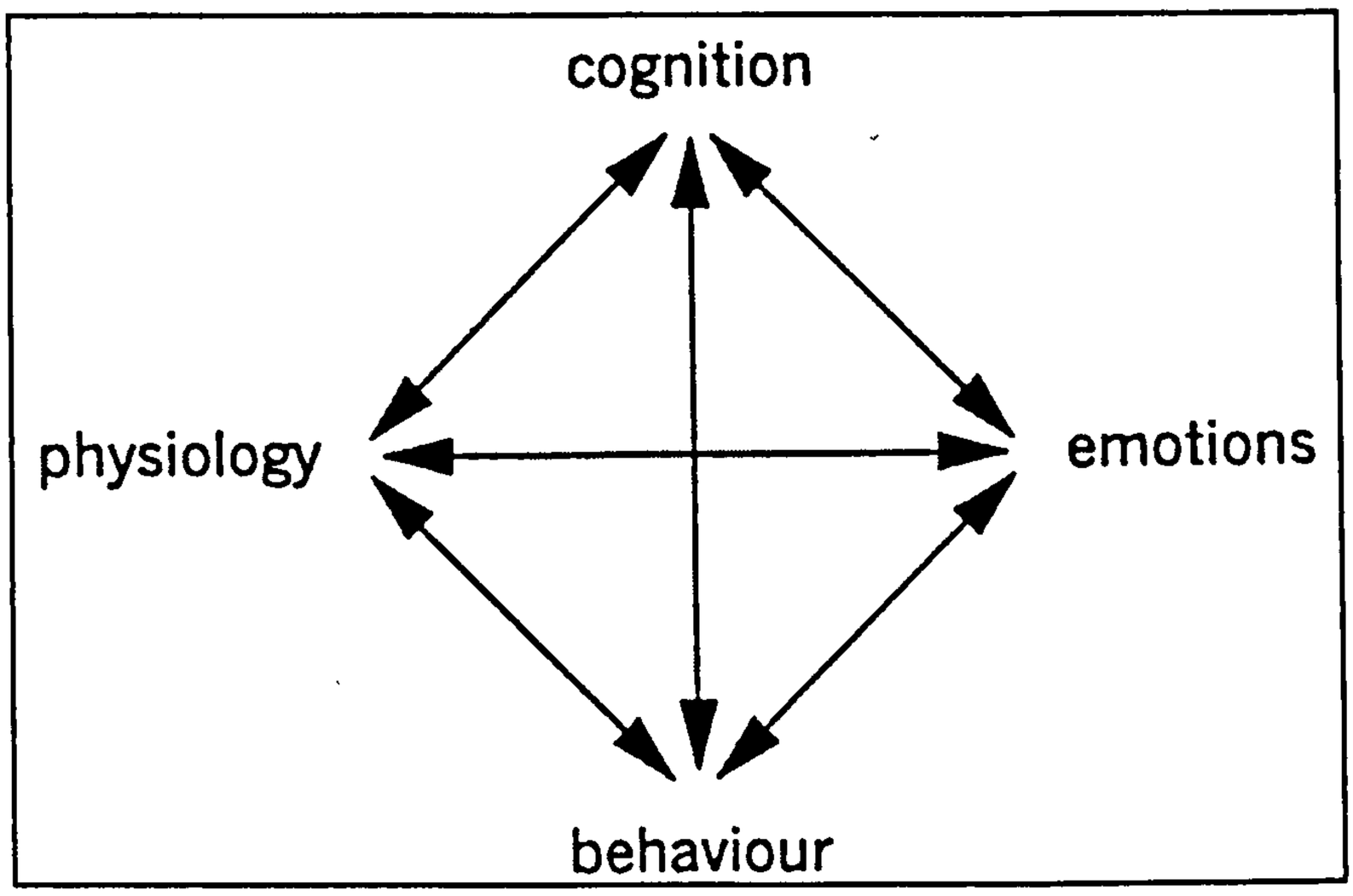
Feelings or emotions: feelings like anxiety, depression and fear of gaining weight. It was identified that one function of his binge-vomit behaviour was to deal with unpleasant emotions: this was explored and alternative ways of coping with these unpleasant emotions developed.

Behavioural: this involved substituting alternative behaviours for vomiting such as walking, talking, playing cribbage or drawing.

Family issues: negative beliefs and themes held within the family system were challenged and addressed.

Table 3.5.4, illustrates the interaction between the different elements that constitute human experience (Scott & Dryden, in Woolfe & Dryden (eds), 1996, p. 156). I worked with Charlie to focus on the cognitions and behaviours as the points of change. This diagram was used in therapy sessions with information gained from his homework diaries to target negative automatic thoughts and behaviours.

Table 3.5.4: The cognitive-behavioural model



The focus of the treatment was to reduce binge-vomit episodes so that his levels of self-esteem and confidence would increase, resulting in improved mood and ultimately cessation of depression (Greenberger & Padesky, 1995). CBT is also regarded as an appropriate framework for voice hearing work (McGowan et al, 2005).

As cognitive behaviour therapy works in the here and now (Fairburn & Cooper, in Hawton et al, 1995, eds), the base issues underlying Charlies difficulties, which stemmed from childhood experiences, would not be the focus of the current piece of work (Cooper 1995; Freeman et al, 1985; Garfinkel & Goldbloom, 1993).

4 The content and process of the sessions

4.1 The overall content of the sessions

During the first few counselling sessions I used CBT techniques to focus on his bulimic behaviour, gathering information about triggers and cognitive distortions. This seemed to be helpful but difficult for Charlie, yet he was able to work directly on the issue that he had presented with in therapy.

The main content of these early sessions was the sense of failure and dissatisfaction with his life. Charlie appeared to be stuck at this stage, and the work we did reflected his feeling of being in a rut. We concentrated on diary keeping of his food, mood and thoughts, but this activity was associated with failed attempts by dieticians in the past and he felt it was an attempt to control him. Charlie managed to keep the diary for half of the week, making meal plans and sticking to them, writing down negative automatic thoughts and challenging them. He then associated feeling good about himself with being happy, an emotion he associated with being fat. This cognitive distortion and affect led to him ripping up his diary and binge-vomiting the rest of the week.

I took his case to supervision, feeling myself that we had become enmeshed in his binge-vomit behaviour and food diary keeping. The issues of keeping a diary were explored and it was identified as effective intervention, as it enabled him to gain control of his behaviour. It was the negative associations that jeopardised the treatment. The diary was replaced with sheets of plain paper as this did not attract the same negative associations of failure and control. Drawing as a method of record keeping was introduced after Charlie revealed he had enjoyed art as a child. This allowed the re-introduction of this skill not only to record information but also as a distraction technique when he felt like bingeing. Charlie said this was a useful intervention, giving him the chance to express himself in a positive way.

The issue of not wanting to eat in public was explored. Charlie reported being anxious about dining out with his fiancée as he felt uncomfortable eating in public, a cognitive process that often results in a loss of confidence and avoidance of social situations (Cooper, 1995). I discovered that he did not experience eating in a country restaurant as threatening as eating in town; while this cognitive distortion was useful in that it allowed him to eat out, it also acted as a barrier to progress and was challenged.

A graded exposure was incorporated into his treatment plan (Fairburn & Cooper, in Hawton et al, 1995 eds) to graduate him from eating out in the country to in town with his fiancée. This led to increased self-esteem through greater social contact and helped address his depression.

While Charlie was highly motivated to change, his core beliefs were difficult to challenge. He fluctuated between good and bad weeks, sometimes keeping his diary and food plan, resisting bingeing and vomiting behaviour, to ripping up his plan and bingeing uncontrollably at other times. We explored this using PCP techniques, laddering and self-characterisation sketches. It became apparent that Charlie fundamentally feared the possible change in his core structure. Kelly 1955 (in Winter, 1992) viewed the core role, which is one aspect of the core structure, as "*a part one plays as if his life depended upon it*" (Kelly, 1955, in Winter 1992, p 11). This was examined, and he expressed fears of change that could lead to him becoming dissatisfied with his new life and fiancée; his eating disorder therefore served a strong purpose in his mind in that it perpetuated a familiar state. This exploration helped Charlie reframe and normalise these fears, allowing him to begin the slow process of change.

There appeared to be a development in the counselling sessions, a movement away from Charlies's difficulty with his binge and vomit behaviour, to exploration of deeper issues and gradual management of his bulimic behaviour.

4.2 The therapeutic relationship

Charlie seemed to relate well to me and had an easy manner, but appeared to have difficulty sharing more personal issues and often avoided eye contact. He acknowledged the need to see a psychologist at this time, recognising that his bulimic behaviour was getting worse and expressing concern that this had not been addressed when he was in psychiatric treatment. My thoughts were that the

impending lifecycle transitions were triggers for the recent increase in his bulimic behaviour, which are associated with increased stress: "*Transitions, it is important to remember, involve considerable stress*" (Herbert, 1988, p110).

4.3 Factors to manage bulimic behaviour

Another technique to help Charlie manage his behaviour was the use of an intervention plan that established permissible binge-vomit times in the week. He was encouraged to use them only as a last resort and was discouraged from binge-vomit episodes outside of these times. Other ways that were introduced to help Charlie manage his behaviour were distraction techniques, developing new skills and engaging in new activities.

Another strategy to manage the binge episodes that Charlie learnt was to use a plate to binge on, and to binge on certain types of food so that he would get full faster, at particular times of the day in a specified room (Fairburn & Cooper, in Hawton et al, 1995 eds). This cut down on the quantity of food consumed. He reported that these techniques worked, and his bingeing and vomiting behaviour dropped from every night in some weeks to about twice a week at allotted times. In other weeks he fluctuated between success and failure.

While the origins of his bulimic behaviour were linked to core beliefs developed in childhood it provided him with a way of avoiding confronting its underlying causes. Bulimia was a lot easier to bear than to acknowledge the role his family had played in the development of his difficulties. It also allowed him to take ownership of his failure and prevented him from returning to his former way of being, which he feared. This was a realistic cognition as his obesity had almost killed him two years earlier.

Paradoxically, the strong core belief of being fat and happy resulted in him now fearing being happy because that would be life-threatening. Once he began to address the bulimic behaviours his awareness turned to their underlying causes. The lack of positive regard between Charlie and his family and the absence of any friendships, excepting Sue, contributed to his feeling of being unlovable and acted as triggers to his binges (Benninghoven et al, 2003).

4.4 Relationship difficulties and trust

I felt his wanting to have more social relationships came from his lack of a real relationship with his parents – an issue found to be a common thread in individuals with eating disorders (Benninghoven et al, 2003) – and the absence of close friends as a child. Hartley (in Dolan & Gitzinger, 1991) reported on the connection between adult men with eating disorders often having poor relationships with their fathers, which appeared to resonate for Charlie.

The use of a genogram (Bor et al, 1993; Burnham, 1993) in the assessment not only illustrated the lack of a relationship with his father, but also gave an immediate connection to other significant information. His maternal grandfather and uncle John had been the only two people in his life who had been concerned about his weight, both advising him to reduce his size. Unfortunately they both died before they saw him lose twenty-six stone in weight. Charlie's low self-esteem and lack of self-confidence were reinforced when his grandfather and uncle died, which he perceived as abandonment: this was internalised, confirming his belief that he could not form a loving relationship because he was fat and unlovable. The deaths of these two important figures in his life acted as catalysts to his tremendous weight loss: using a genogram gave access to this powerful and personal information for use in therapy.

Charlie was beginning to acknowledge that his own childhood was not ideal, wishing to come to terms with it, so that he could "*move on*" and "*be happy with himself*". He was fearful that he might lose out on a relationship with his fiancée if he did not change, and it was this fear that prompted him to seek treatment at this point in his life.

4.5 Body dysmorphia

There is agreement that changes in perception of body image are crucial to effective therapy (Cooper, 1995). It is often reported that people with eating disorders dislike their bodies or have extreme concerns about their shape and weight and attach great importance to it, often leading to low self-esteem (Cooper, 1995; Fairburn & Cooper, in Hawton et al, 1995 eds). Charlie was not happy with his size: he still perceived himself as a forty-stone man rather than his current weight of fourteen and a half stone. Brouwers (1990) felt that individuals must get over the minimisation and denial of their eating disorder and recognise that their body image can change, and in

Charlie's case that his weight has changed. Fairburn and Cooper's cognitive model was used to address this issue.

4.6 Auditory hallucinations

Charlie had auditory hallucinations when he experienced high levels of stress. These would be in the form of derogatory voices, usually *'Mary'*, saying he was a "*fat bastard*" or a "*useless lump of lard*": most painful for him was when the voices said "*no one loves you, you fat piece of shit*". The voices were very distressing and had been one of the reasons why he had previously had psychiatric inpatient treatment. Charlie gave his permission for me to consult with his previous psychiatrist and the current psychiatrist attached to the CMHT to ascertain whether it was safe for him to undertake more challenging aspects of therapeutic work, particularly as he was not currently on any anti-psychotic medication. Some session time was devoted to making sense of the auditory hallucinations to reframe the experience and underlying beliefs in a more helpful way. This psycho-education approach within a CBT framework led to a reduction in occurrence of the auditory hallucinations (Jones et al, 2003; McGowan et al, 2005). Charlie said the intervention gave him great relief, as he no longer felt he was "g*oing mad".*

5 Evaluation

5.1 A critical assessment of the effectiveness of the therapy

The use of CBT is associated with short-term therapist-directed work (Beck, 1991; Cooper, 1995; Fairburn & Cooper, in Hawton et al, 1995 eds). Charlie was at times uncomfortable with CBT, feeling the direct approach was a way of controlling him. He also associated the use of food thought diaries with failure, which was a real barrier when we first started working together.

While this negative association might have been avoided if a less directed therapeutic approach had been used, CBT was chosen because of its acknowledged efficacy as the treatment of choice for bulimia nervosa (Cooper 1995; DoH, 2001; Fairburn & Cooper, in Hawton et al, 1995 eds). Despite the challenges therapy presented to Charlie the therapeutic relationship developed well and a good working alliance was formed, which enabled constructive progress and change to take place.

Therapeutic alliances are recognised as the most important aspect of successful therapy regardless of theoretical orientation (Black et al, 2005). A humanistic framework was considered, as it was important for Charlie to be accepted unconditionally (McLeod, 1993), but CBT was chosen because it addressed the obvious need at the beginning of the therapeutic process for more structure and direction. The venue for the sessions was moved from the CMHT to the psychology department at the local NHS hospital, to enable them to become more therapeutic and less treatment-orientated. The benefit of this increased focus on his personal experience was evident in the strengthening of the therapeutic relationship.

5.2 The client's report of the outcome

Charlie had nine therapy sessions with me. The last one was a review to ascertain his progress and to establish which therapeutic goals had been met. Charlie reported having made real progress with his eating, being able to go for a meal with Sue and to take packed lunches to work. He was now also able eat in front of his colleagues. However, he expressed a need to control his thinking so that his behaviour changes would become permanent, and said he was "*scared of slipping back*". He recognised he was making progress, was pleased with this and wanted to take it further. Because of his fear of slipping back, relapse prevention strategies were planned to help him maintain the change (Fairburn & Cooper, in Hawton et al, 1995 eds).

5.3 Professional dilemmas and concerns experienced

Supervision was used on four occasions to clarify difficult issues that arose in therapy, particularly my feeling that we had become enmeshed in the binge-vomit behaviour cycle. My supervisor encouraged me to explore the possible purposes his behaviour served, which may have been a form of self-punishment and an avoidance technique to prevent examination of painful underlying issues. This prompted me to provide Charlie with an opportunity to express his emotions in a freer way, using paper and drawing, allowing him to make progress. It proved to be a very powerful and useful intervention.

The issue of involving other professionals was discussed, leading to me contacting his former dietician, previous psychiatrist and the CMHT psychiatrist to clarify medication. These communications enabled a safer and better informed therapeutic service to be offered, and fitted with the ethos of open communication held by the CMHT (DoH, 2002). My supervisor supported the formulation that Charlie's

difficulties were very entrenched and that longer-term individual work was appropriate. This decision was also supported by the CMHT at the case discussion meeting.

6 Summary and conclusion

Although Charlie was identified as having a complicated psychological history he was considered psychiatrically stable despite these complications. He made great progress in therapy despite his resistance to the directive CBT approach and was transferred to the psychology department where I continued to see him for weekly therapy sessions following this initial piece of work. The environment at the psychology department was calmer and more predictable. His sessions there were less likely to be disrupted or re-scheduled due to pressure on rooms, as had occurred at the CMHT on several occasions. The change in environment encouraged feelings of self-worth and secure attachment (Goodwin et al, 2003), and permitted the provision of longer term psychotherapy.

7 Retrospective reflections

Even from this distance in time and allowing for developments in theory and practice and increased professional experience, I would again choose a CBT framework for Charlie if he were referred to me as a client now. However, I would place greater emphasis on the cognitive component, as this would reveal dysfunctional core beliefs and core schemas. It would also help identify strengths, which would have boosted self-esteem and self-confidence sooner (Greenberger & Padesky, 1995; Mason et al, 2005), and would probably have been experienced as less controlling. Charlie found CBT challenging, and with the benefit of hindsight I would use a more creative and less 'manualised' approach, encouraging him to use his artistic skills to record his cognitions and behaviours, as this would foster a greater sense of control and mastery.

We explored the impact of family dynamics on his difficulties using a genogram (Bor et al, 1993; Burnham, 1993), which proved to be a powerful means of gaining a lot of

therapeutic information quickly. It also aided the development of the therapeutic relationship. There is a body of literature that suggests that psychosocial family dynamics are a far greater contributor to the development and maintenance of bulimia nervosa than they were considered to be at the time of Charlie's therapy (Benninghoven et al, 2003). While this issue was certainly explored during several sessions, it was not considered a core aspect of accepted CBT treatment for bulimia nervosa at the time (Cooper 1995; DoH, 2001; Fairburn & Cooper, in Hawton et al, 1995 eds).

References

American Psychiatric Association. (1996) *Diagnostic and statistical manual of mental disorders, fourth edition.* Washington: American Psychiatric Association.

Beck, A. (1991). *Cognitive therapy and the emotional disorders*. London: Penguin Books.

Benninghoven, D., Schneider, H., Strack, M., Reich, G., & Cierpka, M. (2003). Family representations in relationship episodes of patients with a diagnosis of bulima nervosa. *Psychology and Psychotherapy: Theory, Research and Practice.* 76. 3: 323-336.

Black, S., Hardy, G., Turpin, G., & Parry, G. (2005). Self-reported attachment styles and therapeutic orientation of therapists and their relationship with reported general alliance quality and problems in therapy. *Psychology and Psychotherapy: Theory, Research and Practice.* 78. 3: 363-377.

Bor, R., Miller, R., & Goldman, E. (1993) *Theory and practice of HIV counselling: A systemic approach*. London: Cassell.

Brouwers, E. (1990) *Treatment of body image dissatisfaction among women with bulimia nervosa*. Journal of Counselling and Development. 6: 144-147.

Button, E. (1995) *Eating disorders personal construct therapy and change*. Chichester: John Wiley.

Burnham, J. (1993) *Family therapy*. London: Routledge.

Cooper. P. J. (1995) *Bulimia nervosa and binge-eating: a guide to recovery*. London: Robinson.

Department of Health, (1999). *National service framework for mental health: modern standards and service models.* London: DoH (Accessed from HTTP web site 4th January 2006: http://www.dh.gov.uk).

Department of Health. (2001). *Treatment choice in psychological therapies & counselling: Evidence Based Clinical Practice Guideline.* London: HMSO.

Department of Health, (2002). *Mental health policy implementation guide Community Mental Health Teams.* London. DoH.

Dolan, B., & Gitzinger, I. (1991). *Why women: gender issues and eating disorders*. London: European Council on Eating Disorders.

Fairburn, C., & Cooper, P. (1995). Eating disorders. In Hawton, K., Salkovskis, P. Kirk, J., & Clark, D. eds *Cognitive behaviour therapy for psychiatric problems: a practical guide.* London: Oxford University Press.

Freeman, R. Beach, B. Davis, R. & Solyom, L. (1985). *The prediction of relapse in bulimia nervosa*. Journal of Psychiatric Research. 1: 349-353.

Garfinkel, P., & Goldbloom, D. (1993). *Bulimia nervosa*. A review of therapy Research. *Journal of Psychotherapy,Practice and Research*. 2. 1: 38-49.

Goodwin, I., Holmes, G., Cochran, R., & Manson, O. (2003). The ability of adult mental health services to meet clients' attachment needs: the development and implementation of the Service Attachment Questionnaire. *Psychology and Psychotherapy: Theory, Research and Practice*. 76. 2: 145-161.

GP Notebook (2006). Pickwickian Syndrome. HPPT Web site. http://www.gpnotebook.co.uk, accessed 06.02.06.

Greenberger, D., & Padesky, C. (1995). *Mind over mood: Change how you feel by changing the way you think.* London :The Guilford Press.

Hartley, (1991). In Dolan, B., & Gitzinger, I. *Why women: gender issues and eating disorders*. London: European Council on Eating Disorders.

Herbert, M. (1988). "*Working with children and their families*". London: Routledge.

Jones, S., Guy, A., & Ormrod, J. (2003). A Q-methodological study of hearing voices: A preliminary exploration of voice hearers' understanding of their experiences. *Psychology and Psychotherapy: Theory, Research and Practice.* 76. 2: 189-209.

Kelly, G., (1955). In Winter, D. (1992) *Personal construct psychology in clinical practice.* London: Routledge.

Mason, O., Platts, H., & Tyson, M. (2005). Early maladaptive schemas and adult attachment in a UK clinical population. *Psychology and Psychotherapy: Theory, Research and Practice.* 78. 4: 549-564.

McGowan, F., Lavender, T., & Garety, P. (2005). Factors in outcome of cognitive-behavioural therapy for psychosis: Users' and clinicians' views. *Psychology and Psychotherapy: Theory, Research and Practice.* 78. 4: 513-529.

McLeod, J. (1993). *An introduction to counselling.* Buckingham :Open University Press.

Scott, M. & Dryden, W. (1996). The cognitive-behavioural paradigm. In Woolfe, R. & Dryden, W. (eds) *Handbook of Counselling Psychology.* London: Sage : 156.

Troop, N., Allan, S., Treasure, J., & Katzman, M. (2003). Social comparison and submissive behaviour in eating disorder patients. *Psychology and Psychotherapy: Theory, Research and Practice.* 76. 3: 237-249.

Winter, D. A. (1992) *Personal construct psychology in clinical practice.* London: Routledge.

SECTION C

PROFESSIONAL PRACTICE:

CLIENT STUDY COMPONENT

Part two

A case study of psychological therapy for anxiety disorder in a female survivor of childhood sexual abuse with a history of psychiatric inpatient treatment for attempted suicide and self-harm behaviour

1 Overview

This case study was conducted while I was employed as a counselling psychologist in a CMHT. It is included in the portfolio because it is an example of a counselling psychologist providing psychological therapy to an individual who has been diagnosed as having severe and enduring mental health problems. The case study demonstrates that counselling psychologists do provide therapy to this complex client group and are employed in secondary mental health care settings contrary to popularly held beliefs.

2 The referral and context

This case study is an example of brief focused therapy in a CMHT, with an individual who had enduring mental health problems. Kath[1] was referred to the CMHT by her GP for psychological treatment and mental health monitoring. Due to Kath's psychiatric history her GP did not consider her suitable for counselling within the primary care team – in line with both the national service framework (DoH, 1999) and referral patterns noted in literature (Gilbert, 2005; Neilson & Hall, 2002). She was on the waiting list for individual therapy from the psychotherapy department; their waiting time was two years, and she attended a self-help group for childhood sexual abuse (CSA) survivors at the psychology department. The CMHT was considered as the first choice – she could be seen quickly and it offered a safety net service should her mental health deteriorate.

Following the referral by the GP an initial assessment was conducted by two of the team members, a psychiatrist and a community psychiatric nurse (CPN). Kath's file was then presented at the weekly allocation meeting where she was allocated to me, the psychologist within the team, for psychological therapy and to be her key worker.

[1] To preserve confidentiality any identifying information has been altered.

3 The assessment session

3.1 First impressions: appearance and behaviour

Kath was punctual for her first appointment, neat and tidy in appearance despite her coat looking a little threadbare. My first impression was that she appeared not to want to stand out – her coat, skirt, blouse, tights, shoes and handbag, glasses, hair and eyes were all brown in colour, making her blur into the background. She was about five feet three inches tall and a slight woman who looked about 10 years younger than her real age of 62. Kath had a hesitant manner, peering out from behind her glasses anxiously. She was short of breath on occasions, and clasped and wrung her hands when discussing issues that were of particular importance to her.

Eye contact was maintained when speaking but she would tend to look away at other times. Her speech was normal in tone and speed though often muted and sometimes difficult to hear. Kath did not initiate conversation in the assessment but waited until prompted to speak. At times she appeared timid but when she spoke she was very articulate and insightful about her difficulties. Kath explained that she was doing her Masters of Philosophy and that she had come straight from seeing her academic supervisor, who had not read her draft thesis. She cried during part of the session and appeared to be under some strain, her face drawn and pale.

3.2 Biographical information of the client and family history

Kath is a 62-year-old white British female, married to Allan, who was 63 years old. They had been married for thirty-nine years and lived in their own home in a semi-rural location on the edge of town. They had three children: Amy the eldest was 37 and married; Stuart was 35 and single; and Terry the youngest son 33 years old, was also single. Terry was living at the family home and helped his mother with her research by typing the drafts. He also did some extra typing to boost his unemployment benefit. Terry was in the process of being assessed at the Portman Clinic to ascertain whether he was suitable for gender reassignment. Kath reported his gender issues were very difficult for her other children and husband to understand, with Allan exhibiting confusion, anger and depression. She reported having mixed feelings about it herself, saying it was hard not to feel embarrassed if

he cross-dressed when people visited, which resulted, Kath explained, in the family not being very sociable.

Kath offered little information about her family of origin, saying she found the subject of her childhood painful. Her parents were dead, her father having died just over a year ago. She described having an older sister who she was not particularly close to, now having only occasional contact with now her. They had been brought up on a farm and she recalled having to help out with many of the jobs, including the physically hard ones. Kath said her father was a disciplinarian and the family had to be quiet and show respect.

Kath described leaving school when she was young without any formal qualifications because her father wanted her to work on the farm. She married Allan, who was a farm worker, when she was 23 years old, starting married life managing a small farm until they could afford their own home. Kath reported that despite working on the land for most of her life she had always wanted to do something academic, but that her husband had not been keen on it, seeing it as a "waste of time". Despite this she enjoyed reading when her children were small and started to do an Access Course, completing a university degree later in life. Kath explained that her past had caught up with her after gaining her degree as her present reality was now so far removed from the core belief instilled in her as a child by her father, who always called her '*stupid*'.

Kath was a survivor of childhood sexual abuse (CSA) and was waiting for an assessment for long-term psychotherapy at the psychotherapy department of the local NHS trust. She also attended a survivor group run by the local psychology department. Kath had a history of self-harm (cutting) and attempted suicide (overdosing on sleeping tablets). At the time of the referral she was psychologically stable and had no ideation of suicide or self-harm.

Kath sought therapy at this time she because of anxiety about finishing her degree. Kath explained that as the anniversary of her father's death approached it became increasingly difficult to study. Recently she had felt very anxious and angry with her supervisor and editors for their relaxed attitude towards her work, explaining that they did not take her seriously. She reported progressive feelings of incompetence due to her poor self-esteem and increasing lack of confidence, saying: "*I feel like a silly old woman who is making a fool of myself.*"

Because of the absence of support and direction from her husband and supervisor, Kath had fallen behind her deadlines. She had no feedback on her completed chapters and hence no idea on how to progress. The provisional deadline for the completion of her thesis was four months from the date of the initial assessment session.

3.3 The reason for referral

Kath explained that she had begun to experience anxiety symptoms (tightness across her chest, palpitations, sweating, feelings of apprehension and dread) (Clark, in Hawton et al, 1995, (eds); Greenberger, & Padesky, 1995). She had visited her local GP who prescribed Lorazepam for anxiety and panic attacks, and referred her to the CMHT due to her psychiatric history. The referral stated that Kath was suffering from anxiety due to academic pressures and lack of support. Following a multidisciplinary team meeting during which new referrals were discussed it was decided she would be referred to me, the psychologist in the team for short-term psychological therapy. The rationale for accepting the referral was that she was identified as 'high risk' (DoH, 2002) due to her history: – the literature highlights the increased likelihood of woman CSA survivors presenting with severe psychological difficulties (Read et al, 2003; Ryan et al, 2005). Kath waited two weeks for her first appointment with me.

3.4 The client's definition of the problem and main concerns

Kath was struggling to progress with her thesis, with negative thoughts such as '*I'm a silly old woman, I shouldn't be doing this* ' eroding her confidence to write her dissertation. Thoughts such as *'I will never finish this work, I can't cope, I am stupid*" increased, leaving her feeling incompetent and resulting in an ever-increasing workload. Kath explained that after her father died she felt she was no longer '*in control*', which was related to his emotional and physical abuse of her as a child. This made her feel anxious, and she defined her problem as being unable to cope with finishing her thesis due to high levels of anxiety. The belief that her work was not good enough discouraged her from studying, and lack of encouragement from her supervisor and editors confirmed this belief.

3.5 The psychologist's definition of the problem

I formulated from Kath's concerns that the main issue was anxiety, meeting the DSM-IV (APA 1996, p. 436), criteria for a diagnosis of generalized anxiety disorder –

excessive worry that is difficult to control, restlessness, difficulty concentrating, muscle tension and sleep disturbance –, of which her difficulty in completing her thesis was the main part. The trigger for the anxiety seemed to be the coinciding of the provisional deadline for her thesis and the first anniversary of her father's death. While the feeling of '*loss of control*' had been triggered by her father's death, she now associated it with her work. This eroded her confidence, resulting in ever-higher levels of anxiety. This perceived lack of ability upset Kath greatly and left her feeling anxious and incapable. I was aware that Kath was lacking in confidence, rather than ability – as she was studying to complete her MPhil – and knew these dysfunctional beliefs and feelings of anxiety had to be reframed and challenged if she was to regain her confidence and finish her thesis.

Kath's apprehension about her research and anxiety about the future were accompanied by the physical symptoms of anxiety described earlier. Person's model (Scott & Dryden, in Woolfe & Dryden, 1996, (eds)) was useful for understanding Kath's anxiety. This model has two levels: the first level is 'overt' – problems with interactions between emotions, behaviours and cognitions. The second level is of 'covert' difficulties – the core belief level. The model can be applied to Kath. The overt level consisted of the emotion of anxiety; the behaviour was to put off writing her thesis; and the cognition was '*I am going to produce a bad thesis and make a fool of myself*'. The covert level or core belief for Kath was '*I am not good enough*'.

The core belief that Kath had of '*not being good enough*' was an inferred belief from responses to a variety of situations and was laid down in childhood. The core belief had developed as a result of the emotional and sexual abuse by her father; this belief was re-triggered by the overlapping of the first anniversary of her father's death and her thesis deadline, resulting in an inferred belief which led to anxiety. Additionally, Kath was finding it hard to work with her male supervisor and editors. She avoided confrontation with them, which relieved anxiety in the short term but increased it in the long term. This coping strategy is common among individuals with anxiety-based disorders (Clark, in Hawton et al, 1995, (eds); Greenberger, & Padesky, 1995).

The anxiety was an indication that her childhood experiences continued to impact on her life. Kath was seen as suitable for CBT as her anxiety was triggered by a particular circumstance and not a pattern of behaviour. The CBT approach was used because it is normally short-term, structured and problem-orientated, providing

clients with a clear rationale for their emotional disturbances (Palmer & Szymanska, 1995).

3.6 Approaches, strategies and techniques adopted with the client

The theoretical approach was cognitive behavioural therapy (CBT). Research suggests that CBT is highly effective for short-term focused work (Woolfe & Dryden, 1996). The assessment indicated that Kath wanted to reduce her anxiety levels so that she could finish her thesis; despite there being other underlying issues contributing to her current symptoms the therapy was goal-orientated and focused on the here and now (Greenberger, & Padesky, 1995). I was mindful that she was currently receiving support from a CSA survivor group and endeavoured not to contradict or undermine any techniques that she may be taught there. To establish consistent practice I clarified any interventions with Kath if there appeared to be any confusion or inconsistency.

My approach was initially to educate her about anxiety and its related physical responses. I explained the cognitive model of anxiety as described by Beck and Emery (1985), which states that distorted perceptions of danger play an important part in the anxiety cycle. Individuals tend to overestimate the danger and underestimate their ability to manage. As a consequence of misinterpreting the physical symptoms, unhelpful coping strategies are triggered; for example, *I'm going to pass out* or *I can't cope.* Beck and Emery suggest that these thoughts lead to increased anxiety and result in avoidance. For Kath this manifested as avoiding work on her thesis.

This physical explanation was very important for Kath: it re-framed her fears and thoughts in a more helpful way, allowing her to understand how the cycle was created and how it could be stopped or managed. Not only were the physical symptoms of anxiety demystified but the importance of relaxation – both muscle relaxation and deep breathing – were clarified. Kath found the relaxation work useful, quickly learning the difference between physical stress and relaxation. This helped reduce anxiety, boosted confidence and in turn her self-esteem, as suggested by Clark (1995) who stated: *"relaxation can be an effective way for patients to demonstrate to themselves that they have control over their symptoms"* (Clark, in Hawton et al, (1995) eds, p 89). Once Kath was confident of her ability to use relaxation techniques to manage anxiety, the therapy moved on to cognitive work.

Kath believed her problems were a loss of ability and competence rather than emanating from cognitive distortions. It was important for her to accept the effect dysfunctional thinking had on her. Thoughts such as "*I am stupid*" produced more anxious thoughts and had a detrimental effect on her work. The re-framing of Kath's difficulties was a great source of relief for her and she was able to see that her problem was not incompetence but a lack of confidence caused by anxiety.

Through the use of a diary as homework it became clear to Kath that the lack of feedback from her supervisor contributed to negative automatic thoughts such as *"I am stupid, so he will not waste his time reading my work*". She was able to challenge this, to look at alternative views and replace them with more helpful, accurate thoughts such as *"I am not stupid, I am only anxious, my supervisor has not read my work because he is busy"*. This resulted in Kath being less anxious but becoming frustrated with her supervisor. We explored techniques to deal with this, leading to her identifying that her supervisor was young and inexperienced, had no knowledge of her specialist subject and may therefore have felt threatened by her age and knowledge. Some assertiveness skills and role-play (Hawton, 1995) were used in the session to enable Kath to practise how she would ask the supervisor to read her work. Kath had great success in encouraging the supervisor and editors to do their jobs, boosting her self-esteem and confidence. The feedback she received from them was very positive, contradicting her assumptions that she 'was stupid' and 'wasn't good enough'. The increasing evidence to invalidate Kath's unhelpful beliefs was further boosted when she was asked to present a paper on her research findings at a conference.

3.7 The nature of the contract agreed upon

3.7.1 Aims and treatment plan

There were a number of issues that Kath brought to the assessment session, some of which as, I knew from the referral letter, she was addressing in the survivor group. With this established, the aim from therapy for Kath was to finish her thesis. I explained to her that the most effective approach would be CBT (Beck, 1991; DoH, 2001). Kath understood and accepted the thought, mood and behaviour cycle and was able to understand how anxiety-provoking thoughts could be altered. The agreed

treatment plan was to support her to manage feelings of anxiety and any symptoms of depression that might arise so that she could finish her thesis.

3.7.2 Time

A contract was established whereby initially weekly meetings would occur lasting approximately fifty minutes in duration. After the sixth session we would discuss whether further sessions would be needed. This contract also fitted with the policy of the CMHT, which allowed for up to six sessions with a review at the sixth session. Renegotiation with the team would need to take place at that stage before other sessions could be offered (Kath never needed further sessions). Two weekly sessions were arranged initially, followed by three fortnightly ones, then a follow-up session six weeks later. Kath attended all of her sessions.

3.7.3 Structure

At the beginning of each session, any homework that had been set in the previous session was reviewed. Problems or issues that had arisen were then addressed, with process from the previous session. Positive feedback was given to Kath when appropriate with education about challenging negative automatic thoughts being the main focus of the sessions; occasionally role-play and assertiveness training were part of the education approach. The sessions ended with Kath reflecting on any issues that she found difficult or unclear. The main points of the session were recapped and homework was set if required.

3.7.4 Limits

The limitations of CBT were discussed in the assessment. As CBT deals with 'here and now' problems (Greenberger & Padesky, 1995; Scott & Dryden, in Woolfe & Dryden 1996, eds), Kath's past was not explored in depth and neither was the relationship between her past and current difficulties.

3.7.5 Boundaries

Kath understood the counselling was to be short-term, focused work, which was restricted to the agreed number of sessions. The therapy sessions took place at the agreed times, on the agreed days. Kath was also made aware that it was possible to leave phone messages for me or contact the CMHT should she need to; she never used this facility.

3.7.6 Confidentiality

The issue of confidentiality was addressed at the end of the assessment session. This covered the use of case material for further educational development and supervision. A letter was written to Kath's GP to inform him about the start of therapy, followed by a report after the final session. The situations when confidentiality would need to be breached were explained, as was CMHT confidentiality policy. She was told I would seek her permission first to breach confidentiality where possible should she become a risk to herself or a third person.

4 The content and process of the sessions

4.1 The overall content of the sessions

The main aim of therapy for Kath was to finish her thesis for her M Phil. The completion of her research was achieved by working on a number of issues, primarily her feelings of anxiety. She was educated about the physical cycle of anxiety, and was taught cognitive behavioural skills to enable her to challenge her dysfunctional thoughts and to replace them with more helpful ones.

To work with Kath's anxiety, the model produced by Butler et al, (1987) (cited in Woolfe & Dryden, 1996, p 176 eds), was used as the basis for treatment. Butler et al's model consists of a number of stages. These were:

- General information about anxiety and what cognitive behaviour therapy entailed: Kath found education about the nature of anxiety very helpful; it served to reduce her level of anxiety

- A cognitive element to target anxiety-producing thoughts: being able to use a diary was helpful to identify negative thoughts such as '*I am stupid*'. These thoughts were then challenged by asking if they were helpful or accurate

- Relaxation and distraction techniques for predicting anxiety: deep breathing exercises (Clark, in Hawton et al, 1995 (eds); Greenberger, & Padesky, 1995) were used prior to her speaking to her supervisor about her work. This

lowered her anxiety level and gave her confidence in her ability to be effective and clear with her supervisor when speaking to him

- Exposure to avoided *in vivo* situations: working on her thesis was no longer avoided as she realised that she had lost her confidence not her ability. Conversing with her male supervisors had previously been another avoided situation

- A self-confidence boosting component, looking at Kath's strengths and abilities: Kath's sense of humour was a real strength and it was possible to use this ability to reframe situations in a helpful way so that she did not feel threatened or chastised when challenging negative thoughts. An invitation from an external supervisor for her to present a paper on her research findings at a conference boosted her self-confidence

4.2 Progress, difficulties encountered and attempts to overcome them

Kath worked well and reported an improvement in how she felt after the first session. She found the diary to be a most helpful tool for challenging negative thoughts. It also helped identify triggers and stimuli to her anxiety. Progress was steady, and after each session improvements were noted by one of us; positive feedback provided by me boosted Kath's confidence. The third session was a difficult one as Kath's thesis had been returned to her with a number of recommended changes. She found this very hard to deal with and had become very anxious and appeared depressed. She felt she was back at the beginning again and that her work, and by inference she, was "*not good enough*". In addition Kath found the experience of accompanying her son Terry to an appointment about his gender reassignment difficult. It was possible to rationalise with Kath how she felt and we identified that she had not used her diary to challenge anxious thoughts nor had she implemented relaxation skills. We focused on her cognitive distortions, particularly catastrophising, overgeneralisation and 'should' statements (Clark, in Hawton et al, 1995, (eds); Greenberger, & Padesky, 1995). She was able to reframe her cognitions, which reduced her anxiety, allowing her to reflect on her supervisor's feedback and to use it effectively to improve her work. The next session was also very positive, with Kath feeling far less anxious and much more confident. At the fifth session Kath had stopped taking her medication (Lorazepam), reporting she was back to being her "*old self*".

4.3 Relationship difficulties and trust

Kath appeared to find it difficult in the earlier sessions to accept that it was she; not me, who was effecting change in her life. We explored this issue in a way that did not harm the therapeutic relationship and strong working alliance that had formed (Catty, 2004). Feedback was received following an interview regarding individual long-term psychotherapeutic work Kath had had at the psychotherapy department of the NHS Trust. Kath had reported that she got on very well with her psychologist and wished she could work further with me. This was very gratifying for me but also worrying because of the risk of Kath having developed a dependency on me. This issue was addressed in the fifth session, during which the limitations and boundaries of our work were reviewed. The relationship appeared not to be damaged by this discussion.

5 Evaluation

5.1 A critical assessment of the effectiveness of therapy

Kath said she felt '*back to her old self*', which she said was "*great*". She completed her thesis before our last session, reporting that she had achieved her goals. A further positive outcome was that Kath no longer needed medication to help with her anxiety problem. At the time of the follow-up session Kath brought a bound copy in for me to see, with news that she had been accepted to go on to study for a PhD. I felt a strong connection with Kath and was genuinely delighted that she had managed so well using a CBT framework.

5.2 Self-evaluation of skills and psychological understanding

Working with Kath had been a very positive experience for me as it provided insight into the importance of humour in therapy, reinforcing for me how it could accelerate the development of a good working alliance and enable me to challenge beliefs in a non-confrontational manner. The use of role-play enabled Kath to learn, practise and hone new skills; it also served to illustrate the importance of realistic cognitive restructuring (Hawton, 1995). Her reporting being accepted to do a PhD was immensely satisfying news for me as a psychologist, confirming the effectiveness of the work we did together. The use of some objective psychometric tests to measure depression and anxiety symptoms would have been valuable – Beck's Depression

Inventory BDI-II and Beck's Anxiety Inventory BAI – for use in auditing and for monitoring practice to ensure its effectiveness and safety (Beck, 1991).

5.3 Professional dilemmas and concerns experienced

A main concern was the issue of confidentiality. Kath had a history of self-harm and attempted suicide, requiring the CMHT to be consulted regarding procedure and her GP to be kept informed of her progress. Kath was aware of this, accepting it as routine.

5.4 The use of supervision related to work with the client

I sought supervision prior to our fifth session to clarify the issue of dependency that Kath may have developed. The supervisor supported the decision to address this with Kath.

6 Retrospective reflections

Writing reflectively several years later, Kath is easy for me to recall despite the initially nondescript figure she cut and her tendency to merge into the background. I am still impressed by her fortitude. She had found the relaxation skills very difficult to practise due to her abusive background, as is reported often to be the case for people who have experienced early CSA (Burke-Draucker, 1996). Nonetheless, she undertook to master them and applied herself fully to every intervention, confident that I would endeavour to keep her safe. I would use the same interventions and framework again if Kath were referred to me now, having discounted Eye Movement Desensitisation and Reprocessing (EMDR) because of her past history of CSA, self-harm and dissociation, which would render her an inappropriate candidate for this type of psychological approach, particularly as she had been referred for short-term therapy (Parnell, 1998). Given the progress that she had made in therapy she appeared no longer to need further individual psychotherapy at that point. She was already attending the CSA survivor group and had successfully completed the time-limited psychological therapy within the CMHT.

Kath made immense progress in a short space of time using a very structured therapeutic framework. Given her high-risk history she would have been one of the least likely individuals to make so much progress in time-limited therapy (Parnell,

1998; Ryan et al, 2005). Kath could have been considered as someone who experienced 'post-trauma growth' in that she moved well beyond any of her family or peers' expectations of her and was able to change those early negatively skewed beliefs that had been laid down as a child into positive cognitions (Parnell, 1998; Woodward & Joseph, 2003).

References

American Psychiatric Association (APA). (1996). *Diagnostic and statistical manual – of mental disorders fourth edition.* Washington. DC: American Psychiatric Association.

Beck, A,. T. & Emery, G., D. (1985) *Anxiety disorders and phobias, a cognitive perspective.* New York: Basic.

Beck, A., T. (1991) *Cognitive therapy and the emotional disorders.* London : Penguin Books.

Burke-Draucker, C. (1996). *Counselling survivors of childhood sexual abuse.* London: Sage.

Catty, J. (2004). The vehicle of success: theoretical and empirical perspectives on the therapeutic alliance in psychotherapy and psychiatry. *Psychology and Psychotherapy: Theory, Research and Practice.* 77. 2: 255-272.

Clark, D., M. (1995) Anxiety states: panic and generalised anxiety. In Hawton, K., Salkovskis, P. Kirk, J. & Clark, D. (1995) (eds). *Cognitive behaviour therapy for psychiatric problems: A practical guide.* London: Oxford University Press.

Department of Health, (1999). *National service framework for mental health: modern standards and service models.* London. DoH (Accessed from HTTP web site 4th January 2006: http://www.dh.gov.uk).

Department of Health. (2001). *Treatment choice in psychological therapies & counselling: Evidence Based Clinical Practice Guideline.* London: HMSO.

Department of Health, (2002). *Mental health policy implementation guide community mental health teams.* London. DoH.

Gilbert, P., Allan, S., Nicholls. & Olsen, K. (2005). The assessment of psychological symptoms of patients referred to community mental health teams: distress, chronicity and life interference. *Clinical Psychology and Psychotherapy.* 12: 10-

Greenberger, D., & Padesky, C. (1995). Mind over mood: change how you feel by changing the way you think. London: The Guilford Press.

Neilson, J. & Hall, A. (2002). Referral patterns for psychology within a community mental mealth team (CMHT). *Counselling Psychology Review,* 17, 2: 32-38.

Palmer, S., & Szymanska, K. (1995) An introduction to cognitive therapy and counselling. *Counselling, Journal of the British Association for Counselling.* 6. 4: 302-6.

Parnell, L. (1998). *Transforming trauma: EMDR. The revolutionary new therapy for freeing the mind, clearing the body, and opening the heart.* London: W.W. Norton.

Read, J., Agar, K., Argyle, N., & Aderhold, V. (2003). Sexual and physical abuse during childhood and adulthood as predictors of hallucinations, delusions and thought disorder. *Psychology and Psychotherapy: Theory, Research and Practice.* 76. 1: 1-22.

Ryan, M., Nitsun, M., Gilbert, L., & Mason, H. (2005). A prospective study of the effectiveness of group and individual psychotherapy for woman CSA survivors. *Psychology and Psychotherapy: Theory, Research and Practice.* 78. 4: 465-479.

Scott, J., & Dryden, W. (1996). In Woolfe, R., & Dryden, W. (eds). *Handbook of counselling psychology.* London: Sage Publications

Woodward, C., & Joseph, S. (2003). Positive change processes and post-traumatic growth in people who experienced childhood abuse: understanding vehicles of change. *Psychology and Psychotherapy: Theory, Research and Practice.* 76. 3: 267-283.

SECTION D

LITERATURE REVIEW

The genesis, services provided,
service users and the role of psychology
in community mental health teams

1. Overview

Community mental health teams (CMHTs) were selected for the literature review because they are the base from which secondary mental health care is provided. There is much literature on the community mental health team *per se* and the function it serves in the National Health Service (NHS) (DoH, 2002; Holloway, 2001; Thornicroft & Tansella, 2004; Tyrer et al, 1998; Tyrer et al, 2001). There are, however, few empirical studies investigating the roles of the professionals involved in them in, particular psychologists (Mistral & Velleman, 1997). This section will review the genesis of CMHTs and how and why they developed, as well as examine the service users for whom the CMHTs were intended. The literature relating to the role of psychology and psychologists has been identified to review, the role of psychological therapy as an effective treatment for this client group is well documented (DoH, 2001; DoH, 2002; DoH, 2004; Layard, 2005; Levant et al, 2001; SCMH, 2006; Turpin, 2005). However, its efficacy within CMHTs in the form of symptom reduction for service users is not well researched. The quality of the literature about the role of psychology within CMHTs is often only satisfactory at best, with the majority of papers drawing conclusions based on anecdotal or descriptive information rather than scientific or systematic methodology – quantative or qualitative.

2. Introduction

The literature reviewed in the study relates primarily to material focusing on adults of working age rather than on children, adolescents or older people; all references to CMHTs in this section therefore relate to an adult service unless otherwise specified by the researcher. Other specialist services may be referred to, for example, assertive outreach, crisis resolution and early intervention teams (SCMH, 2006), but the review focuses specifically on generic CMHTs rather than on all community secondary mental health services.

There are a variety of mental health professionals who provide services within a CMHT but the review will focus on the role of psychology and not examine in detail the roles of these disciplines, as the researcher believes this is not the forum for such a broad investigation. Studies pertaining to the experiences of other disciplines may

be included if they have information that aids understanding of the role of psychology. Therefore, the literature review is not exhaustive and papers have been selected on the basis of representing aspects of the various roles of psychologists within the CMHT. The literature search was limited to the last 15 years and consisted of UK peer-reviewed English-language journals and national organisation web sites. Strategies used to find articles were keyword and wildcard combination searches in title and abstract and full body (if full text): for example, counselling, psychology, CMHT, community, mental, health, team, chronic, mental health care, enduring mental health, serious, secondary, NHS, clinical psychology, counselling psychology. Links that were found in articles to other material were also followed.

In addition to the databases searched, web sites were accessed. These included The Department of Health and associated departments, non-government organisations such as Sainsbury Centre for Mental Health (SCMH) and National Association for Mental Health (Mind) as well as the British Psychology Society (BPS) website. The review will conclude with recommendations for the sound investigation of the role of psychology within CMHTs and consider the positive contribution counselling psychology could make to these teams.

The provision of secondary mental health is facing far-reaching changes, according to the recent report '*The Future of Mental Health: a Vision for 2015*' published by the Sainsbury Centre for Mental Health (SCMH, 2006). The paper calls for a holistic approach to mental 'well-being' rather than focusing on mental 'illness' (BBC HTTP Web site accessed 4th January, 2006; http://news.bbc.co.uk/1/hi/health).

The implications of this report for applied psychology generally and counselling psychology specifically will be considered. Counselling psychology has been singled out for this in-depth analysis, as the proposed changes towards a mental well-being model reflects the existing and historical philosophical focus of this orientation. Counselling psychology places the individual and their strengths at the centre of treatment and is based on the idea of *mental health* rather than mental illness (Van Scoyoc, 2005b).

3. Historical perspective

Over the last forty years there has been a reorientation of mental health services, moving away from institutional care towards care in the community (Carpenter et al, 2003; Gauntlett et al, 1996; Thornicroft & Tansella, 2004), and from confinement to integration (Bugge et al, 1997).

In March 1961 at the annual National Association for Mental Health (Mind) conference the serving Minister of Health, Enoch Powell, announced proposals to close the large psychiatric hospitals (www.mind.org.uk, accessed 4th January 2006), heralding the change that was about to take place in the provision of mental health care. Related to this move from hospital to community care has been the promotion of social and psychological explanations for the cause and treatment of 'mental illness' (DoH, 2001; Galvin & McCarthy, 1994; Layard, 2005; SCMH, 2006).

In addition to the social, political and psychological changes that have led away from institutionalised care to provision within the community is the potential cost savings for the health service. However, Thornicroft and Tansella (2004), who conducted an overview of systematic evidence gained from international papers rather than just the UK, found that:

> "*Quality of care is closely related to the expenditure upon services, and overall community-based models of care are largely equivalent in cost to the services that they replace.*"
>
> (Thornicroft & Tansella, 2004. p. 288).

Clearly a high-quality mental health service delivered within the community is not a cheaper option for the state, if one accepts the findings from an international study can be generalised to the UK.

During the last thirty years, CMHTs have become the framework for providing community mental health services (Holloway, 2001; Hunter et al, 2002; Peck, 1995; Thornicroft & Tansella, 2004). As with any social movement they have undergone establishment, development and change, experiencing all the adjustment problems associated with each stage. In a 1994 Sainsbury Centre for Mental Health (SCMH) study, researchers reported that CMHTs were increasing in size and number without

consideration of findings highlighting problems with fragmented teams (Onyett & Ford, 1996; Onyett et al, 1994) or the lack of sound empirical evidence supporting CMHTs (Galvin & McCarthy, 1994; Holloway, 2001).

As reported by Paxton two years later, CMHTs continued to be the model for providing mental health services in the community despite a *"persistent and growing bad press"* (Paxton, 1995, p 331) and a paucity of evidence supporting their use (Holloway, 2001). Today, CMHTs are very much the way secondary mental health care is provided but they nevertheless continue to attract mixed reviews regarding their efficacy (Holloway, 2001; Thornicroft & Tansella 2004; Tyrer et al, 1998).

Anecdotal claims have been made suggesting that there have been improvements over the last five years, with the National Director for Mental Health, Professor Louis Appleby, reporting that the *National Service Framework for Mental Health* (DoH, 1999) had led to substantial changes:

> "*We have seen record increases in investment and staffing, we now have over 700 specialised community mental health teams and we have the lowest suicide rate since records began.*"
>
> (Appleby, cited BBC web site, accessed 4th January, 2006).

Despite these claims there are still calls from interested parties, mental health groups and social care organisations for a radical reform of mental health care (Mind; accessed 4th January 2006: http://www.mind.org.uk).

4. CMHTs: what are they?

It is accepted that secondary mental health care is provided mainly by CMHTs but the meaning of a CMHT depends on who is interpreting the term and why. Meanings range from a collection of professionals (Watson, 1994; Osborne-Davies, 1996), a social process (Peck, 1995), a health resource (Pugsley et al, 1996) to a management structure (Moss, 1994).

Not only are there differences in the meaning of what a CMHT is but there is equal confusion about the service that a CMHT provides. Primarily it is perceived as

replacing mental hospitals as a location from which a service for mental health care is provided (Bugge et al 1997; Holloway, 2001; Lankshear, 2003; Orford, 1992). It can be an information centre to service users and their carers or family (Gauntlett et al, 1996); or it may be an accessible resources for people who need mental health support (Bugge et al, 1997; Gask et al, 1997).

As can be seen, the definition of a CMHT varies according to who is defining it. The use of five categories to define a CMHT have been suggested, which are:

- Comprising of two or more disciplines
- Serving a client group who are adults with mental health problems
- Majority of work taking place outside of hospital
- Containing at least four members
- Offering a variety of services

(Lingard & Milne, 2004; Onyett, 1994)

Lingard and Milne (2004), who examined CMHTs for older people (OP), define a CMHT– not specifically to OP – as *"at least two professions working together and meeting at least once per week to discuss referrals and current cases"* (p. 37). It is noted that despite being *the* forum for interdisciplinary work, the actual makeup of a CMHT is variable. Lingard and Milne suggest it is appropriate for the composition of CMHTs to vary as each one is unique, serving different populations according to the geographical location of the CMHT and the economic and social mix of its service users.

Lingard and Milne (2004) examined the lack of 'shared understanding' prevalent even among mental health care workers, particularly in relation to CMHTs servicing older people. This lack of agreement has rendered almost impossible the systematic analysis of the effectiveness of CMHTs, with meta-analysis being conducted on incomparable studies and their conclusions being based on positive findings from studies of foreign CMHTs (Holloway, 2001; Tyrer et al, 1998; Tyrer et al, 2001).

The presence of so many conflicting opinions of what constitutes a team inevitably influences the service CMHTs provide, the selection of team members and the role of psychology, if any, within them (Anicano & Kirkpatrick, 1990; Mistral & Velleman, 1997).

Ovretveit's (1993) definition of teams includes three dimensions: structure, process and integration. Structure is how the team is managed and what it is composed of; process refers to how the team obtains referrals for service users and how the team over time works with them; integration describes the working level of congruence between team members.

4.1 Integration

The Department of Health (2002) recognises that an integrated multidisciplinary approach is required for a CMHT to function effectively. Health and social needs alike are addressed for service users through a single contact point once a team has been successfully integrated. The CMHT's response to these needs is planned and monitored in an integrated system, providing seamless care that reduces unnecessary duplication of assessments and makes the process of receiving care from a CMHT less daunting, confusing and distressing. This concept is supported by the National Service Framework (NSF, 1999), which advocates, "*Action on mental health must be integrated into all local delivery systems*" (p.32). However, the reviews and studies that form the basis for the DoH (2002) implementation guide appear to lack any form of national review of CMHTs to ascertain if this policy is pragmatically realistic and its recommendations are therefore unsubstantiated.

Integration has been considered more recently to be an essential aspect of a successful CMHT (Carpenter et al, 2003), certainly when looking at services for older people, as Lingard and Milne (2004) have done. They found, though, that as with the term CMHT, integration is also interpreted differently by different people (Lingard & Milne, 2004). Despite this lack of clarity regarding the meaning of the term 'integration', Lingard and Milne (2004, p. 9) have found that integrated teams "*have the potential to be more than the sum of their parts*". The lack of consistent comprehension about the term integration places the validity of any recommendations in question. In particular, the methodology used in the paper by Lingard and Milne (2004) was a review of published material, local practices and web resources and there is no reference to how the material was gathered for some of the studies they cite. Moreover, questionnaires are mentioned with no comment on analysis or who the respondents to the questionnaires were (Lingard & Milne, 2004, p. 36).

5. Who does a CMHT serve?

CMHTs are usually associated with prioritising and providing care for people with severe and enduring mental health problems (Holloway, 2001; Lankshear, 2003; Thornicroft & Tansella, 2004). According to DoH guidelines (2002), CMHTs provide a service to two distinct groups of people; both groups are typically made up of adults only, with separate specialist services providing mental health care to adolescents and older people.

Most service users have 'time limited disorders' and only use the CMHT for a matter of months at the most (DoH, 2002). The next group are those most commonly associated with the service and are considered to be the "substantial minority" who may well use the service for years (DoH, 2002). It comprises individuals with a variety of presenting difficulties who cannot receive an appropriate service from their GP, primary care team or specialist teams such as assertive outreach or personality disorder teams. This group includes individuals with:

- Poor engagement and complicated needs who are under the Mental Health Act (1983)
- Personality disorders and in need of continued care
- Particular needs from specialist services (e.g. blood tests, CBT)
- Severe and persistent mental disorders causing significant disability (psychoses, bipolar disorder and schizophrenia)
- Other less severe long term disorders with poor treatment compliance
- Disorders with increased risk of self harm (for example severe obsessive compulsive disorder or anorexia nervosa)

(DoH, 2002).

Lankshear (2003) found that referrers invariably interpret who is suitable as a referral for the CMHT service differently, despite the recommendations laid down by the Department of Health. Lankshear noted that some GPs would refer clients to CMHTs who did not fit the criteria for referral, particularly individuals experiencing anxiety and depression. It was considered that the NSF (DoH, 1999; DoH, 2002) did to some extent help clarify appropriate services for anxiety and depression referrals, allowing CMHTs to concentrate on providing a service to individuals with enduring mental health problems. While it is believed that this resulted in a more effective

multidisciplinary service, strict adherence to those guidelines is not always the case (Gilbert et al, 2005; Lankshear, 2003; Neilson & Hall, 2002).

Lankshear emphasised that not all CMHTs provide secondary mental health care, at times playing 'piggy in the middle' to primary care teams and other specialist teams such as early intervention, assertive outreach and crisis intervention (Lankshear, 2003). But the findings from Lankshear's study may not be reliably generalised to other situations, partly due to design problems such as where respondents were interviewed, how freely they could talk about negative aspects of their experiences in their CMHT and how they 'assessed' the diagnoses of an individual. There are also analysis problems with the study due to lack of corroboration with coding of transcripts. Evidently, despite guidelines defining who is a suitable recipient for a CMHT service, this is at times construed differently, as indeed the concept of a CMHT often is (Lankshear, 2003). The referral patterns for psychology within CMHTs was examined by Neilson and Hall (2002) but their study is flawed because of the small sample size and it's reliance on the diagnostic abilities of referrers. Despite this, it seems to support the view that inappropriate referrals are made to CMHTs.

Thornicroft and Tansella (2004) found that CMHTs provide a service for a particular population based on the resources available within a given area. Their paper summarised the results of studies examining the provision of mental health care in the community as opposed to a hospital setting. A particularly important factor was whether the service was provided in a high, medium or low resource area. They noted that there are only limited attempts to review as a whole the results of mental health service studies, resulting in an inadequate evidence base.

From their review of the literature it appeared that areas with low resources are more likely to provide services through primary care. In these settings, individuals with mental health problems would not be referred out for treatment, as occurs in better-resourced areas. This shows which individuals CMHTs offer a service to is also determined by available resources rather than being entirely based on government policy or on evidence-based practice (Thornicroft & Tansella, 2004). The validity of these findings for the UK, however, is highly questionable given that a large proportion of the studies were done abroad.

The CMHT system strives to offer a service to those in society whose mental health care needs – psychological, social or physical – cannot be accommodated within

primary care due to their complexity. Neither can they be offered appropriate care through specialist mental health teams because they either do not fit the criteria for appropriate referral or the service simply does not exist in that geographical area.

According to Hunter et al (2002), the CMHT as a key provider of services to individuals with mental health problems aims to prioritise its service to those with serious and enduring mental health problems, as they cannot be cared for in other specialist teams or primary care (Hunter et al, 2002; Lankshear, 2003). Hunter et al raise the concern that despite the reasonably clear referral criteria generally, what has attracted little research is the actual case-mix that staff carry and the impact of this on them and team dynamics (Hunter et al, 2002). The study looked at a two-week snapshot of referrals and one of the design limitations of the study was the lack of clarity regarding diagnostic criteria. Furthermore, including the time spent travelling to and from clients' homes may invalidate the results and lean to erroneous conclusions, an example of which would be that psychologists tend to see patients with probable personality disorder over other groups. If one of the measurements is time involved in travel, psychologists are likely to record fewer hours as they tend to be based in the CMHT, undertaking assessments and providing psychological therapy sessions and rarely travelling to the same extent as other team members.

Another aspect that is not always reflected in policy documents or the research literature is that individuals who are referred to CMHTs are often experiencing a high degree of distress and suffering (Layard, 2005). This reaction can be amplified by a referral to a CMHT for treatment, as negative associations and social stigmas persist, resulting in an increase in mental health problems (DoH, 2004; Hurley & Linsey, 2005; Layard, 2005; NIMHE, 2005; SCMH, 2006).

6. What functions does a CMHT serve?

The DoH (2002) implementation guide for CMHT states: "*The best structure is a matter for local discretion, but clear pathways to care should be described by locally agreed protocols" (p. 5).* A key message in the DoH guide seems to be that CMHTs may vary one from the other. However, it is through the use of an 'integrated multidisciplinary approach' that CMHTs function most effectively. When they are functioning well they enable primary care services to work more effectively and

efficiently through liaison; they help normalise and promote mental health issues; and aim to provide seamless care through discussion at joint meetings (DoH, 2002, p.5).

On a pragmatic note, the CMHT provides a service to users that entails timely assessments and provision of appropriate evidence-based interventions to alleviate distress experienced by individuals (DoH, 2001; Lingard & Milne, 2004; SCMH, 2006). Assessments are usually conducted within four weeks of referral, but good practice aims for one week. Priority is given to crisis assessments, and ideally medically trained staff assess those with serious mental illness.

The CMHT is a base for local knowledge regarding available services and resources that can be accessed by service users and their families, the provision of which is to be conducted in a socially and culturally appropriate context (DoH, 2002; Lingard & Milne, 2004). However, in reality this is not universally being achieved and has been noted by the SCMH policy paper (2006) as an area for improvement.

Three central purposes to the functions of a team have been identified by the DoH: first, to continue proactive care of those with enduring mental health problems; second, to provide access to support, information, intervention and treatment prior to and during a crisis; and third, to work with primary care by responding to reasonable requests for support (DoH, 1996; DoH, 2002).

Theoretically the CMHT *"provides the range of skills for rapid and effective intervention"* (Onyett & Ford, 1996, p. 48). However, in most instances the team cannot provide all of the services required, so service providers are brought in from outside agencies this: is often referred to as 'Brokerage' (Onyett & Ford, 1996). A relationship has been found between higher levels of outside agency involvement and the breakdown of care, resulting in a desire to provide as many services as possible through the CMHT to reduce the risk of care breakdown (Onyett & Ford, 1996).

6.1 The care programme approach

The care programme approach (CPA) and care management are most commonly used when working with people who have severe and enduring mental health problems. These are not interventions but rather a model for delivering care (Carpenter et al, 2003; DoH, 1999; DoH, 2002; Lingard & Milne, 2004; Thornicroft & Tansella, 2004).

Often CPA is seen as an essential framework for enabling the integrated delivery of services by health and social care workers. Members of the team usually co-ordinate the CPA and act as key workers for the programmes, updating them on a regular basis (DoH, 2002). However, Lankshear (2003) noted that the introduction of this mode of working has also introduced additional tensions into the multidisciplinary CMHT.

The purpose of the CPA as described by Lingard and Milne is to "*provide more co-ordinated care to vulnerable adults*" (Lingard & Milne, 2004, p. 46). Thornicroft and Tansella describe it further as a delivery of individualised care through the integration, co-ordination and allocation of limited resources. Positively, they cite studies indicating that the CPA approach is associated with increased continuity of care and user satisfaction. Once again, however, there is little support regarding its impact on admission rates to in-patient services or symptom reduction generally (Thornicroft & Tansella, 2004).

While the DoH proposal for co-ordinated and integrated care is to be applauded, Lankshear's (2003) observations suggest there is often a divide between the idiom and practical application of the paradigm.

The SCMH (2006) policy paper has clear views regarding the importance of the role of CPAs in its vision of mental health care for 2015. It suggests that every UK mental health service needs to ensure the implementation of care planning and CPAs:

> *"By 2015 not only should everyone have a comprehensive, tailored care plan and be receiving the services stipulated in it, but they should have taken the lead in determining how they want their needs met".*
>
> (SCMH, 2006, p. 10)

This statement illustrates a clear shift in focus from one aligned with the medical model to a more holistic approach. This appears to be a contradictory view to the one held by the traditional majority of medically trained mental health care professionals (SCMH, 2006), including the greater proportion of the psychologists involved in providing a service to this client group (Corrie & Callahan, 2000; Lane & Corrie, 2006; Smallwood, 2002). The SCMH (2006) policy paper is based on a review of literature, consisting primarily of papers produced by the DoH; these are in turn often

reviews of the literature from the same evidence base. The detachment from primary research is perturbing as the proposals are unsubstantiated by evidence.

7. Who are the team members?

The CMHTs are generally composed of a combination of the following disciplines: community psychiatric nurses (CPNs), other nurses, social workers, psychiatrists, other staff grade doctors, clinical psychologists, occupational therapists, mental health support workers and administrative staff (DoH, 2002; Hunter et al, 2002; Lingard & Milne, 2004; Onyett, et al, 1995). Other professionals have also been found to be members of CMHTs, as recognised by Mistral and Velleman (1997): these include family therapists and other applied psychologists rather than clinical psychologists, while Hunter et al (2004) noted that specialist registrars and occupational therapy assistants are also CMHT members.

The composition of the teams can vary greatly: often it may seem there is little or no rationale given for the team make-up (Galvin & McCarthy, 1994; Onyett, et al, 1995; Mistral & Velleman, 1997), and surprisingly the DoH supports this eclectic mix of professionals: "*There is no evidence to justify being too prescriptive. However, the team should reflect the ethnic range of the local population.*" (DoH, 2002, p. 19).

Largely though, it seems that the composition of the team is dependent on the availability of suitably qualified practitioners rather than on the ideal professional mix, with some disciplines being harder to employ than others due to skill shortages (Lingard & Milne, 2004). The lack of clarity about the structure of the CMHT make-up may in part be the result of the lack of methodologically sound research investigating team composition.

7.1 Commitment of team members?

As illustrated earlier the composition of CMHTs varies greatly (DoH, 2002; Watson, 1994) in the form it takes (Holloway, 2001; Lankshear, 2003), the services it delivers (Gauntlett et al, 1996), as well as which professionals make up the team that provides the services (DoH, 2002; Hunter et al, 2002; Lingard & Milne, 2004; Mistral & Velleman, 1997; Onyett et al, 1995). In the study conducted by Onyett et al (1994)

it was found that *"to be truly called a multidisciplinary team one has to have equal commitment from all the services involved"* (Onyett et al, 1994, p. 29).

The issue of equivalent levels of dedication from the different disciplines involved in a CMHT has been raised often (Lankshear, 2003). Psychologists particularly have been cited on many occasions as having responsibility elsewhere and therefore lacking adequate loyalty to the CMHT (Lankshear, 2003; Lingard & Milne, 2004; Onyett et al, 1997; Mistral & Velleman, 1997).

Psychologists are not alone in their documented reticence to join generic CMHTs. Occupational therapists (Bones et al, 1997; Lankshear, 2003) and consultant psychiatrists (Onyett et al, 1994; Royal College of Psychiatrists, 1996) have also been historically equally difficult to recruit.

8. The provision of psychology within CMHTs

With this unstructured and uncertain background it is hardly surprising that there is reluctance among some health care professions to work within CMHTs (Lankshear, 2003; Onyett et al, 1994; Onyett et al, 1995), with a noted difficulty in recruiting psychologists for psychology positions (Bones et al, 1997). Partly as a result of the problem in recruiting psychologists, traditionally clinical psychologists, applied psychologists from different divisions and other mental health care professionals are usually employed to deliver psychological services within CMHTs (DoH, 2002).

The efficacy of psychological interventions for individuals with mental health problems is well documented (DoH, 2001; DoH, 2002; DoH, 2004; Layard, 2005; Levant et al, 2001; SCMH, 2006; Turpin, 2005). The DoH (2002) suggests that the provision of psychological therapy *should* be provided by CMHTs, identifying them as being mainly for those individuals who present with short-term needs. The policy guide states:

> *"This provision does not need to be restricted to clinical psychologists. Post graduate training is available in many of these techniques and staff should be encouraged and supported to obtain these skills".*
>
> (DoH, 2002, p. 10)

While the importance of the provision of psychological therapies within CMHTs is recognised and is set to become even more central to the treatment of mental health problems, the lack of explicit reference in government literature to the role of psychologists in the provision of this care is alarming (Lingard & Milne, 2004; SCMH, 2006).

8.1 Who is providing psychological therapy?

Literature on the role of psychologists in CMHTs is most commonly based on the experiences of clinical psychologists (Anicano & Kirkpatrick, 1990; Cushion, 1997). Researchers cite clinical psychologists as their samples in empirical studies, while acknowledging (off the record) that their sample was composed of a variety of psychologists under the umbrella term '*clinical psychologist*' (Mistral & Velleman, 1997). While grouping together applied psychologists from different divisions may be useful to obtain a reasonable sized sample for statistical analysis, it fails to give a clear picture of the full diversity of psychology divisions engaged with CMHTs.

The difficulty of filling psychology posts within CMHTs (Onyett et al, 1994; Bones et al, 1997) has been mentioned often in literature, with Bones et al (1997) reporting that it was difficult to fill clinical psychology vacancies in CMHTs: *"There are under 3,000 clinical psychologists in the UK. Vacancies are hard to fill, while demand increases."* (Bones et al, 1997, p. 33). Nearly nine years later there continues to be a severe shortage in the number of registered applied psychologists available to provide psychological services to CMHTs (DoH, 2004; Kinderman, 2005; Layard, 2005; Leiper, 2002).

This problem appears to be compounded by psychologists being attracted to specialist secondary mental health care teams such as assertive outreach or crisis resolution teams (Leiper, 2002). The availability of registered applied psychologists may be set to become even scarcer in CMHTs if moves towards psychology treatment centres as envisaged by Layard (2005) are to become a reality' or even if the ambitious plans regarding the mental health vision for 2015 as proposed by SCMH (2006) are to actually occur. The proposals by Layard (2005) are not based on sound methodological designed research, being anecdotal claims based on subjective experience.

Yet as the provision of psychological therapies is not deemed to be the sole preserve of clinical psychologists or, indeed, applied psychologists, with all suitably qualified

mental health professionals capable of providing treatment, shortages are thought to be possible to address through staff training (DoH, 2002; DoH, 2004; SCMH, 2006). All of the references cited supporting this move fail to base their recommendations on empirically sound evidence, with reviews of unrelated research forming the basis of government policy.

In the article by Bones et al (1997) the option of employing community psychiatric nurses (CPNs) and counsellors to provide psychological therapy services was explored, as these professional groups were cheaper and more plentiful than clinical psychologists. But their lack of extensive psychological training and frequent inability to work in a variety of therapeutic frameworks means they are less than ideal choices (Bones et al, 1997). Increasingly, however, the use of mental health professionals other than psychologists is being proposed as the way to bridge the gap between the need for and supply of registered applied psychologists (DoH, 2004; Layard, 2005; SCMH, 2006).

Related to the difficulty of recruiting psychologists for CMHT posts is the increased likelihood that newly trained and less experienced psychologists will be taking up positions in CMHTs due to increased demand and a supply shortage (Bones et al 1997). Moreover, experienced psychologists often view CMHT employment as a stepping-stone in their careers before advancing into specialist mental health or psychological services (Kinderman, 2005). Kinderman's comments are simply opinion rather than fact and need to be interpreted in that context.

One aspect of recruiting newly trained psychologists into CMHTs is the increased risk they will become peripheral group members due to the fact that they are both newcomers and new to the profession, possibly leading to problems of self-esteem, lack of identity and a loss of confidence in their abilities (Jetten, 2006). This is undesirable on all levels – for the individual, the team and the service user.

8.2 What are the roles of psychologists?

In a study by Cushion (1997), it was suggested that the role of psychologist falls into two distinct areas: direct and indirect work. Direct work consists of interventions and assessments; assessments are sub-divided into those for new referrals, complex referrals and psychometric ones, as well as those for specific psychological interventions.

Indirect work includes supervision, research, consultation, service evaluation, care planning, teaching, training and team input (Cushion, 1997). However, Cushion found that often the skills a psychologist has to offer are not used because of the constant demand of referrals within the team that *"have to be mopped up and everyone must roll up their sleeves"* (Cushion, 1997, p. 29). Methodological limitations of the questionnaire study by Cushion include the lack of information regarding reliability of the questionnaire and the limited number of respondents, none of whom were psychologists. This means it is not possible to generalise the findings to all psychologist roles and they may in any event not be applicable. Replication of this study with the inclusion of psychology respondents would be valuable.

Despite CMHTs being a building block of community services for the provision of mental health care (DoH, 2002; Hunter et al, 2002; Lankshear, 2003; Lingard & Milne, 2004; SCMH, 2006; Thornicroft & Tansella, 2004) there is still *" relatively little systematic information available on how teams function and how responsibilities are divided between members with different training and skills"* (Abendorff et al1994, p. 898). A psychologist's commitment in a team therefore varies according to the team's composition and the responsibilities that are held by other team members (Cushion, 1997; Hunter et al, 2002; Lankshear, 2003).

But a psychologist's dual role-responsibilities as a psychologist – direct and indirect client-related work –is mirrored by the direct and indirect referrals they receive from the allocation meetings within the CMHT, from other CMHT members and directly from external referral sources such as GPs and psychiatrists (Pugsley et al, 1996). A possible consequence of this is that psychologists might be providing treatment to service users who are not included in a CMHT's statistics. This can affect team dynamics as it gives the impression their caseload is less than what it actually is, which has a *"negative effect on relationships within the team, causing friction between team members"* (Pugsley et al, 1996, p. 1401).

The issue of *'team input'* is politically sensitive within a team, and conflict can arise when a psychologist does not perform desk duty, new assessments or key worker roles as other team members do. According to Cushion (1997), *"They are highly skilled professionals and should be used for this. Should they therefore be doing routine work like duty?"* (Cushion, 1997, p. 29) Psychologist are placed in a difficult situation – either do the routine work despite perhaps at times lacking the appropriate

skills and fail to use their specialist knowledge appropriately, or not do the routine work and risk being regarded as a true team member.

There is an assumption that every team member can do administrative work and that they have been trained to do this. The overlapping nature of team member's skills has been termed *'role blurring'*, and evolved with the move to functional equality and generic team-work (DoH, 2002; Lingard & Milne, 2004; Onyett, et al, 1997). The assumption that psychologists have the general training to perform core roles of other team members is raised by Mistral & Velleman (1997). While role blurring has mainly been viewed as a means of dealing with the constant flow of referrals and as a way of meeting team members' expectations it potentially results in the deskilling of psychologists (Cushion, 1997; Galvin & McCarthy, 1994).

Lankshear (2003) reports that psychologists use a strategy called demarcation – this is the practice of delineating particular duties or tasks that are undertaken by a particular group in an effort to maintain a professional identity – in response to role blurring, which is perceived as a threat to professional identity (Lankshear, 2003).

Lankshear (2003) also notes that there is debate in CMHTs regarding generic team-work, supporters of mental health professionals acquiring skills from their team colleagues in order to work generically on the one hand. Supporters of the notion that separate professionals are brought together because of the particular unique professional abilities and skills that they bring to the team and users that they provide a service to on the other hand.

Hunter et al (2002) found that psychologists – examined in their study which explored case-mix and clinical activity – tended to be involved with providing a service to clients with possible personality disorders rather than to users with a primary diagnosis of psychosis, unlike other professionals in the team. It would seem that despite general trends towards having generic CMHT staff a definite separation occurs at a user level in terms of which professionals provide a service to particular user groups. (Hunter et al, 2002; Lankshear, 2003)

9. Use of psychologists skills

Therapeutic skills are important to applied psychologists, in particular being intrinsic to counselling psychologists (Van Scoyoc & Bellamy, 2005). They are also now being recognised as essential in the treatment of mental health difficulties (DoH, 2001; DoH, 2004; Layard, 2005; SCMH, 2006), but in CMHTs the role of therapy is not yet prioritised.

Within CMHTs urgent assessments are given a priority over regular therapy. According to DoH (2002) this is partly because one of the functions of a CMHT is to provide same-day crisis response with access to support, information, interventions and treatment prior to and during a crisis. With crisis intervention being one of the primary functions of a CMHT it seems clear that regular therapy with clients becomes a lesser priority. Galvin & McCarthy (1994) identified this dynamic, reporting that provision of direct therapeutic clinical work took second place to community care development.

Anecdotal evidence suggests that on a pragmatic level psychologists often struggle to find suitable rooms available for therapy sessions with clients as priority must always be given to emergency assessments and drop-in clients, leaving the psychologist to compete for limited available space.

Related to the use of skills is case allocation and referrals. As has been highlighted earlier, there is pressure on team members to '*mop up*' cases (Cushion, 1997), with the allocation being determined not on suitability based on a consideration of appropriate skills but on availability or upon which individual in the team has conducted the initial assessment (Lankshear, 2003). *"Allocation depends upon which member of staff has time available rather than who has the particular skills required"* (Paxton, 1995,p. 332). Paxton explores the issue of skill sharing in CMHTs, stating that there is no evidence that this occurs (Paxton, 1995). This sentiment is echoed by Cushion (1997), who states that often the skills that a psychologist has to offer are neither used nor shared because of the constant flow of referrals.

Case discussion presents an opportunity for skill sharing but it has been claimed that the *"ethos of team discussion tends to lower the intellectual contributions of those present"* (Paxton, 1995, p. 332). Galvin & McCarthy (1994) similarly reflect on the

subject of the deskilling that takes place when teams discuss cases, observing that instead of facilitating the various perspectives of different professionals, there is an unfocused muddle of ideas and goals (Galvin & McCarthy, 1994). This often results in the psychologist's role being similar to the team's role, in that it is *"reactive not needs led or skill based"* (Cushion, 1997, p. 29).

However, the influential role accorded to psychology in the bold proposals for the reform of mental health care (SCMH, 2006) might result in skill sharing by psychologists as recommended by DoH (2002). The argument in favour of adopting this sort of holistic approach to mental health wellbeing, where the provision of psychological treatments assumes greater importance (Layard, 2005; SCMH, 2006), is supported by the growing evidence base for the effectiveness of psychological treatments in symptom reduction regardless of the severity of mental health problems (DoH, 2001; Layard, 2005). It therefore seems timely for CMHTs to consider re-prioritising their services.

In the face of the failure of CMHTs to effectively bring about symptom reduction for service users (Holloway, 2001; Thornicroft & Tansella, 2004) it might be prudent to reconsider the most effective use of psychologists within CMHTs. DoH (2001), in their paper *Treatment Choice in Psychological Therapies and Counselling: Evidence Based Clinical Practice Guideline*, recommend that no less than eight sessions of psychological therapy is likely to effectively precipitate symptom reduction in individuals with moderate to severe mental health problems. Despite this knowledge, CMHTs continue to see service users on an average of five to six contacts (DoH, 2002), limiting the likelihood of any symptom reduction occurring and effectively failing to treat mental health problems.

This could be addressed by allowing applied psychologists to use their therapeutic skills to bring about symptom reduction for service users and to help to reduce the distress associated with mental health difficulties (Strawbridge, 2006), and with education about the importance of positive attachments for service users (Goodwin et al, 2003). This would also be in alignment with the proposals for mental wellbeing as set out in the policy paper for mental health care in 2015 (SCMH, 2006), as well as helping to reduce one of the major drains on the health service and on the Treasury (Layard, 2005; NIMHE, 2005).

9.1 Supervision

In addition to therapeutic skills, applied psychologists are usually equipped to supervise therapeutic psychological interventions undertaken by other mental health professionals. There is concern, however, regarding the professional liability of such supervision as highlighted by Pugsley et al (1996). The 'Mental Health Patients in the Community Act' (1996) placed major supervisory responsibility on individual CMHT team members, but *"the law, however, does not recognise any concept of team liability"* (Pugsley et al, 1996, p.1398). Independent practitioners are therefore personally responsible for their professional accountability. In addition, psychologists may not supervise team members who belong to a different professional disciplines (Onyett & Ford, 1996), despite other team members believing supervision is one of the roles of a psychologist (Cushion, 1997; Galvin & McCarthy, 1994). It has been noted that interdisciplinary supervision is unclear, with lack of accountability or responsibility and on occasion a lack of regard for therapeutic ability. Although the validity of such supervision is questioned, uni-professional supervision is none the less encouraged in integrated teams (Lingard & Milne, 2004).

However, examination of the value of interdisciplinary supervision is warranted, particularly in light of the value of psychological therapy for individuals with severe and enduring mental health problems (DoH, 2001; DoH, 2004). The focus on psychological therapies in the SCMH policy paper suggests an urgent and increasing need to supervise psychological interventions conducted by other professionals in order to bring about lasting therapeutic change for users of CMHT services, as well as to ensure safe, informed, respectful user-led psychological therapy (DoH, 2004; SCMH, 2006).

10 Job satisfaction

Despite the difficulty in filling psychology positions within CMHTs (Bones et al, 1997; Catty, 2004; Kai & Crosland, 2002), Mistral and Velleman (1997) found that psychologists recorded high levels of job satisfaction when working in a position that had a defined remit and strong, supportive management from their professional line manager (DoH, 2004; Onyett et al, 1994). Unfortunately this does not often seem to be the case for many psychologists who are CMHT members (Galvin & McCarthy, 1994; Mistral & Velleman, 1997; Onyett et al, 1995; Onyett et al, 1997).

Lower levels of job satisfaction are partly due to role ambiguity within CMHTs for psychologists (Anicano & Kirkpatrick, 1990; Onyett, et al, 1995), as well as the stress associated with team-work and being perceived as a peripheral group member (Jetten, 2006). Although the development of clearly defined and appropriate roles has been recommended as a way to reduce stress and increase job satisfaction within CMHTs it is still not unusual for guidance regarding the role of psychologists to be omitted from operational policies and papers (DoH, 2001; Lingard & Milne, 2004) .

11. What model of team-work suits psychologists?

Related to job satisfaction and the role of psychologist, is the team-work model of the CMHT. Since the formation of CMHTs there has been much debate about the preferred mode for delivering mental health care (Holloway, 2001; Prosser et al, 1996; Thornicroft & Tansella, 2004). Statistically significant results were reported by Mistral and Velleman (1997) in research conducted into the opinion of professionals working in CMHTs. Their findings reveal a preference for independent professional groups as opposed to being a CMHT member, as CMHTs were perceived as being poorly organised with leadership problems and limited opportunities to use professional training (Mistral & Velleman, 1997).

Unfortunately, the study did not discuss the type of team the psychologists were referring to – whether it was a 'formal team' or a 'network association'. As highlighted earlier, 'network association teams' come together in a voluntary way to work with service users or issues, while still being managed by their own professional line manager (Onyett et al, 1994). Collaborative work is seen as being supportive, empowering and brief in terms of time (Moss, 1994) within these types of teams. Other factors that make this type of team more attractive to psychologists are that they provide professional autonomy and avoid operational management.

Unfortunately, however, despite this type of team-work being attractive to many psychologists, it is deemed to have a detrimental effect on team dynamics (Jetten, 2006) and is actively discouraged, and loyalty to an 'outside agency' is viewed as an inherent problem with psychologists (DoH, 2002; Lingard & Milne, 2004).

12. Conclusion

The evidence base is very slim for the role of psychologists and the provision of psychological treatment within CMHTs: the studies that exist are largely anecdotal and descriptive, and are not based on systematic methodology. It is little wonder then that controversy persists around the CMHT framework as an effective provider of mental health care to individuals with enduring mental health problems (Paxton, 1995), with what little evidence there is showing they fail to provide effective treatment when symptom relief is considered (Galvin & McCarthy, 1994; Holloway, 2001; Thornicroft & Tansella, 2004).

The researcher proposes an alternative approach to the current CMHT model in line with the SCMH (2006) vision of an holistic framework for mental wellbeing. This would result in psychologists taking a much more active role, and in a corresponding move away from the traditional medical model of mental health care to a humanistic one in which clients' needs and choices are central to therapeutic processes and service delivery (SCMH, 2006).

Layard (2005) suggests another model, in which psychology centres are headed up by clinical psychologists. These specialist centres would act as a community resource separate from existing psychology departments, from which to consult, communicate and see clients who have been referred by CMHTs.
Either of these two alternatives would enable psychologists to use their specialist skills to maximum benefit, as they are generally unhappy in CMHTs, reporting feeling deskilled, undervalued and 'burnt out' (Anicano & Kirkpatrick, 1990; Galvin & McCarthy, 1994; Onyett et al,1995; Paxton, 1993; Paxton, 1995).

The future role of applied psychology in relation to mental health care delivery has implications for counselling psychologists: training, skill development and professional identity need to evolve to enable counselling psychologists not only to survive in CMHTs but also to contribute to developing a more appropriate service framework in line with their philosophical values (SCMH, 2006).

Clearly articulated in the literature reviewed is a need for further research into the functioning of CMHTs so that proposed mental health service changes are done from an informed evidence-base (Holloway, 2001; Hunter et al, 2002).

It is worth repeating that successive studies have failed to prove that treatment within the current CMHT model results in the reduction of distressing symptoms for individuals. While it is noted that an improvement in continuity of care and an associated increased satisfaction from service users leading to a reduction in relapse rates has been reported (Holloway, 2001; Thornicroft & Tansella, 2004; Tyrer, 1998), Holloway (2001) argues that positive results based on better continuity of care is a truism. It needs to be acknowledged, however, that improved continuity of care does not necessarily equate to effective mental health treatment, as measurements for effectiveness should be based on actual symptom reduction data and not solely on continuity of care.

A problem highlighted regarding using CHMTs as the cornerstones for community mental health care is one of "*deciding on policy in the absence of evidence*" (Tyrer, 2001,p. 216). Given that the proposals for a future mental health care model places CMHT at the centre of service provision, it is essential that sound research be conducted into the efficacy and structure of CMHTs.

References

Abendorff, R., Challist, D. & Netten, A. (1994). Staff activity in a community mental health team for older people. *International Journal of Geriatric Psychiatry*, 9: 897-906.

Anicano, D. & Kirkpatrick, A. (1990). CMHTs and clinical psychology: The death of a profession? *Clinical Psychology Forum*, 26: 9-12.

Bones, K., Heald, M., Boxer, J. & Miller, R. (1997). In the melting pot. *Nursing Times*, August. 20, Volume 93, Number 34: 32-33.

Bugge, C., Smith, L. & Shanley, E. (1997). A descriptive study of multidisciplinary mental health staff moving to the community: the demographic and educational issues. *Journal of Psychiatric and Mental Health Nursing*, 4: 45-54.

Carpenter, J., Schneider, J., Brandon, T. & Wooff, D. (2003). Working in multidisciplinary community mental health teams: the impact on social workers and health professionals of integrated mental health care. *British Journal of Social Work*, 33, 8: 1081-1103.

Cushion, B. (1997). Clinical psychology in community mental health teams: a sample of the views of team managers and members. *Clinical Psychology Forum*, 102: 27-29.

Department of Health, (1999). *National service framework for mental health: modern standards and service models.* London. DoH (Accessed from HTTP web site 4th January 2006: http://www.dh.gov.uk).

Department of Health. (2001). *Treatment choice in psychological therapies & counselling: Evidence Based Clinical Practice Guideline.* London: DoH.

Department of Health, (2002). *Mental health policy implementation guide community mental health teams.* London. DoH.

Department of Health, (2004). *Organising and delivering psychological therapies.* London. DoH.

Galvin, S. & McCarthy, S. (1994). Multi-disciplinary community teams: clinging to the wreckage. *Journal of Mental Health*, 3: 157-166.

Gask, L., Sibbald, B. & Creed, F. (1997). Evaluating models of working at the interface between mental health services and primary care. *British Journal of Psychiatry*, 170: 6-11.

Gauntlett, N., Ford, R. & Muijen, M. (1996). *Teamwork: models of outreach in an urban multi-cultural setting*. Sainsbury Centre for Mental Health.

Gilbert, P., Allan, S., Nicholls. & Olsen, K. (2005). The assessment of psychological symptoms of patients referred to community mental health teams: distress, chronicity and life interference. *Clinical Psychology and Psychotherapy*. 12: 10-27.

Goodwin, I., Holmes, G., Cochran, R. & Manson, O. (2003). The ability of adult mental health services to meet clients' attachment needs: the development and implementation of the service attachment questionnaire. *Psychology and Psychotherapy: Theory, Research and Practice.* 76: 145-161.

Holloway, F. (2001). Invited commentary on: community mental health team management in severe mental illness. *British Journal Of Psychiatry*, 178: 503-505.

Hunter, M., Jadresic, D., Blaine, A., Clancy, L., Leyshon, N., McDonald, E., Sanderson, I., Whiffin, M. & Spearing, G. (2002). Two weeks in the life of a community mental health team: a survey of case-mix and clinical activity in the north-west of Sheffield. *Psychiatric Bulletin.* 26: 9-11.

Hurley, J. & Linsley, P. (2005). Proposed changes to the Mental Health Act of England and Wales – research investigating the debate. *Journal of Psychiatric and Mental Health Nursing.* 12, 1: 121-123.

Kai, J. & Crosland, A. (2002). People with enduring mental health problems described the importance of communication, continuity of care, and stigma. *Evidence-Based Nursing*, 5, 3: 93-94.

Lingard, J., & Milne, A. (2004). *Integrating older people's mental health services: community mental health teams for older people*. Department of Health. London.

Lankshear, A. (2003). Coping with conflict and confusing agendas in multidisciplinary community mental health teams. *Journal of psychiatric and Mental Health Nursing*, 10: 457-464.

Layard, R. (2005). *Sainsbury Centre Lecture: therapy for all on the NHS.* (12th September, 2005). Accessed HTTP Web Site: http://www.babcp.com.

Mistral, W. & Velleman, R. (1997). CMHTs: the professionals' choice? *Journal of Mental Health*, 6, 2: 125-140.

Moss, R. (1994). Community mental health teams: a developing culture. *Journal of Mental Health*, 3: 167-174.

National Association for Mental Health (Mind). (2006). A brief guide to who's who in mental health. (Accessed HTTP web site 4th January 2006: http://www.mind.org.uk/Information/Factsheets).

Neilson, J. & Hall, A. (2002). Referral patterns for psychology within a community mental health team (CMHT). *Counselling Psychology Review,* 17, 2: 32-38.

Onyett, S. & Ford, R. (1996). Multidisciplinary community teams: where is the wreckage? *Journal of Mental Health*, 5, 1: 47-55.

Onyett, S., Heppleston, T. & Bushnell, D. (1994*). The organisation and operation of community mental health teams in England: a national survey. London*, Sainsbury Centre for Mental Health.

Onyett, S., Pillnger, T. & Muijen, M. (1997). Job satisfaction and burnout among members of community mental health teams. *Journal of Mental Health*, 6, 1: 55-66.

Onyett, S., Pillnger, T. & Muijen, M. (1995). *Making community mental health teams work: CMHTs and the people who work in them*. London, Sainsbury Centre for Mental Health.

Orford, J. (1992). *Community psychology: theory and practice*. Chichester: John Wiley & Sons.

Paxton, R. (1995). Goodbye community mental health teams – at last. *Journal of Mental Health*, 4: 331-334.

Paxton. R. (1993). What we want is what they need: fantasies about the organisation of clinical psychology services. *Clinical Psychology Forum*, 57: 24-27.

Peck, E. (1995). On the team. *Health Service Journal*, 6: 28-29.

Prosser, D., Johnson, S., Kuipers, E., Szmukler, G., Bebbington, P. & Thornicroft, G. (1996). Mental health, 'burnout' and job satisfaction among hospital and community-based mental health staff. *British Journal of Psychiatry*, 169: 334-337.

Pugsley, D., Rees, P. & Dimond, B. (1996). Community mental health teams: development in community care. *British Journal of Nursing*, Volume 5, Number 22: 1398-1401.

Royal College of Psychiatrists, (1996). *The responsibilities of consultant psychiatrists, revised statement: council report*, CR 51. London: Royal College of Psychiatrists.

SCMH (2006). *Policy paper: the future of mental health: a vision for 2015*. London: Sainsbury Centre for Mental Health.

Smallwood, J. (2002). Counselling psychology and the NHS: An individual perspective. *Counselling Psychology Review*, 17, 1: 16-20.

Thornicroft, G. & Tansella, M. (2004). Components of a modern mental health service: a pragmatic balance of community and hospital care. *The British Journal Of Psychiatry*, 185: 283-290.

Tyrer, P., Coid, J., Simmonds, S. (1998). Review: community mental health team management for adults with severe mental illnesses increases satisfaction with care. *Evidence-Based Mental Health,* 1: 268.

Tyrer, P., Simmonds, S., Coid, J., Mariott, S. & Joseph, P. (2001). Correspondence: A defence of community mental health teams. *The British Journal of Psychiatry,* 179: 268.

Van Scoyoc, S. (2005b). The future of our profession: time to remember our history. *Counselling Psychology Review,* 20, 2: 49-51.

Van Scoyoc, S. & Bellamy, A. (2005). Talking Point. 'hot issues' for counselling psychologists: a conversation between the Chair-Elect, Susan Van Scoyoc and the Past-Chair, Alan Bellamy. *Counselling Psychology Review,* 20, 3: 22-24.

Watson, G. (1994). Multi-disciplinary working and co-operation in community care. *Mental Health Nursing*, 14. 2: 18-21.

APPENDIX ONE:

List of the databases searched and the search strategies

Strategy used to find articles

The literature search consisted of keyword and wildcard combination searches in title and abstract and full body (if full text): for example, counselling, psychology, CMHT, community, mental, health, team, chronic, mental health care, enduring mental health, serious, secondary, NHS, clinical psychology, counselling psychology, role of psychology, role of psychologists. This search was limited to the last 15 years and consisted of peer-reviewed articles printed in the English language.

Links to other articles were also followed if referred to in papers that were found. The web sites of The British Psychological Society, The Department of Health and other non-government organisations such as The Sainsbury Centre for Mental Health and National Association for Mental Health (Mind) were also accessed.

The databases searched that contained relevant articles were:

- PsycARTICLES on CSA Illumina
- Elsevier Science Direct
- Proquest
- Ovid
- Psychlit
- Bids
- Google scholar
- Pubmed
- Web of science

APPENDIX TWO:

Themes for interview prompt

Themes to be considered when examining the role of a psychologist when working with individuals who have enduring mental health problems.

- Professional training
- Therapeutic skills
- Team Work
- Mentoring role (educational or supervisory)
- Organisational requirements

APPENDIX THREE:

Incentives for return of questionnaire (I-III)

Appendix Three (I)

Incentives to return questionnaires were used in the form of a raffle of £80 worth of book vouchers.

Several book companies who publish specialist literature for psychologists were contacted to see if they would be interested in donating book vouchers. The researcher explained that the vouchers would be used as an incentive to increase responses for a questionnaire about the role of psychologist. As a result of the phone calls, two companies donated three book vouchers. Abbey Books (£30) and the BPS Book Shop (2 x £25).

Two raffle tickets were stapled to the cover of the questionnaire. Respondents were instructed to keep one of the tickets, leaving the other attached to their completed questionnaire. Returning the questionnaire put them in the draw to win the book vouchers. Participants were informed that the winning ticket numbers would appear in a following edition of the '*The Psychologist*'.

When the completed questionnaires were returned any accompanying raffle tickets were removed and placed into a large Tupperware container. A psychologist who worked with the researcher drew three tickets from the container; each of these tickets had the name and address or telephone number of the respondent on the back. The successful raffle ticket holders were contacted by telephone and their book vouchers were dispatched to them with a thank you letter from the researcher. The successful raffle ticket numbers were also published in the next edition of '*The Psychologist*'.

Appendix Three (II)

Annie Maillard
Chartered counselling psychologist
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Tel: (01203) 844061. Work
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Dear Sir or Madam

Please can I submit the following item for the information section of the next publication of *'The Psychologist'*.

Thank you for the large response to my research questionnaire, which looked at 'Psychologists beliefs about their role as a psychologist when working with people who have enduring mental health problems'. The following respondent's tickets were drawn to receive book vouchers:

Yellow ticket number 203: £30. Book voucher from Abbey Books.
Yellow ticket number 96: £25. Book voucher from the B.P.S.
Blue ticket number 100: £25. Book voucher from the B.P.S.

Once again thank you very much for your responses should anyone have any questions about the research then please contact me.

Annie Maillard

Appendix Three (III)

Annie Maillard
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5/6/99

Dear ...

Thank you for your response to my research questionnaire that looked at 'Psychologists beliefs about their role as a psychologist when working with people who have enduring mental health problems'.

Your ticket was drawn to receive a book voucher, ticket number ... I have enclosed a book voucher.

Once again thank you very much for your response should you have any questions about the research then please do not hesitate to contact me.

Yours faithfully,

Annie Maillard
Chartered counselling psychologist

[1]

[1] Names have been removed to maintain confidentiality

APPENDIX FOUR:

Cover Letter:

Chartered counselling psychology group

WIN £80 WORTH OF BOOK VOUCHERS !

Dear counselling psychologist,

Please find enclosed a questionnaire on 'The role of chartered psychologists working with people who have enduring mental health problems'.

The questionnaire takes approximately ten minuets to complete.

Every fully completed questionnaire returned will be entered into a draw to win £80 worth of book vouchers. The winning numbers will appear in the next edition of '*The Psychologist*'.

As a counselling psychologist it is important to support the development of the Division. You can do this by returning your completed questionnaire and of course possibly win £80 worth of book vouchers for your trouble.

Thank you in advance for you co-operation and time.

Yours sincerely,

Annie Maillard

APPENDIX FIVE:

Cover Letter:

Student counselling psychology group

WIN £80 WORTH OF BOOK VOUCHERS !

Dear counselling psychologist in training

Please find enclosed a questionnaire on 'The role of chartered psychologists when working with people who have enduring mental health problems'.

The questionnaire takes approximately ten minuets to complete.

Every fully completed questionnaire returned will be entered into a draw to win £80 worth of book vouchers. The winning numbers will appear in the next edition of '*The Psychologist*'.

As a counselling psychologist it is important to support the development of the Division. You can do this by returning your completed questionnaire and of course possibly win £80 worth of book vouchers for your trouble.

Thank you in advance for you co-operation and time.

Yours sincerely,

Annie Maillard

APPENDIX SIX:

Cover Letter:

Clinical psychology group

WIN £80 WORTH OF BOOK VOUCHERS !

Dear clinical psychologist

Please find enclosed a questionnaire on 'The role of chartered Psychologists when working with people who have enduring mental health problems'.

The questionnaire takes approximately ten minuets to complete.

Every fully completed questionnaire returned will be entered into a draw to win £80 worth of book vouchers. The winning numbers will appear in the next edition of '*The Psychologist*'.

As a clinical psychologist it is important to support research in this area. You can do this by returning your completed questionnaire and of course possibly win £80 worth of book vouchers for your trouble.

Thank you in advance for you co-operation and time.

Yours sincerely,

Annie Maillard

APPENDIX SEVEN:

'The role of chartered psychologists working with people who have enduring mental health problems – A questionnaire study'

'The role of chartered psychologists working with people who have enduring mental health problems'

–

A Questionnaire Study

INTRODUCTION

My name is Annie Maillard, I work as a Counselling Psychologist in the Psychological Therapies Team at Coventry Health Care NHS Trust. This questionnaire is part of my doctorate in Counselling Psychology at City University, London. As a member of the Standing Committee of Scientific and Professional Affairs for the Division of Counselling Psychology I declare my interest in the development of this division and the relevance of this piece of research to that process.

Questionnaire study:

Psychologists bring to a position of employment personal goals in addition to their own unique individuality and needs. It is most helpful then to see role behaviour as a combination of organisational requirements and individual interests. This questionnaire will attempt to begin the exploration of psychologist's beliefs about their 'role' as a psychologist when working with people who have enduring mental health problems.

It is hoped that the investigation will reveal any differences and similarities between Counselling and Clinical psychologists of their beliefs about their role as psychologist when working with this client group. Not only is it essential for applied psychologists to understand the relevance of their particular training but for them to also realise their own and others abilities as professionals.

You will find two raffle tickets attached to this questionnaire, the reason for this is to give participants who respond fully to this survey the opportunity of winning Eighty pounds worth of book tokens that have been kindly donated by B.P.S. BOOKS and ABBEY BOOKS. Before you return your questionnaire, please detach one of the tickets and keep it safe. The winning numbers for the raffle will be advertised in the next edition of 'The Psychologist'. The questionnaire is entirely confidential and any information held relating to the raffle tickets will not be used for any other purpose.

Part One: Background Information

Age: ..... Male / Female (please circle).

Are you a Chartered Psychologist? Yes / No (please circle).

If No, what course are you studying?..... Full-time / Part time (please circle)

If yes, what type of Chartered Psychologist are you? .....

.....

When did you become chartered? (If more than once please indicate).....

.....

What type of setting do you practice in? (If more than one please indicate).....

.....

What is your therapeutic orientation? .....

How long have you practiced as a therapist? .....

What is your annual income? (If you work Part time please calculate Full-time equivalent salary)

(Please tick box to indicate)

☐ Less than £ 9,999. ☐ £10,000- £14,999. ☐ £15,000- £19,999. ☐ £20,000- £24,999.

☐ £25,000-£29,999. ☐ £30,000- £34,999. ☐ £35,000- £39,999. ☐ £40,000 or more.

Part Two: Psychologist Role Definition Instrument

How strongly do YOU believe that a psychologist should or should not do the following things, when working with people who have enduring mental health problems? You are asked to place a mark in the appropriate box for each question to indicate this.

How strongly do YOU believe that a psychologist should or should not do the following things, when working with people who have enduring mental health problems?

1 Have had personal therapy.

☐ absolutely must
☐ preferably should
☐ may or may not
☐ preferably should not
☐ absolutely must not

2 Draw on a basic knowledge of psychopathology.

☐ absolutely must
☐ preferably should
☐ may or may not
☐ preferably should not
☐ absolutely must not

3 Undertake to study the use of psychometric tests if not included in initial training.

☐ absolutely must
☐ preferably should
☐ may or may not
☐ preferably should not
☐ absolutely must not

4 Have further training in therapeutic skills following professional psychology training.

☐ absolutely must
☐ preferably should
☐ may or may not
☐ preferably should not
☐ absolutely must not

5 Employ the principles of a 'scientist practitioner'.

☐ absolutely must
☐ preferably should
☐ may or may not
☐ preferably should not
☐ absolutely must not

6 Conduct research.

☐ absolutely must
☐ preferably should
☐ may or may not
☐ preferably should not
☐ absolutely must not

7 Take responsibility for own lack of knowledge or skill and address this through further training.

☐ absolutely must
☐ preferably should
☐ may or may not
☐ preferably should not
☐ absolutely must not

8 Keep up to date with the progress of their professional psychological division.

☐ absolutely must
☐ preferably should
☐ may or may not
☐ preferably should not
☐ absolutely must not

9 Liaise with other professionals by speaking the 'same language'.

☐ absolutely must
☐ preferably should
☐ may or may not
☐ preferably should not
☐ absolutely must not

10 Work in multidisciplinary teams.

☐ absolutely must
☐ preferably should
☐ may or may not
☐ preferably should not
☐ absolutely must not

How strongly do YOU believe that a psychologist should or should not do the following things, when working with people who have enduring mental health problems?

11 Work in a consultancy role to other Professionals.

- ☐ absolutely must
- ☐ preferably should
- ☐ may or may not
- ☐ preferably should not
- ☐ absolutely must not

12 Supervise other professionals.

- ☐ absolutely must
- ☐ preferably should
- ☐ may or may not
- ☐ preferably should not
- ☐ absolutely must not

13 Train other professionals.

- ☐ absolutely must
- ☐ preferably should
- ☐ may or may not
- ☐ preferably should not
- ☐ absolutely must not

14 Prescribe medication.

- ☐ absolutely must
- ☐ preferably should
- ☐ may or may not
- ☐ preferably should not
- ☐ absolutely must not

15 Train in the 'therapeutic' use of assessment tests.

- ☐ absolutely must
- ☐ preferably should
- ☐ may or may not
- ☐ preferably should not
- ☐ absolutely must not

16 Establish skills for recognising psychotic episodes for clients, so that they can be understood and coped with in a helpful way.

- ☐ absolutely must
- ☐ preferably should
- ☐ may or may not
- ☐ preferably should not
- ☐ absolutely should not

17 Provide clinical supervision on cases to trainee clinical psychologists.

- ☐ absolutely must
- ☐ preferably should
- ☐ may or may not
- ☐ preferably should not
- ☐ absolutely must not

18 Work with a client despite misdiagnosis from a psychiatrist.

- ☐ absolutely must
- ☐ preferably should
- ☐ may or may not
- ☐ preferably should not
- ☐ absolutely must not

19 Discuss with a referrer your assessment of an individual.

- ☐ absolutely must
- ☐ preferably should
- ☐ may or may not
- ☐ preferably should not
- ☐ absolutely must not

20 Have inadequate experience of secondary mental health care.

- ☐ absolutely must
- ☐ preferably should
- ☐ may or may not
- ☐ preferably should not
- ☐ absolutely must not

How strongly do YOU believe that a psychologist should or should not do the following things, when working with people who have enduring mental health problems?

21 Become a friend of a client.

- ☐ absolutely must
- ☐ preferably should
- ☐ may or may not
- ☐ preferably should not
- ☐ absolutely should not

22 Co-work with other professionals.

- ☐ absolutely must
- ☐ preferably should
- ☐ may or may not
- ☐ preferably should not
- ☐ absolutely must not

23 Shout at a client in therapy.

- ☐ absolutely must
- ☐ preferably should
- ☐ may or may not
- ☐ preferably should not
- ☐ absolutely must not

24 Have limited formulation regarding therapy following an assessment session with a client.

- ☐ absolutely must
- ☐ preferably should
- ☐ may or may not
- ☐ preferably should not
- ☐ absolutely must not

25 See a client for therapy who arrives outside of their appointment session.

- ☐ absolutely must
- ☐ preferably should
- ☐ may or may not
- ☐ preferably should not
- ☐ absolutely must not

26 Be able to section a client.

- ☐ absolutely must
- ☐ preferably should
- ☐ may or may not
- ☐ preferably should not
- ☐ absolutely should not

27 Provide clinical supervision to trainee counselling psychologists.

- ☐ absolutely must
- ☐ preferably should
- ☐ may or may not
- ☐ preferably should not
- ☐ absolutely must not

28 Recommend a particular type of medication for a client.

- ☐ absolutely must
- ☐ preferably should
- ☐ may or may not
- ☐ preferably should not
- ☐ absolutely must not

29 Without a client's consent, inform their family about their mental health problems.

- ☐ absolutely must
- ☐ preferably should
- ☐ may or may not
- ☐ preferably should not
- ☐ absolutely must not

30 Work with more than one member of the same family for individual therapy.

- ☐ absolutely must
- ☐ preferably should
- ☐ may or may not
- ☐ preferably should not
- ☐ absolutely must not

If you have any comments about any of the questions or answers in this questionnaire then please use this space to make them here.

Thank you for taking the time to complete this questionnaire.

Any questions that you might have about the questionnaire or its contents may be addressed to:-

Annie Maillard: Counselling Psychologist

Psychological Therapies Team

Sage Ward

Gulson Hospital

Gulson Road

Coventry. CV1 2HR

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- ψ Interview with *Dr John Davies* Consultant Clinical Psychologist, Psychological Therapies Team, Coventry Health Care NHS Trust, Coventry.
- ψ Interview with *Ms Heather Sequira* Counselling Psychologist in Training and Research Psychologist at St Andrews, Psychiatric Hospital, Northampton.
- ψ Interview with *Mr Richard Shuker* Chartered Psychologist, working in a Forensic setting. Buckingham.
- ψ Interview with *Ms Cheryl Tandy* Consultant Clinical Psychologist, Psychological Therapies Team, Coventry Health Care NHS Trust, Coventry.
- ψ Interview with *Ms Ruth Telfor* Consultant Clinical Psychologist, Psychological Therapies Team, Coventry Health Care NHS Trust, Coventry.

APPENDIX EIGHT:

Codes created to give nominal data

Beliefs about the role of a psychologist when working with people who have enduring mental health problems.

Part One

1(Age) NAge: . . . . 2(*Sex*) S Male 2 / Female 1

3 (Chart) SAre you a Chartered Psychologist? 1 Yes / No 2 (please circle).

If no what course are you studying? . . . . . .Full-time / Part time (please circle)

***4 (Typchart)* S If yes what type of chartered psychologist are you?.**

1=Coun 2= Clin 3= Both 4= Stuful 5= Stupart 6= Counoth 7= Clinoth

5 (Length) N When did you become chartered? (If more than once please indicate). . .

. . . . . .

6 (Setting) S What type of setting do you practise in? (If more than one please indicate) . . .

1= NHS 2=Private 3=MT1 (NHS+other) 4= Other 5= Education +other

6= Occupational 7=Educational 8= Private practice+Other 9= Occupational+other

10= Private psychiatric hospital 11=Primary care NHS 12= NHS Secondary m h c

13= Primary care private practice

7 (Therapy) S What is your therapeutic orientation? . . . . . .

1= CBT. 2= Dynamic 3=Humanisitic. 4= Systemic. 5=Intergrated. 6=P.C.P.

7= T A. 8= CBT+other. 9=Dynamic+other 10=Humanistic+Other 11=Syst+other

12=Intergrated+other. 13=P.C.P.+other 14=TA+other.

8(Timepra) N How long have you practised as a therapist? . . . . . .

. . . . . .

9(Income) S What is your annual income (If you work part time please calculate Full-time equivalent salary, Please tick box to indicate)

☐1Less than £ 9,999☐2£10,000- £14,999☐3£15,000- £19,999☐4£20,000-£24,999

☐5£25,000-£29,999 ☐6£30,000- £34,999 ☐7£35,000- £39,999 ☐8£40,000 plus

APPENDIX NINE:

Quantitative analysis and data

Comparison of Mann-Whitney U Tests for clinical psychology and counselling psychology groups

Test Statistics[a]

	QU1	QU2	QU3	QU4	QU5	QU6
Mann-Whitney U	2534.000	5379.000	3810.500	5882.000	4804.500	5529.000
Wilcoxon W	7287.000	13894.000	12325.500	10635.000	13189.500	14044.000
Z	-8.158	-2.531	-5.329	-.980	-3.185	-1.764
Asymp. Sig. (2-tailed)	.000	.011	.000	.327	.001	.078

Test Statistics[a]

	QU7	QU8	QU9	QU10	QU11	QU12
Mann-Whitney U	6108.000	5494.500	5301.500	4507.000	4014.000	5244.000
Wilcoxon W	14623.000	14009.500	13686.500	13022.000	12529.000	13759.000
Z	-.578	-1.841	-2.000	-4.013	-5.044	-2.322
Asymp. Sig. (2-tailed)	.563	.066	.046	.000	.000	.020

Test Statistics[a]

	QU13	QU14	QU15	QU16	QU17	QU18
Mann-Whitney U	4692.500	5733.500	4946.500	6127.500	3466.500	4607.500
Wilcoxon W	13207.500	14118.500	13461.500	14383.500	11722.500	12482.500
Z	-3.835	-.901	-2.378	-.041	-6.095	-2.975
Asymp. Sig. (2-tailed)	.000	.368	.017	.967	.000	.003

Test Statistics[a]

	QU19	QU20	QU21	QU22	QU23	QU24
Mann-Whitney U	3214.500	4399.500	5470.500	4847.000	5463.500	5503.000
Wilcoxon W	11599.500	11302.500	10126.500	13362.000	13978.500	9689.000
Z	-6.501	-1.906	-1.884	-3.181	-1.773	-.525
Asymp. Sig. (2-tailed)	.000	.057	.060	.001	.076	.600

Test Statistics[a]

	QU25	QU26	QU27	QU28	QU29	QU30
Mann-Whitney U	4542.000	5818.000	5041.000	4894.000	5002.000	4816.500
Wilcoxon W	9295.000	10189.000	9697.000	9647.000	9658.000	9569.500
Z	-3.947	-.093	-2.580	-3.049	-2.838	-3.242
Asymp. Sig. (2-tailed)	.000	.926	.010	.002	.005	.001

a. Grouping Variable: TYPES

Comparison of Mann-Whitney U Tests for clinical psychology and student counselling psychology groups

Test Statistics[a]

	QU1	QU2	QU3	QU4	QU5	QU6
Mann-Whitney U	542.500	1242.000	1292.500	1888.500	1550.500	1752.500
Wilcoxon W	5295.500	2022.000	2072.500	2668.500	2330.500	2493.500
Z	-6.894	-4.229	-3.001	-.016	-1.762	-.497
Asymp. Sig. (2-tailed)	.000	.000	.003	.987	.078	.619

Test Statistics[a]

	QU7	QU8	QU9	QU10	QU11	QU12
Mann-Whitney U	1880.000	1820.000	1703.000	1700.000	1288.500	1286.000
Wilcoxon W	6633.000	6573.000	2483.000	2480.000	2029.500	2027.000
Z	-.082	-.390	-.886	-.983	-2.879	-3.001
Asymp. Sig. (2-tailed)	.934	.697	.376	.326	.004	.003

Test Statistics[a]

	QU13	QU14	QU15	QU16	QU17	QU18
Mann-Whitney U	1356.500	1579.500	1299.500	1783.500	1180.000	1458.000
Wilcoxon W	2097.500	2320.500	2040.500	2524.500	1921.000	2161.000
Z	-2.563	-1.231	-2.488	-.240	-3.486	-1.550
Asymp. Sig. (2-tailed)	.010	.218	.013	.810	.000	.121

Test Statistics[a]

	QU19	QU20	QU21	QU22	QU23	QU24
Mann-Whitney U	1163.500	1206.500	1796.500	1705.500	1761.500	1059.000
Wilcoxon W	1904.500	1909.500	2576.500	2485.500	2541.500	5245.000
Z	-3.465	-2.423	-.415	-.958	-.562	-3.767
Asymp. Sig. (2-tailed)	.001	.015	.678	.338	.574	.000

Test Statistics[a]

	QU25	QU26	QU27	QU28	QU29	QU30
Mann-Whitney U	1035.000	1386.000	1456.000	1527.000	1353.000	1527.000
Wilcoxon W	5788.000	2166.000	6112.000	6280.000	6009.000	6280.000
Z	-4.501	-2.217	-2.274	-1.845	** -2.557	-1.886
Asymp. Sig. (2-tailed)	.000	.027	.023	.065	.011	.059

a. Grouping Variable: TYPES

Comparison of Mann-Whitney U Tests for counselling psychology and student counselling psychology groups

Test Statistics[a]

	QU1	QU2	QU3	QU4	QU5	QU6
Mann-Whitney U	2343.500	2041.500	2280.000	2373.000	2391.500	2275.000
Wilcoxon W	10858.500	2821.500	10795.000	3153.000	10776.500	10790.000
Z	-.811	-2.279	-1.038	-.688	-.497	-.830
Asymp. Sig. (2-tailed)	.417	.023	.299	.491	.619	.406

Test Statistics[a]

	QU7	QU8	QU9	QU10	QU11	QU12
Mann-Whitney U	2440.500	2096.500	2366.500	2034.500	2342.500	2133.000
Wilcoxon W	10955.500	10611.500	10751.500	10549.500	10857.500	2874.000
Z	-.502	-1.826	-.623	-2.123	-.554	-1.505
Asymp. Sig. (2-tailed)	.616	.068	.534	.034	.580	.132

Test Statistics[a]

	QU13	QU14	QU15	QU16	QU17	QU18
Mann-Whitney U	2443.500	2309.500	2257.500	2385.000	2276.000	2204.500
Wilcoxon W	3184.500	3050.500	2998.500	3126.000	10532.000	10079.500
Z	-.121	-.582	-.897	-.217	-.663	-.473
Asymp. Sig. (2-tailed)	.903	.561	.370	.828	.507	.636

Test Statistics[a]

	QU19	QU20	QU21	QU22	QU23	QU24
Mann-Whitney U	2181.000	1858.500	2113.000	2116.500	2358.500	1505.500
Wilcoxon W	10566.000	2561.500	2893.000	10631.500	10873.500	9506.500
Z	-1.105	-1.378	-1.892	-1.702	-.773	-3.803
Asymp. Sig. (2-tailed)	.269	.169	.058	.089	.439	.000

Test Statistics[a]

	QU25	QU26	QU27	QU28	QU29	QU30
Mann-Whitney U	2029.000	1857.000	2359.500	2510.000	2325.500	2407.000
Wilcoxon W	10544.000	2637.000	10615.500	3290.000	10840.500	3187.000
Z	-2.104	-2.394	-.571	-.098	-.639	-.511
Asymp. Sig. (2-tailed)	.035	.017	.568	.922	.523	.610

a. Grouping Variable: TYPES

Median scores and ranges for the three groups' responses to the *Psychologist Role Definition Instrument*

Report

TYPES		QU1	QU2	QU3	QU4	QU5	QU6	QU7
student	N	39	39	39	39	39	38	39
	Median	5.0000	5.0000	4.0000	5.0000	4.0000	4.0000	5.0000
	Minimum	4.00	3.00	2.00	3.00	2.00	3.00	4.00
	Maximum	5.00	5.00	5.00	5.00	5.00	5.00	5.00
clin	N	97	96	96	97	97	97	97
	Median	3.0000	5.0000	4.0000	5.0000	4.0000	4.0000	5.0000
	Minimum	2.00	3.00	2.00	3.00	2.00	1.00	4.00
	Maximum	5.00	5.00	5.00	5.00	5.00	5.00	5.00
counc	N	130	130	130	130	129	130	130
	Median	5.0000	5.0000	3.0000	5.0000	4.0000	3.0000	5.0000
	Minimum	2.00	2.00	1.00	3.00	2.00	3.00	3.00
	Maximum	5.00	5.00	5.00	5.00	5.00	5.00	5.00
Total	N	266	265	265	266	265	265	266
	Median	4.0000	5.0000	4.0000	5.0000	4.0000	4.0000	5.0000
	Minimum	2.00	2.00	1.00	3.00	2.00	1.00	3.00
	Maximum	5.00	5.00	5.00	5.00	5.00	5.00	5.00

Report

TYPES		QU8	QU9	QU10	QU11	QU12	QU13	QU14
student	N	39	39	39	38	38	38	38
	Median	5.0000	4.0000	4.0000	3.0000	3.0000	3.0000	4.0000
	Minimum	4.00	2.00	3.00	3.00	2.00	2.00	2.00
	Maximum	5.00	5.00	5.00	5.00	4.00	5.00	5.00
clin	N	97	96	97	96	96	95	95
	Median	5.0000	4.0000	4.0000	4.0000	4.0000	4.0000	5.0000
	Minimum	3.00	3.00	2.00	3.00	3.00	3.00	2.00
	Maximum	5.00	5.00	5.00	5.00	5.00	5.00	5.00
counc	N	130	129	130	130	130	130	129
	Median	4.0000	4.0000	3.0000	3.0000	3.0000	3.0000	4.0000
	Minimum	3.00	3.00	3.00	3.00	2.00	3.00	1.00
	Maximum	5.00	5.00	5.00	5.00	5.00	5.00	5.00
Total	N	266	264	266	264	264	264	262
	Median	4.0000	4.0000	4.0000	4.0000	3.0000	3.0000	5.0000
	Minimum	3.00	2.00	2.00	3.00	2.00	2.00	1.00
	Maximum	5.00	5.00	5.00	5.00	5.00	5.00	5.00

Median scores and ranges for the three groups' responses to the *Psychologist Role Definition Instrument* continued

Report

TYPES		QU15	QU16	QU17	QU18	QU19	QU20	QU21
student	N	38	38	38	37	38	37	39
	Median	3.0000	5.0000	4.0000	3.0000	4.0000	4.0000	5.0000
	Minimum	2.00	3.00	2.00	1.00	1.00	1.00	1.00
	Maximum	5.00	5.00	5.00	5.00	5.00	5.00	5.00
clin	N	92	96	96	94	96	88	96
	Median	4.0000	5.0000	4.0000	3.5000	4.0000	4.0000	5.0000
	Minimum	2.00	3.00	3.00	2.00	3.00	1.00	1.00
	Maximum	5.00	5.00	5.00	5.00	5.00	5.00	5.00
counc	N	130	128	128	125	129	117	130
	Median	3.0000	5.0000	3.0000	3.0000	3.0000	4.0000	5.0000
	Minimum	2.00	3.00	1.00	1.00	1.00	1.00	1.00
	Maximum	5.00	5.00	5.00	5.00	5.00	5.00	5.00
Total	N	260	262	262	256	263	242	265
	Median	3.0000	5.0000	4.0000	3.0000	4.0000	4.0000	5.0000
	Minimum	2.00	3.00	1.00	1.00	1.00	1.00	1.00
	Maximum	5.00	5.00	5.00	5.00	5.00	5.00	5.00

Report

TYPES		QU22	QU23	QU24	QU25	QU26	QU27	QU28
student	N	39	39	39	39	39	39	39
	Median	4.0000	5.0000	4.0000	4.0000	3.0000	4.0000	4.0000
	Minimum	3.00	3.00	1.00	2.00	1.00	1.00	2.00
	Maximum	5.00	5.00	5.00	5.00	5.00	5.00	5.00
clin	N	97	95	91	97	93	95	97
	Median	4.0000	5.0000	3.0000	3.0000	4.0000	3.0000	3.0000
	Minimum	3.00	3.00	1.00	1.00	1.00	2.00	1.00
	Maximum	5.00	5.00	5.00	5.00	5.00	5.00	5.00
counc	N	130	130	126	130	126	128	130
	Median	4.0000	5.0000	3.0000	4.0000	4.0000	4.0000	4.0000
	Minimum	3.00	2.00	1.00	2.00	1.00	2.00	2.00
	Maximum	5.00	5.00	5.00	5.00	5.00	5.00	5.00
Total	N	266	264	258	266	258	263	266
	Median	4.0000	5.0000	3.0000	4.0000	4.0000	3.0000	4.0000
	Minimum	3.00	2.00	1.00	1.00	1.00	1.00	1.00
	Maximum	5.00	5.00	5.00	5.00	5.00	5.00	5.00

Report

TYPES		QU29	QU30
student	N	38	39
	Median	5.0000	4.0000
	Minimum	3.00	2.00
	Maximum	5.00	5.00
clin	N	96	97
	Median	4.0000	4.0000
	Minimum	2.00	1.00
	Maximum	5.00	5.00
counc	N	130	130
	Median	5.0000	4.0000
	Minimum	3.00	2.00
	Maximum	5.00	5.00
Total	N	264	266
	Median	5.0000	4.0000
	Minimum	2.00	1.00
	Maximum	5.00	5.00

age	sex	chart	typchart	types	lengthch	setting	settnew	therapy	newthera	timepra	income
37.00	2	1	3	#NULL!	9.00	1	1.00	6	1.00	10.00	7
47.00	1	1	3	#NULL!	10.00	1	1.00	5	5.00	12.00	6
53.00	2	1	3	#NULL!	10.00	10	3.00	3	3.00	25.00	8
48.00	2	1	3	#NULL!	15.00	3	1.00	5	5.00	20.00	8
35.00	1	1	3	#NULL!	4.00	12	1.00	11	4.00	7.00	5
33.00	2	1	3	#NULL!	5.00	12	1.00	2	2.00	6.00	4
51.00	2	1	3	#NULL!	3.00	12	1.00	9	2.00	24.00	6
45.00	2	1	3	#NULL!	6.00	12	1.00	9	2.00	18.00	8
54.00	2	1	3	#NULL!	#NULL!	3	1.00	5	5.00	20.00	8
53.00	1	1	3	#NULL!	7.00	3	1.00	9	2.00	25.00	8
#NULL!	1	1		#NULL!	8.00	5	3.00	7	3.00	#NULL!	5
42.00	1	1	3	#NULL!	16.00	7	3.00	5	5.00	11.00	5
55.00	1	1	3	#NULL!	9.00	12	1.00	10	3.00	15.00	6
35.00	1	1	3	#NULL!	5.00	12	1.00	10	3.00	5.00	7
57.00	1	1	3	#NULL!	15.00	3	1.00	8	1.00	22.00	3
44.00	1	1	3	#NULL!	10.00	12	1.00	9	2.00	19.00	4
53.00	1	1	3	#NULL!	13.00	12	1.00	2	2.00	15.00	6
35.00	2	1	3	#NULL!	5.00	1	1.00	1	1.00	5.00	8
50.00	1	1	3	#NULL!	14.00	1	1.00	5	5.00	14.00	8
50.00	1	1	3	#NULL!	8.00	12	1.00	9	2.00	11.00	6
49.00	2	1	3	#NULL!	15.00	3	1.00	2	2.00	20.00	8
45.00	2	1	3	#NULL!	14.00	2	2.00	9	2.00	20.00	8
43.00	2	1	3	#NULL!	14.00	12	1.00	5	5.00	14.00	8
43.00	2	1	3	#NULL!	11.00	5	3.00	12	5.00	15.00	8
51.00	2	1	3	#NULL!	20.00	2	2.00	2	2.00	23.00	7
31.00	1	2		#NULL!	12.00	9	3.00	6	1.00	5.00	4
70.00	1	1	3	#NULL!	15.00	2	2.00	2	2.00	28.00	3
38.00	1	2		#NULL!	#NULL!	11	1.00	5	5.00	14.00	4
37.00	1	2	4	1.00	#NULL!	12	1.00	10	3.00	2.00	#NULL!
29.00	1	2	5	1.00	#NULL!		#NULL!		#NULL!	#NULL!	3
34.00	1	2	5	1.00	#NULL!		#NULL!		#NULL!	#NULL!	#NULL!
24.00	1	2	4	1.00	#NULL!	3	1.00	4	4.00	#NULL!	1
34.00	1	2	5	1.00	#NULL!		#NULL!		#NULL!	#NULL!	#NULL!
27.00	2	2	4	1.00	#NULL!		#NULL!		#NULL!	#NULL!	2
49.00	1	2	5	1.00	#NULL!		#NULL!		#NULL!	#NULL!	4
49.00	1	2	5	1.00	#NULL!	4	3.00	3	3.00	4.00	#NULL!
48.00	1	2	5	1.00	#NULL!		#NULL!	3	3.00	#NULL!	1

39.00	1	2	5	1.00	#NULL!	12	1.00	3	3.00	1.00	1
24.00	1	2	4	1.00	#NULL!	4	3.00	3	3.00	#NULL!	2
34.00	1	2	4	1.00	#NULL!		#NULL!		#NULL!	#NULL!	#NULL!
26.00	1	2	4	1.00	#NULL!		#NULL!	1	1.00	#NULL!	1
39.00	1	2	4	1.00	#NULL!		#NULL!	5	5.00	1.00	1
25.00	1	2	4	1.00	#NULL!		#NULL!		#NULL!	#NULL!	#NULL!
25.00	1	2	4	1.00	#NULL!		#NULL!	8	1.00	#NULL!	#NULL!
38.00	1	2	5	1.00	#NULL!	4	3.00	3	3.00	2.00	1
43.00	1	2	4	1.00	#NULL!	4	3.00	10	3.00	2.00	1
35.00	1	2	4	1.00	#NULL!	4	3.00	10	3.00	#NULL!	1
26.00	2	2	4	1.00	#NULL!	11	1.00	13	1.00	#NULL!	1
54.00	1	2	4	1.00	#NULL!		#NULL!		#NULL!	#NULL!	#NULL!
40.00	1	2	4	1.00	#NULL!		#NULL!		#NULL!	#NULL!	#NULL!
#NULL!	1	2	4	1.00	#NULL!	4	3.00	3	3.00	2.00	#NULL!
27.00	2	2	5	1.00	#NULL!	12	1.00	5	5.00	1.00	3
49.00	1	2	5	1.00	#NULL!		#NULL!		#NULL!	#NULL!	#NULL!
51.00	2	2	5	1.00	#NULL!	8	2.00	5	5.00	3.00	1
26.00	2	2	5	1.00	#NULL!	1	1.00	1	1.00	2.00	3
42.00	2	2	5	1.00	#NULL!	1	1.00	1	1.00	1.00	1
27.00	1	2	5	1.00	#NULL!	12	1.00	8	1.00	4.00	2
30.00	1	2	5	1.00	#NULL!		#NULL!		#NULL!	#NULL!	3
47.00	1	2	5	1.00	#NULL!	12	1.00	3	3.00	3.00	1
36.00	1	2	4	1.00	#NULL!		#NULL!		#NULL!	#NULL!	#NULL!
31.00	1	2	4	1.00	#NULL!	3	1.00	8	1.00	1.00	1
23.00	1	2	4	1.00	#NULL!		#NULL!		#NULL!	#NULL!	#NULL!
49.00	1	2	5	1.00	#NULL!		#NULL!		#NULL!	#NULL!	#NULL!
44.00	1	2	5	1.00	#NULL!		#NULL!	5	5.00	1.00	5
25.00	1	2	5	1.00	#NULL!	12	1.00	1	1.00	1.00	1
34.00	1	2	5	1.00	#NULL!	1	1.00	8	1.00	1.00	2
24.00	1	2	5	1.00	#NULL!	10	3.00	1	1.00	#NULL!	2
48.00	2	1	2	2.00	3.00	4	3.00	2	2.00	15.00	8
45.00	1	1	2	2.00	#NULL!	1	1.00	5	5.00	22.00	8
61.00	2	1	2	2.00	20.00		#NULL!	1	1.00	30.00	#NULL!
37.00	2	1	2	2.00	10.00	8	2.00	1	1.00	14.00	7
58.00	1	1	2	2.00	20.00	1	1.00	1	1.00	25.00	4
35.00	1	1	2	2.00	3.00	1	1.00	1	1.00	8.00	5
49.00	2	1	2	2.00	21.00	2	2.00	1	1.00	23.00	7
28.00	1	1	2	2.00	2.00	12	1.00	1	1.00	1.00	4

49.00	1	1	2	2.00	10.00	11	1.00	8	1.00	20.00	5
45.00		1	2	2.00	21.00	12	1.00	11	4.00	20.00	8
44.00	2	1	2	2.00	1.00	12	1.00	8	1.00	5.00	4
33.00	2	1	2	2.00	1.00	4	3.00	1	1.00	3.00	4
32.00	1	1	2	2.00	7.00	12	1.00	9	2.00	6.00	6
37.00	2	1	2	2.00	6.00	12	1.00	4	4.00	8.00	5
37.00	2	1	2	2.00	6.00	12	1.00	1	1.00	7.00	6
43.00	2	1	2	2.00	11.00	1	1.00	5	5.00	20.00	8
37.00	2	1	2	2.00	6.00	1	1.00	8	1.00	10.00	7
30.00	1	1	2	2.00	#NULL!	12	1.00	5	5.00	3.00	5
54.00	2	1	2	2.00	#NULL!	12	1.00	2	2.00	30.00	7
37.00	1	1	2	2.00	9.00	3	1.00	5	5.00	15.00	6
38.00	1	1	2	2.00	8.00	1	1.00	5	5.00	10.00	8
41.00	1	1	2	2.00	7.00	12	1.00	1	1.00	6.00	2
39.00	1	1	2	2.00	10.00	1	1.00	5	5.00	10.00	7
32.00		1	2	2.00	5.00	1	1.00	10	3.00	8.00	5
42.00	2	1	2	2.00	11.00	1	1.00	1	1.00	14.00	7
46.00	1	1	2	2.00	6.00	1	1.00	8	1.00	19.00	8
57.00	1	1	2	2.00	5.00	12	1.00	2	2.00	20.00	6
58.00	1	1	2	2.00	11.00	1	1.00	1	1.00	28.00	8
52.00	2	1	2	2.00	9.00	12	1.00	1	1.00	28.00	8
53.00	1	1	2	2.00	#NULL!	12	1.00	11	4.00	23.00	8
29.00	2	1	2	2.00	3.00	12	1.00	8	1.00	2.00	5
56.00	1	1	2	2.00	11.00	12	1.00	9	2.00	20.00	8
33.00	1	1	2	2.00	9.00	12	1.00	1	1.00	11.00	6
52.00	2	1	2	2.00	9.00	12	1.00	1	1.00	28.00	8
34.00	1	1	7	2.00	8.00	12	1.00	2	2.00	7.00	4
57.00	1	1	2	2.00	9.00	1	1.00	1	1.00	20.00	8
49.00	1	1	2	2.00	9.00	12	1.00	8	1.00	12.00	8
29.00	1	1	2	2.00	4.00	12	1.00	4	4.00	3.00	5
43.00	1	1	2	2.00	11.00	1	1.00	12	5.00	10.00	7
37.00	2	1	7	2.00	10.00	4	3.00	8	1.00	12.00	7
43.00	1	1	2	2.00	15.00	12	1.00	5	5.00	18.00	4
35.00	2	1	2	2.00	9.00	3	1.00	1	1.00	9.00	8
41.00	1	1	2	2.00	15.00	1	1.00	6	1.00	18.00	7
74.00	1	1	2	2.00	20.00	4	3.00	9	2.00	31.00	1
52.00	2	1	7	2.00	20.00	4	3.00	5	5.00	28.00	3
53.00	2	1	2	2.00	20.00	12	1.00	8	1.00	26.00	7

27.00	1	1	2	2.00	2.00	4	3.00	5	5.00	2.00	4
54.00		1	7	2.00	3.00	1	1.00	2	2.00	8.00	3
28.00	1	1	2	2.00	#NULL!	1	1.00	5	5.00	2.00	4
46.00	1	1	2	2.00	6.00	12	1.00	1	1.00	7.00	5
53.00	1	1	2	2.00	6.00	2	2.00	2	2.00	7.00	1
34.00	1	1	7	2.00	6.00	1	1.00	5	5.00	5.00	4
45.00	1	1	2	2.00	15.00	3	1.00	4	4.00	15.00	8
42.00	2	1	2	2.00	6.00	3	1.00	8	1.00	5.00	8
36.00	1	1	2	2.00	10.00	10	3.00	9	2.00	9.00	8
49.00	1	2	2	2.00	25.00	1	1.00	2	2.00	26.00	4
60.00	1	1	2	2.00	20.00	4	3.00	5	5.00	30.00	8
40.00	2	1	2	2.00	12.00	1	1.00	1	1.00	15.00	7
47.00	1	1	2	2.00	5.00	12	1.00	5	5.00	22.00	6
49.00	1	1	7	2.00	20.00	8	2.00	8	1.00	20.00	4
50.00	1	1	2	2.00	20.00	20	#NULL!	1	1.00	25.00	7
50.00	1	1	2	2.00	#NULL!	12	1.00	1	1.00	25.00	8
32.00	1	1	2	2.00	5.00	12	1.00	1	1.00	7.00	5
47.00	2	1	2	2.00	19.00	1	1.00	1	1.00	18.00	8
47.00	2	1	2	2.00	20.00	1	1.00	8	1.00	22.00	8
41.00	1	1	2	2.00	5.00	12	1.00	5	5.00	6.00	4
52.00	2	1	2	2.00	11.00	2	2.00	8	1.00	29.00	5
37.00	2	1	2	2.00	9.00	1	1.00	12	5.00	8.00	6
52.00	1	1	2	2.00	12.00	12	1.00	1	1.00	12.00	8
47.00	1	1	2	2.00	11.00	1	1.00	8	1.00	20.00	8
54.00	2	1	7	2.00	20.00	4	3.00	1	1.00	34.00	8
31.00	2	1	2	2.00	5.00	1	1.00	1	1.00	5.00	6
42.00	1	1	2	2.00	9.00	1	1.00	4	4.00	9.00	7
65.00	2	1	7	2.00	20.00	4	3.00	9	2.00	35.00	8
51.00	2	1	2	2.00	9.00	1	1.00	8	1.00	15.00	4
38.00	1	1	2	2.00	10.00	3	1.00	1	1.00	12.00	5
53.00	2	1	2	2.00	20.00	12	1.00	4	4.00	21.00	8
40.00	1	1	2	2.00	20.00	12	1.00	1	1.00	#NULL!	4
53.00	1	1	2	2.00	7.00	2	2.00	8	1.00	20.00	7
58.00	1	1	2	2.00	6.00	12	1.00	1	1.00	15.00	7
51.00	1	1	2	2.00	9.00	12	1.00	11	4.00	20.00	7
48.00	2	1	2	2.00	2.00	12	1.00	5	5.00	22.00	8
43.00	2	1	2	2.00	10.00	3	1.00	1	1.00	14.00	8
46.00	2	1	7	2.00	7.00	5	3.00	1	1.00	7.00	8

43.00	2	1	2	2.00	8.00	1	1.00	1	1.00	10.00	7
43.00	2	1	2	2.00	#NULL!		#NULL!	1	1.00	22.00	8
51.00	2	1	7	2.00	2.00		#NULL!	5	5.00	25.00	8
38.00	1	1	2	2.00	5.00	3	1.00	1	1.00	4.00	6
45.00	1	1	7	2.00	14.00	5	3.00	1	1.00	13.00	8
36.00	2	1	2	2.00	1.00	12	1.00	4	4.00	7.00	6
36.00	1	1	2	2.00	9.00	12	1.00	1	1.00	11.00	6
43.00	1	1	2	2.00	6.00	12	1.00	12	5.00	6.00	4
31.00	2	1	2	2.00	4.00	12	1.00	1	1.00	7.00	8
40.00	1	1	2	2.00	9.00	12	1.00	9	2.00	9.00	5
49.00	1	1	2	2.00	9.00	4	3.00	9	2.00	25.00	8
45.00	2	1	2	2.00	21.00	6	3.00	8	1.00	21.00	8
42.00	1	1	2	2.00	18.00	12	1.00	2	2.00	18.00	6
76.00	2	1	1	3.00	2.00	2	2.00	8	1.00	20.00	4
44.00	1	1	1	3.00	2.00	3	1.00	5	5.00	12.00	6
73.00	2	1	1	3.00	6.00	2	2.00	3	3.00	18.00	6
57.00	1	1	1	3.00	#NULL!	7	3.00	12	5.00	25.00	7
60.00	2	1	1	3.00	19.00	8	2.00	7	3.00	25.00	4
63.00	2	1	1	3.00	6.00	2	2.00	14	3.00	9.00	8
61.00	1	1	1	3.00	6.00	2	2.00	2	2.00	12.00	1
63.00	2	1	1	3.00	#NULL!	13	2.00	1	1.00	15.00	#NULL!
42.00	1	1	1	3.00	7.00	12	1.00	1	1.00	12.00	6
47.00	2	1	1	3.00	3.00	3	1.00	2	2.00	10.00	8
30.00	2	1	1	3.00	3.00	12	1.00	5	5.00	3.00	4
51.00	1	1	1	3.00	1.00	8	2.00	5	5.00	20.00	5
44.00	1	1	1	3.00	6.00	3	1.00	2	2.00	16.00	5
63.00	2	1	1	3.00	11.00	11	1.00	1	1.00	6.00	2
50.00	1	1	1	3.00	7.00	2	2.00	3	3.00	10.00	4
45.00	1	1	1	3.00	4.00	11	1.00	12	5.00	10.00	5
51.00	2	1	1	3.00	2.00	12	1.00	1	1.00	7.00	7
52.00	1	1	1	3.00	5.00	12	1.00	4	4.00	20.00	#NULL!
67.00		1	1	3.00	2.00		#NULL!	3	3.00	10.00	8
49.00	2	1	6	3.00	9.00	8	2.00	1	1.00	15.00	7
46.00	2	1	1	3.00	7.00	7	3.00	2	2.00	20.00	8
53.00	2	1	6	3.00	11.00	6	3.00		#NULL!	8.00	7
41.00	1	1	1	3.00	2.00	12	1.00	11	4.00	5.00	3
35.00	2	1	1	3.00	3.00	1	1.00	11	4.00	10.00	5
38.00	1	1	6	3.00	6.00	8	2.00	4	4.00	18.00	4

45.00	1	1	1	3.00	2.00	2	2.00	12	5.00	6.00	2
52.00	2	1	1	3.00	2.00	8	2.00	5	5.00	18.00	4
58.00	2	1	6	3.00	11.00	2	2.00	5	5.00	12.00	8
50.00	2	1	1	3.00	6.00	7	3.00	5	5.00	12.00	6
46.00	1	1	1	3.00	4.00	10	3.00	1	1.00	15.00	8
56.00	1	1	1	3.00	6.00	5	3.00	5	5.00	10.00	3
55.00		1	1	3.00	3.00	3	1.00	2	2.00	15.00	5
53.00	1	1	6	3.00	#NULL!	2	2.00	5	5.00	16.00	7
64.00	2	1	6	3.00	15.00	2	2.00	2	2.00	15.00	4
56.00		1	1	3.00	3.00	10	3.00	9	2.00	9.00	8
49.00	1	1	1	3.00	3.00	2	2.00	5	5.00	5.00	4
54.00	1	1	1	3.00	6.00	2	2.00	10	3.00	10.00	4
70.00	2	1	6	3.00	11.00	2	2.00	9	2.00	40.00	7
48.00	2	1	1	3.00	6.00	13	2.00	2	2.00	19.00	7
54.00	1	1	1	3.00	5.00	13	2.00	2	2.00	6.00	5
35.00	2	1	1	3.00	4.00	2	2.00	4	4.00	10.00	6
47.00	1	1	1	3.00	8.00	3	1.00	5	5.00	20.00	5
55.00	2	1	1	3.00	3.00	12	1.00	10	3.00	9.00	4
64.00	1	1	1	3.00	7.00	2	2.00	5	5.00	30.00	3
52.00	1	1	1	3.00	4.00	3	1.00	12	5.00	10.00	1
46.00	1	1	1	3.00	4.00	2	2.00	5	5.00	16.00	8
50.00	1	1	1	3.00	1.00	8	2.00	5	5.00	10.00	8
53.00	1	1	1	3.00	4.00	3	1.00	1	1.00	8.00	5
63.00	1	1	1	3.00	11.00	2	2.00	5	5.00	10.00	6
53.00		1	1	3.00	2.00	1	1.00	5	5.00	7.00	7
62.00	1	1	1	3.00	5.00	2	2.00	8	1.00	5.00	#NULL!
48.00	1	1	1	3.00	5.00	5	3.00	9	2.00	10.00	5
52.00	1	1	1	3.00	2.00	1	1.00	5	5.00	10.00	5
46.00	2	1	1	3.00	2.00	3	1.00	9	2.00	20.00	4
51.00	1	1	1	3.00	3.00	1	1.00	1	1.00	11.00	5
49.00	2	1	1	3.00	6.00	12	1.00	5	5.00	10.00	5
35.00	1	1	1	3.00	6.00	2	2.00	5	5.00	13.00	8
37.00	1	1	6	3.00	10.00	9	3.00	2	2.00	5.00	8
51.00	1	1	1	3.00	4.00	11	1.00	2	2.00	7.00	4
54.00	2	1	1	3.00	7.00	13	2.00	1	1.00	10.00	4
67.00	2	1	6	3.00	9.00	2	2.00	2	2.00	34.00	2
45.00	2	1	1	3.00	2.00	3	1.00	2	2.00	8.00	6
40.00	1	1	1	3.00	6.00	2	2.00	10	3.00	8.00	3

52.00	2	1	1	3.00	2.00	5	3.00	2	2.00	20.00	8
48.00	1	1	1	3.00	4.00	2	2.00	2	2.00	9.00	3
31.00	1	1	1	3.00	1.00	10	3.00	8	1.00	3.00	3
53.00	2	1	1	3.00	5.00	8	2.00	3	3.00	20.00	8
37.00	2	1	1	3.00	4.00		#NULL!	4	4.00	4.00	5
68.00	1	1	1	3.00	7.00	2	2.00	10	3.00	12.00	2
36.00	1	1	1	3.00	9.00	2	2.00	2	2.00	8.00	3
52.00	1	1	1	3.00	5.00	12	1.00	5	5.00	20.00	6
43.00	2	1	1	3.00	6.00	1	1.00	5	5.00	7.00	4
54.00	1	1	1	3.00	5.00	7	3.00	5	5.00	15.00	8
43.00	1	1	1	3.00	7.00	13	2.00	5	5.00	8.00	5
64.00	1	1	1	3.00	6.00	2	2.00	4	4.00	30.00	1
48.00	1	1	1	3.00	2.00	3	1.00	5	5.00	4.00	4
59.00	1	1	1	3.00	6.00	1	1.00	11	4.00	10.00	7
44.00	1	1	1	3.00	2.00	8	2.00	5	5.00	10.00	4
53.00	1	1	1	3.00	7.00	13	2.00	9	2.00	12.00	5
32.00	1	1	1	3.00	2.00	12	1.00	8	1.00	4.00	5
33.00	2	1	1	3.00	2.00	2	2.00	14	3.00	7.00	3
59.00	1	1	1	3.00	9.00	8	2.00	5	5.00	15.00	6
46.00	1	1	1	3.00	1.00	3	1.00	9	2.00	9.00	5
47.00	1	1	1	3.00	2.00	3	1.00	5	5.00	7.00	4
50.00	2	1	1	3.00	6.00	2	2.00	3	3.00	21.00	6
52.00	1	1	1	3.00	#NULL!	10	3.00	5	5.00	7.00	3
51.00	1	1	1	3.00	5.00	2	2.00	7	3.00	10.00	4
64.00	2	1	1	3.00	3.00	2	2.00	12	5.00	15.00	3
62.00	2	1	1	3.00	7.00	5	3.00	5	5.00	24.00	8
38.00	1	1	1	3.00	1.00	1	1.00	1	1.00	4.00	4
60.00	1	1	1	3.00	#NULL!	2	2.00	2	2.00	25.00	5
39.00	1	1	1	3.00	2.00	12	1.00	5	5.00	12.00	4
55.00	1	1	1	3.00	3.00	13	2.00	5	5.00	7.00	4
40.00	1	1	1	3.00	3.00	1	1.00	12	5.00	14.00	4
46.00	1	1	1	3.00	3.00	2	2.00	8	1.00	10.00	8
50.00	1	1	1	3.00	2.00	7	3.00	1	1.00	20.00	7
45.00	1	1	1	3.00	3.00	6	3.00	1	1.00	10.00	4
34.00	1	1	1	3.00	3.00	1	1.00	5	5.00	8.00	4
50.00	1	1	1	3.00	4.00	13	2.00	1	1.00	8.00	8
46.00	2	1	6	3.00	15.00	1	1.00	8	1.00	20.00	6
40.00	1	1	1	3.00	7.00	12	1.00	5	5.00	10.00	5

30.00	2	1	6	3.00	3.00	13	2.00	5	5.00	7.00	3
52.00	1	1	1	3.00	2.00	13	2.00	8	1.00	8.00	2
40.00	1	1	1	3.00	3.00	13	2.00	8	1.00	8.00	1
44.00	2	1	1	3.00	7.00	2	2.00	2	2.00	15.00	8
49.00	2	1	1	3.00	13.00	4	3.00	1	1.00	15.00	4
55.00	1	1	1	3.00	6.00	5	3.00	14	3.00	5.00	5
51.00	2	1	6	3.00	15.00	4	3.00	1	1.00	20.00	7
49.00	2	1	1	3.00	4.00	2	2.00	6	1.00	3.00	7
54.00	2	1	6	3.00	6.00	5	3.00	1	1.00	20.00	6
35.00	2	1	1	3.00	4.00	2	2.00	2	2.00	11.00	6
52.00	1	1	1	3.00	9.00	5	3.00	2	2.00	12.00	5
53.00	1	1	1	3.00	2.00	12	1.00	10	3.00	10.00	5
51.00	1	1	6	3.00	10.00	2	2.00	3	3.00	20.00	3
57.00	1	1	1	3.00	4.00	1	1.00	5	5.00	12.00	5
58.00		1	1	3.00	5.00	2	2.00	3	3.00	20.00	8
35.00	1	1	1	3.00	5.00	12	1.00	10	3.00	13.00	5
34.00	2	1	1	3.00	5.00	12	1.00	10	3.00	10.00	5
51.00	2	1	1	3.00	6.00	2	2.00	14	3.00	10.00	4
57.00	1	1	1	3.00	15.00	2	2.00	2	2.00	8.00	7
40.00	2	1	1	3.00	6.00	12	1.00	5	5.00	10.00	7
48.00	2	1	1	3.00	7.00	8	2.00	5	5.00	18.00	8
58.00	1	1	1	3.00	15.00	8	2.00	5	5.00	20.00	4
27.00	1	1	6	3.00	3.00	5	3.00	8	1.00	4.00	5
46.00	1	1	1	3.00	4.00	12	1.00	5	5.00	9.00	7
54.00	1	1	1	3.00	5.00	5	3.00	2	2.00	11.00	7
65.00	2	1	1	3.00	4.00	2	2.00	3	3.00	15.00	1
55.00	2	1	1	3.00	4.00	11	1.00	1	1.00	15.00	4
50.00	1	1	1	3.00	5.00	8	2.00	5	5.00	8.00	4
39.00	1	1	1	3.00	#NULL!	12	1.00	9	2.00	16.00	4

qu1	qu2	qu3	qu4	qu5	qu6	qu7	qu8	qu9	qu10	qu11	qu12
5.00	5.00	3.00	4.00	3.00	4.00	4.00	4.00	3.00	3.00	3.00	3.00
4.00	5.00	4.00	5.00	4.00	3.00	5.00	4.00	3.00	3.00	3.00	3.00
5.00	5.00	5.00	5.00	5.00	4.00	5.00	5.00	5.00	4.00	4.00	4.00
5.00	5.00	5.00	5.00	5.00	3.00	4.00	5.00	4.00	4.00	3.00	3.00
3.00	5.00	4.00	5.00	4.00	3.00	4.00	3.00	3.00	3.00	5.00	3.00
4.00	5.00	4.00	5.00	3.00	3.00	4.00	4.00	4.00	3.00	4.00	4.00
5.00	5.00	3.00	5.00	4.00	3.00	5.00	5.00	4.00	4.00	4.00	4.00
4.00	5.00	3.00	5.00	4.00	4.00	5.00	5.00	4.00	4.00	4.00	4.00
4.00	5.00	4.00	4.00	4.00	4.00	5.00	4.00	#NULL!	3.00	5.00	4.00
5.00	5.00	5.00	5.00	4.00	4.00	4.00	4.00	4.00	3.00	3.00	3.00
5.00	3.00	5.00	4.00	3.00	5.00	4.00	3.00	3.00	3.00	3.00	3.00
4.00	3.00	2.00	5.00	2.00	3.00	5.00	5.00	3.00	3.00	3.00	3.00
5.00	4.00	5.00	4.00	4.00	3.00	5.00	4.00	4.00	3.00	3.00	4.00
5.00	5.00	4.00	5.00	3.00	3.00	5.00	5.00	4.00	3.00	4.00	5.00
4.00	5.00	4.00	5.00	5.00	4.00	5.00	5.00	5.00	3.00	4.00	4.00
4.00	5.00	4.00	5.00	4.00	3.00	5.00	4.00	5.00	4.00	4.00	4.00
4.00	4.00	3.00	4.00	4.00	3.00	4.00	4.00	4.00	4.00	3.00	3.00
3.00	5.00	3.00	5.00	5.00	4.00	5.00	4.00	4.00	4.00	4.00	4.00
3.00	4.00	4.00	4.00	4.00	3.00	5.00	5.00	4.00	4.00	3.00	3.00
5.00	4.00	4.00	4.00	3.00	3.00	5.00	4.00	3.00	2.00	3.00	3.00
4.00	5.00	3.00	5.00	3.00	4.00	5.00	4.00	4.00	4.00	3.00	3.00
5.00	5.00	3.00	5.00	5.00	3.00	5.00	4.00	5.00	4.00	3.00	3.00
4.00	5.00	4.00	5.00	5.00	4.00	5.00	5.00	4.00	5.00	3.00	3.00
4.00	5.00	3.00	5.00	4.00	4.00	5.00	4.00	4.00	3.00	3.00	3.00
5.00	5.00	3.00	5.00	4.00	4.00	4.00	3.00	3.00	3.00	3.00	3.00
5.00	3.00	5.00	5.00	5.00	3.00	5.00	4.00	3.00	4.00	3.00	4.00
4.00	5.00	3.00	5.00	2.00	3.00	5.00	3.00	4.00	3.00	3.00	3.00
4.00	5.00	3.00	5.00	3.00	4.00	5.00	4.00	3.00	3.00	3.00	3.00
5.00	4.00	3.00	5.00	4.00	4.00	5.00	4.00	4.00	5.00	3.00	4.00
4.00	5.00	3.00	3.00	4.00	4.00	5.00	5.00	4.00	3.00	4.00	4.00
4.00	5.00	5.00	4.00	3.00	4.00	5.00	5.00	4.00	4.00	4.00	3.00
5.00	5.00	4.00	4.00	3.00	4.00	5.00	5.00	4.00	5.00	3.00	3.00
5.00	5.00	2.00	4.00	3.00	4.00	5.00	4.00	4.00	3.00	4.00	4.00
5.00	5.00	3.00	4.00	2.00	3.00	5.00	4.00	3.00	3.00	3.00	3.00
5.00	5.00	5.00	5.00	5.00	5.00	5.00	5.00	5.00	5.00	5.00	4.00
4.00	4.00	3.00	5.00	4.00	4.00	5.00	5.00	5.00	3.00	3.00	3.00
4.00	4.00	3.00	5.00	4.00	#NULL!	5.00	4.00	4.00	4.00	4.00	4.00

5.00	5.00	3.00	5.00	5.00	3.00	5.00	4.00	5.00	4.00	3.00	3.00
5.00	5.00	4.00	5.00	5.00	4.00	5.00	5.00	4.00	4.00	4.00	4.00
5.00	4.00	5.00	3.00	5.00	3.00	5.00	5.00	5.00	3.00	3.00	4.00
4.00	5.00	4.00	4.00	3.00	3.00	5.00	5.00	4.00	4.00	3.00	3.00
5.00	4.00	3.00	5.00	5.00	3.00	4.00	5.00	3.00	3.00	3.00	3.00
4.00	4.00	4.00	3.00	3.00	3.00	4.00	4.00	4.00	4.00	3.00	3.00
5.00	5.00	4.00	3.00	4.00	3.00	5.00	4.00	4.00	3.00	3.00	3.00
4.00	3.00	2.00	5.00	4.00	3.00	5.00	4.00	4.00	4.00	4.00	3.00
5.00	4.00	3.00	5.00	3.00	3.00	5.00	5.00	4.00	3.00	4.00	3.00
5.00	4.00	3.00	4.00	4.00	3.00	5.00	5.00	4.00	3.00	3.00	3.00
5.00	5.00	4.00	5.00	4.00	3.00	4.00	4.00	3.00	3.00	3.00	4.00
4.00	3.00	3.00	5.00	5.00	3.00	5.00	5.00	5.00	4.00	4.00	3.00
5.00	5.00	3.00	5.00	5.00	4.00	5.00	4.00	3.00	5.00	4.00	3.00
4.00	3.00	3.00	4.00	3.00	4.00	4.00	4.00	3.00	3.00	3.00	3.00
4.00	4.00	4.00	5.00	4.00	4.00	5.00	5.00	5.00	4.00	5.00	3.00
4.00	4.00	4.00	4.00	4.00	4.00	5.00	4.00	4.00	4.00	3.00	2.00
5.00	5.00	3.00	5.00	3.00	3.00	5.00	4.00	4.00	3.00	3.00	3.00
5.00	5.00	4.00	5.00	4.00	4.00	5.00	4.00	4.00	4.00	3.00	3.00
5.00	4.00	4.00	3.00	5.00	4.00	5.00	5.00	5.00	3.00	#NULL!	#NULL!
5.00	5.00	4.00	4.00	4.00	3.00	5.00	4.00	5.00	4.00	4.00	4.00
4.00	4.00	3.00	4.00	4.00	3.00	5.00	5.00	5.00	5.00	5.00	4.00
5.00	4.00	3.00	4.00	3.00	4.00	4.00	4.00	4.00	5.00	4.00	3.00
4.00	5.00	4.00	5.00	4.00	3.00	5.00	4.00	5.00	4.00	4.00	3.00
5.00	5.00	4.00	5.00	5.00	5.00	5.00	5.00	2.00	4.00	5.00	3.00
4.00	5.00	4.00	4.00	5.00	3.00	5.00	5.00	4.00	3.00	3.00	3.00
5.00	4.00	4.00	5.00	4.00	4.00	5.00	4.00	4.00	3.00	3.00	3.00
4.00	5.00	4.00	5.00	5.00	4.00	4.00	4.00	4.00	3.00	3.00	3.00
5.00	5.00	4.00	4.00	5.00	4.00	5.00	5.00	5.00	4.00	4.00	3.00
5.00	5.00	4.00	5.00	4.00	4.00	4.00	5.00	5.00	3.00	3.00	3.00
4.00	4.00	5.00	5.00	3.00	4.00	5.00	5.00	5.00	4.00	3.00	3.00
5.00	5.00	4.00	5.00	3.00	4.00	5.00	5.00	5.00	3.00	4.00	5.00
4.00	5.00	4.00	4.00	5.00	4.00	4.00	5.00	5.00	4.00	4.00	3.00
3.00	5.00	3.00	5.00	4.00	4.00	4.00	4.00	4.00	3.00	3.00	3.00
4.00	5.00	5.00	5.00	4.00	3.00	5.00	4.00	5.00	3.00	4.00	3.00
3.00	5.00	5.00	5.00	4.00	4.00	5.00	5.00	4.00	3.00	4.00	4.00
5.00	5.00	5.00	5.00	5.00	3.00	5.00	4.00	4.00	4.00	3.00	3.00
3.00	5.00	4.00	5.00	4.00	3.00	5.00	5.00	4.00	3.00	4.00	3.00
3.00	5.00	4.00	5.00	4.00	3.00	5.00	5.00	4.00	5.00	4.00	4.00

2.00	4.00	4.00	3.00	4.00	4.00	5.00	3.00	4.00	4.00	4.00	3.00
3.00	5.00	4.00	3.00	5.00	3.00	4.00	4.00	4.00	3.00	5.00	3.00
5.00	5.00	5.00	5.00	4.00	3.00	4.00	5.00	5.00	3.00	5.00	5.00
4.00	5.00	4.00	5.00	4.00	4.00	5.00	4.00	5.00	4.00	3.00	3.00
4.00	5.00	4.00	4.00	5.00	4.00	4.00	4.00	5.00	5.00	4.00	4.00
3.00	4.00	3.00	4.00	4.00	4.00	5.00	4.00	3.00	3.00	3.00	3.00
3.00	5.00	5.00	5.00	5.00	3.00	5.00	3.00	3.00	3.00	3.00	3.00
3.00	5.00	3.00	5.00	5.00	3.00	5.00	5.00	5.00	5.00	3.00	3.00
3.00	#NULL!	#NULL!	5.00	5.00	4.00	5.00	5.00	3.00	3.00	5.00	3.00
4.00	4.00	4.00	5.00	4.00	4.00	4.00	4.00	4.00	4.00	4.00	4.00
4.00	4.00	3.00	4.00	4.00	4.00	4.00	3.00	5.00	5.00	3.00	3.00
3.00	5.00	3.00	4.00	5.00	3.00	5.00	5.00	3.00	4.00	4.00	3.00
4.00	5.00	4.00	4.00	4.00	3.00	5.00	5.00	3.00	3.00	3.00	3.00
4.00	5.00	4.00	5.00	5.00	5.00	5.00	4.00	5.00	4.00	5.00	5.00
4.00	5.00	4.00	4.00	5.00	3.00	5.00	5.00	5.00	4.00	3.00	3.00
3.00	5.00	4.00	5.00	4.00	3.00	5.00	5.00	4.00	4.00	4.00	4.00
3.00	5.00	4.00	4.00	5.00	4.00	5.00	4.00	3.00	4.00	4.00	3.00
3.00	5.00	5.00	5.00	5.00	4.00	5.00	4.00	5.00	5.00	4.00	3.00
5.00	5.00	3.00	5.00	2.00	1.00	5.00	4.00	3.00	3.00	4.00	4.00
3.00	5.00	5.00	4.00	3.00	3.00	5.00	5.00	5.00	3.00	5.00	3.00
3.00	5.00	5.00	5.00	5.00	5.00	5.00	5.00	3.00	4.00	3.00	4.00
4.00	5.00	5.00	5.00	4.00	4.00	5.00	4.00	4.00	5.00	4.00	5.00
3.00	5.00	4.00	5.00	5.00	4.00	5.00	5.00	5.00	4.00	4.00	3.00
5.00	5.00	4.00	4.00	3.00	4.00	5.00	5.00	3.00	3.00	4.00	5.00
4.00	4.00	4.00	4.00	4.00	3.00	5.00	4.00	4.00	5.00	4.00	4.00
3.00	5.00	5.00	5.00	5.00	5.00	5.00	5.00	5.00	5.00	5.00	5.00
4.00	5.00	4.00	5.00	4.00	4.00	5.00	4.00	4.00	4.00	3.00	3.00
3.00	5.00	2.00	5.00	5.00	4.00	5.00	4.00	4.00	4.00	4.00	3.00
3.00	5.00	5.00	4.00	5.00	4.00	5.00	5.00	5.00	5.00	5.00	4.00
3.00	5.00	3.00	5.00	5.00	4.00	5.00	4.00	5.00	5.00	4.00	3.00
4.00	5.00	5.00	5.00	5.00	3.00	5.00	4.00	#NULL!	5.00	3.00	3.00
3.00	5.00	5.00	4.00	4.00	3.00	4.00	4.00	5.00	5.00	4.00	4.00
4.00	5.00	3.00	4.00	4.00	4.00	4.00	4.00	4.00	4.00	4.00	4.00
3.00	5.00	4.00	4.00	5.00	4.00	5.00	5.00	5.00	4.00	4.00	4.00
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4.00	5.00	4.00	4.00	3.00	3.00	5.00	4.00	3.00	3.00	4.00	4.00
5.00	5.00	3.00	4.00	4.00	3.00	5.00	4.00	4.00	2.00	4.00	4.00
4.00	3.00	3.00	4.00	4.00	3.00	5.00	4.00	3.00	3.00	4.00	4.00
4.00	5.00	5.00	5.00	3.00	4.00	5.00	5.00	5.00	3.00	3.00	3.00
4.00	5.00	5.00	5.00	5.00	4.00	5.00	5.00	5.00	4.00	4.00	4.00
4.00	5.00	3.00	4.00	3.00	3.00	5.00	5.00	5.00	5.00	#NULL!	#NULL!
5.00	5.00	3.00	4.00	3.00	3.00	5.00	4.00	5.00	4.00	5.00	3.00
5.00	5.00	3.00	5.00	4.00	3.00	5.00	3.00	3.00	2.00	4.00	4.00
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5.00	5.00	3.00	5.00	3.00	3.00	5.00	5.00	5.00	4.00	3.00	3.00
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4.00	5.00	5.00	4.00	5.00	3.00	5.00	5.00	4.00	4.00	4.00	4.00
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2.00	4.00	4.00	4.00	5.00	5.00	5.00	5.00	5.00	2.00	5.00	4.00
3.00	5.00	5.00	5.00	5.00	4.00	4.00	5.00	4.00	4.00	4.00	4.00
3.00	4.00	4.00	4.00	4.00	4.00	5.00	4.00	4.00	3.00	4.00	3.00
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3.00	3.00	2.00	4.00	4.00	3.00	5.00	5.00	3.00	4.00	4.00	4.00
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2.00	5.00	4.00	3.00	3.00	4.00	5.00	4.00	3.00	4.00	3.00	4.00
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5.00	5.00	5.00	5.00	5.00	5.00	5.00	5.00	4.00	3.00	3.00	3.00
4.00	4.00	4.00	3.00	3.00	3.00	5.00	3.00	4.00	3.00	3.00	3.00
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5.00	5.00	4.00	4.00	4.00	3.00	5.00	5.00	4.00	3.00	3.00	3.00
5.00	4.00	4.00	4.00	4.00	4.00	5.00	4.00	4.00	3.00	3.00	3.00
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5.00	5.00	3.00	5.00	5.00	4.00	5.00	5.00	5.00	4.00	5.00	5.00
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3.00	5.00	4.00	4.00	5.00	4.00	5.00	4.00	3.00	3.00	4.00	4.00
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5.00	4.00	3.00	5.00	5.00	4.00	5.00	4.00	4.00	4.00	3.00	3.00
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4.00	5.00	4.00	5.00	5.00	3.00	4.00	4.00	4.00	4.00	4.00	4.00
5.00	5.00	4.00	5.00	4.00	3.00	5.00	5.00	4.00	3.00	3.00	2.00
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5.00	5.00	3.00	5.00	4.00	4.00	5.00	4.00	#NULL!	4.00	4.00	4.00
5.00	3.00	3.00	3.00	3.00	3.00	5.00	4.00	4.00	3.00	3.00	3.00
4.00	3.00	2.00	5.00	4.00	3.00	5.00	4.00	3.00	3.00	3.00	3.00
4.00	5.00	3.00	5.00	5.00	3.00	5.00	5.00	5.00	4.00	4.00	3.00
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3.00	5.00	3.00	5.00	5.00	3.00	5.00	4.00	5.00	3.00	4.00	4.00
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3.00	2.00	2.00	5.00	3.00	4.00	5.00	5.00	5.00	3.00	4.00	4.00
4.00	4.00	4.00	5.00	5.00	4.00	5.00	5.00	5.00	5.00	5.00	3.00
3.00	5.00	5.00	5.00	4.00	3.00	5.00	5.00	5.00	4.00	4.00	4.00
4.00	5.00	5.00	5.00	5.00	4.00	5.00	5.00	5.00	5.00	4.00	4.00

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5.00	5.00	3.00	4.00	2.00	3.00	5.00	4.00	4.00	3.00	4.00	4.00
5.00	5.00	4.00	4.00	4.00	3.00	4.00	3.00	3.00	3.00	3.00	3.00
5.00	5.00	3.00	4.00	4.00	3.00	4.00	5.00	4.00	3.00	4.00	4.00
4.00	4.00	3.00	4.00	4.00	4.00	5.00	5.00	4.00	4.00	3.00	3.00
3.00	3.00	4.00	4.00	3.00	3.00	5.00	4.00	5.00	3.00	4.00	3.00
2.00	5.00	4.00	5.00	4.00	4.00	5.00	5.00	4.00	3.00	3.00	3.00
5.00	5.00	3.00	5.00	3.00	3.00	5.00	4.00	5.00	4.00	4.00	3.00
4.00	5.00	4.00	5.00	4.00	4.00	5.00	5.00	5.00	5.00	4.00	4.00
5.00	5.00	3.00	5.00	5.00	5.00	5.00	5.00	5.00	4.00	4.00	4.00
5.00	4.00	3.00	4.00	#NULL!	3.00	5.00	4.00	4.00	3.00	3.00	3.00
5.00	5.00	3.00	5.00	4.00	3.00	5.00	4.00	4.00	5.00	3.00	4.00
4.00	5.00	4.00	5.00	3.00	4.00	5.00	5.00	5.00	3.00	4.00	4.00
5.00	5.00	4.00	5.00	4.00	5.00	5.00	4.00	4.00	3.00	5.00	5.00
3.00	5.00	3.00	5.00	5.00	4.00	5.00	4.00	4.00	3.00	4.00	4.00
5.00	5.00	3.00	4.00	4.00	3.00	5.00	4.00	4.00	3.00	3.00	4.00
5.00	5.00	3.00	5.00	5.00	4.00	5.00	4.00	4.00	3.00	3.00	3.00
4.00	5.00	4.00	5.00	3.00	4.00	5.00	5.00	4.00	3.00	3.00	3.00
4.00	5.00	3.00	4.00	3.00	3.00	5.00	3.00	3.00	3.00	3.00	3.00
5.00	4.00	3.00	5.00	3.00	3.00	5.00	4.00	4.00	4.00	3.00	3.00
5.00	5.00	3.00	4.00	4.00	4.00	5.00	3.00	4.00	3.00	3.00	4.00
5.00	5.00	3.00	5.00	4.00	4.00	5.00	5.00	4.00	4.00	4.00	3.00
5.00	4.00	3.00	4.00	5.00	4.00	4.00	4.00	4.00	4.00	4.00	3.00
3.00	5.00	3.00	3.00	4.00	3.00	5.00	5.00	4.00	3.00	3.00	3.00
5.00	4.00	3.00	5.00	3.00	3.00	5.00	5.00	5.00	4.00	4.00	5.00
5.00	5.00	4.00	4.00	4.00	3.00	5.00	5.00	3.00	3.00	3.00	3.00
5.00	5.00	3.00	5.00	3.00	3.00	5.00	4.00	3.00	3.00	4.00	3.00

qu13	qu14	qu15	qu16	qu17	qu18	qu19	qu20	qu21	qu22	qu23	qu24
4.00	5.00	4.00	4.00	4.00	4.00	5.00	4.00	4.00	4.00	5.00	2.00
3.00	5.00	4.00	4.00	3.00	3.00	5.00	4.00	5.00	2.00	5.00	3.00
5.00	2.00	4.00	5.00	3.00	3.00	5.00	5.00	5.00	5.00	5.00	4.00
3.00	5.00	4.00	5.00	3.00	3.00	4.00	5.00	3.00	5.00	3.00	3.00
2.00	3.00	3.00	4.00	4.00	5.00	4.00	2.00	5.00	3.00	5.00	2.00
4.00	4.00	4.00	4.00	4.00	4.00	4.00	5.00	5.00	3.00	4.00	2.00
4.00	5.00	4.00	5.00	4.00	5.00	4.00	5.00	5.00	4.00	5.00	5.00
4.00	4.00	3.00	4.00	4.00	4.00	5.00	5.00	5.00	4.00	4.00	4.00
4.00	1.00	5.00	5.00	4.00	#NULL!	4.00	#NULL!	5.00	3.00	#NULL!	3.00
2.00	5.00	3.00	4.00	4.00	4.00	4.00	5.00	5.00	4.00	5.00	2.00
5.00	3.00	4.00	3.00	3.00	3.00	3.00	3.00	5.00	3.00	4.00	3.00
3.00	5.00	2.00	3.00	3.00	4.00	5.00	1.00	5.00	5.00	5.00	2.00
4.00	5.00	4.00	5.00	4.00	5.00	3.00	3.00	5.00	5.00	5.00	2.00
4.00	5.00	4.00	5.00	5.00	3.00	3.00	5.00	5.00	4.00	5.00	2.00
4.00	5.00	5.00	5.00	4.00	3.00	4.00	5.00	5.00	4.00	5.00	3.00
4.00	5.00	3.00	5.00	4.00	5.00	4.00	4.00	5.00	4.00	5.00	3.00
3.00	5.00	3.00	5.00	3.00	5.00	3.00	#NULL!	5.00	4.00	4.00	2.00
3.00	3.00	4.00	4.00	3.00	4.00	4.00	4.00	5.00	3.00	5.00	5.00
3.00	3.00	3.00	4.00	3.00	#NULL!	4.00	#NULL!	5.00	3.00	5.00	#NULL!
3.00	3.00	4.00	4.00	3.00	4.00	3.00	1.00	2.00	3.00	5.00	3.00
3.00	5.00	3.00	5.00	4.00	4.00	5.00	4.00	4.00	5.00	4.00	3.00
3.00	3.00	2.00	5.00	3.00	4.00	5.00	5.00	5.00	4.00	5.00	2.00
3.00	5.00	4.00	5.00	5.00	5.00	5.00	5.00	5.00	5.00	3.00	4.00
3.00	4.00	3.00	4.00	4.00	3.00	4.00	2.00	5.00	4.00	4.00	3.00
3.00	4.00	3.00	4.00	4.00	4.00	4.00	3.00	5.00	3.00	5.00	3.00
3.00	5.00	4.00	5.00	3.00	3.00	4.00	5.00	5.00	4.00	4.00	2.00
3.00	4.00	4.00	5.00	4.00	5.00	3.00	3.00	5.00	4.00	4.00	2.00
5.00	5.00	3.00	5.00	4.00	3.00	5.00	5.00	5.00	5.00	5.00	3.00
4.00	4.00	4.00	5.00	4.00	3.00	4.00	4.00	5.00	4.00	5.00	4.00
3.00	4.00	4.00	5.00	4.00	3.00	5.00	3.00	5.00	5.00	4.00	3.00
3.00	5.00	4.00	5.00	4.00	3.00	4.00	4.00	3.00	4.00	4.00	4.00
4.00	2.00	4.00	5.00	4.00	4.00	3.00	3.00	4.00	5.00	4.00	5.00
3.00	5.00	2.00	5.00	4.00	3.00	5.00	5.00	5.00	3.00	5.00	4.00
3.00	4.00	3.00	5.00	4.00	1.00	3.00	2.00	4.00	3.00	5.00	3.00
4.00	4.00	5.00	5.00	3.00	5.00	5.00	1.00	5.00	5.00	5.00	4.00
3.00	5.00	3.00	4.00	4.00	3.00	2.00	3.00	4.00	4.00	4.00	4.00
4.00	4.00	3.00	5.00	4.00	3.00	3.00	5.00	4.00	3.00	5.00	3.00

3.00	5.00	3.00	5.00	4.00	3.00	3.00	5.00	5.00	4.00	5.00	1.00
3.00	2.00	5.00	5.00	5.00	4.00	4.00	3.00	5.00	4.00	4.00	4.00
4.00	4.00	3.00	5.00	3.00	3.00	2.00	5.00	5.00	4.00	5.00	5.00
4.00	3.00	4.00	5.00	4.00	3.00	3.00	2.00	4.00	3.00	4.00	3.00
3.00	5.00	3.00	4.00	4.00	4.00	3.00	4.00	5.00	4.00	4.00	4.00
3.00	4.00	3.00	4.00	3.00	#NULL!	3.00	4.00	5.00	4.00	5.00	4.00
3.00	5.00	4.00	4.00	3.00	3.00	3.00	4.00	5.00	4.00	5.00	4.00
3.00	3.00	3.00	5.00	5.00	3.00	5.00	3.00	4.00	5.00	3.00	3.00
3.00	3.00	4.00	5.00	3.00	3.00	3.00	5.00	4.00	4.00	5.00	5.00
3.00	4.00	3.00	5.00	3.00	4.00	4.00	5.00	5.00	4.00	5.00	4.00
3.00	5.00	3.00	5.00	5.00	5.00	5.00	3.00	5.00	4.00	5.00	3.00
4.00	5.00	4.00	4.00	2.00	3.00	3.00	5.00	5.00	5.00	4.00	4.00
3.00	4.00	3.00	5.00	5.00	5.00	3.00	4.00	4.00	4.00	5.00	4.00
3.00	4.00	3.00	4.00	3.00	2.00	4.00	4.00	5.00	3.00	5.00	4.00
3.00	3.00	3.00	4.00	4.00	3.00	4.00	2.00	4.00	4.00	5.00	3.00
2.00	5.00	3.00	5.00	3.00	3.00	3.00	4.00	5.00	4.00	4.00	4.00
3.00	2.00	3.00	5.00	3.00	4.00	1.00	3.00	4.00	3.00	4.00	3.00
5.00	4.00	3.00	5.00	4.00	5.00	4.00	4.00	4.00	5.00	4.00	5.00
#NULL!	#NULL!	#NULL!	#NULL!	#NULL!	#NULL!	#NULL!	#NULL!	3.00	5.00	5.00	1.00
4.00	5.00	3.00	4.00	4.00	3.00	5.00	1.00	5.00	4.00	5.00	4.00
4.00	4.00	3.00	3.00	3.00	4.00	3.00	3.00	4.00	3.00	5.00	4.00
4.00	4.00	3.00	4.00	3.00	4.00	4.00	4.00	4.00	5.00	5.00	3.00
3.00	5.00	3.00	4.00	3.00	4.00	5.00	4.00	5.00	4.00	5.00	3.00
3.00	5.00	3.00	5.00	3.00	5.00	5.00	5.00	1.00	3.00	5.00	5.00
3.00	5.00	3.00	4.00	3.00	2.00	4.00	5.00	5.00	4.00	5.00	5.00
3.00	5.00	3.00	4.00	3.00	3.00	3.00	#NULL!	5.00	4.00	5.00	3.00
3.00	5.00	3.00	5.00	3.00	3.00	3.00	4.00	5.00	4.00	5.00	4.00
4.00	4.00	4.00	4.00	5.00	4.00	4.00	5.00	5.00	4.00	5.00	5.00
4.00	4.00	4.00	5.00	4.00	2.00	4.00	3.00	4.00	4.00	5.00	3.00
3.00	4.00	4.00	5.00	3.00	3.00	4.00	4.00	3.00	4.00	4.00	4.00
4.00	4.00	3.00	5.00	5.00	3.00	4.00	5.00	5.00	4.00	5.00	5.00
3.00	5.00	5.00	5.00	4.00	3.00	5.00	1.00	5.00	5.00	5.00	#NULL!
3.00	3.00	3.00	4.00	4.00	4.00	3.00	4.00	4.00	3.00	4.00	4.00
3.00	4.00	4.00	4.00	5.00	4.00	4.00	4.00	4.00	5.00	5.00	4.00
4.00	5.00	3.00	4.00	4.00	3.00	3.00	2.00	4.00	3.00	5.00	2.00
3.00	3.00	5.00	5.00	4.00	3.00	4.00	5.00	4.00	4.00	5.00	5.00
3.00	5.00	4.00	5.00	4.00	4.00	3.00	1.00	5.00	5.00	4.00	1.00
5.00	5.00	5.00	5.00	4.00	4.00	5.00	4.00	2.00	5.00	5.00	4.00

3.00	4.00	3.00	4.00	4.00	3.00	5.00	#NULL!	4.00	3.00	5.00	2.00
3.00	5.00	4.00	5.00	5.00	3.00	5.00	4.00	5.00	3.00	5.00	2.00
5.00	2.00	5.00	5.00	4.00	3.00	3.00	4.00	4.00	3.00	4.00	3.00
3.00	5.00	4.00	4.00	3.00	3.00	3.00	4.00	4.00	4.00	3.00	4.00
4.00	5.00	5.00	4.00	4.00	4.00	5.00	5.00	5.00	5.00	5.00	1.00
3.00	5.00	4.00	4.00	4.00	4.00	4.00	4.00	5.00	4.00	5.00	3.00
3.00	5.00	3.00	5.00	3.00	3.00	5.00	#NULL!	5.00	3.00	5.00	3.00
3.00	5.00	3.00	3.00	3.00	3.00	3.00	3.00	5.00	5.00	5.00	3.00
4.00	5.00	#NULL!	5.00	4.00	4.00	5.00	#NULL!	5.00	4.00	#NULL!	#NULL!
4.00	5.00	4.00	5.00	4.00	5.00	5.00	4.00	4.00	4.00	5.00	4.00
3.00	3.00	3.00	4.00	3.00	4.00	5.00	#NULL!	5.00	4.00	4.00	2.00
4.00	3.00	3.00	5.00	4.00	5.00	4.00	5.00	4.00	3.00	5.00	2.00
3.00	3.00	4.00	5.00	5.00	5.00	3.00	#NULL!	5.00	4.00	5.00	3.00
5.00	4.00	5.00	5.00	5.00	5.00	4.00	4.00	3.00	4.00	4.00	2.00
3.00	5.00	3.00	5.00	4.00	3.00	4.00	5.00	4.00	3.00	5.00	4.00
4.00	5.00	4.00	5.00	4.00	3.00	5.00	5.00	5.00	5.00	5.00	3.00
3.00	5.00	4.00	5.00	4.00	3.00	4.00	#NULL!	5.00	4.00	5.00	3.00
4.00	5.00	3.00	5.00	4.00	2.00	5.00	5.00	5.00	5.00	5.00	2.00
4.00	5.00	3.00	5.00	4.00	5.00	4.00	2.00	5.00	3.00	5.00	2.00
3.00	5.00	2.00	5.00	5.00	5.00	4.00	3.00	5.00	4.00	5.00	2.00
3.00	5.00	#NULL!	4.00	4.00	5.00	4.00	5.00	3.00	5.00	3.00	3.00
5.00	5.00	4.00	5.00	4.00	3.00	5.00	5.00	5.00	3.00	5.00	2.00
3.00	3.00	4.00	5.00	5.00	3.00	5.00	4.00	5.00	3.00	5.00	4.00
4.00	2.00	4.00	5.00	5.00	4.00	4.00	5.00	5.00	4.00	5.00	2.00
4.00	3.00	4.00	5.00	4.00	5.00	4.00	5.00	4.00	5.00	5.00	5.00
5.00	5.00	5.00	5.00	5.00	5.00	5.00	5.00	5.00	5.00	3.00	3.00
3.00	4.00	#NULL!	5.00	3.00	#NULL!	4.00	#NULL!	5.00	4.00	4.00	#NULL!
3.00	5.00	4.00	4.00	4.00	3.00	5.00	5.00	5.00	4.00	5.00	3.00
4.00	3.00	3.00	5.00	4.00	3.00	4.00	5.00	5.00	5.00	4.00	4.00
3.00	4.00	4.00	5.00	5.00	3.00	4.00	3.00	5.00	4.00	5.00	3.00
3.00	5.00	5.00	5.00	4.00	#NULL!	3.00	5.00	#NULL!	5.00	#NULL!	#NULL!
4.00	5.00	4.00	4.00	5.00	4.00	5.00	4.00	4.00	5.00	4.00	4.00
4.00	3.00	3.00	4.00	4.00	4.00	4.00	4.00	5.00	4.00	4.00	2.00
4.00	3.00	3.00	4.00	4.00	5.00	4.00	4.00	4.00	5.00	5.00	3.00
4.00	5.00	3.00	5.00	4.00	5.00	5.00	4.00	5.00	4.00	4.00	2.00
3.00	5.00	4.00	4.00	3.00	3.00	3.00	#NULL!	4.00	5.00	4.00	#NULL!
3.00	3.00	5.00	5.00	3.00	3.00	5.00	3.00	3.00	4.00	4.00	2.00
4.00	5.00	3.00	5.00	4.00	4.00	5.00	5.00	5.00	5.00	5.00	3.00

3.00	3.00	3.00	4.00	3.00	3.00	3.00	2.00	5.00	3.00	5.00	3.00
4.00	5.00	3.00	4.00	4.00	4.00	4.00	2.00	4.00	4.00	5.00	2.00
3.00	5.00	4.00	4.00	4.00	4.00	4.00	4.00	5.00	5.00	5.00	3.00
3.00	4.00	3.00	5.00	4.00	4.00	5.00	4.00	5.00	4.00	5.00	3.00
3.00	5.00	3.00	5.00	4.00	3.00	3.00	5.00	5.00	3.00	5.00	3.00
4.00	4.00	3.00	4.00	3.00	3.00	4.00	3.00	5.00	4.00	5.00	3.00
3.00	3.00	4.00	5.00	3.00	3.00	5.00	5.00	5.00	5.00	5.00	4.00
4.00	5.00	4.00	5.00	4.00	4.00	4.00	5.00	4.00	4.00	5.00	2.00
#NULL!	#NULL!	#NULL!	#NULL!	#NULL!	#NULL!	#NULL!	#NULL!	5.00	3.00	5.00	1.00
3.00	5.00	3.00	4.00	3.00	3.00	3.00	5.00	5.00	4.00	5.00	3.00
4.00	5.00	2.00	5.00	4.00	4.00	3.00	4.00	3.00	4.00	3.00	#NULL!
3.00	5.00	3.00	5.00	3.00	3.00	4.00	4.00	4.00	3.00	5.00	2.00
3.00	#NULL!	3.00	5.00	3.00	3.00	4.00	4.00	5.00	3.00	5.00	2.00
3.00	5.00	#NULL!	5.00	4.00	2.00	5.00	5.00	5.00	5.00	5.00	1.00
3.00	3.00	4.00	5.00	4.00	3.00	4.00	5.00	4.00	4.00	4.00	4.00
3.00	5.00	4.00	5.00	4.00	3.00	3.00	2.00	1.00	5.00	5.00	3.00
3.00	4.00	3.00	4.00	4.00	4.00	5.00	4.00	4.00	5.00	5.00	3.00
5.00	5.00	4.00	4.00	5.00	5.00	4.00	5.00	5.00	4.00	4.00	4.00
5.00	4.00	4.00	5.00	4.00	4.00	4.00	4.00	4.00	3.00	4.00	4.00
4.00	5.00	4.00	5.00	5.00	5.00	5.00	2.00	5.00	5.00	5.00	2.00
3.00	5.00	3.00	5.00	4.00	4.00	4.00	5.00	4.00	5.00	5.00	4.00
3.00	3.00	5.00	5.00	3.00	5.00	3.00	5.00	4.00	5.00	4.00	3.00
4.00	5.00	4.00	4.00	5.00	3.00	4.00	4.00	5.00	5.00	5.00	2.00
4.00	3.00	4.00	5.00	4.00	5.00	5.00	5.00	5.00	5.00	5.00	3.00
4.00	5.00	2.00	3.00	5.00	3.00	3.00	4.00	3.00	3.00	5.00	3.00
4.00	3.00	5.00	5.00	5.00	4.00	5.00	5.00	5.00	5.00	4.00	2.00
4.00	5.00	4.00	4.00	4.00	3.00	5.00	5.00	5.00	3.00	5.00	4.00
4.00	4.00	5.00	4.00	4.00	4.00	5.00	3.00	4.00	3.00	5.00	4.00
4.00	3.00	4.00	5.00	5.00	2.00	3.00	5.00	4.00	4.00	5.00	4.00
4.00	4.00	4.00	5.00	4.00	3.00	5.00	5.00	5.00	4.00	5.00	3.00
4.00	3.00	3.00	5.00	4.00	3.00	4.00	5.00	5.00	3.00	5.00	4.00
3.00	5.00	3.00	4.00	4.00	3.00	5.00	4.00	5.00	4.00	5.00	2.00
4.00	4.00	5.00	5.00	4.00	3.00	5.00	5.00	5.00	3.00	4.00	5.00
4.00	5.00	5.00	5.00	5.00	3.00	5.00	5.00	4.00	5.00	5.00	2.00
3.00	5.00	4.00	5.00	5.00	4.00	4.00	5.00	5.00	5.00	4.00	4.00
3.00	4.00	3.00	3.00	4.00	3.00	4.00	5.00	4.00	4.00	4.00	4.00
5.00	5.00	5.00	5.00	5.00	4.00	4.00	4.00	4.00	4.00	5.00	2.00
5.00	4.00	3.00	5.00	5.00	3.00	4.00	5.00	3.00	5.00	5.00	4.00

4.00	5.00	4.00	5.00	5.00	5.00	5.00	1.00	3.00	5.00	4.00	3.00
4.00	4.00	3.00	4.00	4.00	4.00	5.00	4.00	5.00	4.00	3.00	3.00
5.00	3.00	3.00	5.00	5.00	5.00	5.00	5.00	3.00	5.00	5.00	5.00
5.00	3.00	4.00	4.00	5.00	4.00	5.00	4.00	5.00	4.00	5.00	5.00
4.00	5.00	4.00	5.00	4.00	3.00	4.00	3.00	5.00	4.00	5.00	2.00
4.00	5.00	3.00	4.00	4.00	4.00	4.00	5.00	4.00	4.00	5.00	3.00
4.00	5.00	4.00	5.00	5.00	3.00	5.00	5.00	5.00	5.00	5.00	1.00
4.00	5.00	3.00	5.00	4.00	3.00	5.00	4.00	5.00	3.00	5.00	5.00
4.00	3.00	4.00	4.00	4.00	3.00	4.00	4.00	4.00	5.00	5.00	3.00
3.00	5.00	3.00	5.00	4.00	4.00	5.00	5.00	5.00	3.00	5.00	5.00
4.00	5.00	5.00	5.00	5.00	3.00	5.00	5.00	5.00	5.00	5.00	1.00
4.00	5.00	5.00	5.00	3.00	5.00	4.00	5.00	4.00	3.00	5.00	2.00
4.00	5.00	3.00	4.00	4.00	4.00	5.00	4.00	5.00	5.00	5.00	2.00
3.00	4.00	4.00	4.00	4.00	3.00	3.00	4.00	1.00	3.00	4.00	2.00
3.00	4.00	3.00	3.00	3.00	3.00	4.00	2.00	5.00	4.00	5.00	3.00
3.00	5.00	2.00	5.00	4.00	3.00	3.00	4.00	5.00	3.00	4.00	3.00
3.00	3.00	4.00	5.00	3.00	3.00	3.00	5.00	5.00	4.00	5.00	3.00
3.00	3.00	4.00	4.00	3.00	3.00	3.00	4.00	3.00	3.00	3.00	3.00
3.00	5.00	3.00	5.00	3.00	4.00	3.00	#NULL!	5.00	3.00	4.00	2.00
3.00	5.00	3.00	4.00	3.00	3.00	3.00	4.00	1.00	4.00	5.00	2.00
3.00	5.00	3.00	3.00	1.00	3.00	3.00	4.00	2.00	3.00	5.00	3.00
4.00	5.00	3.00	5.00	4.00	3.00	5.00	5.00	5.00	4.00	5.00	3.00
5.00	5.00	3.00	5.00	4.00	1.00	4.00	5.00	5.00	5.00	5.00	1.00
3.00	2.00	5.00	5.00	3.00	3.00	5.00	1.00	5.00	5.00	5.00	1.00
4.00	5.00	3.00	5.00	4.00	3.00	3.00	4.00	5.00	5.00	3.00	3.00
3.00	4.00	3.00	5.00	3.00	5.00	3.00	5.00	5.00	3.00	5.00	2.00
3.00	4.00	3.00	4.00	3.00	4.00	3.00	4.00	4.00	3.00	4.00	3.00
4.00	4.00	3.00	4.00	4.00	3.00	2.00	3.00	5.00	3.00	5.00	4.00
4.00	5.00	3.00	5.00	5.00	5.00	2.00	3.00	5.00	4.00	5.00	3.00
3.00	5.00	4.00	5.00	4.00	3.00	4.00	5.00	5.00	4.00	5.00	2.00
3.00	5.00	4.00	5.00	4.00	3.00	5.00	5.00	5.00	5.00	4.00	3.00
3.00	4.00	3.00	4.00	4.00	5.00	3.00	4.00	4.00	3.00	4.00	3.00
3.00	4.00	4.00	5.00	5.00	3.00	3.00	2.00	5.00	3.00	5.00	4.00
4.00	3.00	3.00	5.00	4.00	3.00	3.00	4.00	5.00	4.00	5.00	2.00
3.00	4.00	4.00	5.00	4.00	#NULL!	3.00	#NULL!	5.00	5.00	5.00	2.00
4.00	4.00	4.00	5.00	4.00	#NULL!	3.00	#NULL!	5.00	3.00	5.00	4.00
5.00	5.00	5.00	5.00	5.00	5.00	5.00	1.00	5.00	3.00	4.00	2.00
4.00	5.00	4.00	5.00	4.00	4.00	4.00	4.00	5.00	5.00	5.00	2.00

3.00	4.00	4.00	5.00	3.00	3.00	1.00	4.00	5.00	3.00	5.00	3.00
3.00	5.00	4.00	5.00	4.00	4.00	2.00	4.00	5.00	4.00	5.00	2.00
3.00	5.00	5.00	5.00	1.00	3.00	1.00	5.00	5.00	5.00	5.00	4.00
3.00	5.00	3.00	5.00	3.00	3.00	3.00	5.00	5.00	5.00	5.00	5.00
3.00	4.00	5.00	5.00	5.00	2.00	5.00	3.00	5.00	3.00	5.00	2.00
3.00	3.00	4.00	5.00	4.00	4.00	3.00	5.00	5.00	5.00	5.00	4.00
4.00	5.00	3.00	5.00	4.00	3.00	4.00	4.00	4.00	4.00	4.00	3.00
3.00	3.00	4.00	5.00	3.00	#NULL!	4.00	3.00	5.00	4.00	5.00	5.00
3.00	5.00	3.00	4.00	3.00	2.00	4.00	#NULL!	5.00	4.00	5.00	2.00
4.00	4.00	4.00	5.00	4.00	4.00	4.00	4.00	5.00	4.00	5.00	5.00
3.00	5.00	4.00	5.00	3.00	3.00	3.00	3.00	4.00	3.00	5.00	3.00
3.00	3.00	3.00	5.00	3.00	3.00	3.00	4.00	4.00	3.00	4.00	3.00
3.00	5.00	2.00	4.00	4.00	4.00	3.00	4.00	4.00	4.00	4.00	#NULL!
5.00	5.00	3.00	5.00	4.00	3.00	3.00	4.00	5.00	3.00	4.00	4.00
4.00	5.00	5.00	5.00	4.00	3.00	3.00	5.00	5.00	4.00	5.00	2.00
3.00	4.00	3.00	4.00	3.00	4.00	4.00	5.00	5.00	4.00	4.00	4.00
4.00	5.00	3.00	5.00	4.00	4.00	3.00	4.00	5.00	5.00	5.00	5.00
3.00	4.00	4.00	4.00	4.00	3.00	4.00	4.00	5.00	5.00	4.00	3.00
3.00	4.00	3.00	5.00	3.00	2.00	3.00	2.00	5.00	3.00	5.00	3.00
3.00	4.00	3.00	3.00	3.00	4.00	4.00	4.00	5.00	3.00	4.00	4.00
3.00	4.00	3.00	5.00	3.00	4.00	4.00	2.00	5.00	4.00	5.00	2.00
4.00	4.00	4.00	5.00	4.00	3.00	3.00	4.00	5.00	3.00	3.00	3.00
5.00	3.00	5.00	5.00	3.00	4.00	5.00	5.00	5.00	5.00	5.00	5.00
3.00	5.00	4.00	5.00	3.00	3.00	3.00	5.00	4.00	3.00	5.00	4.00
3.00	5.00	3.00	4.00	3.00	3.00	3.00	5.00	5.00	4.00	3.00	3.00
4.00	5.00	4.00	5.00	3.00	4.00	3.00	4.00	4.00	3.00	4.00	3.00
3.00	3.00	5.00	5.00	4.00	3.00	3.00	4.00	5.00	4.00	5.00	#NULL!
3.00	4.00	3.00	5.00	3.00	3.00	3.00	5.00	5.00	3.00	5.00	3.00
3.00	5.00	4.00	3.00	3.00	3.00	3.00	5.00	4.00	4.00	5.00	2.00
4.00	5.00	4.00	5.00	4.00	3.00	4.00	5.00	4.00	4.00	4.00	4.00
4.00	4.00	3.00	4.00	4.00	3.00	4.00	5.00	4.00	4.00	4.00	2.00
4.00	#NULL!	3.00	4.00	4.00	4.00	4.00	4.00	5.00	4.00	4.00	4.00
5.00	3.00	5.00	4.00	3.00	1.00	4.00	5.00	4.00	5.00	2.00	5.00
3.00	5.00	4.00	4.00	3.00	3.00	4.00	4.00	5.00	3.00	5.00	4.00
4.00	4.00	4.00	5.00	4.00	5.00	5.00	4.00	4.00	4.00	4.00	4.00
4.00	4.00	4.00	4.00	3.00	4.00	3.00	3.00	4.00	3.00	3.00	2.00
3.00	5.00	3.00	4.00	3.00	4.00	5.00	4.00	5.00	4.00	5.00	2.00
3.00	5.00	3.00	4.00	#NULL!	3.00	3.00	5.00	5.00	5.00	5.00	#NULL!

4.00	3.00	4.00	#NULL!	#NULL!	#NULL!	#NULL!	#NULL!	4.00	3.00	4.00	3.00
3.00	5.00	3.00	5.00	4.00	2.00	3.00	4.00	5.00	4.00	4.00	2.00
4.00	5.00	4.00	4.00	3.00	4.00	3.00	4.00	5.00	4.00	5.00	2.00
4.00	4.00	4.00	5.00	4.00	4.00	5.00	4.00	5.00	4.00	5.00	2.00
3.00	4.00	4.00	5.00	3.00	3.00	4.00	4.00	5.00	4.00	5.00	3.00
4.00	5.00	2.00	5.00	3.00	4.00	1.00	3.00	5.00	3.00	5.00	3.00
3.00	5.00	3.00	5.00	3.00	4.00	4.00	5.00	5.00	4.00	4.00	4.00
3.00	5.00	3.00	4.00	3.00	4.00	3.00	4.00	5.00	3.00	4.00	3.00
4.00	3.00	4.00	4.00	4.00	2.00	2.00	4.00	5.00	4.00	5.00	3.00
3.00	5.00	3.00	3.00	3.00	3.00	3.00	#NULL!	5.00	4.00	5.00	4.00
4.00	3.00	5.00	4.00	3.00	4.00	4.00	5.00	4.00	5.00	4.00	4.00
4.00	5.00	3.00	5.00	3.00	3.00	3.00	5.00	4.00	3.00	5.00	4.00
3.00	5.00	3.00	5.00	4.00	3.00	5.00	4.00	5.00	5.00	5.00	4.00
3.00	4.00	4.00	5.00	3.00	3.00	5.00	4.00	5.00	3.00	5.00	5.00
3.00	4.00	3.00	5.00	5.00	3.00	4.00	1.00	5.00	3.00	4.00	3.00
3.00	5.00	4.00	5.00	2.00	2.00	4.00	5.00	5.00	3.00	4.00	1.00
3.00	4.00	3.00	5.00	4.00	3.00	5.00	5.00	4.00	4.00	5.00	1.00
3.00	5.00	3.00	5.00	3.00	3.00	3.00	5.00	5.00	4.00	5.00	3.00
3.00	3.00	3.00	5.00	3.00	2.00	3.00	5.00	4.00	4.00	4.00	3.00
4.00	5.00	3.00	4.00	4.00	5.00	2.00	#NULL!	5.00	4.00	5.00	2.00
3.00	5.00	3.00	5.00	3.00	#NULL!	3.00	4.00	5.00	5.00	5.00	3.00
3.00	4.00	2.00	4.00	3.00	3.00	2.00	4.00	4.00	3.00	3.00	4.00
3.00	5.00	3.00	5.00	3.00	3.00	3.00	4.00	5.00	4.00	5.00	3.00
3.00	3.00	3.00	5.00	5.00	3.00	3.00	4.00	4.00	3.00	4.00	2.00
3.00	5.00	3.00	5.00	4.00	4.00	5.00	2.00	5.00	5.00	4.00	2.00
3.00	5.00	2.00	#NULL!	3.00	3.00	3.00	3.00	5.00	4.00	4.00	4.00
4.00	5.00	4.00	5.00	4.00	3.00	4.00	3.00	5.00	4.00	5.00	2.00
4.00	4.00	4.00	5.00	4.00	3.00	3.00	4.00	5.00	3.00	4.00	2.00
3.00	5.00	4.00	4.00	3.00	3.00	4.00	3.00	5.00	3.00	5.00	3.00
3.00	3.00	3.00	5.00	4.00	4.00	3.00	5.00	5.00	3.00	4.00	3.00
3.00	5.00	3.00	4.00	3.00	3.00	4.00	4.00	5.00	3.00	5.00	1.00
3.00	5.00	3.00	5.00	3.00	4.00	3.00	4.00	4.00	3.00	5.00	3.00
3.00	4.00	4.00	4.00	4.00	3.00	3.00	4.00	5.00	4.00	5.00	3.00
3.00	5.00	4.00	4.00	3.00	2.00	4.00	4.00	4.00	3.00	5.00	4.00
4.00	5.00	3.00	5.00	4.00	5.00	3.00	5.00	5.00	3.00	5.00	2.00
3.00	5.00	4.00	5.00	3.00	3.00	5.00	5.00	5.00	3.00	5.00	5.00
4.00	1.00	5.00	4.00	4.00	5.00	5.00	4.00	4.00	5.00	4.00	2.00
3.00	3.00	3.00	5.00	4.00	4.00	3.00	#NULL!	4.00	5.00	5.00	5.00

3.00	2.00	4.00	4.00	3.00	3.00	3.00	4.00	4.00	4.00	4.00	4.00
4.00	4.00	4.00	5.00	3.00	3.00	3.00	4.00	5.00	3.00	4.00	4.00
3.00	3.00	3.00	5.00	4.00	2.00	4.00	3.00	4.00	4.00	4.00	3.00
3.00	2.00	2.00	5.00	4.00	4.00	4.00	3.00	5.00	4.00	5.00	2.00
3.00	3.00	3.00	4.00	3.00	4.00	4.00	4.00	4.00	4.00	4.00	3.00
4.00	5.00	4.00	5.00	4.00	4.00	3.00	5.00	5.00	4.00	5.00	2.00
3.00	5.00	3.00	4.00	4.00	1.00	3.00	5.00	4.00	4.00	5.00	4.00
3.00	3.00	4.00	4.00	3.00	3.00	4.00	4.00	5.00	4.00	4.00	4.00
3.00	3.00	4.00	5.00	3.00	4.00	4.00	5.00	5.00	4.00	4.00	4.00
4.00	3.00	3.00	5.00	4.00	3.00	5.00	2.00	5.00	4.00	4.00	3.00
3.00	5.00	4.00	5.00	4.00	3.00	3.00	#NULL!	5.00	3.00	5.00	2.00
4.00	5.00	3.00	5.00	5.00	3.00	4.00	3.00	5.00	4.00	5.00	4.00
3.00	5.00	3.00	4.00	3.00	3.00	2.00	#NULL!	5.00	3.00	5.00	3.00
3.00	5.00	3.00	5.00	4.00	2.00	4.00	4.00	5.00	4.00	5.00	4.00
4.00	4.00	3.00	5.00	3.00	4.00	4.00	#NULL!	3.00	3.00	5.00	#NULL!
4.00	5.00	4.00	4.00	5.00	4.00	5.00	4.00	4.00	4.00	4.00	4.00
4.00	4.00	3.00	4.00	4.00	3.00	4.00	5.00	4.00	3.00	5.00	4.00
4.00	3.00	4.00	5.00	4.00	3.00	3.00	4.00	5.00	3.00	5.00	3.00
3.00	4.00	3.00	4.00	3.00	4.00	3.00	#NULL!	5.00	4.00	5.00	2.00
3.00	5.00	3.00	5.00	3.00	3.00	3.00	#NULL!	5.00	4.00	5.00	2.00
3.00	4.00	4.00	5.00	3.00	3.00	3.00	4.00	5.00	4.00	5.00	4.00
3.00	5.00	3.00	5.00	3.00	3.00	3.00	#NULL!	5.00	4.00	5.00	2.00
3.00	4.00	4.00	5.00	3.00	3.00	3.00	4.00	5.00	4.00	5.00	4.00
3.00	5.00	2.00	5.00	3.00	4.00	3.00	4.00	4.00	4.00	5.00	2.00
3.00	5.00	3.00	4.00	4.00	3.00	4.00	3.00	4.00	4.00	5.00	4.00
3.00	5.00	4.00	5.00	4.00	3.00	4.00	5.00	5.00	5.00	5.00	4.00
3.00	3.00	3.00	5.00	3.00	3.00	3.00	5.00	4.00	4.00	4.00	2.00
3.00	3.00	3.00	4.00	3.00	4.00	1.00	3.00	4.00	4.00	3.00	3.00
3.00	2.00	4.00	5.00	4.00	5.00	4.00	3.00	5.00	4.00	5.00	3.00
3.00	3.00	3.00	5.00	3.00	3.00	4.00	5.00	5.00	5.00	4.00	3.00
3.00	4.00	3.00	5.00	4.00	1.00	3.00	2.00	5.00	3.00	5.00	3.00

qu25	qu26	qu27	qu28	qu29	qu30	profess	cpt	research	teamwrk	organ	therape
2.00	5.00	4.00	5.00	3.00	3.00	4.38	4.00	3.50	3.33	3.67	3.63
3.00	5.00	3.00	5.00	5.00	5.00	4.25	4.60	3.50	2.83	3.44	4.13
5.00	2.00	3.00	2.00	5.00	5.00	3.75	4.20	4.50	4.50	4.00	4.75
3.00	5.00	1.00	3.00	4.00	4.00	3.88	4.60	4.00	3.67	3.11	3.75
4.00	3.00	2.00	3.00	5.00	5.00	3.25	3.80	3.50	3.17	3.67	3.88
4.00	3.00	4.00	4.00	4.00	4.00	4.13	4.20	3.00	3.67	3.89	3.88
3.00	3.00	4.00	3.00	5.00	4.00	4.25	4.40	3.50	4.00	4.22	4.50
3.00	5.00	4.00	4.00	5.00	4.00	4.63	4.00	4.00	4.00	4.22	3.88
3.00	3.00	4.00	#NULL!	4.00	4.00	4.17	3.80	4.00	3.80	4.00	4.14
4.00	5.00	3.00	5.00	5.00	3.00	4.38	4.40	4.00	3.17	3.44	3.88
4.00	5.00	3.00	3.00	4.00	4.00	3.38	4.00	4.00	3.33	3.33	4.00
3.00	5.00	3.00	5.00	5.00	5.00	3.75	3.80	2.50	3.33	3.56	3.63
5.00	5.00	4.00	5.00	4.00	5.00	4.25	4.60	3.50	3.83	3.78	4.50
4.00	5.00	4.00	5.00	5.00	5.00	4.88	4.60	3.00	4.00	4.00	4.38
3.00	2.00	4.00	3.00	5.00	4.00	4.13	4.80	4.50	4.00	3.89	4.25
4.00	5.00	3.00	3.00	5.00	5.00	4.13	4.40	3.50	4.17	4.11	4.25
3.00	3.00	3.00	3.00	3.00	4.00	3.43	3.80	3.50	3.50	3.33	3.75
3.00	3.00	4.00	3.00	5.00	4.00	3.88	4.00	4.50	3.67	3.89	4.13
4.00	3.00	3.00	3.00	3.00	3.00	3.71	3.80	3.50	3.33	3.25	3.86
3.00	4.00	3.00	3.00	5.00	5.00	3.38	4.00	3.00	2.83	3.22	3.88
3.00	3.00	3.00	4.00	4.00	4.00	4.00	4.20	3.50	3.67	3.67	3.75
3.00	3.00	3.00	3.00	4.00	5.00	3.88	3.60	4.00	3.67	3.56	4.00
4.00	3.00	4.00	5.00	5.00	4.00	4.63	4.60	4.50	3.83	4.22	4.13
4.00	4.00	3.00	5.00	4.00	4.00	4.00	4.00	4.00	3.33	3.33	3.88
5.00	5.00	4.00	5.00	5.00	5.00	4.13	3.80	4.00	3.00	3.67	4.38
4.00	4.00	3.00	3.00	4.00	5.00	3.75	4.80	4.00	3.50	3.44	4.25
4.00	3.00	3.00	3.00	4.00	3.00	3.63	4.20	2.50	3.33	3.44	3.88
3.00	5.00	3.00	4.00	5.00	4.00	4.38	4.20	3.50	3.67	3.78	4.00
5.00	3.00	4.00	4.00	5.00	5.00	4.00	4.20	4.00	4.00	4.00	4.75
5.00	3.00	4.00	3.00	5.00	4.00	4.00	3.80	4.00	3.83	3.89	4.25
3.00	3.00	4.00	3.00	4.00	4.00	4.13	4.60	3.50	3.67	3.67	3.88
4.00	3.00	3.00	3.00	4.00	2.00	3.88	3.80	3.50	4.00	3.67	4.13
4.00	5.00	4.00	5.00	5.00	5.00	4.63	3.60	3.50	3.50	3.89	4.38
3.00	4.00	4.00	4.00	5.00	4.00	4.00	3.80	2.50	3.00	3.22	4.00
4.00	4.00	5.00	4.00	5.00	5.00	4.00	4.80	5.00	4.67	4.56	4.75
4.00	4.00	4.00	5.00	4.00	4.00	4.25	4.20	4.00	3.50	3.22	3.88
4.00	3.00	3.00	3.00	4.00	4.00	3.88	4.00	4.00	3.83	3.67	4.00

3.00	5.00	4.00	5.00	5.00	5.00	4.63	4.20	4.00	3.67	3.56	4.00
4.00	3.00	4.00	2.00	4.00	3.00	4.00	4.20	4.50	3.83	4.00	4.38
5.00	5.00	1.00	5.00	5.00	4.00	4.13	4.00	4.00	3.83	3.11	4.63
4.00	2.00	4.00	3.00	5.00	4.00	3.75	4.00	3.00	3.50	3.67	4.00
5.00	3.00	3.00	5.00	5.00	4.00	4.00	4.00	4.00	3.17	3.44	4.25
4.00	3.00	3.00	4.00	5.00	5.00	3.63	3.60	3.00	3.50	3.38	4.25
4.00	4.00	3.00	4.00	5.00	3.00	4.00	4.20	3.50	3.33	3.22	4.25
5.00	2.00	5.00	3.00	5.00	3.00	3.75	3.60	3.50	3.83	4.11	3.75
4.00	3.00	3.00	3.00	4.00	4.00	3.88	4.00	3.00	3.50	3.22	4.50
3.00	3.00	3.00	4.00	5.00	4.00	4.00	3.80	3.50	3.33	3.44	4.25
5.00	5.00	4.00	5.00	5.00	3.00	4.38	4.20	3.50	3.33	4.11	4.25
4.00	2.00	4.00	4.00	4.00	3.00	3.75	4.40	4.00	4.17	3.44	4.00
4.00	3.00	4.00	4.00	4.00	4.00	4.25	4.00	4.50	3.67	4.00	4.25
4.00	5.00	4.00	5.00	5.00	5.00	4.00	3.60	3.50	3.00	3.33	4.25
5.00	3.00	4.00	4.00	3.00	4.00	3.88	4.00	4.00	4.00	3.67	4.00
3.00	5.00	3.00	5.00	5.00	3.00	4.13	4.20	4.00	3.17	3.11	3.88
2.00	4.00	3.00	2.00	5.00	4.00	3.63	3.60	3.00	3.17	3.11	3.75
5.00	2.00	5.00	2.00	4.00	4.00	3.88	4.20	4.00	4.00	4.11	4.38
3.00	2.00	3.00	2.00	4.00	5.00	3.50	4.00	4.50	4.33	3.33	3.67
4.00	5.00	5.00	2.00	5.00	5.00	3.88	4.20	3.50	4.17	4.22	4.38
4.00	3.00	4.00	3.00	5.00	4.00	3.75	3.80	3.50	4.33	4.11	3.88
4.00	3.00	3.00	5.00	#NULL!	3.00	3.75	3.60	3.50	4.17	3.75	3.88
4.00	5.00	4.00	4.00	5.00	5.00	4.25	4.40	3.50	3.83	3.89	4.13
4.00	3.00	3.00	5.00	5.00	4.00	4.25	4.40	5.00	3.33	4.00	4.00
5.00	5.00	3.00	5.00	5.00	3.00	4.50	4.20	4.00	3.33	3.22	4.25
4.00	3.00	3.00	5.00	3.00	3.00	3.86	4.40	4.00	3.33	3.00	4.00
4.00	5.00	3.00	5.00	4.00	4.00	4.13	4.20	4.50	3.33	3.11	4.25
4.00	1.00	5.00	3.00	5.00	5.00	4.25	4.20	4.50	4.00	4.22	4.63
3.00	3.00	4.00	2.00	5.00	4.00	3.75	4.20	4.00	3.67	3.56	4.13
4.00	2.00	3.00	4.00	5.00	4.00	3.75	4.60	3.50	3.67	3.44	4.00
4.00	2.00	5.00	2.00	4.00	4.00	4.25	4.20	3.50	4.17	4.11	4.50
3.00	3.00	3.00	4.00	4.00	4.00	3.63	4.40	4.50	4.00	3.67	4.43
3.00	2.00	4.00	2.00	4.00	3.00	3.63	3.60	4.00	3.17	3.44	3.50
4.00	4.00	#NULL!	3.00	4.00	4.00	4.29	4.60	3.50	3.83	3.75	4.13
4.00	5.00	3.00	3.00	4.00	4.00	4.00	4.60	4.00	3.67	3.56	3.63
5.00	2.00	5.00	5.00	5.00	4.00	4.38	4.60	4.00	3.50	3.78	4.75
3.00	3.00	3.00	4.00	5.00	5.00	3.75	4.60	3.50	3.67	3.56	3.75
3.00	5.00	4.00	3.00	5.00	4.00	4.38	4.80	3.50	4.50	4.44	3.88

3.00	3.00	2.00	3.00	3.00	4.00	3.43	3.80	4.00	3.50	3.44	3.38
3.00	5.00	3.00	5.00	5.00	4.00	4.38	4.00	4.00	3.50	3.89	3.88
4.00	2.00	5.00	2.00	4.00	4.00	3.88	4.20	3.50	4.33	4.11	4.25
3.00	4.00	3.00	5.00	4.00	3.00	4.13	4.60	4.00	3.67	3.22	3.63
3.00	4.00	3.00	5.00	4.00	4.00	4.25	4.40	4.50	4.50	4.11	3.88
3.00	5.00	3.00	5.00	5.00	3.00	4.25	4.20	4.00	3.17	3.56	3.75
2.00	5.00	3.00	3.00	3.00	3.00	3.86	4.60	4.00	3.00	3.22	3.63
3.00	5.00	3.00	3.00	3.00	3.00	4.00	4.20	4.00	4.00	3.22	3.50
3.00	5.00	3.00	5.00	#NULL!	4.00	4.50	5.00	4.50	3.67	3.88	4.00
3.00	5.00	4.00	4.00	5.00	2.00	4.13	4.40	4.00	4.00	4.33	3.88
3.00	#NULL!	3.00	2.00	4.00	4.00	3.17	3.40	4.00	3.83	3.67	3.63
4.00	2.00	4.00	4.00	4.00	3.00	4.25	3.60	4.00	3.50	4.00	3.63
4.00	4.00	4.00	3.00	4.00	3.00	4.43	4.00	3.50	3.17	3.67	4.13
3.00	4.00	4.00	3.00	4.00	3.00	4.25	4.60	5.00	4.67	4.56	3.63
3.00	5.00	3.00	5.00	3.00	4.00	4.63	4.20	4.00	3.50	3.33	4.00
3.00	2.00	4.00	4.00	3.00	4.00	4.25	4.60	3.50	4.17	3.89	4.00
3.00	4.00	3.00	3.00	3.00	4.00	4.00	4.40	4.50	3.50	3.44	4.00
4.00	5.00	3.00	5.00	4.00	4.00	4.50	4.60	4.50	4.33	3.78	3.88
5.00	4.00	3.00	5.00	5.00	5.00	4.00	4.20	1.50	3.50	4.00	4.38
3.00	5.00	3.00	4.00	5.00	3.00	4.38	4.20	3.00	3.83	4.00	3.50
3.00	2.00	2.00	5.00	5.00	2.00	4.13	5.00	5.00	3.67	3.78	3.00
4.00	5.00	3.00	3.00	5.00	5.00	4.25	4.80	4.00	4.33	4.33	4.25
4.00	3.00	3.00	2.00	4.00	4.00	4.00	4.20	4.50	3.67	3.78	4.25
5.00	2.00	4.00	3.00	5.00	5.00	4.25	3.80	3.50	3.83	4.22	4.50
3.00	4.00	3.00	2.00	5.00	4.00	3.88	4.00	3.50	4.33	4.22	4.25
5.00	1.00	5.00	5.00	5.00	3.00	4.50	5.00	5.00	5.00	5.00	4.00
3.00	4.00	3.00	3.00	4.00	4.00	3.86	4.50	4.00	3.50	3.38	4.17
3.00	4.00	3.00	3.00	4.00	3.00	4.13	4.20	4.50	3.67	3.67	3.75
3.00	4.00	4.00	3.00	5.00	3.00	4.38	4.00	4.50	4.67	4.22	3.75
4.00	4.00	4.00	3.00	5.00	4.00	4.13	4.20	4.50	4.00	4.00	4.13
3.00	#NULL!	4.00	3.00	5.00	4.00	4.29	5.00	4.00	3.80	3.75	4.20
3.00	4.00	4.00	4.00	5.00	3.00	4.25	4.40	3.50	4.50	4.44	3.63
3.00	4.00	4.00	3.00	4.00	4.00	4.00	3.40	4.00	4.00	4.00	3.63
4.00	3.00	3.00	3.00	4.00	4.00	4.00	3.80	4.50	4.33	4.00	3.75
3.00	5.00	4.00	4.00	4.00	4.00	4.50	4.20	3.00	3.83	4.00	3.63
3.00	#NULL!	3.00	3.00	4.00	3.00	3.83	4.40	3.50	3.83	3.22	3.57
3.00	3.00	4.00	3.00	3.00	2.00	3.88	4.40	4.00	3.67	3.44	3.63
3.00	5.00	3.00	5.00	4.00	2.00	4.63	4.40	4.50	4.50	4.11	3.63

4.00	3.00	3.00	3.00	3.00	3.00	3.50	3.40	4.00	3.17	3.00	3.88
3.00	3.00	3.00	4.00	5.00	3.00	3.75	4.60	4.50	4.17	4.00	3.63
3.00	4.00	3.00	4.00	5.00	4.00	4.00	4.00	3.00	3.33	3.56	3.88
5.00	5.00	3.00	5.00	5.00	5.00	4.38	4.00	3.00	3.50	3.89	4.38
4.00	5.00	4.00	3.00	4.00	5.00	4.38	4.00	3.50	3.33	3.44	4.38
3.00	4.00	3.00	3.00	5.00	3.00	3.50	3.80	3.50	3.67	3.67	3.75
4.00	3.00	3.00	3.00	4.00	4.00	4.00	4.40	3.50	3.67	3.33	4.38
4.00	5.00	4.00	3.00	4.00	3.00	4.50	4.80	4.50	4.17	4.00	3.88
4.00	4.00	3.00	3.00	5.00	5.00	4.17	4.00	3.00	4.33	4.33	4.00
4.00	5.00	3.00	4.00	5.00	5.00	4.25	4.00	3.00	4.00	3.56	4.25
3.00	3.00	4.00	5.00	5.00	2.00	4.13	4.00	3.50	3.50	3.78	3.29
3.00	4.00	3.00	4.00	3.00	3.00	3.88	4.20	4.50	3.17	3.11	3.63
4.00	5.00	4.00	3.00	5.00	4.00	4.25	4.00	3.00	3.50	3.56	4.13
2.00	#NULL!	4.00	3.00	3.00	3.00	4.29	5.00	4.50	3.50	3.33	3.57
3.00	3.00	3.00	3.00	5.00	3.00	4.00	4.20	5.00	3.67	3.56	3.75
3.00	5.00	4.00	3.00	5.00	4.00	3.88	4.20	4.00	4.33	3.89	3.50
3.00	3.00	3.00	3.00	3.00	4.00	3.88	4.20	3.50	4.17	3.89	3.63
3.00	5.00	3.00	3.00	4.00	3.00	4.50	4.80	4.00	4.17	4.33	3.75
3.00	5.00	4.00	4.00	5.00	4.00	4.50	4.20	3.50	4.00	4.11	3.88
3.00	5.00	3.00	4.00	4.00	3.00	4.25	4.40	4.50	4.83	4.56	3.88
3.00	4.00	3.00	5.00	4.00	4.00	4.50	4.40	4.00	4.00	3.78	4.00
4.00	3.00	3.00	3.00	4.00	4.00	4.00	4.60	4.50	4.33	3.78	4.00
3.00	5.00	3.00	4.00	4.00	4.00	4.50	4.60	4.50	4.33	3.89	3.75
3.00	3.00	3.00	3.00	5.00	4.00	4.13	4.40	3.50	4.17	4.11	4.00
3.00	2.00	3.00	5.00	5.00	3.00	4.13	4.00	5.00	3.83	3.78	3.00
4.00	3.00	4.00	2.00	5.00	3.00	4.13	4.40	4.50	4.17	4.33	3.88
4.00	4.00	3.00	4.00	3.00	4.00	4.13	4.40	4.00	3.50	3.56	4.13
4.00	4.00	3.00	4.00	5.00	4.00	4.13	4.60	4.00	3.50	3.89	4.25
4.00	4.00	5.00	3.00	4.00	5.00	4.38	4.20	4.50	4.17	3.89	4.38
3.00	4.00	3.00	3.00	3.00	4.00	4.13	3.80	4.50	4.33	3.89	4.00
4.00	4.00	2.00	3.00	5.00	4.00	3.88	4.00	4.00	3.67	3.78	4.25
4.00	4.00	3.00	3.00	5.00	5.00	4.13	4.20	4.50	3.83	3.78	3.88
3.00	4.00	3.00	4.00	4.00	3.00	4.38	4.60	4.50	3.83	3.89	4.13
3.00	2.00	3.00	2.00	4.00	3.00	4.00	5.00	4.50	3.83	3.89	3.75
3.00	3.00	3.00	3.00	4.00	4.00	4.13	4.60	4.00	3.50	3.56	4.00
3.00	3.00	3.00	3.00	3.00	4.00	4.00	4.00	3.00	3.50	3.33	3.50
5.00	4.00	4.00	4.00	4.00	4.00	4.50	4.60	4.50	4.17	4.22	4.13
3.00	4.00	3.00	2.00	4.00	1.00	4.25	3.80	4.00	4.50	4.11	3.38

1.00	5.00	3.00	1.00	2.00	2.00	3.75	4.40	4.00	4.50	4.11	3.13
4.00	3.00	4.00	3.00	5.00	3.00	4.13	4.20	4.50	3.83	4.11	3.50
3.00	3.00	4.00	3.00	5.00	4.00	4.38	4.00	4.50	4.83	4.78	3.88
4.00	5.00	3.00	3.00	5.00	5.00	4.25	4.40	4.00	4.33	4.44	4.38
3.00	4.00	4.00	4.00	4.00	3.00	4.00	4.00	4.50	3.83	3.78	3.88
3.00	5.00	3.00	3.00	4.00	5.00	4.13	3.80	3.50	3.83	3.89	3.75
3.00	5.00	4.00	4.00	5.00	3.00	4.50	4.20	4.50	4.17	4.33	3.63
4.00	5.00	4.00	4.00	5.00	5.00	4.38	4.20	3.50	4.17	4.22	4.50
3.00	3.00	3.00	3.00	3.00	4.00	3.88	3.80	3.50	3.83	3.56	3.63
4.00	5.00	3.00	3.00	4.00	4.00	4.25	4.40	3.50	3.50	3.78	4.38
4.00	5.00	3.00	3.00	4.00	5.00	4.38	4.60	3.00	4.33	4.00	4.13
2.00	5.00	3.00	2.00	5.00	3.00	3.88	4.80	4.00	3.50	3.67	3.63
3.00	5.00	3.00	5.00	5.00	4.00	4.25	4.00	3.00	4.50	4.22	3.63
4.00	4.00	4.00	4.00	4.00	3.00	4.38	4.20	5.00	3.00	3.33	3.38
4.00	5.00	4.00	3.00	5.00	4.00	3.63	3.80	3.50	3.67	3.67	3.88
4.00	5.00	4.00	5.00	5.00	5.00	4.63	3.60	3.00	3.17	3.33	4.13
4.00	3.00	3.00	3.00	5.00	4.00	4.00	4.40	5.00	3.33	3.22	4.38
3.00	3.00	3.00	3.00	4.00	3.00	3.50	3.80	3.00	3.17	3.11	3.38
4.00	5.00	3.00	5.00	4.00	4.00	4.43	4.20	3.00	3.17	3.22	4.00
4.00	5.00	3.00	4.00	4.00	3.00	4.25	4.20	3.50	3.33	3.11	3.38
3.00	5.00	#NULL!	5.00	5.00	3.00	4.00	4.20	4.00	3.17	3.00	3.38
4.00	5.00	4.00	3.00	5.00	5.00	4.50	4.20	4.50	4.50	4.33	4.38
3.00	3.00	4.00	5.00	5.00	5.00	4.50	4.20	3.50	4.33	3.78	3.88
3.00	5.00	3.00	3.00	3.00	3.00	3.63	4.00	4.00	3.67	3.22	3.88
3.00	5.00	4.00	5.00	5.00	3.00	4.50	4.20	3.50	4.17	3.89	3.75
3.00	4.00	4.00	4.00	5.00	5.00	4.13	3.80	3.50	3.83	3.89	4.00
3.00	4.00	3.00	4.00	4.00	3.00	3.63	3.60	3.00	3.00	3.22	3.50
4.00	5.00	4.00	5.00	5.00	5.00	4.13	3.80	3.00	4.00	3.78	4.38
5.00	5.00	5.00	5.00	5.00	4.00	4.38	4.00	3.00	3.83	4.22	4.38
5.00	3.00	3.00	5.00	4.00	3.00	4.00	3.80	3.50	4.33	3.89	4.13
4.00	5.00	4.00	3.00	4.00	5.00	4.50	4.40	4.00	3.83	3.67	4.38
2.00	4.00	3.00	4.00	5.00	4.00	4.13	3.80	3.50	3.17	3.56	3.50
3.00	2.00	3.00	3.00	5.00	4.00	3.75	4.20	3.50	3.50	3.56	4.13
4.00	3.00	4.00	5.00	5.00	5.00	4.13	4.00	3.50	3.67	3.78	4.25
4.00	4.00	3.00	3.00	5.00	5.00	3.86	3.60	3.50	3.67	3.50	4.25
4.00	#NULL!	4.00	3.00	5.00	5.00	4.33	4.40	5.00	3.83	4.00	4.38
4.00	4.00	4.00	4.00	5.00	3.00	4.00	4.40	4.00	4.50	4.78	3.88
4.00	4.00	4.00	3.00	5.00	3.00	4.25	4.20	3.50	4.00	4.00	4.13

4.00	5.00	3.00	4.00	5.00	5.00	4.13	4.20	3.50	3.00	3.00	4.25
4.00	5.00	3.00	5.00	4.00	5.00	4.38	4.40	3.00	3.50	3.33	4.38
5.00	5.00	3.00	3.00	5.00	5.00	3.88	5.00	4.00	3.67	2.78	4.75
4.00	4.00	3.00	2.00	3.00	4.00	3.88	4.20	3.50	3.83	3.11	4.38
4.00	2.00	5.00	5.00	5.00	5.00	4.13	4.20	4.00	3.33	3.78	4.50
2.00	1.00	3.00	3.00	5.00	5.00	3.88	4.40	4.50	3.83	3.67	4.38
4.00	4.00	4.00	3.00	5.00	5.00	4.13	4.40	3.50	3.67	3.67	4.00
4.00	3.00	3.00	3.00	5.00	5.00	3.75	4.20	4.50	3.33	3.38	4.50
4.00	4.00	3.00	4.00	5.00	4.00	3.86	4.00	3.00	3.33	3.22	4.00
4.00	4.00	2.00	4.00	5.00	3.00	4.13	4.40	4.50	4.17	4.00	4.50
4.00	3.00	3.00	5.00	5.00	5.00	3.88	4.40	3.50	3.17	3.22	4.38
4.00	3.00	3.00	3.00	5.00	4.00	3.75	3.80	4.00	3.33	3.22	4.00
4.00	4.00	3.00	5.00	5.00	4.00	4.00	4.00	3.50	3.67	3.67	3.57
5.00	5.00	5.00	4.00	4.00	5.00	4.50	4.00	3.50	3.83	3.89	4.50
3.00	5.00	4.00	5.00	5.00	5.00	4.63	4.80	4.50	4.17	3.89	4.25
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4.00	1.00	4.00	5.00	4.00	3.00	4.00	4.20	2.50	4.17	3.89	4.38
4.00	4.00	4.00	3.00	3.00	4.00	4.25	4.40	3.50	3.67	3.56	4.13
4.00	5.00	3.00	5.00	5.00	4.00	3.88	4.20	3.50	3.17	3.11	4.25
4.00	3.00	4.00	4.00	4.00	4.00	3.88	3.80	3.50	3.17	3.56	4.00
3.00	2.00	3.00	3.00	5.00	3.00	3.38	4.00	3.50	3.67	3.56	3.88
5.00	2.00	4.00	3.00	5.00	3.00	3.88	4.40	4.00	3.67	3.78	4.00
4.00	3.00	4.00	3.00	3.00	4.00	4.13	4.40	5.00	4.50	4.00	4.75
4.00	5.00	3.00	5.00	5.00	4.00	4.38	4.40	4.00	3.17	3.22	4.25
3.00	4.00	3.00	3.00	5.00	4.00	4.00	4.00	4.00	3.33	3.22	3.63
4.00	3.00	4.00	3.00	5.00	3.00	3.75	4.60	3.50	3.67	3.78	4.00
4.00	2.00	5.00	3.00	4.00	4.00	4.13	4.60	4.50	3.83	3.78	4.71
4.00	4.00	3.00	3.00	4.00	5.00	4.00	3.80	4.00	3.00	3.11	4.38
4.00	5.00	3.00	5.00	5.00	3.00	4.38	4.40	2.50	3.50	3.33	3.63
3.00	5.00	4.00	3.00	4.00	5.00	4.38	4.40	4.50	3.67	3.78	4.00
4.00	4.00	4.00	3.00	5.00	4.00	4.25	4.20	4.00	3.67	3.89	3.75
3.00	1.00	4.00	3.00	4.00	3.00	3.63	4.25	4.00	4.17	4.00	3.88
5.00	4.00	5.00	5.00	5.00	5.00	4.25	4.00	2.50	3.67	3.56	4.25
5.00	5.00	3.00	5.00	5.00	5.00	4.13	4.40	4.50	3.33	3.44	4.63
4.00	4.00	5.00	3.00	5.00	3.00	4.38	4.60	5.00	3.83	4.33	4.13
3.00	4.00	3.00	3.00	4.00	5.00	3.88	4.20	4.00	3.50	3.44	3.75
4.00	5.00	3.00	4.00	5.00	5.00	4.00	3.80	3.00	3.50	3.67	4.13
3.00	4.00	3.00	4.00	5.00	5.00	4.29	4.00	3.00	3.83	3.38	4.29

4.00	4.00	4.00	4.00	5.00	3.00	4.17	4.00	4.50	3.83	4.17	3.86
4.00	4.00	4.00	5.00	5.00	5.00	4.50	4.00	4.00	3.50	3.44	4.00
4.00	5.00	4.00	5.00	5.00	5.00	4.25	4.60	3.50	3.83	3.78	4.13
3.00	4.00	4.00	4.00	4.00	4.00	4.38	4.20	3.00	3.83	4.00	4.00
4.00	3.00	4.00	4.00	4.00	2.00	3.88	4.20	4.00	3.67	3.56	4.13
3.00	5.00	4.00	5.00	5.00	4.00	4.13	4.00	3.00	3.17	3.33	4.00
4.00	5.00	3.00	4.00	5.00	4.00	4.13	4.20	3.50	3.33	3.44	4.25
4.00	4.00	3.00	4.00	4.00	4.00	3.88	3.80	4.00	3.00	3.22	4.00
4.00	2.00	4.00	3.00	5.00	4.00	3.88	3.80	4.00	3.67	3.44	4.25
4.00	4.00	4.00	5.00	5.00	5.00	4.00	4.00	4.50	3.67	3.56	4.25
4.00	4.00	4.00	3.00	5.00	3.00	3.88	4.20	4.00	4.00	3.89	4.13
3.00	5.00	3.00	3.00	5.00	3.00	4.25	4.20	5.00	3.50	3.33	4.00
4.00	5.00	3.00	3.00	4.00	4.00	4.13	3.80	5.00	3.67	3.44	4.38
3.00	3.00	3.00	4.00	5.00	4.00	4.00	4.40	4.00	3.33	3.56	4.50
4.00	5.00	4.00	3.00	3.00	5.00	3.88	4.00	4.00	3.67	3.78	4.13
3.00	5.00	#NULL!	4.00	4.00	5.00	4.43	4.60	3.50	3.00	2.88	4.00
3.00	4.00	4.00	3.00	4.00	4.00	4.13	3.40	4.00	3.50	3.56	3.63
3.00	5.00	3.00	4.00	5.00	5.00	4.13	4.20	3.00	3.17	3.22	4.25
4.00	3.00	4.00	5.00	4.00	4.00	4.25	3.80	3.50	3.67	3.33	3.88
5.00	5.00	5.00	5.00	5.00	5.00	4.71	4.20	4.00	4.00	4.11	4.25
5.00	5.00	3.00	5.00	5.00	5.00	4.00	3.80	3.00	3.50	3.25	4.50
4.00	4.00	3.00	4.00	5.00	4.00	3.75	3.60	3.50	3.00	3.11	3.63
4.00	5.00	3.00	5.00	5.00	5.00	4.38	4.20	4.00	3.83	3.44	4.25
5.00	2.00	3.00	3.00	4.00	4.00	3.63	3.40	3.00	3.17	3.33	4.00
2.00	3.00	4.00	4.00	4.00	4.00	3.75	3.80	3.50	3.67	3.78	3.75
3.00	5.00	3.00	5.00	4.00	3.00	3.75	3.80	3.50	3.33	3.22	3.43
3.00	5.00	4.00	5.00	5.00	4.00	4.38	4.40	4.00	4.00	3.89	3.88
5.00	5.00	3.00	4.00	5.00	3.00	4.25	4.00	3.50	3.67	3.67	4.00
4.00	5.00	3.00	5.00	5.00	5.00	4.00	4.40	3.50	3.17	3.33	4.38
4.00	3.00	3.00	3.00	5.00	4.00	4.00	3.60	3.00	3.50	3.67	4.00
4.00	5.00	3.00	4.00	5.00	4.00	4.13	3.80	3.50	3.17	3.33	3.75
3.00	2.00	3.00	5.00	4.00	4.00	3.75	4.20	3.00	3.00	3.22	3.88
3.00	3.00	5.00	3.00	5.00	4.00	4.13	4.40	4.50	3.50	3.67	4.00
4.00	4.00	4.00	3.00	5.00	3.00	3.88	4.20	4.00	3.17	3.33	4.00
4.00	4.00	5.00	4.00	5.00	4.00	4.25	4.00	3.50	3.83	4.11	3.88
4.00	5.00	3.00	3.00	5.00	4.00	4.13	4.60	4.50	4.00	3.89	4.50
4.00	2.00	4.00	2.00	4.00	3.00	3.88	4.20	3.50	4.33	4.22	3.63
3.00	4.00	4.00	2.00	4.00	4.00	4.14	4.20	4.50	4.33	3.89	4.13

3.00	2.00	3.00	2.00	4.00	3.00	3.50	3.60	4.50	3.33	3.11	3.75
3.00	4.00	3.00	3.00	4.00	4.00	3.75	4.20	3.00	3.50	3.33	4.13
3.00	3.00	4.00	3.00	4.00	4.00	3.88	3.60	3.50	3.33	3.44	3.75
4.00	4.00	4.00	3.00	5.00	5.00	4.00	3.20	2.50	3.67	3.89	4.13
3.00	4.00	3.00	3.00	4.00	4.00	3.63	3.60	3.50	3.17	3.33	3.75
4.00	4.00	4.00	5.00	5.00	5.00	4.50	4.00	3.50	3.83	3.89	4.38
4.00	5.00	4.00	5.00	5.00	4.00	4.63	4.00	4.00	3.50	3.33	4.00
3.00	3.00	3.00	3.00	3.00	5.00	3.50	4.00	3.00	3.67	3.22	4.00
4.00	3.00	4.00	3.00	3.00	4.00	4.13	4.20	4.00	3.33	3.33	4.00
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4.00	#NULL!	4.00	4.00	3.00	4.00	4.50	4.60	4.00	4.00	3.67	4.13
4.00	3.00	5.00	4.00	3.00	5.00	4.38	4.20	5.00	4.17	4.00	4.50
3.00	5.00	3.00	5.00	5.00	3.00	4.14	4.00	3.00	3.17	3.11	3.88
3.00	4.00	4.00	5.00	4.00	4.00	4.38	4.20	3.50	3.83	3.67	4.25
3.00	4.00	3.00	4.00	5.00	3.00	4.14	4.20	3.50	3.83	3.78	3.71
4.00	5.00	4.00	4.00	5.00	5.00	4.50	4.60	4.50	4.17	4.44	4.25
4.00	5.00	4.00	4.00	5.00	4.00	4.50	4.00	4.50	3.67	3.89	3.88
5.00	3.00	4.00	3.00	4.00	4.00	4.00	3.80	3.50	3.50	3.56	4.50
4.00	5.00	3.00	5.00	5.00	4.00	4.29	4.00	4.50	3.33	3.33	4.00
2.00	#NULL!	3.00	5.00	3.00	4.00	4.33	4.40	3.50	3.33	3.00	3.75
3.00	4.00	4.00	4.00	4.00	4.00	4.00	4.00	3.00	3.17	3.22	4.25
5.00	4.00	3.00	4.00	5.00	4.00	3.88	4.00	3.00	3.50	3.44	4.00
4.00	#NULL!	4.00	5.00	5.00	3.00	4.14	4.00	4.00	3.50	3.67	4.00
4.00	4.00	4.00	5.00	4.00	3.00	4.63	4.40	4.00	3.83	3.67	4.38
4.00	4.00	3.00	2.00	4.00	4.00	3.63	3.40	4.50	3.67	3.33	3.88
3.00	4.00	3.00	4.00	5.00	3.00	4.00	3.40	3.50	3.33	3.11	3.25
5.00	2.00	4.00	2.00	5.00	5.00	3.63	3.80	3.00	4.17	4.22	4.63
3.00	3.00	3.00	3.00	3.00	3.00	4.00	3.80	3.50	3.33	3.11	3.88
3.00	4.00	4.00	4.00	4.00	4.00	4.00	4.00	3.00	3.17	3.22	4.13

Ztypes	Zlengthch	Ztimepra	ZSco01
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#NULL!	0.42615	-0.14618	#NULL!
#NULL!	0.42615	1.50899	#NULL!
#NULL!	1.36965	0.87238	#NULL!
#NULL!	-0.70606	-0.78279	#NULL!
#NULL!	-0.51735	-0.91011	#NULL!
#NULL!	-0.89476	1.38167	#NULL!
#NULL!	-0.32865	0.61774	#NULL!
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#NULL!	1.55835	-0.27350	#NULL!
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#NULL!	0.61485	0.23578	#NULL!
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-0.47430	0.23745	1.89095	-0.47430
-0.47430	#NULL!	1.25435	-0.47430
-0.47430	-0.89476	-1.41939	-0.47430
-0.47430	0.61485	0.87238	-0.47430
-0.47430	0.23745	-0.27350	-0.47430
-0.47430	0.23745	1.89095	-0.47430
-0.47430	0.04875	-0.78279	-0.47430
-0.47430	0.23745	0.87238	-0.47430
-0.47430	0.23745	-0.14618	-0.47430
-0.47430	-0.70606	-1.29207	-0.47430
-0.47430	0.61485	-0.40082	-0.47430
-0.47430	0.42615	-0.14618	-0.47430
-0.47430	1.36965	0.61774	-0.47430
-0.47430	0.23745	-0.52815	-0.47430
-0.47430	1.36965	0.61774	-0.47430
-0.47430	2.31316	2.27291	-0.47430
-0.47430	2.31316	1.89095	-0.47430
-0.47430	2.31316	1.63631	-0.47430

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-0.47430	-0.32865	-1.03743	-0.47430
-0.47430	1.36965	0.23578	-0.47430
-0.47430	-0.32865	-1.03743	-0.47430
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-0.47430	0.80355	0.23578	-0.47430
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-0.47430	2.31316	1.50899	-0.47430
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-0.47430	2.31316	1.12703	-0.47430
-0.47430	-0.51735	-0.91011	-0.47430
-0.47430	0.61485	2.01827	-0.47430
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-0.47430	0.80355	-0.14618	-0.47430
-0.47430	0.61485	0.87238	-0.47430
-0.47430	2.31316	2.65488	-0.47430
-0.47430	-0.51735	-1.03743	-0.47430
-0.47430	0.23745	-0.52815	-0.47430
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-0.47430	0.23745	0.23578	-0.47430
-0.47430	0.42615	-0.14618	-0.47430
-0.47430	2.31316	0.99970	-0.47430
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-0.47430	-0.32865	0.23578	-0.47430
-0.47430	0.23745	0.87238	-0.47430
-0.47430	-1.08346	1.12703	-0.47430
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-0.47430	-0.13995	-0.78279	-0.47430

-0.47430	0.04875	-0.40082	-0.47430
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-0.47430	-0.70606	-0.78279	-0.47430
-0.47430	0.23745	-0.52815	-0.47430
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-0.47430	1.93575	0.61774	-0.47430
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0.91211	-1.08346	-0.14618	0.91211
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0.91211	2.12446	1.50899	0.91211
0.91211	-0.32865	-0.52815	0.91211
0.91211	-0.32865	-0.14618	0.91211
0.91211	#NULL!	0.23578	0.91211
0.91211	-0.13995	-0.14618	0.91211
0.91211	-0.89476	-0.40082	0.91211
0.91211	-0.89476	-1.29207	0.91211
0.91211	-1.27216	0.87238	0.91211
0.91211	-0.32865	0.36310	0.91211
0.91211	0.61485	-0.91011	0.91211
0.91211	-0.13995	-0.40082	0.91211
0.91211	-0.70606	-0.40082	0.91211
0.91211	-1.08346	-0.78279	0.91211
0.91211	-0.51735	0.87238	0.91211
0.91211	-1.08346	-0.40082	0.91211
0.91211	0.23745	0.23578	0.91211
0.91211	-0.13995	0.87238	0.91211
0.91211	0.61485	-0.65547	0.91211
0.91211	-1.08346	-1.03743	0.91211
0.91211	-0.89476	-0.40082	0.91211
0.91211	-0.32865	0.61774	0.91211

0.91211	-1.08346	-0.91011	0.91211
0.91211	-1.08346	0.61774	0.91211
0.91211	0.61485	-0.14618	0.91211
0.91211	-0.32865	-0.14618	0.91211
0.91211	-0.70606	0.23578	0.91211
0.91211	-0.32865	-0.40082	0.91211
0.91211	-0.89476	0.23578	0.91211
0.91211	#NULL!	0.36310	0.91211
0.91211	1.36965	0.23578	0.91211
0.91211	-0.89476	-0.52815	0.91211
0.91211	-0.89476	-1.03743	0.91211
0.91211	-0.32865	-0.40082	0.91211
0.91211	0.61485	3.41880	0.91211
0.91211	-0.32865	0.74506	0.91211
0.91211	-0.51735	-0.91011	0.91211
0.91211	-0.70606	-0.40082	0.91211
0.91211	0.04875	0.87238	0.91211
0.91211	-0.89476	-0.52815	0.91211
0.91211	-0.13995	2.14559	0.91211
0.91211	-0.70606	-0.40082	0.91211
0.91211	-0.70606	0.36310	0.91211
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0.91211	0.61485	-0.40082	0.91211
0.91211	-1.08346	-0.78279	0.91211
0.91211	-0.51735	-1.03743	0.91211
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0.91211	-1.08346	-0.40082	0.91211
0.91211	-1.08346	0.87238	0.91211
0.91211	-0.89476	-0.27350	0.91211
0.91211	-0.32865	-0.40082	0.91211
0.91211	-0.32865	-0.01886	0.91211
0.91211	0.42615	-1.03743	0.91211
0.91211	-0.70606	-0.78279	0.91211
0.91211	-0.13995	-0.40082	0.91211
0.91211	0.23745	2.65488	0.91211
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0.91211	-0.32865	-0.65547	0.91211

0.91211	-1.08346	0.87238	0.91211
0.91211	-0.70606	-0.52815	0.91211
0.91211	-1.27216	-1.29207	0.91211
0.91211	-0.51735	0.87238	0.91211
0.91211	-0.70606	-1.16475	0.91211
0.91211	-0.13995	-0.14618	0.91211
0.91211	0.23745	-0.65547	0.91211
0.91211	-0.51735	0.87238	0.91211
0.91211	-0.32865	-0.78279	0.91211
0.91211	-0.51735	0.23578	0.91211
0.91211	-0.13995	-0.65547	0.91211
0.91211	-0.32865	2.14559	0.91211
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0.91211	-0.70606	-0.65547	0.91211
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0.91211	-0.89476	-0.65547	0.91211
0.91211	-0.13995	0.23578	0.91211
0.91211	0.99225	0.23578	0.91211
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0.91211	-0.89476	-1.16475	0.91211
0.91211	-0.70606	-0.52815	0.91211
0.91211	-0.51735	-0.27350	0.91211
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0.91211	-0.70606	0.23578	0.91211
0.91211	-0.51735	-0.65547	0.91211
0.91211	#NULL!	0.36310	0.91211

APPENDIX TEN:

Qualitative data

Qualitative comments

Students

10. Work in multidisciplinary teams.

258. Usually would anyway.

19. Discuss with a referrer your assessment of an individual.

258. To explain continued care.

21. Become a friend of a client.

272. Depends if there are dual professional roles.

25. See a client for therapy who turns up outside of their appointment session.

281. Depends on circumstances.

26. Be able to section a client.

281. There may be a case for input from a C.P., GP and C.P.N.

28. Recommend a particular type of medication for a client.

284. Via GP

29. Without a clients consent inform a clients family about his/her mental health problems.

255. Excluding the obvious life threatening exclusions to this i.e. dangers to other.

272. Unless danger to themselves.

281. Except as per contract or with clients permission.

284. Depends whether they are a threat to themselves or others, and cannot see this due to mental state. In consultation with other MDT members.

Free response section: if you have any comments about any of the questions or answers in this questionnaire then please use this space to make them here.

258. There are always situations that are not clear cut and I think cannot be categorised in response, so some should not's where absolutely must not's would go if had more detail.
276. Some times answered may or may not in the sense that it depends, and some times because no strong commitment either way.
278. Some questions depend on individual circumstances of the case, unsure how to answer them. Also I did not like "musts" and "shoulds". neither would Albert Ellis!
290. Questions 14 & 28 re-medication unless one has appropriate training and experience it is inappropriate to prescribe medication.

Clinical

1. Have had personal therapy.

207. Personal choice.
219. Should of some kind, but not long-term psychotherapy particularly.

2. Draw on a basic knowledge of psychopathology.

199. Depends which knowledge base.

3. Undertake to study the use of psychometric tests if not included in initial training.

207. Included in training.
215. Depends on test.
219. But this is included in all basic training of clinical psychologists. It would not be necessary for counselling.

5. Employ the principles of a 'scientist practitioner'.

256. I'm sick of this phrase.

7. Take responsibility for own lack of knowledge/ skill and address this through further training.

256. This should be a joint responsibility with employers.

9. Liase with other professionals by speaking the 'same language'.

192. If you mean looking for a common language. – but different, professionals have different languages.

10. Work in multidisciplinary teams.

214. At least liasing with other disciplines is a must.

219. It helps to liase at the very least.

11. Work in a consultancy role to other professionals.

167. Must on occasions.

12. Supervise other professionals.

183. Depending on grade.

14. Prescribe medication.

182. Hypothetical – as things stand only possible answer is must not.

183. We are not able to prescribe but we might advise or suggest this to client or medical colleagues.

210. Usually not accepted practice in U.K.

213. Until the legislation is changed.

247. Not trained, although through work we may well gain an extensive knowledge.

15. Train in the 'therapeutic' use of assessment tests.

192. Like assessment tests could cover a huge area, I would need more detail as to what you mean.

199. If appropriate.

213. But not actually covered in training.

219. If this means understanding then yes. If this means cutting corners to administer tests in a non-standard way then no.

17. Provide clinical supervision on cases to trainee clinical psychologists.

160. Must if taken on/should take on trainees.

18. Work with a client despite misdiagnosis from a psychiatrist.

160. Should if psychologist believes this to be beneficial.
172. Misdiagnosis of what? Only a consultant psychiatrist is properly qualified to give a psychiatric diagnosis, therefore only a differing second opinion diagnosis could clarify a misdiagnosis of a psychiatric illness/diagnosis. Or did you have something else in mind – like opinions and if so whose?
183. One would discuss this with the psychiatrist and hopefully arrive at a suitable outcome.
192. Depends on circumstances, who referred, what diagnosis was, and the outcome of the psychologist assessment.
213. To work on the above if nothing else.
219. Best to find non-confrontational ways around this.

19. Discuss with a referrer your assessment of an individual.

158. Or communicate (e.g. by letter).
183. And within the max response time agreed in quality standards.
197. Later may be sufficient.
199. Whilst respecting confidentiality.
219. Some feedback is required. This can be written.

20. Have inadequate experience of secondary mental health care.

213. Or adequate.
215. We need to have experience of secondary mental health care.

21. Become a friend of a client.

160. Should not out side professional contact.
163. Not precluded following discharge. Having worked with a client and discharged him or her should not mean that one never should form a friendship with the client at a later date or as a result of circumstances unrelated to the therapy.
164. Should in therapeutic relationship – not outside work. I would not define this as friendship.
165. Should not – personal friend, should – professional friend.
173. What do you mean by friend, if it means going to the pub with, then no.
183. Can be supportive without becoming a friend.
197. Friendly not a friend.
207. Should not outside of therapeutic relationship.

210. Be friendly towards them in a session.
229. But can be friendly.
235. Not a personal friend.

23. Shout at a client in therapy.

163. There may be occasions when it is a good strategy for the benefit of the client to shout at him/her.
169. I dithered here, I guess you might shout for therapeutic reasons, I'm struggling to think of one but it seems theoretically possible.
183. Some people may argue this may be a therapeutic intervention.
197. Depends on situation e.g. crisis?

24. Have no formulation regarding therapy following an assessment session with a client.

183. Sometimes, depending on experience of therapist and complexity of client may not have clear formulation after first appointment, but should be aiming for this as soon as possible.
207. Often takes longer! And reformulation needed always!
219. You should have some hypothesis even if further information is required.
222. Depends on complexity of problem and aims of session i.e. relationship building may be a priority.
226. Assume that the formulation could be more than a limited one.
255. I believe you should always have a tentative formulation after assessment.

25. See a client for therapy who turns up outside of their appointment session.

158. Depends on circumstances.
183. Particularly if this happens more than once.
192. Depends on the client and the circumstances.
207. Depends on circumstances and boundaries of time.
213. Unless contract negotiates for client contact.
219. Depends on what is possible.
222. May see briefly to reschedule or establish what has happened.

26. Be able to section a client.

164. I do not think it is the role of the clinical psychologist to prescribe medication or section people. This would require medical training on top of the already long training we have had.
176. No one professional can section a client on their own.
182. Hypothetical – only possible answer is must not.
197. Interesting – only if trained to do so.
213. Unable under current legislation.
222. Provide a perspective on e.g. impact on sectioning and hospitalisation on person.

27. Provide clinical supervision to trainee counselling psychologists.

160. Must if taken on.

28. Recommend a particular type of medication for a client.

183. May at times have knowledge of what works with a particular client. But remit to recommended medication.
192. Ok to have a view but if I had wanted to be a doctor I would have trained to be one.
214. In discussion with GP / psychiatrist not the patient.
247. Should not actually prescribe drugs, but well be in a position to offer an opinion.

29. Without a clients consent inform a clients family about his/her mental health problems.

158. Unless family in danger.
183. May be a situation when you have to tell a client you cannot keep confidences perhaps if some ones safety.
192. Depends on age, etc.
197. Unless special circumstances and unable to give consent and in their interests.
213. Unless for safety etc.
219. Where the client is an adult this is tricky.
222. If person unable to give consent or problems are such that "duty to warn" /outside limits of confidentiality e.g. threats of harm.
228. Depends.
255. Excluding the obvious life threatening exclusions to this i.e. dangers to other.

30. **Work with more than one member of the same family for individual therapy.**
164. Unless in family therapy setting.
219. Individual circumstances prevail. Only if each family member requests & therapists clear to client on how to use "secret" information.

Free response section: if you have any comments about any of the questions or answers in this questionnaire then please use this space to make them here.

136. My setting is not a medical one, though we do work with people with enduring mental health problems. Would always get permission to liase with GP and any other involved professionals, before undertaking on going work.
142. I am very pleased to see this work happening and would like to see the total of your dissertation. Good luck.
149. It's a personal choice if a counselling psychologist does or does not supervise.
151. It does not reflect the reality of working within a NHS community mental health team with the enduring mentally ill e.g. attending care conferences/adult & child protection/writing reports/court work/working with the police/probationary offices/social workers/child & family guidance/CPN's/liasing with psychiatrists/ward staff/working on wards/administration & business issues/ managing & evaluation of work etc.
160. In various ?'s e.g. q29 the specific circumstances would be a crucial determinacy factor when deciding the appropriateness of a range of possible options.
164. I would value feedback from this study. Best wishes.
172. "role of psychologists……," which would include trainees, assistants and under current legislation anyone else who so chooses.
182. Only minor niggles in a worthwhile research project. The world is still waiting for a 100% bombproof questionnaire! Good luck.
196. Flexibility within a professional structure – respect for the clients.
200. Q 20 is leading in that it uses the word "inadequate".
203. Don't see the relevance of income to the study, so I have therefore omitted it.
207. I don't believe in absolutes – there are far too many individual differences involved in anything like this and most of the Q's depend on personal choice! – but I presume you'll be taking these factors into account in the write up.
209. Good luck with your research.

211. It was unclear which "type" of psychologist this questionnaire was aimed at. It is my belief that the role and therefore care skills and training of for example a clinical psychologist and a counselling psychologist are different. Some items, that I might have considered absolutely necessary for one of these professions, I would not necessarily have considered to be the case for the others. Therefore I have answered this with the lowest common denominator in mind.

216. The prescription of medicines is an ambiguous Q where I would not prescribe prescription items, I have suggest to patients that they ask there GP about certain medications and also might suggest they take vitamins, minerals and other food supplements. While I don't believe psychologist should section patients, I strongly believe they should have immediate access to such procedures when needed, particularly in private practice. As far as multidisciplinary teams are concerned, in private practice I have some times had to liase because of legal reasons with incompetent and over worked social workers who have obstructed and not helped. There are few assessment tests that are sufficiently valid and reliable to use in a one to one clinical setting.

219. Some Q's are hard for me to answer. I work as a "school counsellor" and not with adults with "enduring mental health problems".

222. Many of the items seem to be too "black and white". In reality idiosyncratic clinical judgements and responses are required and fit the uniqueness of the individual, the problem and the setting must take account of the nature and strength of the relationship between client, family member, other professional and therapist.

233. I perceive myself as being "employed" by the patient – reports/ recommendations/ opinions are passed on to others and I follow them up to ensure their implementations only a limited number are taken on for therapy on a basis of urgency e.g. self injurious behaviours, preparation for surgery etc.

240. A number of questions could produce "quantified" answers – some irrelevant or to test concentration.

248. Depends on some what on what psychologists is chartered as they are not interchangeable e.g. health and clinical. Also very little evidence base. Which is largely lacking at present for counselling practice. Ultimately we are employed to be effective rather than just opinionated about what's best for the client.

2. Draw on a basic knowledge of psychopathology.

59. Depends what you mean by knowledge, much of the accepted wisdom is very questionable.

106. Assumes psychopathology has a reality and the question has two elements. May have the "basic knowledge" but not want to use it or not have the knowledge.

3. Undertake to study the use of psychometric tests if not included in initial training.

54. Although I ticked "preferably should", I feel that there may always be another psychologist who is experienced and could undertake this instead, if required.

110. Only to learn they have no predictive validity.

4. Have further training in therapeutic skills following professional psychology training.

5. The professional training should include therapeutic skills.

6. Training implies trainer and formality. Practitioner should constantly update informally.

42. Yes!!

5. Employ the principles of a 'scientist practitioner'.

6. Practitioner should not be hostile to the notion of Scientist- Practitioner, as some social constructionists seem to be.

147. It depends whose definition is used.

7. Take responsibility for own lack of knowledge/ skill and address this through further training.

48. Although I believe it is our own responsibility to take care of professional development, it is not always possible, e.g. when I worked in psychology department,(for 4 years) my manager turned me down for courses he felt were unnecessary. He being a CBT man, didn't appreciate or hold value to psychodynamic work . I therefore didn't go on any courses. Now that I have left the NHS, my problem is (1) Accessing courses. (2) Affording them. I believe there should be ongoing PD at the universities where we had training, so that at

least we would have the opportunity to continue developing. Initial training is not adequate when working with serious mental health patients.

101. Although I think employers also have some responsibility to support this.

8. Keep up to date with the progress of his/her professional psychological division.

6. Focus on the "Division" in this question seems Institutionalised. Practitioner should keep up to date though.

9. Liase with other professionals by speaking the 'same language'.

51. Would have preferred something like "a co-constructed understanding".
59. As long as s/he doesn't "believe" the language!
142. Should but not always possible!

10. Work in multidisciplinary teams.

59. Depends on setting – private practise Vs NHS.
136. Or at least liase across disciplines.

11. Work in a consultancy role to other Professionals.

142. Must, depending on grade.

12. Supervise other professionals.

79. With supervisory training for themselves and in supervision of supervision.
100. Should not until trained to do so.
142. Must, depending on grade.

14. Prescribe Medication.

6. Practitioner should have a good up to date knowledge of neurochemistry – and not simply pharmacology.
13. Can't just now.
54. I feel that in order to prescribe, psychologists would need much more training and it throws up many questions about our work. Preferably psychologists should not prescribe.
71. Cannot!
117. Unless the law is changed.
125. If the laws allow and has specific training.
136. Even if allowed, not allowed in this role/setting.

16. Establish skills for recognising psychotic episodes for clients, so that they can be understood and coped with in a helpful way.

106. Assume acceptance of the term psychotic and such disturbance is episodic. I don't make these assumptions but have tried to answer what I think your asking.

17. Provide clinical supervision on cases to trainee clinical psychologists.

79. Having been trained in supervision and partaking of supervision.
136. If a clinical psychologist.

18. Work with a client despite misdiagnosis from a psychiatrist.

6. I am familiar with DSMIV and would if necessary dispute a psychiatric diagnosis.
11. Depends on psychiatrist-depends on nature of misdiagnosis – Is psychiatrist "attached" to diagnosis or does he/she have limited knowledge of clients-hence, misdiagnosis?
13. Depends, if client does have a problem, and wants other, should continue.
14. Depends on the Psychiatrists misdiagnosis, the patient's state of mental health, their suitability/ or the kind of treatment that can be offered.
29. When I work with client, I work to my own assessment.
41. I would only agree to the work following a discussion, if I believed there was a misdiagnosis. I would want to address that with the psychiatrist.
46. If client understands a contract.
51. Is the misdiagnosis term a bit of a red herring? I assess my referrals and would renegotiate with any referrer should I find my self at odds with a "diagnosis"- before offering input.
56. What about the diagnosis by the psychologist?
59. All diagnosis is misdiagnosis!
66. Response might depend on work setting.
88. I would work with client despite diagnosis. My experience is of a psychiatrist with very different perception of mental health causes. Sometimes our views of treatment were very different.
106. A referral from a psychiatrist might include at least two kinds of "mis" diagnosis (I find diagnosis a problematic term anyway). If I felt the client was available for psychological work (that I could establish and maintain sufficient psychological contact to enable the development of a relationship) I would work with the client. (what ever the psychiatric diagnosis). If I felt that the psychiatrist had

missed seeing the degree of disturbance which prevented psychological contact I would not.

112. In whose opinion?
136. Would presumably liase to clarify assessment.
137. Prefer to dialogue with psychiatrist, if they are amenable.
142. "mis-diagnosis from a psychiatrist", irrelevant.
156. If it means the referral is not appropriate for psychology, my answer would be must not.

19. Discuss with a referrer your assessment of an individual.

6. Depends on referrer.
12. E.g. by letter.
14. The key word is discuss which implies a 2-way interaction-many referrals do not want to "discuss". It must also be within the bounds of appropriate confidentiality. Referrals should be informed that the client has been seen; will or will not be working with the psychologist.
59. By letter at least.
66. Would depend on various factors. If doing assessment I found a client might harm self/others I would obviously discuss with referrer. It also depends on level of risk/disturbance.
96. May be via a report rather than verbal.
104. Only in general terms.
132. Depends on contract.
136. Depends on context, but likely to do so in medical setting.

20. Have inadequate experience of secondary mental health care.

59. Do you mean "adequate"?
65. Psychologists preferably should have experience of secondary mental health care.
137. Everyone has to start somewhere.

21. Become a friend of a client.

102. Should not unless the client is dying, or an adequate number of years has passed (v. variable).
110. Except in the counselling session- you become a friend for that period of time depending on your orientation.
127. Friendly not a friend.

142. Clients can conceptualise of therapeutic relationship as friendship as closest concept.

22. Co-work with other professionals.

59. In the NHS.
79. Absolutely must e.g. superiors even post qualification.
136. But links should be there or permission to liase as necessary.

23. Shout at a client in therapy.

13. Must not of course.
14. Interesting! Shouting could be a skill the client needs to learn or an inhibition that she/he needs to overcome. In this context shouting as mutually agreed therapeutic activity may be important. A shouted word or command might be necessary to captive the attention of a client who is already shouting. Shouting is never acceptable if it is the psychologist who cannot contain or deal with their own levels of emotional affect appropriately.
36. Unless in some psychodrama technique!
42. Bloody Hell!!!!
51. I answered – and then remembered shouting at a client in therapy but not "during" therapy. He was about to cross the road in front of a car, just after leaving the centre.
101. I personally wouldn't.
102. Must not unless it is not "for real" and is part of a specific therapeutic intervention.
110. It could be a RARE effective intervention.
115. Unless client is deaf!
132. Unless part of role-play.
136. Or if it happened would have to try and use it in a way to restore or maintain therapeutic relationship.
156. Unless for self-defence.

24. Have no formulation regarding therapy following an assessment session with a client.

29. Depends how client assessment is going.
54. There may be a situation where a psychiatrist or previous psychologist had made a full report and then one would only need to make a linked formulation if one agreed with the previous formulation.

65. I believe a psychologist should have a formulation for therapy following an assessment session with a client.
106. "Limited formulation" seems to specific to a certain range of therapies. Not all therapy undertakes values "objective" assessment etc.
136. If not would need a longer assessment period.
142. I think one should have a rough idea what they intend to do in terms of therapy and desired outcomes, and a lot of this can often be done after initial assessment (which in my practice, can take 2-4 hourly sessions.

25. See a client for therapy who turns up outside of their appointment session.

14. Depends why the client has turned up; the availability of the psychologist.
39. If a client turned up outside of their normal time, I'd see them briefly (5-10 mins.) to ascertain the situation, alternative support systems and how able they are to continue to the next scheduled session. I'd also compliment them for seeking appropriate help if they are distressed. I'd do all this when I had free time, if I had any. Even 3 mins might help.
54. This is difficult. There may have been a genuine mistake in the department or the clients or other circumstance that may cause "suicidal fears".
100. Depending on problem and availability.
101. Depends on circumstances.
105. Not for therapy, may speak and arrange something.
117. Depends on the reason.
136. Might speak to them briefly to check what is happening.
147. Should, to explain the need to come at appointed times only.
151. But it happens if someone is in crisis.
156. Preferably not, but depends on circumstances.

26. Be able to section a client.

6. If needs must, but preferably not, though I would not go as far as to say <u>should</u> not.
21. I am an A.S.W. and have had no problem switching roles and maintaining this therapeutic relationship with clients who I have sectioned.

88. I would not be against informing a client that I was wanting to liase with GP over possible seriousness of client state in extreme cases. I would then leave it with GP and progress section.
98. Not alone!
122. Should not only advise.
136. In my role I'm not allowed to do this, can envisage it may be appropriate in some psychologists roles.
147. Under the 1983 MHA they cannot do so

27. Provide clinical supervision to trainee counselling psychologists.

79. Having been trained in supervision and partaking of supervision of supervision, you may or may not.
100. Preferably need to be counselling psychologists themselves at least.
142. Should, depending on grade.

28. Recommend a particular type of medication for a client.

3. In consultation with Dr.
6. Practitioner should have a good up to date knowledge of neurochemistry – and not simply pharmacology.
117. Unless the law changes.
136. Though I might want to check medication with GP, with clients knowledge/permission.
137. I must admit that I have done so.

29. Without a clients consent inform a clients family about his/her mental health problems.

13. Depends, e.g. suicidal intent.
51. It depends, my initial wish was to say clearly no. However there may be circumstances where this is necessary.
53. Unless there is an issue of safety.
61. Protocol for risk factors essential.
84. Only if person is underage or has been said to be too ill by a court to make decisions for self.
92. Must not unless life threatening.
95. Except when it might be our statutory duty e.g. self-threatening or threatening others, child abuse etc.
96. Preferably should not only if harm to family involved, and consent not given.

101. Should not except in actual danger.
102. Must not unless client is unable to give reliable consent.
136. Only if there was a risk of harm to them, would discuss it first in supervision.
137. Depends on mental state of client.
142. Depends on harm – risk.
147. Only in the event of sever danger.
151. But may have to if someone else is at risk e.g. parent/child/client has over dosed as often happens just before they attend a session.
156. Depends on circumstances.

30. Work with more than one member of the same family for individual therapy.

13. Could do.
29. Not at the same time.
79. If individuals were to be seen alternately between a lone and then joint session- I think that combination would be fine.
136. Unless it is preparatory to working with couple or group of individuals together – and then I would consider it, unlikely to be best plan.
142. Must not, except family therapy.
143. Should not – but at different points in time, it may happen.

Free response section: if you have any comments about any of the questions or answers in this questionnaire then please use this space to make them here.

4. Don't like the word "absolutely" – too dogmatic . "feel strongly" might be better. Have had some problem defining "enduring mental health problems". As a counselling psychologist working in a GP surgery some people may feel that these GP referrals would not fall into a category of "enduring mental health problems". Some questions – mainly Q14 onwards seem to be more oriented towards clinical psychologists rather than counselling psychologists. I have answered these questions as a counselling psychologist dealing only with referrals from within the GP practice.
16. Good luck with your research. Raffle – a good idea.
20. I would have appreciated a detailed definition of "enduring mental health problems". My experience is that as a counselling psychologist I have a very different perception of what these are than many clinical psychologists.

25. It would have been of interest to know the underlying purpose of the questionnaire.

29. Do you intend to do any interviews? Otherwise good luck.

37. I have chosen "may or may not" for several answers because there are other factors involved, including personal reference. In particular, working in H.E. I am aware that we (are able to?) have greater sensitivity to boundary issues, especially around who talks to whom about the client, than I perceive it to be in the N.H.S.- so context is also important I think.

38. Some answers are dependant on what setting one might work. Some mode of work i.e. drug prescribing should not be carried out at present but as nurses do this, there may be an argument for us to prescribe limited drugs or supervise repeat prescriptions under guidance of GP

41. Most of the questions would have a different answer depending on the working context. I do not use the term 'limited formulation', if this means therapeutic approach then my response stands.

42. All of this applies to me, i.e. a psychologist working in a private practice with psychodynamic training. Answers don't apply to every counselling psychologist, 29 and 30 are quite wrong for a psychodynamic therapist, but would be ok for others.

45. Some questions are a matter of choice for individuals but collectively essential e.g. 17? supervision is essential but not everyone has to provide it. Some are a matter of specific training /experience and job spec. e.g. 14 – If this is a specific question about the right to prescribe, I think there arguments for and a against and in any case specific training would be required.

58. Good luck with the doctorate work.

64. Some questions are ambiguous on assuming that only clinical psychologists should work with clients. If these questions are meant to apply to counselling psychologists, then my response would here be "it depends on the level of competence in ……."

70. Good luck with the Doctorate.

74. None – But I'm interested in the direction/philosophy of this research

76. I am a chartered psychologist in two areas. This has inevitably affected my opinions. Also I have worked as a psychologist in five different areas (educational, forensic, counselling, hypnosis and lecturer). This means that I have seen lots of clients, etc but I do not have much recent experience of people who have enduring mental health problems.

88. I have 7 years experience of working with relatively unqualified staff team, multidisciplinary, who had little expertise or idea of psychology, client/ their own mental state. I found this alarming/ worrying.

100. The issues are difficult ones and I often felt the urge to answer "may or may not". They often relate to other issues such as context or further training beyond psychologist.

102. I had problems in understanding what you meant by "enduring mental problems". Also, by "working with people with enduring mental problems" I assume you mean "doing therapy".

103. Some of these? were in the present climate unanswerable, e.g. re-medication, prescription, and sectioning. Otherwise interesting and useful.

122. Some of the ?'s are not able to allow for different working environments, e.g. when working for GP at GPs – will depend a good deal on individual GPs needs/expectations.

124. It might be interesting to go into how psychologists working with E.M.H. clients are trying to develop their role. For example, by engaging with the organisation to change an ethos.

130. Nothing is as cut and dried as your questions suggest!

135. Thank you for your work in preparing this useful and important piece of research.

136. As a chartered counselling psychologist who applied (successfully) for a clinical psychology vacancy, your ?'s touch on many of the issues I deal with/question re my role. Therefore your research is very interesting, I think, and will provide much needed information.

APPENDIX ELEVEN:

Summary of findings

Summary of Findings (I)

Psychologist Role Definition Instrument	
1.Have had personal therapy	A sig. difference between clinical and the two counselling psychology groups was found. No sig. difference between the counselling and student counselling psychology groups.
2.Draw on a basic knowledge of psychopathology	A sig. difference between the clinical and student counselling psychology group. No sig. difference between the other two groups was found.
3.undertake to study the use of psychometric tests if not included in initial training	A sig. difference between the clinical and counselling psychology groups. No sig. difference between the other two groups was found.
4.Have further training in therapeutic skills following professional psychology training	No sig. difference between the three groups was found.
5.Employ the principles of a 'scientist practitioner'	A sig. difference between the clinical and counselling psychology groups. No sig. difference between the other two groups was found.
6.Conduct research	No sig. difference between the three groups was found.
7.Take responsibility for own lack of knowledge or skill and address this through further training.	No sig. difference between the three groups was found.
8. Keep up to date with the progress of their professional psychological division	No sig. difference between the three groups was found
9. Liaise with other professionals by speaking the 'same' language	No sig. difference between the three groups was found
10. Work in multidisciplinary teams	A sig. difference between the clinical and counselling psychology groups. No sig. difference between the other two groups was found.

Summary of Findings (II)

Psychologist Role Definition Instrument	
11. Work in a consultancy role to other professionals	A sig. difference between the clinical and counselling psychology groups. No sig. difference between the other two groups was found.
12. Supervise other professionals	No sig. difference between the three groups was found.
13. Train other professionals	A sig. difference between the clinical and counselling psychology groups. No sig. difference between the other two groups was found.
14. Prescribe medication	No sig. difference between the three groups was found.
15. Train in the 'therapeutic' use of assessment tests.	No sig. difference between the three groups was found.
16. Establish skills for recognising psychotic episodes for clients, so that they can be understood and coped with in a helpful way	No sig. difference between the three groups was found.
17. Provide clinical supervision on cases to trainee clinical psychologists	A sig. difference between the clinical and two counselling psychology groups was found. No sig. difference between the counselling and student counselling group was found.
18. Work with a client despite misdiagnosis from a psychiatrist	No sig. difference between the three groups was found
19. Discuss with a referrer your assessment of an individual	A sig. difference between the clinical and the two counselling psychology groups was found. No sig. difference between the counselling and student counselling group was found.
20. Have inadequate experience of secondary mental health care	No sig. difference between the three groups was found

Summary of Findings (III)

Psychologist Role Definition Instrument	
21. Become a friend of a client	No sig. difference between the three groups was found.
22. Co-work with other professionals	A sig. difference between the clinical and counselling psychology groups. No sig. difference between the other two groups was found.
23. Shout at a client in therapy	No sig. difference between the three groups was found.
24. Have limited formulation regarding therapy following an assessment session with a client	A sig. difference between the clinical and student counselling psychology groups and between the counselling and student counselling psychology groups. No sig. difference between the clinical and counselling psychology group was found.
25. See a client for therapy who arrives outside of their appointment session.	A sig. difference between the clinical and two counselling psychology groups was found. No sig. difference between the counselling and student counselling psychology group was found.
26. Be able to section a client	No sig. difference between the three groups was found.
27. Provide clinical supervision to trainee Counselling psychologists	No sig. difference between the three groups was found.
28. Recommend a particular type of medication for a client	No sig. difference between the three groups was found
29. Without a client's consent, inform their family about their mental health problems	No sig. difference between the three groups was found
30. Work with more than one member of the same family for individual therapy	A sig. difference between the clinical and counselling psychology groups. No sig. difference between the other two groups was found.