Research Project Reports and Ethical and Professional Issues Report

by

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Three placements project reports and one report addressing areas of professional and ethical issues in the practice of Clinical Psychology submitted in partial fulfilment of the requirements for the Doctor of Psychology (Clinical).

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Statement of Authorship

Except where overt reference is made in the text of this manuscript, this body of work does not include information that has been published elsewhere or been removed in full or part from a thesis by which I have been eligible for or been awarded another degree or diploma. No individual's work has been used without appropriate acknowledgement in these four reports.

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Preamble

The three clinical case studies presented represent part of the clinical experience acquired throughout 200 days of unpaid clinical placements over a three-year period. The fourth report is a review of the professional and ethical issues that were encountered during the clinical placements.

The first adult placement was at Community Psychology Service, Pomegranate House, St John of God Healthcare in Ballarat. My role was to assess and treat patients presenting with chronic complex mental health conditions, such as schizophrenia, and to provide low-cost treatment to patients presenting with high prevalence disorders. Assessment and treatment were under the supervision of clinical psychologist, Erica Echstein.

The second adult placement was the Clinical Health Psychology Department, Queen Elizabeth Centre, Ballarat Health Services. My role was to assess and treat patients presenting with physical health conditions that were complex or not responsive to treatment due to underlying clinical issues, such as depression or anxiety. I also co-facilitated and evaluated the healthy weight management program for overweight patients with chronic health conditions complicated by their obesity. Assessment and treatment were under the supervision of clinical psychologist, Peta Price.

My child/adolescent placement was at a Community Psychology Service, Pomegranate House, St John of God Healthcare in Ballarat. My role was to help establish a low-cost child and adolescent service within the practice. Direct clinical work involved assessment and treatment of individuals and families presenting, predominantly with behavioural and mood disorders. The placement also involved inter-agency liaison to establish networks with services referring to the program. Assessment and treatment were under the supervision of clinical psychologist, Erica Echstein.

The third adult placement was at the Primary Mental Health Team, Barwon Health in Geelong. My role involved screening and assessing patients for the SHADES program, an eight-week group treatment for depression and anxiety disorders. I also co-facilitated and evaluated the program. Assessment and treatment were under the supervision of clinical psychologist, Dr Mari Molloy.

The placement reports were compiled under the supervision of Associate Professor Suzanne McLaren. In the program evaluations, only de-identified group results are reported. In the case report and the professional and ethical issues report, the names and identifying details of patients have been altered to protect their anonymity.

Placement Report 1

Ballarat Health Services - Queen Elizabeth Centre

An evaluation of the longer-term effectiveness of a six-week Healthy Weight Management Program for overweight and obese individuals with a chronic health condition.

Acknowledgements: Clinical Health Psychology Department and Dietetics Department, Queen Elizabeth Centre, Ballarat Health Services.

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Abstract

Australia has followed a worldwide trend of an increase in the number of people overweight and obese. The long-term health risks associated with obesity include diabetes, heart and circulatory diseases, high blood pressure, certain cancers, osteoarthritis and complications of sleep apnoea. Obesity is more prevalent amongst people with disabilities and functional limitations. Research suggests that even modest weight loss of 5-10% can result in significant health improvements in a range of conditions. The treatment of obesity is often complicated by the co-morbidity of depression and low self-esteem. Cognitive-behavioural treatments for obesity and binge eating disorder are among the leading treatments. This research evaluated the longer-term effectiveness of a Healthy Weight Management Program for overweight and obese adults with chronic health conditions. It found the weight loss attained during the six-week program was maintained for twelve months following the program. Significant improvements in mental health were also noted during the six-week program. Results indicated that the number of chronic health conditions did not initially impact upon weight loss, however it was related to weight loss at the sixteen-week milestone. Further research would benefit from efforts to continue to track the progress of participants who drop out of the program during the twelve-month period of monitoring and support. Results indicate that the Healthy Weight Management Program resulted in significant weight loss during the six-week program, which was maintained for one year following the program.

The prevalence of obesity has been called a ‘global epidemic’ by the World Health Organisation (2000). Australians have followed this global trend, with data indicating that in 2004-5, an estimated 2.5 million Australians were obese (Australian Institute of Health and Welfare, 2006). The World Health Organisation defines ‘overweight’ as a body mass index (BMI) equal to or greater than 25, and ‘obesity’ as a BMI equal to or greater than 30 (World Health Organization, 2000). The prevalence of obesity in Australia has increased significantly over the past 10 years. Between 1995 and 2004-5, the prevalence of obesity in Australians increased from 11% to 16% (Australian Institute of Health and Welfare, 2006). In addition to the increase in obesity, there is concern about the rate of overweight people in the population. A further 4.9 million Australians were estimated to be overweight but not obese (Australian Institute of Health and Welfare, 2006).

The Australian Bureau of Statistics (ABS) National Health Surveys conducted in 1989 and 2001 revealed an 80% increase in male obesity and a 71% increase in female obesity during this period (Australian Bureau of Statistics, 2002). There was a 14% increase in overweight, but not obese adults during the same time period. The ABS data is based upon self-reported height and weight collected from respondents. The true extent of obesity in Australia is unknown, as previous research suggests that when people self-report they tend to overestimate their height and underestimate their weight (Flood, Webb, Lazarus, & Pang, 2000).

Health risks of obesity

There are a number of significant long-term health risks associated with obesity. Long-term or chronic health conditions are defined as conditions present or are expected to last for more than six months (Australian Institute of Health and Welfare, 2003). In Australia, there is significantly elevated prevalence of diabetes, heart and circulatory

diseases, high blood pressure and high blood cholesterol among obese people (Australian Institute of Health and Welfare, 2004). There is also growing evidence of an increased risk of developing certain cancers, sleep apnoea, and osteoarthritis associated with obesity (World Health Organization, 2000). Research indicates that 26% of obese men have five or more long-term health conditions compared with 19% of healthy weight men (Australian Institute of Health and Welfare, 2004). This relationship is even stronger for obese women, with 36% of obese women having five or more long-term health conditions, compared with 23% of women of a healthy weight.

Obesity has been identified as a significant risk factor for a number of long-term health conditions. Obesity is a key risk factor in the development of Type 2 diabetes (Australian Institute of Health and Welfare, 2002). Self-reported diabetes is four times more prevalent among obese women and two times more prevalent among obese men. In addition, the relationship between obesity and cardiovascular disease in men and women has been well documented, with increased risk associated with the duration and degree of obesity (World Health Organization, 2000).

Beyond these well-known physical health complications, excess body weight is also thought to be a risk factor for a number of other health conditions. Excess body weight has been identified as a modifiable risk factor in the development of knee osteoarthritis (Focht, 2006). This condition is associated with adverse symptoms such as knee pain, stiffness, and functional limitations. Research suggests that weight loss reduces the risk of developing knee osteoarthritis (Focht, 2006). Even modest amounts of weight loss have been found to yield clinically significant improvements in physical function, pain and level of disability. Further research find evidence of a relationship between osteoarthritis of the hip and obesity (Marks & Allegrante, 2002). A retrospective study on 1,021 adults requiring surgery for end stage hip osteoarthritis were assessed at the time of their surgery.

It was found that patients who were overweight or obese accounted for almost 70% of the surgical cases. The obese patients were also at increased risk for removal and re-implantation of their prosthetic hip.

Further research identifies that obesity is associated a range of chronic health conditions. A sample of 30,526 women from the US aged between 18-34 years were investigated (Jones & Bell, 2004). Among these women, 31% reported having one or more functional limitations or disabilities. The women with severe functional limitations were more likely to be obese, to be physically inactive, and to be heavy smokers. The obese women also had the highest rates of every chronic health condition. The researchers suggest that there is complex and reciprocal relationship between obesity and the level of disability among women. They suggest that obesity and a pre-morbid disability contribute to the level of impairment due to restrictions caused by both conditions, such as reduced physical mobility and access to conventional exercise equipment. There is evidence to suggest that obesity is associated with the development and increased probability of a number of health conditions.

Physical Benefits of Weight Loss

Research on women with functional disabilities suggest that even a modest weight loss of 10% has long-standing benefits for reducing physical limitations, reducing pain, and increasing physical activity (Larsson, 2004). Functional improvements include everyday behaviours such as walking up stairs with shopping bags and rising from the floor or low furniture. Evidence suggests that even a modest weight loss of 5-10% is associated with clinically significant improvements in insulin sensitivity, cholesterol and blood pressure (Goldstein, 1992; Pi-Sunyer, 1993). This research suggests that even modest weight loss is associated with an improvement in mobility and general health.

There is limited evidence about the long-term health benefits of this modest weight loss, as people typically regain weight that is lost. A study followed a group of 57 obese women for a year following a 12-week weight loss program (Krebs et al., 2002). No further intervention was provided beyond the twelve week program. The women were monitored for weight, fat mass, fasting plasma insulin, lipids and blood pressure measured at 0, 12, 24 and 52 weeks. Results indicated that the initial weight loss in the first 12 weeks was positively correlated with greater long-term weight loss. During the acute weight loss phase, there were significant reductions in insulin sensitivity, lipid profile and blood pressure. Only the improvement in blood pressure was maintained after 52 weeks. For the participants who maintained more than 5% of weight loss at 52 weeks, improvements in insulin sensitivity were maintained. The researchers concluded that achieving an initial weight loss of greater than 10% was associated with maintaining a longer-term loss of 5%, which had associated health benefits.

Psychological Complications of Obesity

Beyond these physical health implications, obesity is also associated with a number of long-term psychological and social problems (McIntyre, 1998). A US study investigated the longitudinal relationship between psychopathology and obesity during young adulthood (Pine, Cohen, Brook, & Coplan, 1997). This research assessed 776 adolescents in 1983 when they were 9 to 18 years old and reassessed them in 1992 when they were 17 to 28 years old. Participants were assessed for their height and weight, and a range of psychiatric disorders, including major depressive disorder. The results indicated that obesity was related to female adolescent depression. Contradictory results were found in the adult sample, with adolescent obesity positively related to depression in females, however negatively related to depression in males. These results suggest that the

relationship between weight and mental health is gender-related. Other research suggests that young females are at a significantly increased risk of developing an eating disorder (Alonso et al., 2005). Twelve percent of young females are in the high risk population for developing an eating disorder of any kind, compared with only 3% of males. There are considerable mental health issues associated obesity in adolescence.

Despite rapid advances in other fields of science and technology, understandings about the causes of obesity have made relatively small advances in the past forty years. In a seminal paper published in the late 1960's, Rosenstock (1969) suggested that eating behaviour in overweight and obese people was triggered more by external stimuli than by internal stimuli. He advocated introducing small and gradual changes to the diet, and keeping a record of food and drink intake. Rosenstock concluded the article with helpful advice when working with obese adults unmotivated to change. He advocated providing these adults with educational material about the long-term health consequences of obesity, to enable them to make more 'rational choices'.

The advent of cognitive-behavioural therapy since Rosenstock published has provided countless examples of the way 'rational choices' are commonly not the basis for many human behaviours. Commonly practised irrational thinking includes mind reading, catastrophising, emotional reasoning and all-or-nothing thinking (Beck, 1995). Cognitive theory has clearly established that merely knowing the rational reaction or behaviour in a situation is not enough to alter behaviour. It is only through continued practice and the restructuring of core beliefs that long-term changes can be achieved (Beck, 1995).

The growth of bariatric surgery to alter the gastrointestinal anatomy reflects the increasing appreciation of the psychological difficulties experienced by people attempting to achieve long-term weight loss. There has been a ten-fold increase in bariatric surgery in Australia in the past ten years, with rates expected to continue to increase (Nogrady, 2004).

Following bariatric surgery, two-thirds of patients no longer require medical treatment for diabetes and about 60% of patients with hypertension no longer require treatment (Nogrady, 2004).

Despite these encouraging results, the long-term efficacy rates of bariatric surgery are not clear. An Australian study of 63 patients undergoing bariatric surgery revealed that only 88% still had their lap-band in situ at twelve months following surgery (Tweddle, Woods, & Blamey, 2004). The group had lost 45% of their excess weight at twelve months post surgery. At two years post surgery, only 62% still had their lap-bands in situ, and the excess weight loss remained relatively unchanged at 47%. This study highlights that the surgical treatment of obesity is not a panacea. Even thought bariatric surgery removes the physical barriers to weight loss, the psychological barriers remain and continue to work against long-term weight loss.

Cognitive-Behavioural Therapy for Obesity

Cognitive-behavioural therapy (CBT) is thought to be the most comprehensive means of treating obesity, however only relatively few studies have been published regarding its long-term effectiveness (Melchionda et al., 2003) The majority of CBT research treating obesity has specifically examined the treatment of binge eating disorder (BED). BED is characterised by recurrent episodes of binge eating in the absence of regular compensatory behaviours, such as vomiting, laxative abuse or excessive exercise (De Zwaan, 2001). BED is also associated with eating until uncomfortably full, eating when not physically hungry, eating alone, and feelings of depression or guilt. The disorder is not limited to obese individuals, however it occurs more frequently in obese people seeking treatment for their weight (De Zwaan, 2001). In community samples, BED has a prevalence of 2-5% of the population, however the prevalence of BED is significantly higher in adults enrolled in weight loss programs (30%) (De Zwaan, 2001). Although there

is a considerable overlap between BED and obesity, there is a substantial gap in the literature evaluating the effectiveness of CBT treatment for obesity in adults without BED.

One of the most promising theories to emerge in recent years is the transdiagnostic theory and treatment of eating disorders (Fairburn, Cooper, & Shafran, 2003). The theory is based upon the cognitive-behavioural therapy for bulimia nervosa, which is the gold standard treatment for bulimia nervosa (Grave, 2005). The transdiagnostic approach suggests that the traditional categorical system of diagnosing eating disorders does not appreciate the many overlapping dimensions between all eating disorders (Fairburn, Cooper, & Shafran, 2003). The theory proposes that the 'core psychopathology' of all eating disorders is a dysfunctional system for evaluating self worth. People with eating disorders judge themselves largely, or even exclusively, in terms of their eating habits, shape or weight (or all three) and their ability to control them (Fairburn et al., 2003). This over-evaluation of eating, shape and weight is associated with low self-esteem and mood intolerance.

The transdiagnostic treatment of eating disorders is CBT-based, and aims to increase the client's understanding about the emotional triggers to their eating and compensatory behaviours. The theory is yet to receive extensive empirical testing or evaluation for the treatment of obesity. It has promising theoretical links to the CBT treatment of BED that has already been conducted.

In general, CBT treatment of obesity focuses on weight loss, but also incorporates psychological strategies to promote lifestyle changes. A review of CBT programs for weight loss suggests that between 5% and 20% of weight is typically lost during treatment, however this is usually followed by a steady regain to baseline within five years (Rapoport, Clark, & Wardle, 2000). Research suggests that CBT treatment for binge eating disorder can be highly effective (Stewart, Telch, & Arnow, 1997). A study of 93 obese women also

diagnosed with binge eating disorder found that the group as a whole maintained reductions in binge eating at one-year post-treatment. The participants who stopped binge eating during the CBT treatment maintained an average weight loss of 4kgs over the follow-up period. The participants who continued to binge eat during the treatment phase had an average weight gain of 4kgs by one year post-treatment. This research highlights the importance of achieving behavioural change during the active component of the treatment.

Some of the individual components of CBT therapy for obesity have also been evaluated. Australian research has found that exercise enhances the benefits of CBT in the treatment of BED (Pendleton, Goodrick, Poston, Reeves, & Foreyt, 2002). This research randomly assigned 114 obese female binge eaters into four groups, varying the components of CBT, exercise and maintenance over the 16-month research period. It was found that participants who received CBT in addition to exercise experienced significant reductions in binge eating frequency, compared with those who received CBT only. This suggests that making significant behavioural changes by introducing exercise in conjunction with CBT is more effective than CBT alone.

The practice of regularly weighing obese people has also been evaluated. Critics of this practice have suggested that regular weighing of obese people can generate negative mood states and increased body dissatisfaction, resulting in decreased motivation to lose weight (Dionne & Yeudall, 2005). The scientific literature suggests this assertion is not correct, as regular monitoring of body weight is associated with better weight control in the short and long term (O'Neil & Brown, 2005).

Research suggests that CBT is only an effective component of a weight loss program when it is incorporated into a balanced eating plan. Recent research has found that the addition of CBT does not improve weight loss outcomes when participants are placed

upon a very-low-calorie-diet (VLCD) (De Zwaan et al., 2005). The VLCD programs typically require participants to only consume calorie-controlled drinks, which are nutritionally supplemented. This suggests that CBT is associated with a change in the thinking patterns and behaviours that have contributed to the obesity. When programs eliminate the components of food education and menu planning by advocating only VLCD, they also appear to eliminate the value of making other cognitive and behavioural changes.

Current Research

The Healthy Weight Management Program, developed by the staff at the Queen Elizabeth Centre (QEC), is multi-disciplinary, multi-component weight loss program designed for patients with chronic health conditions, who are overweight or obese. The program comprised of nutrition education, cognitive-behavioural strategies, and exercise therapy. The cognitive-behavioural elements were designed to address the key deficiencies in self-esteem and emotional dysregulation. The multi-disciplinary program was run by the psychologist, dietician and exercise therapist. The aim of the program was to educate patients about the behavioural and psychological contributions to being overweight or obese. Long-term management strategies were taught, which were reinforced by monitoring and support provided for one year beyond the six-week program.

The aim of the current research was to investigate the longer-term effectiveness of the Healthy Weight Management Program. It was expected that the program would be effective in the short and longer-term reduction of weight. It was also expected that the program would improve self-rated mental health in the short-term. It is hypothesised that weight loss achieved during the six-week program will be maintained for one year; that

mental health will improve during the six-week program; and that the number of health conditions will be negatively related to weight loss.

Method

Participants

The sample consisted of 82 female and 20 male participants enrolled in the Healthy Weight Management Program. Participants were referred to the program by their General Practitioner or Allied Health Professional. All participants had a chronic health condition and were overweight or obese, with a BMI > 27. The males were significantly heavier, taller and had greater waist girth than the females (Appendix A). There were no significant differences between the female and male participants in terms of their age, number of their health conditions, systolic or diastolic blood pressure, and their resting heart rates. Given the lack of significant differences, and the limited sample size, the results for the female and male participants were combined in all subsequent analyses.

Measures

The participants completed the Screening Pro-forma, the Mental Health Screening Tool and the General Health Questionnaire (GHQ-30). Anthropometric measurements were also recorded, including weight and waist circumference. Blood pressure and resting heart rate were recorded using an electronic blood pressure monitor.

The Screening Pro-forma (Appendix B) is a brief screening tool developed by the QEC staff. It records details regarding the patient's current weight, their ideal weight, and their expectations of a realistic weight loss goal. The tool also screens for motivation and reasons for participating in the program. Patients also indicate their beliefs about the cause of their current weight and their expected outcome from the program. Patients were

considered to be appropriate for the program if they had realistic weight loss goals, and had appropriate motivation and realistic expectations of the program.

The Mental Health Screening Tool is a 10-item scale developed by QEC staff. It is designed to explore the patient's subjective ratings of their depression, anxiety, motivation and self-efficacy (Appendix C). Participants completed a six-point Likert scale for each question ranging from, (1) all of the time to (6) none of the time. A high score on this scale indicated a higher level of anxiety and depressive symptomatology, and a lesser degree of motivation and self-efficacy. This scale is for screening purposes only, therefore no formal psychometric properties are available. The depressive symptoms measure contains four items, such as "I have felt sad and unhappy" (internal consistency coefficient alpha, 0.79). The motivation measure contains two items such as "I have been able to do the things that I needed to do," (alpha 0.19). The self-efficacy measure contains three items such as "I have felt that I can manage my weight" (alpha 0.76). The anxiety measure only contained one item, "I have felt anxious and easily upset". The depressive symptomatology and self-efficacy scales achieved a satisfactory degree of internal consistency, therefore only these scales and the anxiety item were used in subsequent analysis.

The General Health Questionnaire-30 (GHQ-30) is a 30-item self-report questionnaire designed to assess mental health (Goldberg & Hillier, 1979) (Appendix D). It was developed as a screening instrument in community settings, primary care, and with medical out-patients (Goldberg & Hillier, 1979). It contains a four-point Likert scale, with responses ranging from (0) better than usual to (3) much less than usual with greater scores indicating higher psychological distress. The GHQ-30 has been found to have adequate levels of internal consistency and reliability (Sriram, Chandrashekar, Isaac, & Shanmugham, 2005).

Procedure

Potential participants referred to the program were invited to a screening session. Individual assessments were conducted by the psychologist, dietitian and exercise therapist. Candidates were screened during 30-minute interviews with the clinicians to ensure they were aware of the program goals, and to discuss any acute physical or mental health problems that would limit their benefit from the program. The psychological screening required the candidate to complete the questionnaire package and discuss their relevant motivational and mental health issues. The screening with the dietician involved recording the candidate's current anthropometric measures, current diet, and any current or past medical conditions. The exercise therapist assessed the candidate's current fitness level by conducting a fitness assessment.

Suitable candidates were invited to join the next program. Candidates determined to be unsuitable were referred to alternate weight loss programs in the community. The program was delivered over a six-week period, comprised of weekly three-hour sessions. The groups contained 6-10 participants with a range of chronic health conditions. The first half of the program was delivered by the psychologist and dietitian. This focussed upon cognitive-behavioural strategies and food education (Appendix E). The dietary advice followed the *12345+ Food and Nutrition Plan* developed by the CSIRO and the Cancer Council of South Australia (Jacobon, 1991). The second half of the program was delivered by the exercise therapist, who developed an individual exercise plan for each participant.

Participants were given homework goals each week to develop their application of the program content. Anthropometric and psychological measures were taken at week one, four and six of the program. All participants completed a program evaluation at the end of week six (Appendix F). Following the six-week intensive program, participants were provided with periodic support and monitoring over the following year. Participants were

invited to attend booster education sessions and to monitor their progress at 10, 16, 26 and 52 weeks from the beginning of their program.

Results

Average weight and BMI were calculated for the twelve-month period of investigation. As can be seen in Table 1, the average weight and BMI of participants decreased consistently until the 26-week milestone. The greatest weight loss peaked at 5% at the six-month milestone. At 12 months following the program, participants had begun to regain weight, reducing the average weight loss to 3% of their initial weight. The trend of gradual weight loss and reduction in BMI, until the 26-week milestone can also be seen in Figure 1.

Table 1

Average Weight and BMI During the 12-Month Period

	Initial (N = 102)	6 week (N = 92)	10 week (N = 77)	16 week (N = 54)	26 week (N = 37)	52 week (N = 36)
Weight (kgs)	102.1	100.7	97.7	96.6	92.4	94.8
BMI (kg/m²)	31.1	30.6	29.7	29.3	28.1	28.6
% Change	-	-2.3	-3.5	-4.7	-5.1	-3.3

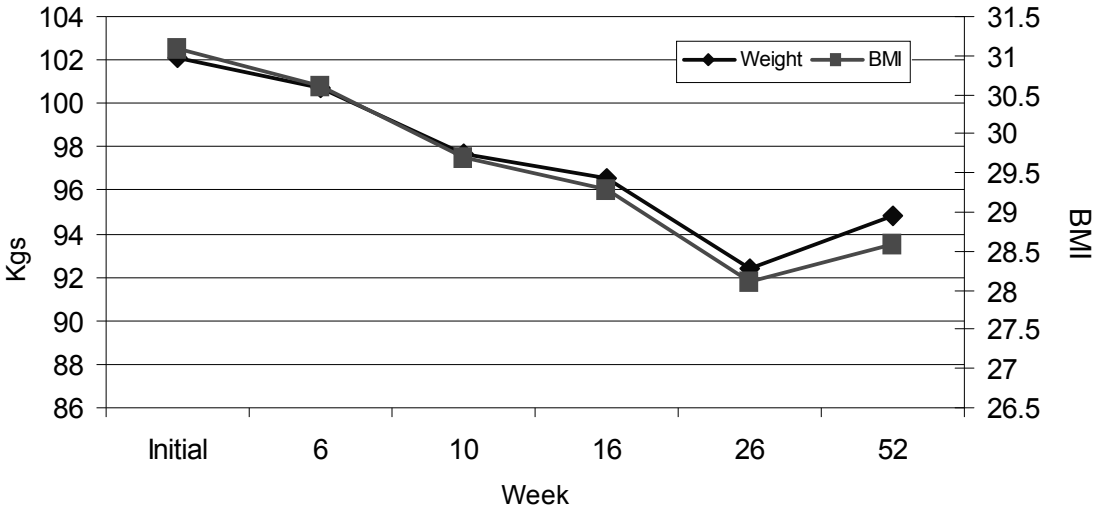

Figure 1. Changes in weight and BMI over the 12-month period.

A number of paired samples *t*-tests were conducted to investigate if these changes in weight were significant. This method was chosen rather than repeated measures analysis of variance as ANOVA does not allow any missing data. This would have reduced the analysis to the 25 cases that had a complete data set over the 12-month period. The paired samples *t*-tests revealed that there was significant weight loss by the end of the six-week program, $t(91) = 8.14$, $p < .001$. There was no difference in weight between the end of the six-week program and the 12-month milestone , $t(34) = 1.24$, $p > .05$. There was significant weight loss between the six and ten week milestones, $t(74) = 5.43$, $p < .001$, and between the 10 and 16 week milestones, $t(52) = 2.67$, $p < .01$. There was not significant additional weight loss between the 16 and 26 week milestones, $t(33) = 0.66$, $p > .05$. Although there appears to be a weight gain between the 26 and 52 week milestones, this increase was not found to be significant, $t(28) = -1.99$, $p > .05$. Overall, these results suggest that the optimal benefit from the program in weight loss is achieved by the sixteen week milestone, with a plateau occurring after this time.

The average psychological measures before and after the six-week program can be seen in Table 2. The most significant change was in the rating on the General Health

Questionnaire, which improved by 33% by the end of the 6-week program, $t(31) = 4.96$, $p < .001$. This suggests a significant improvement in subjective perception of mental health. There was also a highly significant reduction in depressive symptoms by the end of the six-week program, $t(24) = 3.64$, $p < .001$. Participants also rated significantly improved self-efficacy about their ability to manage their weight, $t(22) = -3.01$, $p < .01$. There was no significant reduction in the anxiety item by the end of the program, $t(24) = 0.83$, $p > .05$.

Table 2

Average Psychological Measures Pre-and Post-Program

		Pre		Post	
	N	*M*	*SD*	*M*	SD
General Health Questionnaire	32	32.69	11.49	21.88	9.81
Depressive symptoms	25	11.76	2.95	8.96	3.23
Anxiety symptom	25	2.56	1.41	2.28	1.17
Self-efficacy	23	8.96	3.83	13.09	4.02

The impact of the number of health conditions upon weight loss was tested. The percentage weight loss at 6 weeks (the end of the program) and at 16 weeks (the optimal period of weight loss) were used as significant time periods in which weight loss occurred. A simple linear regression found that the number of health conditions did not significantly predict weight loss at six weeks, $F(1,90) = 0.21$, $p > .05$. The number of health conditions did account for a small but significant degree of variance in weight loss at 16 weeks, $F(1,52) = 4.16$, $p < .05$, *Adjusted* $R^2 = 0.06$. At 16 weeks after beginning of the program, 6% of the variance in weight loss could be explained by the number of health conditions. A

greater number of health conditions was related to less weight loss after the completion of the program.

Discussion

The aim of the current study was to evaluate the longer-term effectiveness of a Healthy Weight Management Program for overweight and obese individuals with chronic health conditions. It was hypothesised that weight loss achieved during the six-week program would be maintained for one year following the active phase of the program. This hypothesis was supported. There was no significant difference in weight between the end of the six-week program and at one year after completing the program, suggesting that the weight loss obtained during the six-week program was maintained at one year after the program. There is also evidence that participants continued to lose weight beyond the end of the six-week program. Maximal weight loss was achieved by the 16 week milestone, then plateaued after this time. Despite the continued weight loss after the six-week program, there was no evidence of this further weight loss being maintained at 12 months.

These results are consistent with previous research suggesting that weight management programs including cognitive-behavioural strategies, as well as nutrition education, are effective at reducing overweight and obese individuals' weight and BMI (Pendleton et al., 2002; Rapoport et al., 2000; Stewart et al., 1997). The results are also consistent with other research that suggest that the greatest weight loss is achieved during the active component of the treatment (Stewart et al., 1997).

The second hypothesis predicted that participants would report significant improvements in their mental health by the end of the six-week program. This hypothesis was supported. Self-reported mental health on the General Health Questionnaire improved by 33% over the six-week period. This finding is consistent with the significant improvement in participant's ratings of depressive symptomatology. The findings of the

current study are consistent with the substantial body of evidence that has confirmed CBT as an effective treatment for depression (Beck, 1995). The improvement in mental health associated with weight loss is consistent with the established link between obesity and psychological and social problems (Falkner et al., 2001; McIntyre, 1998). The improvement in mental health is consistent with the transdiagnostic model for treating eating disorders, which aims to provide alternative skills for mood regulation and changing eating patterns (Fairburn et al., 2003). The concurrent weight loss and improvements in mental health demonstrated in this study are consistent with transdiagnostic model which aims to link physical and emotional health.

The third hypothesis predicted that the number of health conditions would be negatively related to weight loss. There was partial support for this hypothesis. The number of health conditions was found to be unrelated to weight loss at the end of the six-week program. Results indicated that the number of health conditions predicted a small but significant degree of variance in weight loss at the 16-week milestone. The participants with a greater number of health conditions had a lesser degree of continued success in losing weight. This result is consistent with research confirming the strong connection between the degree of functional limitation and obesity (Jones & Bell, 2004). These results may suggest that during the active phase of the program, when there was regular contact with staff and other participants, there was a greater drive to overcome functional limitations. By four months after the commencement of the program, when this reinforcement ended, there may have been a gradual return to old eating and exercise habits. In addition, without ongoing treatment for their mental health, the participants with greater functional limitations may have been more vulnerable to deterioration in their mental health once contact with staff and other participants ceased. This may at least in

part account for a lesser degree of continued success in losing weight for those with a greater number of health conditions.

Implications

This research adds to the body of knowledge about the effectiveness of CBT treatment for obesity. Although CBT is a common treatment component of programs to treat obesity, there are few published studies regarding its longer-term effectiveness (Melchionda et al., 2003). The body of research has predominantly focused upon the CBT treatment of binge eating disorder, rather than purely obesity in the general population. This current study indicates that the Healthy Weight Management Program is an effective weight loss program for individuals living in the community with chronic health conditions. The relatively small weight loss achieved is consistent with the modest losses achieved by other programs (Krebs et al., 2002). The maintenance of the weight loss achieved during the 6-week program at one year after completing the program is likely to have had longer-term benefits for the participant's insulin sensitivity, blood pressure and cholesterol (Goldstein, 1992; Krebs et al., 2002; Pi-Sunyer, 1993).

Within the literature on obesity, there is substantial evidence of the connection between obesity and numerous health risks (Australian Institute of Health and Welfare, 2002, 2004; Focht, 2006; World Health Organization, 2000). There is a substantial gap in the literature regarding the extent of obesity, and the associated health conditions, on the capacity of the individual to lose weight. The literature frequently stresses the importance of losing weight for optimal health, however it does not consider the substantial barriers to losing weight when an individual is considerably obese, or has health conditions, or both. The current research is one of the few studies in which all participants already had a substantial health condition as a condition of entry into the program. It is likely that these participants faced additional barriers to losing weight due to their health conditions. The

results of the current study indicate that the burden of the number of health conditions impacts upon the capacity to continue losing weight around the 16-week milestone. Despite this barrier, the current research suggests that this weight management program for overweight and obese individuals with a chronic health conditions remains effective at one year after the intervention. The concurrent weight loss and improvement in mental health provides some evidence about the importance of considering physical and emotional health in the same treatment program.

Limitations and Future Research

The results and implications of this study need to be considered in light of some of the study's limitations. Due to the ongoing nature of the program, full 12-month data was not available on all participants who had completed the program. This reduced the sample size for the 26 and 52-week milestones, and reduced the power of the analysis that was conducted. The chart containing weight and BMI over time suggest further weight loss by the 26-week milestone, however this could not be statistically confirmed. The incomplete set of psychological measures also reduced the sample size for these analyses. Future research would benefit from collecting a full 12-month sample of data from all available participants. This would allow a clearer picture to emerge of the longer-term efficacy of the program.

The true efficacy of the current program is also limited by the quality of the data. The data is limited by the ongoing participation of participants who stay in the program for the full 12-month monitoring and support period. Reasons why participants did not continue with the monitoring and support are unknown. Presumably a significant reason for not continuing with the monitoring was because they begun to regain the weight lost during the six-week program. Therefore the data only reflects the participants who were motivated to continue the program, biasing the results towards those who were successful.

Future research would benefit from attempting to follow up with people who dropped out of the program to understand their reasons for not continuing.

Based upon the existing research, it would be expected that approximately 30% of participants would have had a binge eating disorder in addition to being overweight or obese (De Zwaan, 2001). Due to the current screening process of not diagnosing BED, it is unable to be determined whether the participants with BED also benefited from the program. It is also unable to be determined if participants with BED were overly represented in those who discontinued with the program during the 12-month monitoring and support period. The program would benefit from introducing a screening for binge eating disorder during the assessment process. This would allow future researchers to determine if the program is effective for individuals with binge eating disorder, and to establish if the program needs to be modified to retain these participants.

Conclusion

There is evidence that the Healthy Weight Management Program for overweight and obese individuals with chronic health conditions is effective in maintaining weight loss achieved during a six-week program at twelve months. There is also evidence to suggest that participants continue to lose weight for four months, at which stage a plateau in weight loss was reached. Despite the limitations discussed, weight loss achieved during the 6-week program was maintained for at least 12 months following the initial program. The program is also effective in improving subjective ratings of mental health during the six-week program. Analysis revealed some evidence that a greater number of health conditions impacts upon participant's capacity to continue losing weight by the 16-month milestone. The program provides evidence that participants with varying degrees of health conditions can benefit from a 6-week weight management program, and sustain these improvements over a 12-month period.

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Appendix A

Initial Characteristics of Female and Male Participants

	Female (n = 82)	Male (n = 20)	*df*	*t*
Age (yrs)	55.0	50.1	100	-1.31
Height (cms)	161.3	175.5	99	8.08 ***
Number of health conditions	5.2	5.5	100	0.48
Initial weight (kgs)	99.8	112.0	100	2.50 *
Initial waist measurement (cms)	109.3	121.6	96	4.03 ***
Initial blood pressure	139/84	127/82	74	-0.51
Initial heart rate (bpm)	76.3	68.5	100	-1.95

Note: * $p < 0.05$. ** $p < 0.01$. *** $p < 0.001$.

Appendix B

SCREENING PROFORMA

NAME
ADDRESS

PHONE

CURRENT WEIGHT
IDEAL WEIGHT
REALISTIC WEIGHT

REASONS FOR PARTICIPATION IN WEIGHT LOSS PROGRAM

WHAT HAS WORKED IN THE PAST

WHAT HAS NOT WORKED IN THE PAST

BELIEF ABOUT CURRENT WEIGHT

ANTICIPATED OUTCOME

Appendix C

Mental Health Screening Tool

BallaratHealthServices

Weight Management Program

Name_____

[ ] Pre program [ ] Post program [ ] Follow up program Week ___

Your response to the following statements are designed to help us to understand how you have been feeling over the last two weeks and about the challenges ahead.

If

1 = all of the time
2 = most of the time
3 = a good bit of the time
4 = some of the time
5 = a little of the time
6 = none of the time

please indicate with a 4in the box the number which closely matches your response.

In the last two weeks	1	2	3	4	5	6
I have felt full of life						
I have felt anxious and easily upset						
I have felt sad and unhappy						
I have felt more tired than usual						
I have been able to do the things that I need to do						
I have felt less energetic than usual						
I have felt that I can manage my weight						
I have felt that I can control my diet.						
I have been able to exercise regularly						
I am confident that I have the knowledge and resources to manage my weight						

Please return the completed form to a member of the Weight Management team.

C:\Documents and Settings\LyndaB\Local Settings\Temporary Internet Files\OLK36\Weight Management Questionaire.doc

Base Hospital
Drummond Street North, Ballarat
PO Box 577, Ballarat 3353
Telephone 03 5320 4000 /
Facsimile 03 5320 4828

Queen Elizabeth Centre
102 Ascot Street South, Ballarat
PO Box 199, Ballarat 3353
Telephone 61 3 5320 3700
Facsimile 61 3 5320 3850

Psychiatric Services
Sturt Street, Ballarat
PO Box 577, Ballarat 3353
Telephone 03 5320 4100
Facsimile 03 5320 4835

Appendix D

GENERAL HEALTH QUESTIONNAIRE

NFER NELSON

GHQ-30

Please read this carefully:

We should like to know if you have had any medical complaints, and how your health has been in general, over the past few weeks. Please answer ALL the questions on the following pages simply by underlining the answer which you think most nearly applies to you. Remember that we want to know about present and recent complaints, not those you had in the past. It is important that you try to answer ALL the questions.

Thank you very much for your co-operation.

HAVE YOU RECENTLY:

1	– been able to concentrate on whatever you're doing?	Better than usual	Same as usual	Less than usual	Much less than usual
2	– lost much sleep over worry?	Not at all	No more than usual	Rather more than usual	Much more than usual
3	– been having restless, disturbed nights?	Not at all	No more than usual	Rather more than usual	Much more than usual
4	– been managing to keep yourself busy and occupied?	More so than usual	Same as usual	Rather less than usual	Much less than usual
5	– been getting out of the house as much as usual?	More so than usual	Same as usual	Less than usual	Much less than usual
6	– been managing as well as most people would in your shoes?	Better than most	About the same	Rather less well	Much less well
7	– felt on the whole you were doing things well?	Better than usual	About the same	Less well than usual	Much less well
8	– been satisfied with the way you've carried out your task?	More satisfied	About same as usual	Less satisfied than usual	Much less satisfied
9	– been able to feel warmth and affection for those near to you?	Better than usual	About same as usual	Less well than usual	Much less well
10	– been finding it easy to get on with other people?	Better than usual	About same as usual	Less well than usual	Much less well
11	– spent much time chatting with people?	More time than usual	About same as usual	Less time than usual	Much less than usual
12	– felt that you are playing a useful part in things?	More so than usual	Same as usual	Less useful than usual	Much less useful
13	– felt capable of making decisions about things?	More so than usual	Same as usual	Less so than usual	Much less capable

PLEASE TURN OVER

HAVE YOU RECENTLY:

14 – felt constantly under strain?	Not at all	No more than usual	Rather more than usual	Much more than usual
15 – felt you couldn't overcome your difficulties?	Not at all	No more than usual	Rather more than usual	Much more than usual
16 – been finding life a struggle all the time?	Not at all	No more than usual	Rather more than usual	Much more than usual
17 – been able to enjoy your normal day-to-day activities?	More so than usual	Same as usual	Less so than usual	Much less than usual
18 – been taking things hard?	Not at all	No more than usual	Rather more than usual	Much more than usual
19 – been getting scared or panicky for no good reason?	Not at all	No more than usual	Rather more than usual	Much more than usual
20 – been able to face up to your problems?	More so than usual	Same as usual	Less able than usual	Much less able
21 – found everything getting on top of you?	Not at all	No more than usual	Rather more than usual	Much more than usual
22 – been feeling unhappy and depressed?	Not at all	No more than usual	Rather more than usual	Much more than usual
23 – been losing confidence in yourself?	Not at all	No more than usual	Rather more than usual	Much more than usual
24 – been thinking of yourself as a worthless person?	Not at all	No more than usual	Rather more than usual	Much more than usual
25 – felt that life is entirely hopeless?	Not at all	No more than usual	Rather more than usual	Much more than usual
26 – been feeling hopeful about your own future?	More so than usual	About same as usual	Less so than usual	Much less hopeful
27 – been feeling reasonably happy, all things considered?	More so than usual	About same as usual	Less so than usual	Much less than usual
28 – been feeling nervous and strung-up all the time?	Not at all	No more than usual	Rather more than usual	Much more than usual
29 – felt that life isn't worth living?	Not at all	No more than usual	Rather more than usual	Much more than usual
30 – found at times you couldn't do anything because your nerves were too bad?	Not at all	No more than usual	Rather more than usual	Much more than usual

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Appendix E

Summary of Healthy Weight Management Program

Week 1

- Recording of measurements
- Introductions
- Expectations
- Motivation to change
- Introduction of food pyramid
- Issuing of program diary to record food intake and exercise
- Development of individual exercise goals.

Week 2

- Review of previous week's goals and food consumption
- Recording of subjective ratings of hunger
- Self-care and relaxation
- Setting of goals and homework for upcoming week
- Exercise therapy

Week 3

- Review of previous week's goals and food consumption
- Triggers of emotional eating
- Self-talk
- Alternatives to eating
- Setting of goals and homework for upcoming week
- Exercise therapy

Week 4

- Recording of measurements
- Review of previous week's goals and food consumption
- Understand social and environmental queues for eating
- Living for today
- Modifications to recipes
- Setting of goals and homework for upcoming week
- Exercise therapy

Week 5

- Recording of measurements
- Review of previous week's goals and food consumption
- Pleasant activity scheduling
- Goal setting
- Cooking demonstration
- Setting of goals and homework for upcoming week
- Exercise therapy

Week 6

- Recording of measurements
- Review of previous week's goals and food consumption
- Reflection upon accomplishment and challenges
- Relapse prevention
- Exercise therapy
- Program evaluation

Appendix F

Healthy Weight Management Program Evaluation

Please circle your response:

1. How much did you enjoy the Healthy Weight Management Program?

Not at all | A little | Somewhat | Quite a bit | Very much

2. How informative did you find the program?

Not at all | A little | Somewhat | Quite a bit | Very much

3. How much help were the sessions about food and nutrition?

Not at all | A little | Somewhat | Quite a bit | Very much

4. How much help were the sessions about changing your behaviour?

Not at all | A little | Somewhat | Quite a bit | Very much

5. How much help were the exercise sessions?

Not at all | A little | Somewhat | Quite a bit | Very much

6. How could the program be improved?

7. Any other comments?

Thank you very much

Placement Report 2

Ballarat Health Services - Queen Elizabeth Centre

A clinical case study on the assessment and treatment of social phobia.

Acknowledgements: Clinical Health Psychology Department, Queen Elizabeth Centre Ballarat Health Services.

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Abstract

Social phobia is as a pervasive mental health disorder due to the marked social avoidance and excessive fear associated with social and performance situations. Although the cause of social phobia is unknown, the risk factors of family adversity and shyness during childhood are identified in the literature. The cognitive model suggests that when people with social phobia are placed in socially threatening situations, they shift their attention inwards and engage in a harsh and detailed monitoring and observation of their thoughts, emotions and physiological reactions. This case study research evaluated the treatment of a 58-year-old male presenting with social phobia and co-morbid major depressive disorder. The brief cognitive-behavioural treatment outlined resulted in a significant reduction in social impairment and depressive symptoms. This case highlights the idiosyncratic nature of the disorder, and the need for individualised treatment plans to be developed. There remains a need for further research to improve the identification and treatment of this disorder.

The physiological symptoms associated with social phobia result in significant emotional distress and avoidance. These physiological signs of increased arousal include sweating, blushing, trembling, difficulty breathing and heart palpitations (Edelmann & Baker, 2002). The interpretation of these physiological signs is a key factor in the development of a social phobia (Gerlach, Mourlane, & Rist, 2004). Individuals this this disorder feel extremely uncomfortable or paralysed in social situations, and are intensely fearful of being scrutinised or embarrassed (Shields, 2005). As a result, the condition typically results in fear or avoidance of some or all social or performance situations. The scientific understanding of social phobia has expanded since it first appeared in the Diagnostic and Statistical Manual of Mental Disorders (DSM) in 1980 (American Psychiatric Association, 1980). When it first appeared, it was conceptualised as a relatively simple phobic disorder, limited to one or two social situations, with a minimal impact upon functioning. Social phobia is now recognised as a pervasive mental health disorder.

Diagnostic Features

The DSM details the criteria and diagnostic features of social phobia. The essential feature of the disorder is a marked and persistent fear of social or performance situations in which embarrassment may occur (American Psychiatric Association, 2002). Exposure to these situations consistently provokes an immediate anxiety response, which can escalate into panic attacks (American Psychiatric Association, 2002). Individuals with the disorder have sufficient insight to acknowledge that their response is excessive or unreasonable, but feel powerless to overcome it. The most common coping strategy associated with the disorder is complete avoidance, although at times situations may be endured with considerable dread. For a diagnosis to be made, the individual's avoidance, fear or anxious anticipation of encountering the social or performance situation needs to significantly

interfere with the person's daily routine, occupational functioning, relationships or social life (American Psychiatric Association, 2002).

Unlike many other anxiety disorders, there was little research about social phobia before 1985 (Montejo & Liebowitz, 1994). It is only in recent years that is has been recognised to have a considerable impact upon public mental health (Furmark, 2002). It is now known that individuals with the disorder are agonised by the potential risk of performing inadequately or showing overt signs of nervousness, and consequently they anticipate embarrassment or humiliation (Furmark, 2002). They are overly concerned that others will judge them to be anxious, weak, crazy or stupid (American Psychiatric Association, 2002).

The increased arousal associated with these fears results in common physiological symptoms of anxiety such as palpitations, tremors, sweating, gastrointestinal discomfort, diarrhoea, muscle tension and blushing (American Psychiatric Association, 2002) . Other features commonly associated with the disorder include hypersensitivity to criticism, negative self-evaluation, difficulty being assertive, and low self-esteem (American Psychiatric Association, 2002). Feared performance situations include speaking, writing, eating or drinking in public and social situations such as parties, social gatherings, and conversations with strangers. Social fears range from a generalised fear of numerous or most social situations, to a fear of specific settings such as formal public speaking (Furmark, 2002).

Prevalence Rates

Studies investigating the prevalence of social phobia reveal a wide range of estimates of its prevalence. Estimates of the prevalence in the community range from 3% to 13% in Western countries (American Psychiatric Association, 2002; Kessler et al., 1994;

Montejo & Liebowitz, 1994). The variability in the prevalence figures is due to several methodological issues, including the use of different diagnostic criteria, diagnostic thresholds, assessment methods and the number of situational probes investigated (Furmark, 2002). Researchers have recently evaluated the size and burden of social anxiety disorder throughout Europe (Fehm, Pelissolo, Furmark, & Wittchen, 2005). It was found that the median lifetime presence of social phobia was 6%, and the prevalence in the general population in the previous twelve-month period was 2%. This research revealed that younger individuals showed the highest rates, and women were more frequently affected than men.

Research indicates there is a high degree of co-morbidity between social phobia other psychiatric disorders (Montejo & Liebowitz, 1994). There is evidence that in terms of lifetime prevalence, social phobia is co-morbid with simple phobia 59% of the time; agoraphobia, 44%; obsessive-compulsive disorder, 11%; and panic disorder, 5% (Schneier, Johnson, Hornig, Liebowitz, & Weissman, 1992). When social phobia is co-morbid with other disorders it is more likely to present with severe and chronic features (Schneier et al., 1992). The severe expression of this disorder is associated with impaired response to treatment, reduced help-seeking behaviour, and frequent attempts to self-medicate through substance abuse (Montejo & Liebowitz, 1994). Patients with co-morbid social phobia and other psychiatric conditions are associated with a six-fold increase in the rate of suicide attempts (Schneier et al., 1992).

Aetiology and Causes of Social Phobia

The cause of social phobia is unknown, however a number of risk factors have been identified in the development of the disorder. Family adversity during childhood has been linked to the development of the disorder, with gender moderating the influence of the

specific factors (DeWit et al., 2005). The development of social phobia in men is uniquely linked to the absence of a parent or other close confidant during childhood (DeWit et al., 2005). For females, the unique predictive factors are parental conflict while growing up, childhood physical abuse by a father figure, and maternal mania (DeWit et al., 2005). The causal link for males is thought to be associated with the process of identification, and the development of a positive sense of self. In females it is thought to be linked to the emotional stability and maintenance of boundaries within the home environment.

The presence of excessive shyness in childhood has also been suggested as a significant predictor of social phobia in adulthood (Cox, MacPherson, & Enns, 2005). However this relationship is not absolute, as approximately 50% of individuals with a lifetime history of complex social phobia do not retrospectively view themselves as being excessively shy as a child (Cox et al., 2005).

A number of theoretical hypotheses have been postulated about the causes of social phobia. Strict or uncaring parenting can result in emotions being forbidden by caregivers, such as sadness or disappointment (Helsel, 2005). The dissonance created between the experience of the emotion and expectations surrounding its appropriateness, can result in developmental fractures that inhibit the experience of these emotions in adulthood (Helsel, 2005). It has been suggested the sense of shame created by this dissonance is at the root of social phobia. Shame develops in environments that fail to meet a child's needs, and its effects become internalised as a generalised sense of failure in the child's self-concept (Helsel, 2005). This poor self-concept in childhood is thought to become the basis of the adult personality susceptible to developing social phobia.

Very little is currently known about the functional neuroanatomy underlying the processing of emotional stimuli in patients with social phobia. Recent advances in functional magnetic resonance imaging (FMRI) have allowed researchers to better

understand the neurological basis and processes involved with social anxiety disorder. Recent research has investigated the specific brain activation that is associated with the processing of threat and safety signals in social phobia (Straube, Mentzel, & Miltner, 2005). Participants in the research were nine adults with social phobia, and nine healthy control participants. All the participants were free from other psychopathological or neurological disorders.

FMRI was used to measure brain activity in the participants while being presented with angry, happy and neutral facial expressions. The results suggested that the participants with social phobic had increased activation of the extrastriate visual cortex, regardless of the facial expression that was presented. The angry and happy faces led to increased activation in the amygdala in the socially phobic participants. The researchers believe it is further evidence that the amygdala is involved in the processing of negative and positive stimuli. It was found that patients with social phobia are overly sensitive to not only threatening faces, but also to accepting ones. The researchers conclude there is a general augmentation of visual processing, which accounts for increased attention upon, and evaluation of, socially relevant stimuli.

Social phobia has been theoretically linked to faulty processes of social comparison (Straube et al., 2005). It is thought that people with social phobia are more prone to making upward social comparisons, whereby the anxious person judges themselves as being inferior or not measuring up to others (Straube et al., 2005). Recent research provided diaries to 59 patients with social phobia and 58 non-clinical controls, and asked them to record their social comparisons made during the 2-week study period (Antony, Rowa, & Liss, 2005). Results suggested that the two groups did not differ in number of comparisons made, however they differed in the quality of their comparisons. The socially phobic patients made more upward comparisons and fewer downward comparisons (where they

assessed themselves as being superior to others). The socially phobic patients tended to experience greater changes in their affect following their social comparisons. The elevation in upwards social comparisons was associated with increased ratings of anxiety and depression. The results suggest the tendency towards negative self-evaluation in comparison to others underlies the persistent fears of embarrassment and negative evaluation from others.

The cognitive model of social phobia attempts to describe the development and maintenance of the disorder. This model places an emphasis upon self-perception as the most important maintaining factor for the disorder (Hofmann, Moscovitch, Kim, & Taylor, 2004). It is argued that patients with social phobia tend to interpret social situations as threatening because of the dysfunctional beliefs they hold about themself. These beliefs can be conditional, such as "If they really knew what I was like, they wouldn't like me" or unconditional beliefs regarding their social evaluation, such as "I am ugly". The cognitive model assumes that when people with social phobia are confronted with a socially threatening situation, they shift their attention inwards and engage in a harsh and detailed monitoring and observation of their thoughts, emotions and physiological reactions (Hofmann et al., 2004). They become acutely aware of their anxiety symptoms, and perceive these symptoms as being out of their control (Hofmann et al., 2004) The model predicts that interventions that challenge these dysfunctional beliefs result in positive changes in self-representations, and consequently reduces the socially phobic symptoms (Hofmann et al., 2004). In addition, education and training to gain mastery of physiological anxiety symptoms reduces the fearful response at the core of the disorder.

The cognitive behavioural model of social phobia proposes that a patient's evaluation of their physiological symptoms of anxiety is the main source of their anxiety (Gerlach et al., 2004). There is typically a vast history of negative evaluations of their

bodily sensations occurring in a variety of social contexts. The presence of blushing and sweating most typically distinguishes social phobia from other anxiety disorders, and are the symptoms patients with social phobia most commonly complain of (Fahlen, 1996; Reich, Noyes, & Yates, 1988). Due to blushing and sweating being the main physiological symptoms most likely to be noticed by others, they are symptoms most connected to personal distress (Hartman, 1984).

Treatment of Social Phobia

The treatment of social phobia is moving towards integrating cognitive-behavioural techniques with psychopharmacology. A longitudinal study of anxiety disorders over a 12-year period revealed that benzodiazepines were the medications most commonly used for generalized anxiety disorder and social phobia (Vasile, Bruce, Goisman, Pagano, & Keller, 2005). The study revealed a recent trend away from prescribing benzodiazepines, and an increased trend towards prescribing selective serotonin reuptake inhibitors (SSRIs).

SSRIs are now considered to be first-line pharmacotherapy for social phobia (Zhang, Connor, & Davidson, 2005). A study of 619 participants diagnosed with social phobia participated in a 12-13 week placebo-controlled trial of sertraline, commercially known as Prozac (Zhang et al., 2005). Results indicated significant improvements in the treatment group on a diagnostic scale of symptoms, including significant reductions in blushing and heart palpitations.

The key to the psychological treatment of social phobia is for patients to learn to control their physiological anxiety symptoms, and accept that people will not necessarily judge them harshly, even if they experience anxiety (World Health Organization, 2000). Cognitive-behavioural treatments generally result in good outcomes, however parallel drug treatment can also be beneficial. The management of social phobia varies considerably between patients, depending upon their particular complaints. A core component of

treatment is education about the nature of anxiety, including basic information about the nature of anxiety such as the fight or flight response, the role of hyperventilation in anxiety, and education about phobic avoidance (World Health Organization, 2000). Strategies are taught to control anxiety symptoms, with breathing control a critical component of the treatment for most patients.

Cognitive-behaviour therapy for social phobia emphasises the behavioural interventions to actively address the avoidance component of the disorder (Becker, 1992). The deeply held fears and expectations of social phobia are best challenged and altered when the patient confronts situation they fear, tolerates the anxiety, and copes effectively with the situation (Freeman, Pretzer, Fleming, & Simon, 2004). Behavioural experiments are designed for systematic desensitisation of feared situations and feelings through imaginary or in vivo exposure. These experiments are used to strategically to challenge and modify the patient's maladaptive beliefs (Freeman et al., 2004)

Summary

The increased interest in studying social phobia has resulted in a detailed contemporary understanding of the cognitive, emotional, biological and social aspects of the disorder. The relatively high prevalence of this complex disorder, with its far-reaching social implications, makes it a disorder of high importance for clinical attention. A number of theoretical perspectives identify the importance of early experiences. Cognitive theory specifically aims to shift the underlying thoughts and behaviours that maintain the disorder. The use of exposure-based treatments is a critical component of gaining sustainable changes in thinking and behaviour. The strongest evidence for treatment is with SSRIs, cognitive-behavioural therapy, and their combination.

The following clinical case study details a patient seen at the Clinical Health Psychology Department, Ballarat Health Services, during a clinical placement. Identifying information has been altered to protect the anonymity of the patient. The report aims to highlight the complex and individualised approach to treatment that is required for this chronic condition.

Method

Participant

Reason for referral

A 58-year-old Caucasian male was referred for treatment by the psychologist conducting the Diabetes Management Program. The psychologist was concerned about the patient's significant difficulties adjusting to his recent diagnosis of Type 2 Diabetes Mellitus. He felt unable to make the necessary dietary changes, and felt overwhelmed by his existing social phobia.

Presenting Issues

The patient described persistent fears of a number of social and performance situations. Situational concerns included using the telephone, shopping, ordering or eating in a restaurant, attending social functions and public speaking. The patient's concerns related to most social situations, including public performance and social interaction. When he anticipated or was exposed to these feared situations, he became concerned and focussed upon a number of physiological symptoms, including his increased heart rate, diarrhoea, perspiration, trembling and confusion. He acknowledged his fear in these situations was excessive, but felt powerless to do anything to change it. He frequently avoided feared situations, requiring his wife and children to perform everyday tasks such as answering the telephone, ordering a meal at a restaurant and shopping for his clothes.

His generalised fear of social interaction had significantly impacted upon all his interpersonal relationships, and had caused him pervasive problems throughout his family life and working career.

Mental Status Examination

The patient presented as a casually dressed, bearded, 58-year-old man, with a flushed face, who perspired excessively throughout the initial interview. He sat with a hunched posture and averted eye contact throughout the assessment. Mental status examination revealed that his affect was flattened with reduced reactivity, mood was dysthymic, and tempo of speech was slow, which increased in rate and volume when he became anxious or distressed. Content of thought included a reluctance to begin psychological treatment due to a negative past experience with a psychiatrist. When discussing his current concerns he became distressed and sobbed. His anxiety escalated further when he became embarrassed about his distress and uncontrolled expression of emotion. Insight was good as the patient was aware his emotional and behavioural responses were excessive and maladaptive.

History

The patient reported a difficult childhood, raised by a strict and demanding father. His father was highly critical of all family members, and regularly intimidated the family with verbal and physical abuse. He reported a history of social phobia beginning in late adolescence when he left school to work for the telephone company. He had greater success managing his anxiety during his early career, however it became increasingly problematic when his job required frequent overnight travel. He experienced chronic diarrhoea, which was maintained by a pervasive fear he would have an urgent bowel movement. For many years, he covertly carried toilet paper and spare underwear in a sports bag whenever he left his home. He was renowned for carrying the bag throughout his adult

life. He had ceased carrying the bag when he commenced SSRI treatment on Aropax, two years prior to the assessment.

He married his wife at age 25 and they had three children together. He was employed as a telephone technician from leaving school until he begun an early retirement two years prior, when his job was made redundant. He reported having a good relationship with his wife, however he remarked it was "a wonder she has put up with me all these years". Their relationship had been affected by his socially avoidant behaviour and his periodic angry outbursts. He doubted he had been a good father, as he avoided most social and recreational activities throughout his children's upbringing. The chronic nature of the patient's condition significantly impacted upon all of his interpersonal relationships. His overwhelming anxiety had prevented him from attending numerous family functions and significant events in his children's lives. He described a distance in his current relationship with his two sons, yet a close relationship with his daughter. He was saddened by the restrictions in his quality of life and was overwhelmed by guilt for the impact of his condition upon his family.

Extensive medical investigations had previously ruled out any organic cause of the patient's physical symptoms. His General Practitioner diagnosed him with social phobia two years prior to the assessment, and initiated a daily dose of 20mg of the SSRI commonly known as Aropax. He reported his anxiety had reduced "100%" since this treatment began. This account was inconsistent with his general presentation. He later admitted he felt he was on an inadequate dose of the SSRI. He had felt unable to initiate this discussion with his doctor, due to his fear of embarrassment and avoidance of any situation in which a conflict might arise. Despite having a chronic anxiety condition that had impacted every facet of his life, he had never received specialised psychological assessment or treatment.

Additional Clinical Features

The patient also currently experienced a number of depressive symptoms. He reported a diminished interest and pleasure in most activities, including a loss of sexual interest. He experienced fatigue and a loss of energy most days, at times struggling to find the motivation or enthusiasm to maintain his responsibilities around the house. His weight had gradually increased during the two years since his retirement, eating excessively when he felt guilty, upset or angry. He also had considerable current feelings of worthlessness. He had never attempted suicide, and had no current ideation, however he reported a significant history of suicidal ideation.

Measures

The Symptom Checklist-90-R (SCL-90-R) is a 90-item self-report symptom inventory that provides a measure of psychological symptoms experienced in the previous seven days (Derogatis, 1994). Each item is rated on a five-point scale of distress (0-4) ranging from "Not at All" to "Extremely". The SCL-90-R has been found to have satisfactory internal consistency, test-retest reliability and discriminant validity (Derogatis, 1994). The checklist produces nine primary symptom dimensions (somatization, obsessive-compulsive, interpersonal sensitivity, depression, anxiety, hostility, phobia anxiety, paranoid ideation and psychoticism) and three global indices of distress. The global measures communicate the depth and breadth of the individual's psychological distress in single scores. The Global Severity Index (GSI) is the best single indicator of the current impairment (Derogatis, 1994). This index combines the number of symptoms reported with the intensity of the reported distress. The Positive Symptom Distress Index (PSDI) functions as a measure of response style. It reflects the average level of distress reported for the symptoms that were endorsed, and thus can be interpreted as a measure of symptom intensity. The Positive Symptom Total (PST) is a reflection of the number of symptoms

endorsed by the respondent, regardless of their level of distress. It can be interpreted as a measure of symptom breadth.

Procedure for Assessment and Treatment

A clinical interview was conducted over the first two sessions, at which time the SCL-90-R was also administered to provide a comprehensive assessment of the pattern and strength of the patient's current psychological symptoms (Derogatis, 1994). Following the assessment, treatment was conducted in six weekly sessions. A combination of cognitive-behavioural and supportive counselling approaches was used. Due to the patient's marked fear of social situations, including treatment itself, it was essential to first establish and safe and supportive therapeutic relationship. Once this therapeutic relationship was established, the more directive and challenging aspects of the treatment were introduced. An individualised treatment plan was developed consisting of the following key components:

a) Education

The patient was educated about the nature of anxiety, including the fight and flight response, and education about the physiological symptoms of anxiety. Information was given about the prevalence of social phobia and its typical response to treatment.

b) Breath control training

A simple breathing technique was demonstrated and rehearsed to control and focus the patient's attention upon his breathing. The technique aimed to increase the oxygen intake of each breath, and slow the rate of breathing. An initial prescription was given to perform the exercise for five to seven minutes per day, for at least five days a week.

c) Grief and loss counselling

Supportive counselling was used to discuss a number of grief and loss issues. After symptom reduction occurred, the patient was encouraged and supported to discuss his long-standing grief and loss issues with his family.

d) Systematic desensitisation

A hierarchy of anxiety provoking events was constructed to conduct exposure-based systematic desensitisation of distressing thoughts and situations.

e) Medication review

The patient was provided with a letter for his GP outlining the assessment and recommended treatment plan, and a request for a medication review of his SSRI.

Results

Assessment

The results of the SCL-90-R can be seen in Table 1. The patient's initial GSI rated his global distress in the 86th percentile, compared with outpatient males in a psychiatric setting. The initial PSDI rated the intensity of his symptoms in the 65th percentile. The PST was in the 94th percentile, indicating an extreme depth of reported symptoms. Overall, this clinical profile indicated a broad range of symptoms, of moderate intensity, causing significant global distress.

Table 1

Pre-and Post-Treatment Global Measures on the SCL-90-R

	Pre-treatment		Post-treatment	
	T Score	Percentile	T Score	Percentile
GSI	62	86	36	8
PDSI	54	65	32	4
PST	67	94	39	15

As can be seen in Figure 1, the most elevated scale was for 'Phobic Anxiety', which measures persistent fears and avoidance of specific people, places, objects or situations. This elevation is consistent with his history and presentation of social phobia. The patient's gastrointestinal and other somatic concerns are reflected in the elevated Somatization scale. The elevated Depression scale is consistent with his subjective and objective depressive symptoms. The elevated Psychoticism scale reflected the patient's belief that his fears were obvious to other people, and his fear that there was something wrong with his mind.

Formulation

This patient presented with a history and current symptom profile consistent with a diagnosis of Social Phobia, Generalized Type, and Major Depressive Disorder (Recurrent). The specifier refers to his generalised fear of public performance situations and social interact situations. The chronic nature of his symptoms and their pervasive impact on his personality suggests a diagnosis of Avoidant Personality Disorder cannot be ruled out. His current distress is likely to have originated from his traumatic and volatile home environment as a child. This environment suppressed the expression of strong emotions to avoid abuse from his father. This appears to have resulted in a lifelong difficulty experiencing, tolerating and regulating his emotions. His underlying schemas are likely to reflect a deeply held belief about his personal defectiveness. This schema operates in all social environments, which floods him with fears of harsh negative judgement from others.

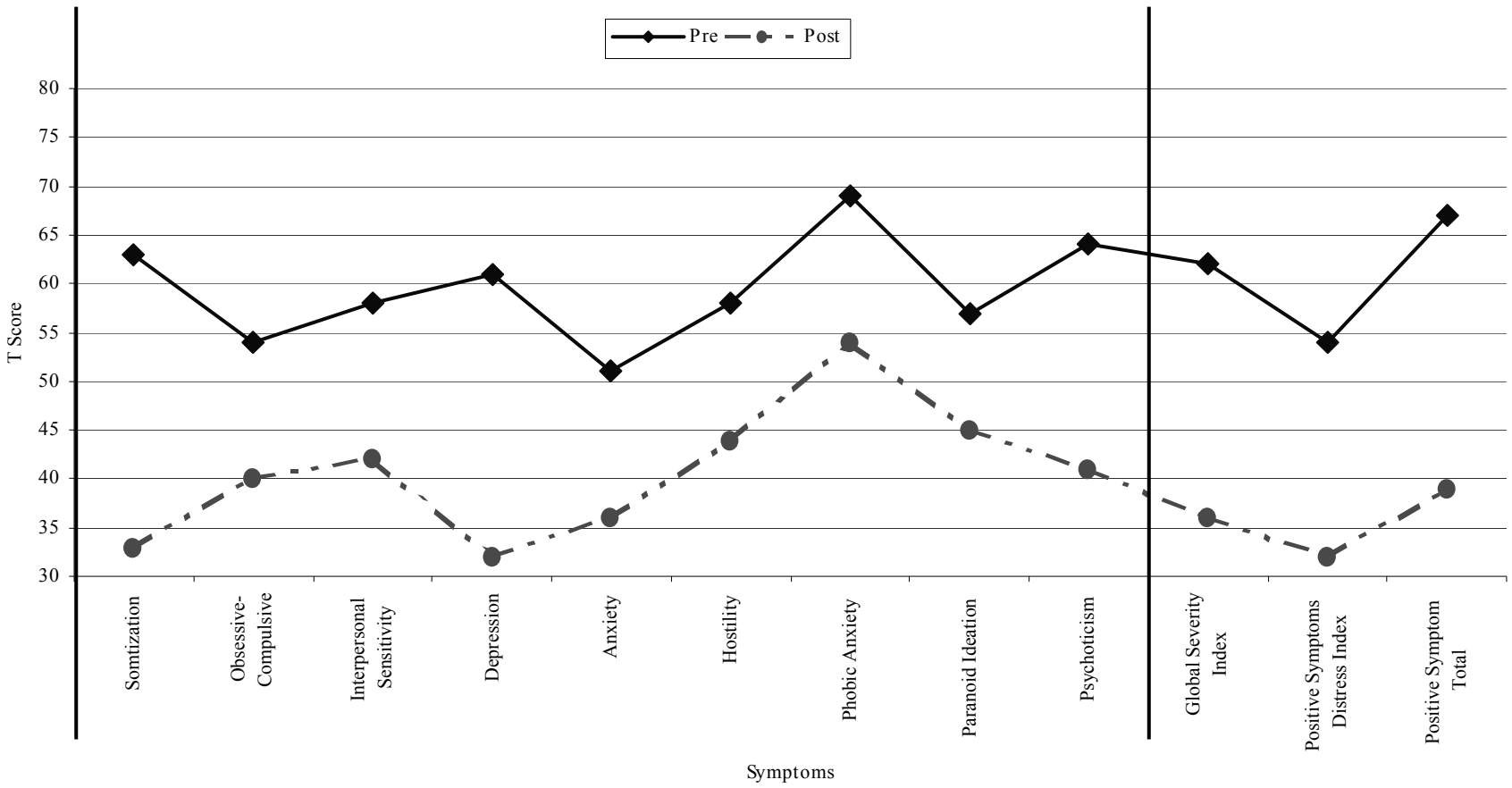

Figure 1. Pre-and post-scores on the Symptom Checklist-90-R.

Response to Treatment

The patient found the educational material to be highly informative, and provided him with techniques to discuss and apply in later sessions. He took great solace is discovering a large number of people experienced a similar condition, and wished he had been diagnosed and treated at an earlier stage. The patient expressed great relief in being able to openly discuss his condition after experiencing many years of secrecy and shame. It is likely that the strong therapeutic relationship established enabled the patient to truly express his emotions and fears for the first time.

His clinical response to treatment suggested the breathing control training provided the greatest symptomatic relief. He was compliant with the prescribed treatment, and his mood benefited from decreased general anxiety and the increased self-efficacy that resulted. He initiated using the breathing technique as soon as he felt the initial physiological signs of increasing anxiety. Towards the end of the treatment, the patient gained initial mastery of his physiological symptoms. He reported a number of examples of applying the technique during actual and anticipated experiences of anxiety.

The patient became extremely anxious when a hierarchy of feared situations was developed. During the next session he declined to begin the systematic desensitisation procedure. He had been highly anxious in the days following the previous session, had nightmares and briefly returned to carrying his bag containing toilet paper and underwear. He could not be reassured to continue the procedure. This impasse was resolved by reinforcing his assertive behaviour in refusing the treatment, and it was validated as a sign of his improving self-efficacy. The strong therapeutic relationship that had already been established is likely to be a strong factor in working through this impasse. The patient was able to experience the benefits of openly discussing his concerns, rather than reverting to avoidance behaviour which had been his primary coping mechanism.

Over the course of treatment, he shared some of his current and past experiences with his family. Towards the end of treatment, he spoke to his wife and children about his guilt and remorse. Family members offered him their support, and shared their own struggle to understand his behaviour. During the final session, he noted that his wife and children had all commented on the changes they observed in him. He reported improved relationships with all family members. Towards the end of treatment, he attended an appointment with his GP to request a review of his SSRI. He felt this was a concrete step forward in his recovery. The GP increased the dosage, realising it had never been adjusted beyond an introductory dose.

The SCL-90-R was readministered in the final session. As can be seen in Table 1, all measures of distress reduced significantly by the end of treatment. A major reduction can be noted in the GSI, reducing from the 86th percentile to the 8th percentile over the course of treatment. This suggests that the patient's overall psychological distress reduced considerably over this period. Improvements are also reflected in the reductions in the PDSI and PDI, which indicate that the severity of his symptoms reduced, as well as the breadth of his symptom profile.

Further evidence of treatment success can be seen in the improved ratings on the primary symptom dimensions. The Somatization and Depression scales recorded considerable reductions from the initial ratings. This suggests that as the patient gained mastery of the breathing technique, the anxious thinking maintaining his somatic symptoms was reduced. The significant reduction in his depression symptomatology is likely to be attributable to the treatment, and as a consequence of his increased sense of well-being and self-esteem due to his reduced social anxiety and improved relationships. Despite the subjective report of generalised improvement, the Phobic Anxiety scale remained elevated at the end of treatment.

At the cessation of treatment, the patient articulated a number of achievements due to his reduced symptomatology. He reported that he was less fearful of all situations, and was continuing to surprise himself at the situations he could now manage, such as making telephone calls. He felt more confident in social situations, and had successfully initiated conversations with a number of strangers. His self-esteem had improved and he had more positive perceptions about himself as a husband and father. He felt the therapeutic alliance had given him the confidence to try new experiences. He strongly expressed his gratitude for the trusting and supportive relationship that had been established, believing that he could have not have progressed without such this component of treatment. He had reached the conclusion that most people do not even notice other's behaviour, let alone judge it harshly. At the termination of therapy, the patient felt ready and motivated to begin addressing the management of his diabetes. He planned to enrol in the Healthy Weight Management Program to work on his excess weight.

Discussion

This clinical case study highlights a number of the challenging issues associated with the treatment of social phobia. From his initial presentation, it was evident that this patient was highly distressed and had substantial impairment due to his mental health issues. His considerable fear of social interaction had prevented him from seeking almost any form of assistance. He lacked education about his condition and was unaware of techniques to better manage his anxiety symptoms. Despite being on an inadequate dose of his SSRI, he was fortunate to have been on this low dose for two years prior to the current psychological treatment (Zhang et al., 2005).

Outcome of Treatment

During the course of the six-week treatment, the patient's subjective account of his distress reduced significantly. In particular, his symptoms of social anxiety and depression reduced over the course of treatment. Significant reductions in distress and improved functioning are also reflected in the SCL-90-R profile. The consistency between these subjective and objective accounts suggests that there is likely to have been real and significant improvement in this patient. Throughout the treatment, the patient challenged his cognitions and fears that other people judge him harshly in social or performance situations. His depressive symptoms remitted quickly, and appeared to be linked to improvements in his quality of life, social functioning and improved relationships.

At the end of treatment this patient's SCL-90-R profile remained above the 50th percentile in the Phobic Anxiety scale. Despite the significant reduction in his physiological anxiety symptoms, his fear of social interactions and performance situations remained in the clinical range. The generalised subtype of social phobia is the most chronic form of the condition, and thus has a poorer prognosis and slower recovery pattern (World Health Organization, 2000). Despite the rapid increase in his functioning over the short treatment period, the need to continue using the techniques and challenging his social avoidance was discussed. The patient intended to seek support as required within the community and was discharged from the Clinical Health Psychology Department.

Evaluation of Treatment

The case study reflects how the treatment of social phobia requires highly individualised treatment planning. The treatment for generalised subtype requires far greater assessment of the needs of the individual. In the case study presented, the least successful component of the treatment was the systematic desensitisation component. The

patient found the construction of the hierarchy highly distressing, and became overwhelmed thinking about the vast number of situations that he found unbearable. Upon reflection, the hierarchy would have been more effective if it had been introduced after some initial symptom reduction. All other components of the treatment are likely to have contributed to the apparent recovery. The education component was important and was frequently referred back to when the patient began conducting behavioural experiments. The patient quickly and readily adopted the breath control training. He demonstrated spontaneously generalisation of the technique to any situation in which he began to feel anxious, including applying it to anticipatory anxiety. Perhaps the most important aspect of treatment was the strong therapeutic relationship that was established and maintained through the course of treatment. For such patients with social phobia, experiencing a supportive relationship in which their fears can be discussed without judgement is likely to be a profound and valued experience in itself.

The treatment had a number of limitations. It did not follow any manualised treatment, with strictly controlled therapeutic procedures. However the flexible and patient-focussed approach to treatment empowered the patient to be an active participant in his own recovery. The time-limited nature of the treatment limited treatment gains. It is likely that the patient would have made greater recovery with additional therapeutic time. In the context of this public hospital setting, the treatment goals were achieved that enabled him to participate in a group-based program designed to improve his diabetes management.

The case study presented highlights a number of theoretical issues. The patient's core belief was that he was deficient as a person was frequently observed, often referring to himself as a "silly old fool". He had similar dysfunctional beliefs about his capacity as a husband, father and a provider. These self-beliefs were unconditional and generalised across all situations and circumstances. The cognitive model of social phobia would

suggest that this patient's cognitions were associated with the development and maintenance of his dysfunction (Hofmann et al., 2004).

He also had a number of family background risk factors, including a strict and demanding father, who was frequently abusive (DeWit et al., 2005). The childhood origins of the disorder were evident in this case, however they received minimal clinical attention. The combination of his harsh early environment and his negative evaluative style is consistent with the chronic history of this patient. These factors suggest a moderate prognosis, warranting a conservative long-term approach to his treatment, focusing upon improving his quality of life, avoidance and reducing his residual symptomatology.

Recommendations and Future Directions

Future directions for research and clinical practice must address the shortcomings in current practice. Epidemiological studies should be designed to allow greater access to socially phobic people, to allow more accurate determination of the prevalence and distress caused by the disorder. The use of individualised treatments should be developed and researched, allowing an integration of theoretical orientations to achieve the maximal benefit for the patient. This integrated approach would allow clinicians to be conscious of significant cognitive styles maintaining the disorder, whilst utilising theory and research driven interventions to address the longstanding personality and childhood contributories. This approach would also benefit from developments in psychopharmacology to better manage social phobia. An integrated treatment approach that combines psychological and pharmacological treatments is likely to be most successful in reducing the prevalence and burden of this disorder.

Conclusion

The clinical practice of treating social phobia continues to be informed by advances in functional neuroanatomy and cognitive theory. The fear and avoidance of these patients typically prevents them from seeking treatment and impacts upon future directions in the treatment of the disorder. Social phobia is a relatively unique condition, in which the symptoms themselves prevent the sufferer from seeking appropriate treatment or support. This limits the clinical treatment and opportunities for research about the disorder. While sufferers remain unable to seek treatment, the burden of the disorder will continue to be significant. Case study research has an important role to inform clinical practice and to contribute to the body of research about idiosyncratic nature of the disorder and its treatment.

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Placement Report 3

Barwon Health – Mindlinx, Primary Mental Health Service

An evaluation of the eight-week SHADES cognitive-behavioural group treatment for adults in the community with anxiety and depression.

Acknowledgements: Mindlinx, Primary Mental Health Service, Barwon Health.

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Abstract

Cognitive-behavioural therapy (CBT) is the leading treatment for a number of highly prevalent mental health disorders. There is only limited research about the efficacy of mixed-diagnosis group treatment programs for anxiety and depression. The SHADES program is an eight-week, group CBT treatment for patients with a range of mood and anxiety disorders. The aim of the following study was to evaluate the short and long-term effectiveness of the SHADES program. The Depression Anxiety Stress Scale and the Kessler-10 were administered to the 140 community patients who received the group treatment. The instruments were administered at the initial screening interview, at Week 1 and Week 8 of the program, and at 6 and 12 months post treatment. The results indicate that the program resulted in a clinically significant reduction in the reported symptoms of depression, anxiety, stress and psychological distress. This reduction in symptoms was maintained at 12 months post treatment. Future research will benefit from examining the unique response to treatment for each of the specific mental health disorders.

The Australian Psychological Society recently produced a systematic review of the scientific literature examining the efficacy of psychological treatments (Australian Psychological Society, 2007). This review reflects an international movement towards evidence-based practice. Evidence-based practice was developed in the field of medicine, and has been applied to a broad range of health and human services (Barlow, 2004). Within psychological practice, evidence-based practice evaluates the research evidence to deliver interventions that maximise the chance of benefit, and minimise the risk of harm (Australian Psychological Society, 2007). A range of evidence-based therapies have been developed for the high prevalence disorders, including effective treatments for anxiety and depression (Hunsley & Lee, 2006). Limited evidence exists about the successful application of these evidence-based treatments into clinical practice in the community (Hunsley, 2007). The SHADES program is an evidence-based, group treatment for primary care managed patients with anxiety and depression. This research evaluates the short and long-term effectiveness of this group cognitive-behavioural therapy (CBT) intervention.

Evidence-Based Treatment for Anxiety and Depression

Based upon a systematic review of all relevant randomised controlled trials, CBT has the highest level of available evidence for the treatment of anxiety and depression (Australian Psychological Society, 2007; National Health and Medical Research Council, 1999). It is a recognised treatment for a range of anxiety disorders, including obsessive-compulsive disorder, panic disorder, generalised anxiety and phobic disorders (Australian Psychological Society, 2007). The CBT treatment of depression increases the proportion of patient recovery, and reduces symptoms scores when compared with treatment as usual or supportive therapy (Australian Psychological Society, 2007).

CBT has become the gold standard treatment for depression and anxiety. It features in all the leading clinical practice guidelines produced worldwide. The CBT treatment of depression and anxiety is promoted by organisations including the American Psychiatric Association (American Psychiatric Association, 1998, 2000) and the UK-based National Health Service (National Institute for Health and Clinical Excellence, 2007a, 2007b). The Royal Australian and New Zealand College of Psychiatrists (RANZCP) emphasise the use of CBT in their clinical practice guidelines for depression (Ellis, 2004). These guidelines recognise the use of antidepressants, CBT and interpersonal therapy as equally effective treatments for moderately severe depression. The practice guidelines promote CBT as the most effective and efficient treatment of anxiety. The RANZCP guidelines advocates CBT as the first-line treatment for panic disorder and agoraphobia (Andrews, 2002).

Effective Treatment Delivery

Recent CBT-based research reveals that group treatments of mixed-diagnosis groups are an effective and efficient method of service delivery to treat anxiety and depressive disorders (McEvoy & Nathan, 2007). This research recruited 143 adults with affective and anxiety disorder, and treated them in mixed diagnosis CBT groups over 10 two-hour sessions. The researchers followed up on the maintenance of symptom reduction one month after treatment. Results revealed that depression and anxiety significantly improved during the treatment, and the anxiety symptoms further reduced by the one-month review. The effect of the improvement was comparable with other disorder-specific and individually delivered treatments (McEvoy & Nathan, 2007). This research provides evidence of the potential for mixed diagnosis groups to deliver effective, low-cost treatment to a range of disorders.

There are numerous benefits of developing unified group treatments for a range of mental health disorders (Barlow, Allen, & Choate, 2004; Erickson, 2003). This includes reducing the expense and time spent training clinicians in a range of diagnosis-specific interventions. These savings in time and resources could be spent in direct service delivery. Unified group treatments also simultaneously target primary and co-morbid disorders, and eliminate the need for sequential treatment of each disorder. There is also an additional practical benefit of not requiring an entire cohort of participants with the same condition, therefore making recruitment of participants less time consuming.

Self Help Anxiety Depression Education Sessions (SHADES)

The SHADES program is a cognitive-behavioural, mixed-diagnosis, group treatment for anxiety and depression disorders. It was developed by Mindlinx, the Primary Mental Health Service, Barwon Health, which services the primary care sector in the broader Geelong region. In the state of Victoria, primary mental health teams have the responsibility to expand the capacity of the area mental health service to provide clinical treatment of high prevalence disorders (Department of Human Services, 2002). The Mindlinx service provides clinical services in consultation and community training, and provides group treatment for anxiety and depression. The SHADES program was revised in 2005, and has experienced a strong growth in the number of referrals and successful treatment outcomes. The effectiveness of this eight-week mixed-diagnosis treatment has not been formally evaluated.

The key components of the SHADES program are psycho education, behavioural activation, relaxation training and cognitive restructuring (Appendix A). The program is designed to introduce new educational material and techniques each week that build upon the previous material and practice tasks that have been set. A wide range of techniques are

introduced, mindful that participants are only likely to continue using a selection of techniques after the completion of the program. Each week the program begins with a review of the practice tasks that have been set, educational material and techniques are introduced and experienced, finally practice tasks for the next week are prescribed. Participants receive written summaries at the conclusion of each session.

The aim of this study was to evaluate the short and long-term effectiveness of the SHADES program. It was expected that the program would result in a significant reduction of anxiety and depressive symptoms by the end of the program. It was also expected that these improvements would be maintained for one year after completing the program. It was hypothesised that there will be significant reductions in the reported symptoms of depression and anxiety by the end of the treatment; and that these reductions would be maintained for one year post treatment.

Method

Participants

In the two years since the SHADES program was revised, 140 patients had been treated for anxiety and depression using the new treatment protocol. The sample consisted of 108 females and 32 males. All participants were diagnosed with at least one depressive or anxiety disorder by the Mindlinx team during the assessment process, and were managed by their GP or primary care provider. A wide range of disorders were diagnosed in the sample, including Major Depressive Disorder, Dysthymic Disorder, Social Phobia, Panic Disorder, Generalised Anxiety Disorder and Post-Traumatic Stress Disorder. Demographic details about the participants are not available at the time of analysis.

Measures

Depression, Anxiety Stress Scale (DASS)

The DASS (Lovibond & Lovibond, 1995) is a 42-item self-report inventory, with three self-report scales. It is designed to measure the negative emotional states of depression, anxiety and stress. Each of the 3 DASS scales contains 14 items. It is scored using a four-point Likert scale to rate the extent to which the participant had experienced each item over the past week (0 = *did not apply to me at all; 3 = applied to me very much, or most of the time*). High scores indicate the greater presence of symptoms. The DASS has been shown to have high internal consistency and to yield meaningful discriminations in a variety of settings (Lovibond & Lovibond, 1995). Research indicates that Cronbach alphas for the depression, anxiety and stress subscales are .97, .92 and .95 respectively (Antony, Bieling, Cox, Enns, & Swinson, 1998). The DASS is correlated with established measures including the Beck Depression Inventory (r = .77), the Beck Anxiety Inventory (r = .84) and the State-Trait Anxiety Inventory-Trait Version (r = .59) (Antony et al., 1998).

Kessler-10 (K-10)

The 10-item, K-10 (Kessler et al., 2002) was first developed as a tool for screening populations for psychological distress. The K-10 consists of questions on non-specific psychological distress and about the level of anxiety and depressive symptoms experienced in the most recent 4-week period. The items are rated on a five-point Likert scale (*1 = none of the time; 5 = all of the time*). Higher scores indicate a greater risk of developing an anxiety or depressive disorder. The K-10 has established construct validity with General Health Questionnaire, and with a current diagnosis of an anxiety or depressive disorder (Andrews & Slade, 2001). The instrument is considered to be moderately reliable, with

kappa and weighted kappa scores ranging between 0.42 and 0.74 (Dal Grande, Taylor, & Wilson, 2002).

Procedure

Referrals to the SHADES program were made by General Practitioners and primary care providers. An introductory letter from Mindlinx was sent to the potential participant with information about the program. They were waitlisted for an assessment interview upon return of a slip confirming their contact details. Potential participants attended a screening interview to discuss their history and current complaints. At the end of the interview they completed the DASS and K-10 measures. All interviewed candidates were discussed at the weekly clinical review, to determine their diagnosis and recommendations for treatment. Candidates not accepted in the SHADES program were recommended other suitable services in the area. Candidates were primarily excluded due to clinically significant personality disorders, substance-abuse disorders and the immediate risk of suicide.

Participants were also administered the DASS and K-10 at the beginning of weeks one, four and eight. Participants who consented to receiving follow-up questionnaires also completed these at 6, 12 and 18 months post treatment. A session outline was provided at the beginning of the eight-week program (Appendix A). Each session was highly structured to provide weekly content containing education, psychological techniques and discussion of the application of techniques to current problem situations. The structure of each session was consistent, beginning with a review of the week's homework, and ending with the setting of homework to apply newly learnt material. Upon completion, the participant and referrer were provided with a written assessment of their progress, and further recommendations.

Results

Related samples *t*-tests were used to investigate changes in the DASS and K-10 scores. The scores used in this study were taken at the screening, weeks 1 and 8 of the program, and during reviews at 6, 12 and 18 months post-treatment. Analysis using repeated measures ANOVA or MANCOVA designs would have provided stronger statistical evidence. This ongoing study is currently limited by incomplete data from all respondents over the 18-month period of investigation. To compensate for the number of *t*-tests conducted, a significance level of 0.01 has been used throughout to reduce to probability of finding a significant difference by chance.

Descriptive Statistics

As can be seen in Table 1, there was a reduction in the average number of symptoms endorsed on the DASS and K-10 from the screening until six months post treatment. At 12 months post treatment, there is an increase in the average number of symptoms endorsed across all scales. The small sample size at 18 months post treatment indicates a further improvement, however the small same size precludes it from being included in further analysis. This general trend towards a decreasing number of symptoms endorsed over time can be clearly seen in Figure 1. It is noted that by 6 months after the end of treatment, only 42 respondents, or 32% of the sample had returned the follow-up instruments, consequently limiting the power of subsequent analysis.

Table 1

Means and Standard Deviations of the Mental Health Measures from Screening until 18- Months Post-Treatment

		Depression		Anxiety		Stress		K-10	
	N	*M*	*SD*	*M*	*SD*	*M*	*SD*	*M*	*SD*
Screening	77	23.66	11.30	21.39	11.22	25.57	10.07	33.69	8.43
Week 1	130	19.92	11.45	18.38	10.63	23.38	10.10	29.92	8.88
Week 4	111	14.93	11.15	12.88	9.57	18.09	10.29	24.66	8.30
Week 8	104	12.24	9.56	10.35	8.47	15.02	9.37	21.44	8.09
6 months	42	9.62	8.89	8.57	8.61	10.79	8.58	19.75	7.97
12 months	24	10.79	10.03	8.79	8.57	12.33	9.03	20.08	8.09
18 months	7	9.29	11.69	4.57	5.88	8.71	8.56	17.57	9.11

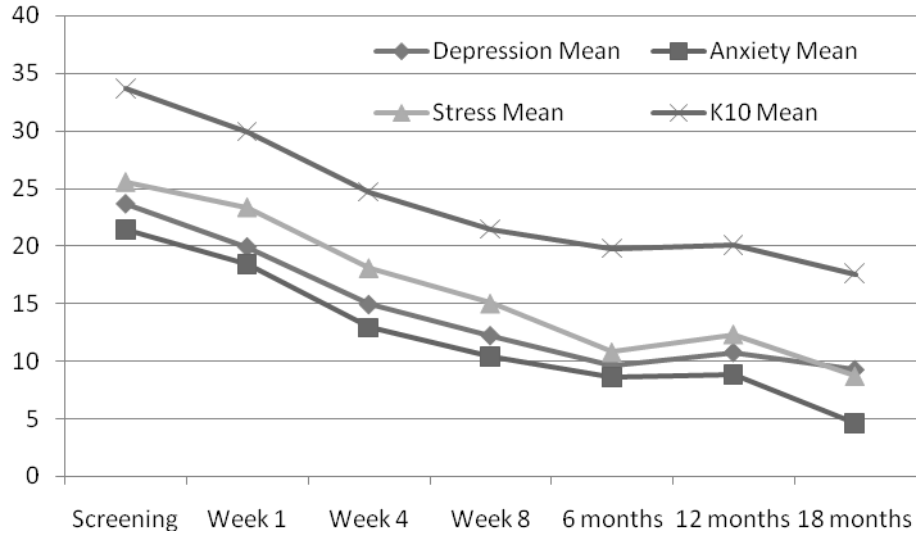

Figure 1. Changes in average DASS and K-10 symptom endorsement from screening until 18-months post-treatment.

Comparative Statistics

The results of the related samples *t*-tests can be seen in Table 2. Comparisons were made on the DASS and K-10 measures at a number of key stages during treatment and post-treatment. There was a significant reduction in the rating of depression, anxiety and psychological distress between the screening and the commencement of the program.

Comparisons of the average DASS and K-10 scores between Week 1 and 8 can be seen in Table 2. They reveal significant improvements across the course of the program in all the measures. Improvements in the DASS and K-10 achieved by the end of treatment were maintained for 6 and 12 months post treatment. Further reductions in reported symptoms at 6 and 12 months post treatment were not at a significant level. Based on Cohen's original interpretations, all effect sizes were found to be large and therefore suggest the results are clinically significant (Cohen, 1977).

Table 2

Changes in DASS and K-10 Scores During Treatment and for 12-Months Post-Treatment

	Depression			Anxiety			Stress			K-10		
Changes between	*df*	*t*	*d*	*df*	*t*	*d*	*df*	*t*	*d*	*df*	*t*	*d*
Screening – Week 1	70	3.85 **	0.65	70	2.73**	0.46	70	1.88		69	4.74 **	0.80
Week 1 – Week 8	102	7.58 ***	1.07	102	9.20 ***	1.32	102	10.28 ***	1.44	104	10.73 ***	1.49
Week 1 – 6 months	38	4.79 ***	1.09	38	5.16 ***	1.18	38	7.26 ***	1.67	40	6.29 ***	1.40
Week 1 – 12 months	22	4.02 ***	1.19	22	4.45 ***	1.34	22	3.90 **	1.13	23	5.78 ***	1.67
Week 8 – 6 months	38	0.07		38	0.00		39	1.23		40	0.02	
6 months – 12 months	21	-0.20		21	-0.77		21	-0.20		21	-0.34	

Note: *d* = Cohen's *d*

*$p < .05$. **$p < .01$. ***$p < .001$.

Discussion

This research aimed to evaluate the short and long-term effectiveness of the SHADES program. It was hypothesised that there would be significant reductions in the reported symptoms of depression and anxiety by the end of the treatment, and these improvements would be maintained for one-year post treatment. This hypothesis was supported. Results indicate there were clinically significant improvements in the ratings of depression and anxiety by the end of the program, and these improvements were maintained for one-year post treatment. The SHADES program also resulted in clinically significant reductions in stress and psychological distress by the end of treatment. These reductions were also maintained for one-year post treatment. The significant reduction in the rating of depression, anxiety and psychological distress between the screening and the commencement of the program suggests that assessment process and beginning treatment had additional therapeutic value.

The results of this study are consistent with a wide body of research providing strong evidence for the CBT treatment of anxiety and depression (Australian Psychological Society, 2007; National Health and Medical Research Council, 1999). CBT has been found to be an efficacious and cost-effective treatment for these highly prevalent disorders. The strong efficacy of CBT is the result of many years of systematic research refining its theory and techniques. The current research provides further evidence of the efficacy of CBT treatment for primary care patients with a variety of anxiety and depressive disorder.

The movement towards mixed-diagnosis, group CBT treatment is supported by the results of the current study. It was found that clinically significant improvements were achieved across the symptoms of depression, anxiety, stress and psychological distress during the treatment, and these gains were maintained for 12-months post treatment. This finding is consistent with recent research investigating the effectiveness of mixed-

diagnosis groups at one-month post treatment (McEvoy & Nathan, 2007). The current research finds that this mode of treatment delivery continues to be effective at one-year post treatment.

CBT offers an evidence-based, efficacious treatment for many of the highly prevalent disorders (Hunsley & Lee, 2006). Research confirming the effectiveness of mixed-diagnosis, group treatment, will have significant implications upon future approaches to primary care management. There is growing evidence that the educational material and techniques taught in these programs are of substantial benefit for a range of symptoms, regardless of the diagnosis (McEvoy & Nathan, 2007). The establishment of low-cost, CBT group treatments in the primary care sector may provide a cost-effective and unified approach to treatment. The simultaneous treatment of a range of co-morbid disorders would also reduce the need for sequential treatment. These benefits would allow specialist mental health clinicians, such as clinical psychologists, to specialise in working with the most complex and chronic of patients.

There are a number of limitations in the design of the current study. Due to the ongoing nature of the treatment, full 12-month data was not available for all participants. The reduction in sample size at the 6 and 12-month intervals also reduced the power of the statistical analysis. Although symptom reduction was maintained for 12-months post treatment, the chart indicates some evidence of symptom reduction beyond the end of the treatment. Future research with a complete data set will be able to better establish the long-term effectiveness of the program.

The current study would also have benefited from coding the diagnostic categories and co-mobidities of patients receiving treatment. This would have allowed a detailed analysis of the diagnosis-specific benefits of the treatment. Future research should establish effectiveness of the treatment for each disorder. The current research is also unable to

ascertain if participants who did not return follow-up questionnaires were different in some clinically significant way from those who did return them. It is likely that participants who did not continue to improve beyond the program would be less inclined to return the follow-up questionnaires.

Conclusion

There is evidence to suggest that the SHADES program, a mixed diagnosis group treatment for anxiety and depression, resulted in clinically significant improvements. The CBT treatment was associated with reduced symptoms of anxiety, depression, stress and psychological distress by the end of treatment. This improvement was maintained for 12 months following treatment. The results of this study are consistent with an extensive body of research that has established CBT as the gold standard treatment for anxiety and depression. The current study provides evidence of an effective, low-cost delivery method for delivering CBT to patients in primary care sector. The mixed-diagnosis group treatment setting is likely to increase in clinical practice as research further establishes the efficacy of this treatment mode. This shift towards non-specific, group treatment of prevalence disorders will have substantial benefits in the management of public mental health.

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Appendix A

SHADES Session Outline

Session 1

- Introductions
- Group Rules
- Expectations of the course
- Outline of the course
- What is depression, what is anxiety?
- Physical symptoms of anxiety and depression
- Breathing exercise
- Practice tasks and handouts

Session 2

- Review of practice tasks
- Behavioural symptoms of depression and anxiety
- Thought stopping
- Progressive Muscle Relaxation
- Activity scheduling
- Practice tasks and handouts

Session 3

- Review of practice tasks
- Cognitive symptoms and thinking errors
- Challenging negative thoughts and developing balanced thinking
- Practice tasks and handouts

Session 4

- Review of practice tasks
- Thinking errors
- Avoidance
- Isometric Relaxation
- Practice tasks and handouts

Session 5

- Review practice tasks
- Problem solving
- Visualisation Relaxation
- Practice tasks and handouts

Session 6

- Review of practice tasks
- Self-esteem
- Mindfulness Relaxation
- Medication
- Practice tasks and handouts

Session 7

- Review of practice tasks
- Expressing anger
- Anger management
- Assertiveness
- Practice tasks and handouts

Session 8

- Review of practice tasks
- Lifestyle issues
- Individual Relapse Prevention plans
- Resources for further information and support
- Handouts

Ethical and Professional Issues Report

TABLE OF CONTENTS

Abstract

A key component of the Doctor of Psychology (Clinical) program is the completion of four clinical placements. These placements provide a rich opportunity to apply theoretical knowledge obtained at university, and to gain direct clinical experience working under an experienced psychologist. This supervised clinical experience provides a unique opportunity to work through the various ethical and professional issues that arise for the developing practitioner. This report outlines the various issues and experiences encountered during the completion of these clinical placements. These placements were undertaken in a range of settings in the public and private sectors. The placements were located at a Community Psychology Service in a regional city, the Psychology Department of a regional hospital, and the Primary Mental Health Team of a regional area mental health team. The patients treated in these clinical placements suffered from a wide range of mental health issues, and ranged in age from children to the elderly. This report reflects upon the ethical and professional issues encountered during this clinical experience. It draws upon the guidelines outlined in the codes of practice from the Australian Psychological Society and the Psychologists' Registration Board of Victoria.

Within the last decade there has been an increased recognition of the widespread mental health problems that exist in the community (World Health Organization, 2001). This has resulted in an increased awareness of the need to adequately assess, diagnose and treat mental health disorders. The field of clinical psychology is a specialisation of the profession that aims to offer unique psychological input into the aetiology and treatment of mental health disorders (Montgomery, 2003). The vulnerability of people with mental health disorders has resulted in strict ethical codes of behaviour being developed by the Australian Psychological Society (2006) and the Psychologists Registration Board of Victoria (1997). These ethical guidelines are designed to maintain the integrity of the profession and to safeguard the welfare of clients receiving psychological services. The interpersonal nature of clinical psychological work can give rise to a vast number of ethical issues. During academic training in clinical psychology, these issues are only understood at an intellectual level. It is during extended clinical placements that probationary psychologists first encounter the sensitivities and unique challenges of implementing these ethical guidelines in real world settings.

This report discusses the range of ethical and professional issues encountered during the completion of four clinical placements as part of the Doctor of Psychology (Clinical) program at the University of Ballarat. The clinical placements were located at a Community Psychology Service in a regional city, the Psychology Department of a regional hospital, and the Primary Mental Health Team of a regional area mental health team. The patients treated in these clinical placements experienced a wide range of mental health issues, and ranged in age from children to the elderly. The ethical issues arising out of these placements are discussed by drawing upon case examples. References to the relevant ethical codes and guidelines are made. The supervisory and self-reflective processes used in resolving these issues are also discussed.

Ethical Issues

The guiding principles of sound psychological practice are outlined in the Australian Psychological Society's Code of Ethics (Australian Psychological Society, 2006). These guidelines are designed to provide psychologists, their clients, and the broader public a clear indication of the accepted standards of psychological practice and ethical behaviour. They are designed to cover the wide variety of circumstances and contexts in which psychologists work. The specialisation of clinical psychology has expertise in the individual and group therapy of psychiatric disorders (Farhall, 2001). This client group is particularly vulnerable to ethical breaches due to their mental health and potentially problematic economic and social circumstances.

The following discussion is a reflection upon the ethical issues encountered during the completion of four clinical placements. These ethical issues are discussed under the categories of professional competency, relationships with clients, boundary issues, gifts from clients, confidentiality and terminating relationships.

Professional Competency

Within the state of Victoria, the professional competence of the psychology profession is maintained by the regulations of the Psychologists Registration Board. The Code of Behaviour states that services should be limited to the psychologist's areas of competence (Psychologists Registration Board of Victoria, 1997). This expectation is further reinforced by the Australian Psychological Society's Code of Ethics (2003), which states that psychologists are expected to bring a satisfactory level of proficiency and knowledge to their areas of professional practice. These two principles strive to ensure that psychologists only provide services to their level of professional competence, and that they are transparent about areas beyond their proficiency. This requirement poses a particular challenge for probationary psychologists, who by definition have considerable limitations

upon their professional experience and competence. This situation gives rise to the need to carefully balance the competence of the student, the experience and expertise of the supervisor, and the organisational context in which the work is taking place.

This issue quickly emerged during the second clinical placement at the Psychology Department of a regional hospital. This placement involved the assessment and treatment of patients with an emotional, behavioural or cognitive problem impacting upon their physical health condition. The majority of the work was in the area of clinical assessment and treatment, however a small number of cases were allocated for neuropsychological assessment and behavioural management. At the commencement of the placement, a client was allocated who had received a traumatic brain injury due to an assault. Prior to the assault, this patient had been living independently in the community. At the time of referral, I had a very elementary understanding of neuropsychology and its clinical practice. When the client was an inpatient on the rehabilitation ward, he was observed to be emotionally labile, impulsive, disinhibited and frequently wandered from the ward. This complex presentation was far beyond my level of training or competence at the time.

Additional supervision was received from the senior neuropsychologist regarding the assessment, neuropsychological testing and behavioural management of this patient. As the case continued, a number of legal, financial and other ethical issues emerged. Most notably, the patient expressed a wish to return to independent living in the community. The management team, including the rehabilitation consultant, felt this was beyond his level of competence. A case needed to be presented to the guardianship board to prevent this request to return to independent living. Due to the rapport already established, it was decided that I would administer the neuropsychological tests to establish the patient's level of competence. This case provided a clear example of how specialist supervision was the key to maintaining professional competence whilst working outside of my field of

expertise. It allowed me to extend upon my existing skills of engagement and rapport building to conduct a complex neuropsychological competency assessment. The potential ethical dilemma was resolved by utilising specialist supervision.

Boundary Issues: Dual Relationships

A key benefit of a psychological relationship is that it provides an experience of a clearly defined, appropriate professional boundary. The APS Code of Ethics (2006) and the Psychologists Registration Board Code of Behaviour (1997) both clearly state that psychologists should avoid dual relationships with friends and relatives. A dual relationship is when a psychologist is in another significant different relationship with one of their patients (Pope, 1999). These dual relationships are avoided to ensure that a psychologist's judgement is not influenced by their external relationships. This issue is particularly problematic when working in regional and rural communities due to the smaller population density in these areas (Scopelliti et al., 2004). The inevitability of these relationships is the source of a unique challenge for clinicians working in regional and rural areas.

This issue emerged during the third clinical placement in a Community Psychology Service. A patient in his late fifties was referred by his GP with a recurrent major depressive disorder. During the assessment, I became aware that a previous relationship existed, however at the time I could not recall how I knew him. Following the assessment session, I recalled that the patient had been a fellow member of a local meditation group. Although this meditation group had ended some months earlier, the ethical dilemma of continuing the professional relationship was taken to the senior psychologist during supervision. Issues discussed during supervision included: the nature and frequency of contact with the patient; whether the former relationship was a friendship or an acquaintance; the likelihood of a dual relationship occurring in a small regional town; and

the probable impact of the previous relationship on the therapeutic relationship. It was determined that it was a relatively superficial acquaintance, that had ended some months prior, and was therefore unlikely to impact upon the current therapeutic relationship. The former relationship was discussed with the client at the next session. He did recall the former acquaintance, and after the discussion was happy to proceed with the treatment of his depression.

The psychological contact with this client predominantly involved conducting a thorough psychological assessment and providing support while he adjusted to mood stabilising medication. Throughout the contact, the patient occasionally brought up issues relating to the meditation group. On a number of occasions this issue was taken to supervision for guidance. It was decided to acknowledge the patients interest in talking about the former relationship, but to redirect his attention towards the psychological treatment he was receiving. Treatment was ceased when the client's mood stabilised and he successfully returned to employment. Upon reflection, the former relationship, and the way it was managed appeared to have no detrimental impact upon the outcome for this patient. This case highlights the often complex dual relationships than can exist within small communities. In regional and rural areas, it would be extremely difficult to completely avoid any dual relationship. In these circumstances there is an even greater onus upon the practitioner to manage this relationship to ensure their judgement is not impaired and there is not an increased risk of harm to the client.

Gifts from Clients

A common ethical dilemma arises when gifts are presented to psychologists by their clients. The APS Code of Conduct specifies that that psychologists are not to accept private fees, gratuities or other reimbursements for professional work other than that provided by their organisation (Australian Psychological Society, 2006). There are few

guidelines on appropriate therapeutic responses to client gift-giving (Gerig, 2004). This can become a challenging situation to manage as patients commonly give gifts to their psychologists to mark a transition or the termination of the relationship (Spandler, Burman, Goldberg, Margison, & Amos, 2000). The guidelines are intended to prevent detrimental outcomes such as patients receiving preferential treatment or clinical judgement being compromised (Gutheil & Gabbard, 1999). The negative consequences of refusing gifts needs to be weighed up against the positive or benign consequences of receiving the gift.

Throughout all the clinical placements, this situation occurred when patients presented a gift at the end of the therapeutic relationship. These gifts were of a small monetary value and were often a small personal gesture from the patient, such as a home-made jam. This issue was discussed during supervision. It was concluded that it was appropriate to receive such gifts, as the refusal of a gift can convey rejection to the patient (Gerig, 2004).

An exception to this occurred when a telephone call was received from a client a few days before her final session. She rang inquiring about the nature of my home décor. Although not stated, it became obvious that she wanted to purchase a substantial gift to be presented at the final session. When asked directly about this, she revealed this was her intention. To avoid causing offence, I discussed the professional issues relating to receiving gifts, and suggested a gesture such as a card would be appreciated. This telephone exchange was discussed during supervision before her final session. It was agreed that the intended message of her gift was to reinforce her ‘special’ status, which had been expressed throughout the treatment in her narcissistic personality style. Receiving the gift would undoubtedly have reinforced her need to be perceived as special, and would have sent unhelpful messages about the boundaries of the therapeutic relationship.

In the absence of any substantial research investigating the implications of receiving gifts from clients, the issue needs to be assessed on a case-by-case basis (Gerig, 2004). It seems that to maintain ethical practice in receiving gifts, a psychologist needs to consider the idiosyncratic meaning of the gift from the patient. These gifts range from communicating a simple message of appreciation and marking the end of the relationship, through to an overt intention to manipulate the psychologist and alter the power balance in the therapeutic relationship.

Confidentiality

The presence of confidentiality is one of the key characteristics that distinguish a psychological relationship from that with many other professionals. The APS Code of Conduct clearly defines the need for confidentiality and the requirement for psychologists to uphold this (Australian Psychological Society, 2006). This provision ensures that patients can disclose information in the knowledge that this will not become public information. The code specifies that such confidential information may only be revealed with the consent of the person. The limitations upon confidentiality are explained to patients, explaining that confidentiality will be breached if the patient reveals information suggesting they or someone else is at risk.

During all clinical placements, issues surrounding confidentiality were raised. It was discovered that in practice, confidentiality is often not as black and white as it is described to clients. In all clinical placements, there was a common practice of discussing patient details among other staff members. Sometimes this would be done in a careful way to remove any specific references that might identify the patient. More commonly, any interesting or relevant patient details were openly discussed during clinical meetings or informal gatherings. These practices directly contradict the message given to clients that information remains confidential ‘within these four walls’.

It is not suggested that staff broke these confidences for the sake of gossip or mere conversation. In almost all cases it was evident that staff were sharing details about a learning from a particular patient, or were seeking assistance to conceptualise or treat a patient effectively. In practice, when a patient is offered confidentiality, they are really being offered such confidentiality within the service, not to the specific clinician. This difference is commonly not elucidated to patients. This experience reflects a discussion in the literature about differences in perceptions of confidentiality between psychologists/therapists and other primary health-care providers (Jenkins, 1999). Psychologists tend to view confidentiality as a form of interpersonal contract, whilst other health care providers within medical setting view confidentiality as a structural concept relating to the organisation. Upon reflection, it appears that ethical practice requires being clear to clients about the level of confidentiality that is being offered. In practice this is commonly confidentiality within the context of the organisation.

The issue of confidentiality also includes provisions around the secure storage of confidential information. The APS Code of Conduct states psychologists must make provisions for maintaining confidentiality in the access, storage and disposal of records (Australian Psychological Society, 2006). This issue was inadvertently raised during the second placement at a regional hospital. A male patient in his late forties was referred for outpatient psychological treatment due to emotional issues preventing him from successfully losing weight. At the conclusion of the third session, this client was sent home with butcher's paper to construct a pictorial representation of major events in his life. A session was scheduled for the same time the following week.

Between sessions, the patient came into the centre and gave the rolled up butcher's paper to the receptionist, asking it to be given to me. When the client arrived for the scheduled appointment, he was horrified to discover his drawing had been lost. He

revealed that the drawing contained references to his childhood sexual abuse, which he had never previously spoken about. The patient became enraged and left the session despite attempts to calm and reassure him.

An investigation revealed that the receptionist misunderstood the patient and had accidentally thrown the drawing in the bin. Numerous attempts were made to engage the patient by telephone, however he did not answer his phone for days following the incident. It was agreed during supervision that the best course of action was to write to him confirming that his drawing had been destroyed, allaying his fears that his private details may have been discovered. The patient did not respond to a request to contact the service, therefore treatment could not be continued. This unfortunate series of events highlighted the need for secure storage of all client-related material. The client made himself vulnerable by his handling of such a personal document, and the receptionist made the mistake of not listening to the patient's request. In retrospect, I bear the responsibility for not specifying to the patient that the document was to only be returned directly to me. These series of events, relating to the secure storage of documents, resulted in an adverse outcome for this patient.

Terminating Relationships with Clients

The ending of any significant relationship can cause distress or discomfort for both parties. This reality is acknowledged within the APS Code of Conduct, which specifies that psychologists need to exhibit due regard for the psychological processes inherent in their services being provided and the psychological wellbeing of the client in ending the relationship (Australian Psychological Society, 2006). In practice this results in procedures such as giving the patient forewarning of the termination, taking reasonable steps to transfer responsibility to another provider, or making appropriate referrals for unmet needs (American Psychological Association, 1992). The short-term nature of clinical placements

almost always requires that a number of therapeutic relationships have to be prematurely terminated. This requires sensitivity and careful planning to avoid causing harm to the patient.

This problem was particularly evident when working with children during the third clinical placement at the Community Psychology Service. It was observed that engaging these children took considerably longer than engaging adult clients in the same service. This was particularly apparent when working with an anxious eight-year-old girl. Due to her separation anxiety, it took several months to reach the point where she could relax with only the two of us in the room. Almost as soon as this comfort level was reached, the end of the clinical placement was approaching. At this time it was necessary to begin talking about ending the therapeutic relationship. This sent confusing and mixed messages to the young patient.

Her severe separation anxiety would have benefited from continued treatment for the next six to twelve months. The family was offered the opportunity to continue therapy with a permanent staff member, however the family declined this offer due to the difficulties she experienced in establishing a sense of safety with me. A considerable ethical dilemma arose between the best interests of the patient and the time-limited restrictions of the clinical placement. This issue received considerable discussion in supervision sessions. My supervisor encouraged my self-reflection around the theme of my need to ‘rescue’ patients, even when they could not be treated within practical limits. In this case, every practical step was taken to provide the family with appropriate continuation of treatment. It highlights the ethical problems and conflicts that can arise out of the short-term clinical placements.

Summary of Ethical Issues

The completion of four clinical placements demonstrated the value of ongoing supervision and reflection upon professional practice. The ethics of professional practice only become relevant to the developing psychologist in their application to real life circumstances. The ethical issues identified in this report highlight the need for ethical guidelines. It has also identified a need for sound ethical management when situations are less than ideal. It appears that it is only with experience and honest self-reflection that wisdom and truly ethical practice can develop.

Professional Issues

When training as a clinical psychologist, not only are ethical issues encountered, but also a number of professional issues. The four clinical placements provided an opportunity for many of these professional issues to be raised during a supervised environment. Many of these professional issues are derived from the scientist-practitioner model, which has been the hallmark of clinical psychology for over 50 years (Conway, 1988). The scientist-practitioner is clinically engaged, but works across both research and clinical practice. A scientist-practitioner closely follows the body of research, and strives to implement evidence-based clinical interventions. A professional issue can emerge between a scientist-practitioner taught to work within best practice, and a workplace that does not value this philosophy. Psychologists also work within a mental health system that can be ambivalent about the value of clinical psychology. Despite the training and expertise of clinical psychologists, the ultimate authority is commonly deferred to a consulting psychiatrist. The presentation of these professional issues during the four clinical placements is discussed below.

The Scientist-Practitioner Model

In the practice of psychology, the scientist–practitioner model emphasises the assimilation of science and practice (Cherry, Messenger, & Jacoby, 2000). This requires psychologists to use practices and techniques that have a body of evidence that support their use. Beyond this, it requires clinicians to have a solid theoretical position that can be articulated and confirmed in research evidence. Throughout the four clinical placements, I was exposed to a range of theoretical perspectives and understandings about human behaviour. These workplaces varied in the extent to which they valued and encouraged a scientist-practitioner model.

Two placements were completed in a Community Psychology Service with a psychodynamic orientation. This service specialised in providing a low-cost service to clients with chronic mental health problems, many of whom also had a personality disorder. The training in this environment emphasised developing a psychodynamic understanding about the origins of psychopathology. The techniques were non-directive, patient-centred and unstructured. Reading material and in-house training frequently discussed the original texts of Sigmund Freud and Melanie Klein. Contemporary cognitive perspectives or techniques were typically dismissed as mere ‘band-aids’. This organisation did not express an interest in modern approaches such as schema-based cognitive therapy or cognitive analytic therapy, which attempt to bridge the gap between psychodynamic and cognitive perspectives.

Despite this narrow view of clinical psychology, much was learnt from these psychodynamic placements. This included working with the transference that occurs between client and therapist, utilising the power of silence, and developing a deep empathic understanding of the client’s distress. These skills have transferred across other clinical placements and into two subsequent employment situations. This training has had

immense value in the development of rich case conceptualisations that give strong consideration of early attachment and a sense of self. However despite this value, this type of practice sits outside of the scientist-practitioner model. Psychodynamic understandings and techniques do not lend themself to scientific investigation and consequently have a relatively poor body of evidence to support them. This approach is often ridiculed within modern psychological circles due to its paucity of rigorous evidence.

This approach is contrasted with the theoretical orientation of the final placement at the Primary Mental Health Service. This team has a mandate to build the capacity of the region by delivering treatment and training driven by best practice. All programs are strongly evidence based, primarily coming from a cognitive-behavioural perspective. This workplace strongly advocated the scientist-practitioner model and contributed to the body of research. The treatment offered by this program was an eight-week group CBT program for anxiety and depressive disorders. The program developed patient's awareness of their harmful patterns of thinking and behaviour. The predominant message was that emotional problems could be resolved by focussing upon current thinking and behaviour. This program has statistical evidence to suggest that their patients benefitted from this skill-based program. However it became clear during the delivery of the program that not all patients had the same capacity to benefit from the program. These patients could have benefitted from more time, greater opportunities for self reflection, and a greater understanding about the origins of their emotional problems.

Therefore a dilemma is elucidated between a patient-led process without strong research evidence, and an evidence-led process without individual considerations. Neither of these workplaces fully achieved the aspirations of the scientist-practitioner model. The single-focussed approach of each workplace obscured the value that could be seen from the other perspective. Furthermore, the value of a neuropsychological approach was

discovered during the second placement at the regional hospital. This discipline adds another perspective again to the complex determinants of human behaviour.

At various times throughout all four clinical placements, there was an intangible sense that something was missing in the theoretical orientations of the agencies. It raised a significant professional issue of how to effectively work within a team that had 'tunnel vision' for alternative explanations or conceptualisations. My training as a scientist-practitioner reinforced the value of collecting a variety of forms of evidence. These experiences have solidified my understanding of the scientist-practitioner model. It has reinforced my value of keeping an open mind to all understandings, to be a truly effective scientist-practitioner.

Relationships with Psychiatrists

One of the benefits of all clinical placements is the opportunity to develop relationships with other mental health professionals. These other professionals include those within the organisation, who are subject to similar expectations of conduct. It can also involve working with health professionals from other organisations and external providers, in which fewer assumptions can be made about common expectations of conduct. One of the most complex relationships for a psychologist is the relationship with psychiatrists. Although both professions share many common understandings about human behaviour, there can also be vast differences in their theoretical models of psychopathology. Tensions can arise in interdisciplinary team environments when the least experienced team members, commonly psychiatry registrars, are responsible for case formulation and treatment decisions (Farhall, 2001).

The role of psychologists and psychiatrists is often misunderstood outside of the mental health field. The Australian Psychological Society (2007) and the Royal Australian and New Zealand College of Psychiatrists (2007) have specific statements on their

websites explaining the differences between these professions. These differences are commonly misunderstood, and often need to be clarified with patients. From within these professions, it is better understood that these roles are complimentary, and each serve a specific purpose. The ultimate clinical authority of a patient is normally vested with the psychiatrist, due to their extensive training and experience (Herrman, Trauer, & Warnock, 2002). This situation typically requires psychologists to work in with this hierarchy to achieve the best outcome for the patient.

At several times throughout the clinical placements, the need for strong communication with psychiatrists was essential. During the first clinical placement at the Community Psychology Service, several clients were referred to see a psychiatrist for diagnostic clarification and pharmacological treatment. This was particularly relevant for clients presenting with bi-polar disorder and complex anxiety disorders such as obsessive-compulsive disorder. These conditions typically require a combination of pharmacological and psychological interventions.

In this environment, the referrals were made to psychiatrists working in private practice. Contact was typically in the form of written referrals and reports sent between professionals. Such written contact benefited from careful wording to ensure that respectful relationships with patients were maintained. For example, a patient was referred to a psychiatrist with a suspected bi-polar disorder and the presence of considerable narcissistic personality features. The correspondence in this case requested assistance clarifying the Axis 1 and 2 diagnoses, and their opinion and management regarding the most appropriate pharmacological treatments. It was generally found that an approach of deferring to their expert judgement of the psychiatrist resulted in cooperative and thoughtful opinion and management of the case.

During the final clinical placement at the Primary Mental Health Service, an opportunity existed to work closely with the team psychiatrist. Every week at the clinical review, cases were presented to the team psychiatrist for diagnostic clarification and recommended management. This provided an opportunity to discuss issues face-to-face, and for the psychologists to have an active contribution to the formulation and management. This was a particularly helpful process, as the team psychiatrist commonly explained his thinking behind a particular diagnosis, and was open to discussing alternate conceptualisations.

An even closer working relationship was established with the team psychiatrist when attending GP rooms to conduct assessments and case conferences. This allowed me to have a dynamic input into the assessment and conceptualisation. It was a rich learning experience to be able to discuss the same presentation and material, and reflect upon differences in how this was interpreted. On a number of occasions, a different point of view was held regarding the diagnosis and treatment. It raised the professional issue of working with another professional who ultimately held superior professional standing. It highlighted the need to develop effective relationships with psychiatrists to allow psychological input to be valued and included in the understanding about the patient.

Summary of Professional Issues

The process of becoming a psychologist is evolutionary in its acquisition of subtle characteristics of the role. The advanced training in a professional doctorate provides the final step of formal training as a scientist-practitioner. The internalisation of the scientist-practitioner approach only comes with direct experience as a clinician, beyond the end of formal training. Working within teams that do not value the scientist-practitioner approach to the same degree can produce a difficult environment for the psychologist to navigate. It raises ethical and professional concerns when working in organisations that do not require

an evidence-base for their practice. Additionally, it raises concerns when practices are so deeply grounded in research that they lose contact with the unique realities and challenges of the patients' individual experiences.

Further professional issues can arise in developing good working relationships with psychiatrists. Differences in status and authority can be overcome by establishing respectful collaborative relationships to determine the best assessment and management of patients. A strong working relationship allows differences of opinion to be discussed, and a continuity of care to be achieved across a range of treating professionals.

Conclusion

The completion of four clinical placements has been an essential element of my professional development and training. It has allowed me to experience and work my way through a number of ethical and professional issues. It has demonstrated that despite the most careful provisions to ensure ethical practice, a range of challenging situations and circumstances can still arise. A truly ethical practitioner is one that can continue to operate with ethical values, even when outside of expected circumstances. Such a clinician has accumulated enough experience and wisdom to choose an ethical path through difficult and challenging circumstances. This wisdom is scaffolded around a scientist-practitioner model, which calls for psychologists to integrate scientific findings into their healthcare practices. The completion of a postgraduate training in clinical psychology provides the graduate with the greatest opportunity to fully develop into this role. The adoption of the scientist-practitioner framework allows clinical psychologists to interact with other health professions, such as psychiatrists, in a common language and with a shared value of empiricism. From this empirical and ethical basis, clinical psychology will continue to grow as a profession in its understanding and treatment of human behaviour.

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