Psychological distress of asylum seekers in immigration detention.

by

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Volume One

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The academic dossier contains two essays and three problem based learning reflective accounts. Summaries of two case discussion group process accounts are also included. Complete versions of the process accounts can be found in volume II.
Adult Mental Health Essay

Compare and contrast the theoretical underpinning and effectiveness of two formal models of psychological intervention that are used in the treatment of generalised anxiety disorder.

January 2005

Year 1
Introduction

GAD is characterised by excessive, persistent anxiety or worry about a variety of life circumstances. It causes significant psychological distress, in part because the persistent nature of the anxiety is felt subjectively to be an indication that the worry is uncontrollable. It is accompanied by physical symptoms, including restlessness, muscle tension and sleep disturbance, as well as cognitive problems such as concentration difficulties and irritability (Wells, 1997). The theoretical underpinnings, treatment and effectiveness of two models are discussed. Firstly Wells’ (1997) disorder specific, cognitive model for GAD is outlined. This model emphasises the role of ‘meta worry’ or ‘worry about worry’ in maintaining anxiety, as well as the contribution of positive beliefs about the usefulness of worry as a coping strategy. Secondly, an attachment informed psychotherapy approach (hereafter referred to as attachment therapy), is contrasted with this model. This model construes GAD as a possible (though not inevitable) developmental consequence of insecure attachment in childhood. As a result of this difference in conceptualisation of GAD, the inevitable differences in treatment are discussed. These differences centre around the age range of clients at whom intervention is targeted, the aims of therapy and treatment techniques, and the role of the therapist in treatment outcome. Evidence of the effectiveness of the two treatment approaches are outlined, and problems in the research are highlighted.

Wells’(1997) disorder specific cognitive model of GAD

Wells (1997) has created a disorder specific cognitive model for GAD. Wells construes GAD as essentially a disorder of worrying, in that clients report worrying extensively about a number of different issues, and describe feeling anxious or apprehensive most of the time. Research suggests that it is not the content of worries which differs from other anxious patients, but the perceived controllability of these worries (e.g. Craske et al, 1989). According to Wells (1995) GAD patients report chronic, repeated worrying
and rumination which can be focused on discrete issues, or can be a more general 'feeling of being worried'. Attempts to control the worrying often fail, leaving the patient with the feeling that they cannot control their worrying.

Wells (1995) describes how in GAD patients, worry can be initiated deliberately, as a problem solving strategy (e.g. Borkovec et al 1983, Davey & Tallis, 1994). This is an important component of Wells's conceptualisation of GAD as it emphasises the importance of the patient's appraisal of worry. If worry is being initiated as a problem solving activity then the client is taking a conscious decision to worry in order to gain relief from the initial anxiety. It is Well's assertion that this positive belief about worry is an important maintenance factor. It also implies the necessity of helping the client to reassess this belief as well as explore alternative strategies to cope with anxiety. Wells distinguishes between initiation of worry and maintenance of worry (experienced as extremely distressing and uncontrollable). This negative appraisal of worry can lead to an increase in anxiety as the patient begins to 'worry about worry'. According to Wells' (1995) model, it is this 'meta-worry' which is specific to GAD sufferers.

The 'meta-worry' aspect of GAD has been distinguished explicitly from external worry in Well's model. Wells refers to external concerns about daily events as Type 1 worry. This type of worry also includes internal events which are non-cognitive, i.e. physical sensations. The meta-cognitive dimension of worry is described as type 2 worry. This includes a focus on the nature and occurrence of the worries themselves. They reflect negative beliefs about worrying, for example, 'I might go crazy with worrying'. In addition to holding negative views of worry, the patient holds positive views about worry as a coping strategy. For example, 'If I worry I can always be prepared'. Once the person has recognised they are feeling anxious about something, these positive beliefs about the value of worrying result in extended rumination with the aim of finding a solution and preventing catastrophe. Unfortunately, rumination does not increase problem solving
ability (Dugas et al, 1995), and as a result of type 2 worry, is likely to increase anxiety. It has the additional effect of increasing sensitivity to threat related information and generating an elaborated range of possible negative outcomes likely to increase worry (Wells, 1995). Furthermore, rumination is likely to have generated a range of negative scenarios which depict non-coping, likely to increase anxiety.

A pictorial diagram of Well’s model is shown below:

(Wells, 1995)
The model shows that once meta worry or ‘worry about worry’ has been established, there are three additional factors which escalate and maintain the problem. These are ‘behavioural responses’, ‘thought control’ and ‘reassurance seeking’. Cognitive Theory postulates that avoidance behaviours are important in maintaining anxiety regarding type 1 worries. Wells adds avoidance of situations likely to incur type 2 worry to this, for example avoidance of news items in order to avoid worrying. Thought control is another strategy used to minimise the distress of worrying and may include worrying within strict limits so as to exploit the supposed benefits of worrying without the negative effects. Alternatively, the patient may attempt to suppress worrying completely, which has been shown experimentally to lead to an increase in unwanted thoughts (Wegner et al 1987 as cited in Wells, 1997) The disadvantage of this strategy is that it is likely to increase the patients belief that worrying is uncontrollable. Furthermore, whereas type 1 worry can occasionally lead to a reduction in anxiety, type 2 worry can only escalate anxiety.

In summary, Wells’ disorder specific model constructs GAD as essentially a disorder of worrying. In particular, repeated type 1 worry is maintained through positive beliefs regarding the problem solving advantages of worry. Prolonged experience of type 1 worry results in the formation of type 2 worry or ‘meta worry’ in which the person becomes concerned about the worry itself. This leads to certain safety behaviours such as avoidance as well as increased negative affect and thought control strategies. These strategies are doomed to fail and actually reinforce negative beliefs about worry as well as increasing the occurrence of type 2 worry. Constructing GAD in this way highlights a number of implications for treatment which are outlined below.
Treating GAD with Wells’ (1997) model

1. Assessing and socialising the patient to the model.

According to Wells, although type 1 worry is highly prevalent in this group, it is really type 2 worry that is escalating and maintaining the high level of anxiety in these patients. It is therefore type 2 worry which is targeted in this intervention. Type 2 worries are elicited through the use of specific questionnaires designed by Wells. The patient’s beliefs about worry are also crucial to address, as these positive and negative thoughts about worry are likely to be maintaining the problem. The therapist should ask the patient to list advantages and disadvantages of worry at the assessment stage, paying particular attention to negative beliefs about the danger and uncontrollability of worrying. As we have seen, positive and negative beliefs about worry are often held simultaneously, and it is important for the client to recognise that both these types of beliefs are maintaining the problem. Positive beliefs about worry prompt type 1 worry, and encourage strict worrying strategies. Negative beliefs about worry as uncontrollable, or as a sign of approaching mental breakdown increase anxiety and type 2 worry. Wells recommends that when socialising the patient to the model, an emphasis on the lower half of the model is most beneficial, with later work aimed at the role of positive and negative beliefs of worry and the problematic use of worry as a coping strategy.

Understanding the importance of meta worry is crucial to the patient’s acceptance of the model, and therefore the effectiveness of the intervention. In my experience, it is likely that the patient will be primarily occupied with the content of the type 1 worries they present with and the therapist will need to encourage a shift in perspective to enable the patient to understand that meta worry may be most problematic. Wells suggests encouraging the patient to recognise that if they thought they could control their worrying it wouldn’t cause them so much distress.
2. Treatment techniques

Wells describes treatment techniques aimed at modifying meta worry and in particular, challenging negative beliefs about the uncontrollability of worry. After initially socialising the client to the model and assessing the type 2 worries and particular beliefs each client holds about worry, treatment can be seen to be in three stages. These are 1) challenging negative meta beliefs and meta worries with a particular emphasis on uncontrollability beliefs; 2) challenging positive meta beliefs and 3) practicing alternative processing strategies. Negative thoughts regarding meta worry can be challenged by providing counter evidence and questioning the validity of the client’s perceived evidence for these beliefs. Normalising worry, perhaps with the use of a behavioural experiment in the form of a small survey, may weaken beliefs about the catastrophic effects of worry. For example, the client may discover that most people worry and yet most people have not gone mad.

Once the consequences of the worries being uncontrollable have been addressed, it is possible to work on the idea that worrying is actually uncontrollable. Wells suggests that the nature of worry as a complex cognitive task means that it is possible to disrupt this activity with distractions. The therapist can ask the patient for examples of occasions when the worrying has stopped, even temporarily, to highlight that distraction can stop worrying and hence are not entirely uncontrollable. Wells suggests a number of possible techniques aimed at challenging uncontrollability beliefs. These involve behaviour experiments such as postponing worry. Patients are told that they should stop worrying as soon as it begins, by allowing themselves 15 minutes later in the day to worry about it then. If they are still concerned at this time, they can worry about it at that time. Well’s reports usually finding that patients can postpone their worry which increases their feelings of control. They may even find that they do not need to use the time to worry. I would question whether clients who are extremely anxious would be able to postpone worry in this way, especially if their positive beliefs about worry are active. Clients who feel a sense of
urgency to manage the anxiety, for example type 1 worries related to unexpected events, are least likely to be able to postpone worry. With very anxious individuals it may therefore be better to use this technique later on in therapy, after effective alternative coping strategies have been developed and positive beliefs about the benefits of worry reduced. Failing to be able to postpone worry in an experiment would have negative consequences, reinforcing the belief it was intended to reduce, that worry is uncontrollable.

A final technique advocated by Wells is using 'loss of control experiments' whereby patients are encouraged to push their worrying to the limits, engage in extreme catastrophising, and try to lose mental control, in order to prove that excessive worry does not result in madness.

The above techniques are aimed at challenging negative beliefs about meta worry, with a particular focus on uncontrollability beliefs. It is also important to challenge positive beliefs about worry. This may involve looking at the evidence supporting the value of worry, assessing the value of this evidence and looking for counter evidence. Experiments around worry enhancement can be used to show that exaggerating worry episodes does not help to find solutions. An effective strategy which can target positive and negative beliefs at the same time is cognitive dissonance. This is often used to encourage motivation for change and is most effective when incompatible beliefs are heightened and held at the same time. Eliciting both positive and negative beliefs from the client’s list of advantages and disadvantages of worrying and pointing out that they cannot both be true. It doesn’t matter which belief is weakened by this process, as Well’s model requires that both sets of beliefs are weakened. Wells points out that if negative beliefs about the dangers of worrying are not reduced it is important to address these separately as this type of meta worry is maintaining the general anxiety.

Finally, if the client holds strong positive views about the usefulness of worrying, and has had these beliefs for a long time, they are unlikely to have alternative problem solving skills. They may be unable to deal with uncertainty in their lives without catastrophising in this way. The therapist
should spend time helping the client to generate more positive outcomes which are less catastrophic and to give these thoughts at least equal probability. I would envisage that this could involve practice at generating alternative interpretations on thought records. Wells suggests that encouraging clients to ‘let go’ of worries may be useful, at this stage in therapy. The client can be encouraged to say ‘I am worrying, it doesn’t help me, let it go’. If clients find this difficult it may suggest that they do not have a strong enough belief that worrying is not useful. I would suggest that the client may benefit at these times of initiation of worry from looking at a record from a previous experiment which showed that worries are not reliable predictors of events, or thought records from earlier sessions, to help them to feel they are not losing out by ‘letting go’ of worrying.

In summary, Wells advocates treating people suffering from GAD firstly by socialising them to the model and assessing their positive and negative beliefs about worrying. Following this, work can begin on challenging negative meta beliefs and meta worries with a particular emphasis on uncontrollability beliefs; challenging positive meta beliefs and finally, practicing alternative processing strategies. Wells describes a number of techniques, particularly behaviour experiments, which are useful in tackling these issues.

How effective is Wells' (1997) Cognitive Model for GAD?

CBT approaches which are not disorder specific are useful in treating GAD according to Butler et al, (1987) as cited in Wells (1997). Durham and colleagues (1994) report an advantage of cognitive therapy over analytical psychotherapy. Improved functioning is reported by about 50% of the patients who are treated with general cognitive therapy. According to Wells (1997) a specific model which targets GAD specifically should lead to an increase in treatment effectiveness. However, to my knowledge, there are no randomised controlled trials of this approach. This severely limits how much
we know about the effectiveness of this model. Research into this area has been mainly focused on theoretical questions regarding the validity of the concept of meta worry. Wells and Carter (1999) conducted a regression analysis on scores on a measure of pathological, GAD type worry. They found that type 2 worry is strongly associated with pathological worry and that this association is independent of type 1 worry and trait anxiety. This association suggests that it is crucial to address these beliefs in GAD patients. This suggests that this treatment will be effective to the extent that these beliefs are changed.

In a separate study, Davis and Valentiner (2000) looked at whether type 2 worries are more fundamental to the distinction between normal and pathological worries than other associated constructs such as trait worry and anxiety symptoms. They found that although this was supported by their study, not all of the subscales on the measure of type 2 worry were relevant to this distinction. In particular, they found that reduced confidence in memory and attentional functioning contributes to anxiety beyond more general measures of trait worry and trait anxiety. They also found that groups of people with GAD, non anxious and non-worried anxious people were most different in terms of beliefs in the necessity of controlling worry and beliefs that worry is uncontrollable. The authors suggest that not all meta cognitive beliefs are crucial for this distinction. However, Wells has emphasised beliefs about the uncontrollability of worry as being especially important in treating GAD which would suggest that the most problematic beliefs are being targeted in the model. The study also found that GAD patients held both positive and negative beliefs about worry.

In summary, it is clear that there is evidence for the theoretical underpinnings of Well’s model, and in particular, there is evidence that holding beliefs about the uncontrollability of worry is associated with GAD. It is clearly necessary for more research to be directed at assessing the effectiveness of treatment using this model.
Conceptualising GAD from an attachment perspective. How is it different from the cognitive model?

As we have seen, a central feature of Wells’ model is that people who are prone to worry believe that there positive coping outcomes associated with worry. Janis (1958) introduced the idea that worrying may be adaptive. He suggested that worrying is triggered by perception of impending danger and is a form of inner preparation which increases the individual’s tolerance for threat or danger stimuli. This is consistent with attachment ideas about the adaptive role of certain psychological behaviours.

According to Bowlby (1973), infant attachment to their primary caregiver can be classified in three ways, all of which constitute organised behaviour aimed at maintaining optimum proximity (physically and emotionally) to the caregiver. (A fourth category, disorganised attachment was added later to describe the behaviour of children who’s experience of attachment was so chaotic that the associated behaviours were incoherent and were not organised into a strategy of increasing caregiver attachment). According to Wells’ model, GAD can be seen to occur through a cognitive development pattern of certain meta beliefs. By contrast, attachment theory views GAD to be a possible developmental consequence of insecure attachment in childhood. Indeed, Borkovec (1994) (as cited in Davey & Tallis, 1994) describes Bowlby’s description of insecure attachment as a ‘virtual prototype’ of adult GAD.

Insecure attachment and anxiety in children

It is easiest to understand how attachment theory contributes to our understanding of GAD in adults from the perspective of understanding child anxiety. Attachment theory postulates that attachment behaviours are evoked in order to maintain proximity to the primary caregiver. When adequate proximity has been reached, these behaviours subside. However, when
inadequate proximity is available, attachment behaviours escalate, at the expense of other behavioural strategies such as the exploratory system (Mannassis, 2001 as cited in Silverman & Treffers, 2001). Using the strange situation paradigm designed by Mary Ainsworth and colleagues (1978), insecure attachment was characterised by either minimal distress upon separation from caregiver and ignoring the caregiver upon reunion (the ‘insecure-avoidant pattern’); or high distress on separation and anger towards caregiver on reunion (insecure-ambivalent/resistant). Unlike caregivers of securely attached children (who were distressed on separation and responded positively on reunion), the caregivers of insecurely attached children do not respond sensitively and predictably towards their infants. Rather, they typically show rejection or unavailability towards infants in the insecure-avoidant style, and intrusiveness or inconsistency in the insecure ambivalent/resistant style (Manassis, 2001 as cited in Silverman & Treffers, 2001).

**Attachment patterns into adulthood: the role of cognition.**

The attachment style is crucial in the formation of ideas and beliefs held about the self, intimate relationships and the world. These mental representations are stored in the ‘internal working model’ and form the basis of understanding adult relationships. Through the use of measures such as the adult attachment interview (Main, Kaplan & Cassidy 1985), it has been possible to explore these mental representations held into adulthood. Adults who were previously described as insecure in childhood hold views about themselves, others and the safety of the world consistent with their earlier attachment security. According to Cassidy (1999) as cited in Cichetti and Toth, (1995), threat related beliefs of insecurely attached children mirror those of adults with GAD in that both view the world as a dangerous place and doubt their capacity to cope with the threat.

As a result of these beliefs, insecurely attached children experience their attachment system as chronically activated (subjectively experienced as
intense anxiety and loss), as they are not confident of their caregiver’s ability to look after them (Manassis, 2001 as cited in Silverman & Treffers, 2001). The incompatible exploration system is curtailed, even when danger is limited. This results in the overly cautious behaviour exhibited by anxious individuals. According to Sroufe, (1996) separation distress is one of the earliest forms of anxiety. Insecure infants experience this repeatedly and it is internalised in their internal working models. According to attachment theory then, anxiety originates in the infants uncertainty about caregiver availability. Behavioural responses to this are likely to vary, but are aimed at increasing contact with the caregiver. It is also important to recognise the importance of other factors such as temperament which has been shown to be predictive of anxiety. Insecure attachment is not a cause of anxiety in children but a risk factor, and secure attachment may be a protective factor in regulating anxiety. Cassidy (1995) (as cited in Cichetti & Toth, 1995), argues that cognitions may hold the key to understanding the developmental outcome of early attachment insecurity. This highlights the view of attachment theorists that insecure attachment is one of a number of biological and experiential risk factors for psychopathology.

Treating GAD from an attachment perspective.

1. Infants and children

In contrast to Wells’ model of GAD, attachment theory is often applied to treating children with anxiety disorders. Treatment often involves the whole family, and focuses on reducing insecurity between the child and caregiver. When attachment interventions are aimed at reducing anxiety in children, Manassis (2001) (as cited in Silverman & Treffers, 2001), argues that a therapeutic emphasis on sensitivity is crucial. Reliable sensitivity, which Bowlby (1973) argues is crucial to forming a secure attachment is not the same as over attentive parenting and extreme vigilance, which actually serves to increase anxiety. The parent learns through attachment therapy to ‘read’ their infants signal more accurately, intervening when necessary in a
reliable and consistent fashion. In this way, the child learns to handle minor problems independently, but becomes certain of parental intervention if real danger occurs. Interventions are most effective if the therapist can act as a secure attachment figure (Manassis, 1996) (as cited in Cassidy & Shaver, 1999). This is also the case in adult attachment oriented psychotherapy which demonstrates the flexibility and scope of this model in comparison with Wells’ cognitive model, which is only applicable to individual adults. Interventions aimed at increasing coping skills in children are also effective at reducing anxiety and may prevent longer term problems (Bernstein & Borchartd, 1991). This is because if the individual feels sufficiently empowered to cope their anxiety levels will be reduced.

2. Adults

Treating adults from an attachment model involves understanding how the representations of relationships are explained in the patient’s narrative. Following on from Mary Main’s work in developing the adult attachment interview, psychotherapy research has shown that narrative coherence, metacognitive monitoring and reflective functioning are related to attachment security (Slade, 1999 as cited in Cassidy & Shaver, 1999). Coherence is suggestive of an active ‘constructivist’ process, indicating that the person is re-evaluating their story as they tell it. According to Fonagy and Target (1996), metacognitive monitoring within the individual’s narrative suggests an ability to reflect on what is being described, a sign of attachment security.

In attachment therapy, it is how a person’s story is told, and more specifically how it breaks down which is important and not the content of the story itself (Slade, 1999 as cited in Cassidy & Shaver, 1999). Main suggests that incoherence in narrative, in its’ varying manifestations are “linguistic efforts to manage what cannot be integrated or regulated in experience or memory” (Slade, 1999 pg 582 as cited in Cassidy & Shaver, 1999). Slade suggests that listening for inconsistencies in a patient’s narrative is in many
ways what constitutes good clinical listening. In attachment therapy, these changes in voice, lapses and contradictions, provide useful information on how the patient defends themselves from intolerable or unacceptable affect. This helps the therapist to understand how the patient relates to others, what it is safe to know and feel and what cannot be contained. What is implied here is that the caregivers response to the child seeking care is an organising dynamism in the infants developing mind, and that the adult’s narrative reflects the extent to which this organisation has been successful.

Main also emphasised the importance of the ability to integrate semantic generalisations and episodic memories. Asking for episodic evidence of statements can be useful in determining the extent of abandonment, early loss and trauma which may not be overtly expressed. Asking for specific memories in this way was useful to me in my work with one particular client suffering from anxiety as well as moderate depression. This client often contradicted herself when describing her relationship with her parents. She often described her mother as being a very humorous person. However, when I asked if she could remember any occasions when she and her mother had shared a joke as a child, she could only remember times when her mother laughed at her scornfully and her experience was of being completely humiliated. This was very useful therapeutically and had I been working from an attachment perspective, I might have used this as an opportunity to encourage more reflective thinking, to construct a new meaning of the episode in a way which would encourage re-thinking old stories and re-construction of them in the here and now. If this was successful it would result in a more coherent, collaborative and organised narrative which is a sign of progress in attachment therapy. Holmes (1998) emphasises that attachment therapy involves ‘story-making’ and ‘story breaking’ in that the patient is helped to tell a coherent story, whilst at the same time they are encouraged to include new experiences, reflections and understanding to break up rigid stories. In insecure attachment related to GAD, rigid stories (in the dismissive pattern) and an overwhelming unstoried experience (in the
The role of the therapist in attachment therapy

As a result of the differences in treatment between Wells’ model and attachment informed psychotherapy, the role of the therapist in the two types of intervention are very different. Wells’ model segregates the therapist from the client’s experience, placing a responsibility of skill and expertise on the therapist in enabling effective intervention. Attachment therapy by contrast involves the therapist directly in the treatment of patients. As GAD is conceptualised within this model as resulting from insecure childhood attachment, attachment therapy will be effective to the extent that the patient is able to use the therapist as a secure base, from which to explore their inner emotional experience. The patient is able to re-experience their life story in a safe and healing environment with a therapist who is emotionally available and responds sensitively, ‘marking’ affect. With insecurely attached individuals, breaking rigid stories and encouraging the development of structures capable of containing overwhelming affect is crucial to the treatment process (Slade, 1999 as cited in Cassidy & Shaver, 1999).

In summary, attachment therapy can be focused on a wider age range of clients than Wells’ model. It aims to break down rigid stories and contain emotion in order to improve the reflective ability of the client around attachment ideas. This improvement can be seen in increased coherence of the attachment narrative. The therapist is viewed as directly involved in this process, ideally providing a secure base to allow this healing process to occur.
How effective is the attachment model in treating GAD?

Similarly to research surrounding Wells’ model, empirical investigation is mainly focused around theoretical components of the model, rather than the effectiveness of interventions. This evidence is useful however in demonstrating an empirical relationship between GAD and attachment insecurity. For example, Roemer and colleagues (1991)(as cited in Davey & Tallis, 1994) compared GAD patients, non GAD patients and anxious but not GAD individuals on 6 dimensions of attachment related memories. The GAD group were found to be significantly more insecurely attached than both other groups on measures of a) enmeshment/role reversal (the need to protect, and fear of losing the primary caregiver) and b) preoccupying anger and oscillating feelings towards the caregiver (Borkovec, 1994 as cited in Davey & Tallis, 1994). They also reported feeling more rejected as children.

Data from the Penn State programme (Cassidy & Shaver, 1999) also suggest differences on attachment measures between GAD patients and matched controls. In support of the above study, GAD patients scored higher than controls on the enmeshment/role reversal dimension. In addition, GAD patients reported greater anger/oscillation towards their caregiver, greater balance/forgiveness, and lack of childhood memory. Borkovec (1994) (as cited in Davey & Tallis, 1994) suggests that the presence of both greater anger and forgiveness suggests greater inner conflict in these patients, which in turn is suggestive of a more distressed and insecure childhood. This is also consistent with lack of childhood memory. Furthermore, social evaluative concerns are central to the content of worrying exhibited by GAD patients. Borkovec (1994) suggests that this may indicate the lack of a secure relationship with a primary caregiver in childhood.

The advantage of Wells’ model is that it is a consistent and thorough manualised treatment which enables the clinician to follow a carefully organised and detailed treatment plan. I would feel more comfortable that I would not get ‘lost’ with the client using this approach. However, it is my
feeling that the attachment model allows for a richer understanding of the patient and that treatment could potentially feel more comforting and healing at a deeper level than the cognitive approach.

Concluding remarks.

GAD is an extremely distressing psychological condition which is characterised by excessive worry. According to Wells’ model, it is a combination of meta worry and positive beliefs which contribute primarily to the maintenance of the disorder. Wells (1997) specific, manualised treatment plan highlights ways of tackling both the positive and negative beliefs maintaining worry, as well as de-coupling the associated behaviours and thought control. Attachment theory suggests GAD is a possible (but not inevitable) developmental consequence of insecure attachment in childhood. Similarly to Wells’ model, attachment theorists view cognition as important in forming this link, represented along with emotion in an internal working model. Treatment is possible for a more diverse age range, has different treatment aims (involving reconstructing attachment stories), involves a range of different treatment techniques, and views the ability of the therapist to provide a safe, secure space as directly related to the success of the treatment. Both Wells model and the attachment model are supported empirically in terms of theoretical underpinnings. Randomised controlled trials are necessary to determine how effective they are.
References:


Professional Issues Essay

Under the proposed changes to the Mental Health Act, Clinical Psychologists will be able to assume greater involvement in the process of 'sectioning' and supervising the treatment of people who are subject to compulsion. What are the advantages and disadvantages of our profession getting involved with these processes? What issues and dilemmas might need to be considered by Clinical Psychologists as they make a decision about whether or not to accept these responsibilities? How would you decide?

December 2005

Year 2
The Mental Health Act (1983) is widely recognised by professionals, service users and carers and by the UK Government as being out of date and in need of revision (Cogan, 2004). A draft Bill was first published in 2002 which outlined proposed changes to the 1983 Act. A revised draft of the Bill was published in 2004 following consultation with a number of professional groups. The proposed changes to the Mental Health Act (1983) have attracted widespread criticism owing to concerns raised by a range of professional groups that they are unworkable, unethical and politically motivated. In particular, the proposed changes are criticised for bowing to pressure exerted by an ill-informed general public, who are vulnerable to the influence of sensationalistic and over zealous reports of mental issues in the media (Harper, 2005).

Generally, the changes can be seen as representing a shift towards increased coercion in the treatment of mental health problems (Moncrieff, 2003). In itself, this shift towards increased coercion and detention is cause for concern for any professional group who aim to deliver person-centred interventions. However, for some groups, the proposed changes actually involve a change in professional role. This is the case for clinical psychologists who, under the proposed change would be able to assume the ‘Clinical Supervisor’ role, which would include involvement in sectioning procedures. Advantages and disadvantages, issues and dilemmas associated with the new role can be organised into two main areas. These are: 1) the affect on our clinical work, and 2) the affect on our professional identity.

Underlying these issues are fundamental philosophical issues pertaining to the nature of mental illness, the nature and value of our subjective experience as well as our ability to examine it, and ethical questions of social control. In my view, considering these changes in the context of underlying philosophical ideas and assumptions is valuable in terms of widening our view on how these changes are likely to affect our work. These philosophical issues will be addressed as they arise. These themes may be useful to clinical psychologists in terms of arriving at a decision of whether or not to accept
the changes, and were influential in my personal decision making process. An initial exploration of the proposed changes and the practical implications for clinical psychologists is outlined below.

Overview of the proposed changes to the Mental Health Act (1983): Practical implications for clinical psychologists.

The new legislation has been described by Moncrieff (2003) as being ‘destined to make it easier to be subject to compulsory powers and more difficult to be rid of them.” (pg8). The draft bill reflects the Governments wish to break the link between compulsory treatment and detention in hospital. It reflects public concern, perpetuated by the media, that people with mental health problems pose a risk which cannot be adequately contained. The changes will mean it is possible for service users to receive compulsory treatment within a community setting. According to Cogan (2004), this development could potentially contravene European Convention on Human Rights, as it sets a lower threshold for compulsory hospital admission than currently applies. Moncrieff (2003) argues that the effect of these changes will be that it is more difficult to be free of compulsory powers once an individual has become subject to them. This is because it will be more difficult to argue effectively for discharge from a community order. She also suggests that extending the scope of the mental health act into community settings will increase the overall use of the mental health act and to decrease the threshold of dysfunction necessary for such measures to be considered. Recent revisions to the 2002 draft have limited compulsion in the community to service users who are well known to services, and are prone to cycles of discharge, relapse and readmission to hospital (Winterton, 2004).

The most important change likely to affect psychologists is the introduction of the Clinical Supervisor role, which will replace the Responsible Medical Officer role of the Mental Health Act 1983. Clinical Psychologists can undertake this role which involves responsibility for sectioning decisions.
Winterton (2004) describes that choosing a clinical psychologist over a psychiatrist for this role is most likely to be deemed appropriate if the primary intervention is of a psychological rather than a medical nature. The impact of these changes is discussed in terms of the clinical work of psychologists below.

1) Advantages and disadvantages of the role in our clinical work.

Adopting the clinical supervisor role would have a large impact on our clinical work with clients. A number of writers have raised important issues and dilemmas which clinical psychologists are likely to face if the proposals become law. Much of this discussion has focused on the disadvantages of the changes, although some advantages have also been identified, which are discussed first.

Proponents for the changes have argued that if clinical psychologists take on the role of Clinical Supervisor they can reduce the reliance on medical treatments which service users have criticised, such as ECT and over medication. Psychologist such as Kinderman (2005) have suggested that working as clinical supervisors will help to redress the balance which currently biases the medical model as the preferential way of understanding mental health problems. Theoretically, this is in line with the philosophy of the post psychiatry movement, which proposes that the medical model is one of many different ways to conceptualise mental health, and that this model should not automatically be prioritised over other models, particularly where the service user conceptualises their difficulties within an alternative framework (Bracken, 2001). Kinderman (2005) suggests that with psychologists holding more power within the mental health system, there would be an increase in exposure to psychological rather than medical
models of illness. More service users would be treated using psychological treatment packages, which are inherently more client focused than medical models designed to eradicate symptoms as far as possible. Pilgrim (2005) takes a similar line, arguing that psychologists have specific skills which could be utilised in a manner which reduces the reliance on psychiatric models. He suggests psychologists would favour formulation over diagnosis; contract formation over application of drug therapy; and a person centred, meaningful and collaborative dialogue over one way descriptions of symptoms.

A second line of argument in support of psychologists accepting the proposed changes involves the effect on numbers of service users who are sectioned. Pilgrim (2005) for example has suggested that psychologists will be less willing to section service users. Diammond and colleagues (2005) have argued that this is unlikely however, as psychologists will be subject to the same pressures currently experienced by psychiatrists. Issues of clinical responsibility may also result in conservative decision making in order avoid false negatives.

It is important to recognise that psychiatrists make sectioning decisions within a professional context and are subject to a number of environmental pressures. These external influences occur as a result of this role, and would therefore presumably transfer to the role of clinical supervisor. Clinical psychologists should not consider themselves to be somehow immune to these pressures. However, research reviewed by Churchill and colleagues (1999) indicated that there is some suggestion that assessments made by non medical professionals are less likely to result in the service user being sectioned. (63% of cases assessed by social workers resulted in sectioning compared with 81% by psychiatrists). They also report a general trend for psychiatrists to be most likely to recommend formal admissions, while Approved Social Workers are more cautious. More research is needed in this area in order to determine what the affect of having psychologists’ make these decisions would be. It is possible however that conceptualising mental
health problems within frameworks which rely less heavily on medical criteria and include more social factors affects decision outcome.

The identified advantages of clinical psychologists becoming clinical supervisors have therefore been focused around issues of increasing use of non-medical formulations and treatments to the most severely distressed clients we work with. It is assumed that this is preferable to medical interventions. However, it may be that it is the compulsion itself that is adverse to service users and not simply the treatment methods (Churchill et al, 1999). The type of professional involved in the decision process will therefore not affect this aspect. It is naïve and insulting to our psychiatrist colleagues to assume that psychologists are in some way intrinsically more empathic and caring and that psychiatrists are insensitive to the experiences of the service user under section.

A number of psychologists have objected to the proposed changes, citing a number of disadvantages associated with our clinical work with clients. These have focused around two areas, the unwillingness of psychologists to become more involved with sectioning and compulsory treatment for ethical reasons, and the negative affect of this on relationships with individual clients. As discussed above, the latter is a very real concern, supported by research which indicates that the therapeutic relationship will be adversely affected if the service user is subject to compulsory detention and treatment. The voluntary, collaborative nature of our current work is threatened by these changes. However, an interesting finding by Churchill and colleagues (1999) suggests that clinical psychologists may be naïve to assume that service users do not presently consider them to be implicated in this practice. The findings suggested that service users who were admitted informally considered their treatment to be coercive, believing that refusal would result in admission under the MHA. This suggests that service users may already
feel coerced by clinical psychologists who participate in discussion with service users resulting in informal admissions. Further research is needed to determine how service users differentiate between presumed motivations of different professional groups. It may be that at present service users believe refusal of advice to accept informal admission by a clinical psychologist would result in the involvement of a psychiatrist for sectioning.

The ethical objection to undertaking the new responsibilities is a more problematic argument. This is because, as Pilgrim (2005) writes, we are already involved in the system which subjects service users to compulsory treatment. We are all employed by the same state funded system and it is therefore naïve to consider our work to be morally exempt from the ethical problems which exist at another point in the same system.

Ethical objections to the use of compulsory treatment were first raised as part of the antipsychiatry movement in the 1960s (Thomas & Bracken, 2004). Arguments centred around the use of inhumane treatments against disadvantaged members of society in order to exercise social control. The movement rejected the existence of mental health diagnostic categories and questioned both the scientific reality and the wider social motivations of compulsory treatment. It demonstrated how psychiatry had been used as a means of control over individuals who did not conform to societal norms, and as an attempt to legitimise the oppression of disadvantaged groups. The use of psychotropic medication has been viewed as an attempt to alter the way an individual thinks in line with accepted societal norms. Compulsory treatment, viewed within this framework therefore becomes repression of individual freedom of thought for the purpose of social control (e.g. Szasz, 1970).

In my view, psychology can not consider itself to be exempt from these dilemmas. Clinically, psychology is also implicated in attempting to alter an individual’s thinking in ways which are more representative of the norm, albeit with the aim of minimising subjective distress. The use of cognitive
behavioural therapy aims to enhance an individual’s ability at ‘rational’ thinking, reducing thinking errors which are causing biases in thinking which do not reflect reality. This could be viewed as a more subtle form of the cognition alteration that occurs in drug therapy. Like medical treatment, psychological therapy also involves a powerful professional assuming a position of knowing what is best for someone suffering distress. It still assumes that the practitioner’s idea of reality is correct and that an individual’s thinking style is preventing them from seeing this reality. It takes a westernised view of ‘reality’ which may not be appropriate for other cultural groups. Compulsory psychological treatment is therefore no less problematic than compulsory drug treatment (and as Holmes (2001) acknowledges, not pragmatically possible). Psychological treatment does however avoid two additional ethical problems related to psychiatric treatment. These are that psychiatry is particularly vulnerable to the influence of the pharmaceutical industry which has profit rather than person centred care at its core (Moncrieff et al, 2005). Additionally, unlike psychiatric treatments, psychological treatment packages do not have equivalent unwanted side effects and have not received the same level of criticism by service users who have received them.

In summary, objections to psychologists taking on the role of clinical supervisor have focused on the damage to the therapeutic relationship we have with our clients, which currently involves voluntary participation and collaboration. Whilst psychological therapies may be viewed as more humane, in that they do not involve equivalent side effects to psychiatric interventions, they are not exempt from the criticisms upheld by the antipsychiatry movement. In particular, psychological interventions are still aiming to alter unconventional thinking in favour of a more rational norm. How we characterise this unconventional thinking and the accepted norm is wholly dependent on social constructs and is dependent on our own subjective beliefs and cultural values. Therefore, the argument that the increased use of psychologists rather than psychiatrists in compulsory treatment is inherently more ethical is too simplistic. Furthermore, as
Holmes (2001) highlights, no service user group has campaigned for psychologists taking on this role.

Ethical objections to the use of compulsory treatment, and those more widely applied to psychiatric treatment in general, are closely related to philosophical arguments. 'Philosophy of mind' arguments concern the nature of the human mind and the degree to which it can be understood to be distinct from the brain. Historically, authors writing from within an 'antipsychiatry framework have argued against psychiatry on the grounds that it places a socially contextual concept such as 'madness' within a biological framework (e.g. Szasz, 1970). It is therefore following a materialistic philosophy of mind, assuming that the activity of the mind can be mapped on to the workings of the brain. Problems with the mind can therefore be understood as having a physical manifestation in the brain. Following this framework, it is therefore possible (and preferable) to intervene at this physical level in order to bring about change at the 'mind' level. The success of science and medicine in the early part of the last century provided a strong motivation for adopting a materialistic philosophy of mind over a dualistic framework (Braddon-Mitchell & Jackson, 1996). Dualism assumes that mental states are different from neurological states, that they both exist, and that there is an interaction between them, (although the mechanism via which this interaction occurs is currently unknown). The lay persons understanding of the mind / body distinction tends to be dualistic, as this fits with our subjective experience of our minds. However, it is rejected in philosophy (Braddon-Mitchell & Jackson, 1996).

Psychology can be understood as inherently a dualistic discipline, as it involves the application of theory and investigation to mental states, whilst assuming that changes in mental states can affect brain states and vice versa. Alternative psychological approaches to philosophical understandings of mind have included behaviourist and functional philosophical approaches.
The rise in cognitive psychology is an example of a functionalist approach. Functionalism sidesteps philosophical questions relating to the nature of the difference between mental states and brain states. Instead it seeks to understand mental states as functional states which are definable in terms of its causal relations to other mental states, as well as inputs and outputs (which may or may not be physical in nature). Functional approaches therefore allow us to understand qualities about mental experience which neurological explanations cannot elucidate (O’Hear, 1998).

These underlying philosophical frameworks have important consequences for how we view mental illness. Medical models of mental illness are essentially reductive materialistic models of the mind. These contrast starkly with the qualitative psychological models which are likely to be either dualistic (if focusing on the subjective experience of mental events) or functionalist (if prioritising understanding mental states in terms of series of inputs / outputs and the relation to other mental states). In my view, these fundamental differences between psychology and psychiatry result in many of the opposing attitudes experienced within professional mental health settings. The different conceptualisations also influence how we wish to intervene in minimising the distress caused by mental health difficulties. Understanding conflicts within a philosophical framework may be helpful in reducing these professional conflicts. This is because it provides an alternative to lead us away from the unhelpful rhetoric of viewing psychiatrists as motivated by social power and control.

Advantages and disadvantages of the changes for the professional identity of clinical psychologists.

Quite apart from the issues and dilemmas the proposed changes bring in terms of our work with clients, there are also a number of implications for our professional identity. The changes are likely to affect how we work in terms of the balance between time spent providing psychological therapies
and other roles. It is likely to affect how we are viewed by service users and also by the general public. It also may affect how we view our own role in providing mental health services.

Some writers have argued that the proposed plans offer a number of advantages in offering the opportunity for professional development. Holmes (2001) has questioned the validity of these claims, arguing that the changes will negatively affect our work in that the bureaucratic and administrative requirements of the Act would take considerable time away from client care. It would also mean increased unsocial working hours for psychologists and possibly a requirement to be available to work 'on call'.

Others have taken a more optimistic approach to understanding how the changes will improve our professional identity. Kinderman (2005) for example has suggested that many psychologists “relish positions which gave them greater leadership, influence and(...)power within the system”. Kinderman (2005) is arguing that a more powerful position for psychology would inevitably result in a more psychologically minded care approach, and that this would benefit service users. However, I think that these issues need to be de-coupled from assumed benefits for service users. This is because as discussed above, it is too simplistic to assume that psychological approaches are inherently more ethical and preferable to service users. An important concept within the post psychiatry and critical psychiatry and psychology movements is the recognition of the diversity of service users' attitudes towards conceptualising their problems and how they want to be treated (Thomas & Bracken, 2004). Whilst some service users have voiced concerns over psychiatric treatments, others may prefer a medical model to a psychological model. Furthermore, it is premature to hypothesise the affects of a more powerful psychological position which has not yet materialised. I think that these arguments are interesting in terms of the wider issues underlying them.
Arguments which suggest that increased power is something which would be beneficial to clinical psychologists seem to me to suggest an underlying sense of powerlessness within the profession. Psychodynamic theorists have viewed power striving as indicative of feelings of powerlessness and feelings of ineffectual operating (Bateman & Homes, 1995). This raises questions regarding the robustness of our professional identity, the extent to which it is held in high regard by the general public and other professionals, and the extent to which we are confident that psychological interventions are benefiting clients. Increasingly, within the NHS it is necessary to prove cost effectiveness. This is coupled with an inter-professional emphasis on 'continuing professional development' which has resulted in increased training of other professionals in psychological therapeutic models. Increasing numbers of less expensive staff are therefore able to provide psychological interventions, which may have resulted in a sense of psychologists feeling under threat. In addition, the advance of neuroscience has compounded this problem, as it has encouraged a shift towards a materialistic philosophy of mind which renders psychology less useful (Braddon-Mitchell, 1996). In fact, neuroscientific findings can be incorporated into a functionalist philosophy and is therefore consistent with psychological frameworks. Nonetheless, this may have added to an increased sense of threat to psychology as a profession.

In her argument against the use of psychiatric classifications to understand the difficulties faced by individuals referred to as 'psychotic', Mary Boyle (1990) argues that professional power and identity is a motivating factor sustaining a medical (and reductionist) understanding of mental distress. She proposes that psychiatry as a discipline is in a disadvantaged position to other branches of medicine, as a result of the lack of objective measures. It has therefore been necessary to stress the role of physical factors affecting a physical organ (the brain) in order to compare with other medical disciplines. In my view, clinical psychology can also be seen as lacking a sense of a strong professional identity in this way, in that a more medical model is perceived necessary in order to compare with medical professionals. These
issues may help to explain why a more powerful place within a medical system is attractive to some clinical psychologists.

**How will clinical psychologists decide?**

As described above, the advantages and disadvantages to the role are often linked with complex underlying themes. The question of how clinical psychologists will decide whether or not to work with these changes is an interesting one. It is necessary to consider how psychologists can influence the changes and the repercussions of accepting or distancing oneself professionally from the new role. In my view, psychologists' have five options to choose from. These could be described as 1) Direct activism 2) Personal rejection of the role 3) Involvement in government consultation 4) Critical acceptance of the role 5) Supportive acceptance of the role. These are outlined below.

1) **Direct activism:** This approach has been taken by service user groups and a small number of psychologists. It involves external political pressure on the government to oppose the changes without engaging in negotiating. This avoids the problem which may occur with engagement in the consultation process of ‘falling into a position of collusion or making a compromise too far’ (Harper, 2005 pg 70). Groups such as ‘Mad Pride, Critical Psychiatry Network and The Forum, amongst others, have taken this approach’. This has resulted in a number of successful demonstrations, which contributed to pressure on the Government to redraft the legislation.

2) **Personal rejection of the role:** This could involve refusal of the clinical supervisor role and seeking jobs which are not likely to involve pressure to become involved in compulsory treatment. Personally, I feel that this is the avenue I will be most likely to take, as I am not willing to accept the new role as it currently stands, for the ethical reasons outlined above. In a survey of attitudes of Clinical Psychologists carried out by Cooke and colleagues,
2002 (in Harper, 2005), 29% of respondents felt that the proposed new role should be resisted. At the time of the study, 32% were unwilling to become clinical supervisors and 16% were ‘willing to refuse even if put under pressure’. This position is problematic for a number of reasons. Most worryingly, it is likely to result in psychologists who are strongly motivated to reduce compulsory treatment moving away from this area of work. This may mean a reduction in discussion and criticism of the changes if they come into effect by those who are actively involved in working with group.

Working within client centred frameworks inherently reduces the emphasis on compulsory treatment. Client generated priorities for change may differ from the hierarchy of symptom elimination, which is the focus of compulsory treatment. A number of mental health directives in Europe and Australasia have taken a person centred approach focusing on identifying the ‘unmet needs’ of service users. Meeting these needs has resulted in an increase in subjective wellbeing (Slade et al, 2005).

3) Involvement in government consultation: This involves attempting to influence the proposals to make them as client centred as possible, acknowledging the views of service users and carers. Cogan (2004) describes representing the BPS in submitting a brief examining the proposed changes for Parliamentary debate. Cogan (2004) highlights the recommendations made by the panel in order to render the Act compatible with human rights legislation. Key recommendations included an increased emphasis on capacity to consent, so that those individuals who were thought to hold the capacity to consent were able to refuse treatment. The proposed changes made by the committee are in line with the views of a number of service user, carer and professional groups (Cogan, 2004).

Involvement in the decision making process at a national level is important if it results in changes which benefit service users in this way. Harper (2005) reviews his own involvement in this process, representing the British Psychological Society. He argues that the opportunity to engage in
negotiations affecting mental health legislation is rare, and so should be utilised wherever possible. He acknowledges a number of difficulties however including the failure to gain consensus on key issues as well as the significant time and resource commitment required.

4) Critical acceptance of the role: The advantage of this position is that it ensures that people who are critical of the changes are still working with this client group. The use of client centred interventions such as advance directives, which enable the service user to clarify treatment preferences should they lose capacity to consent and require sectioning, may be employed in order to reduce adverse affects of sectioning. However, (Thomas & Cahill, 2004) report low uptake of advance statements by service users. The authors' hypothesise that years of oppression by compulsion in the mental health system make service users feel disempowered and demoralised. This is mirrored in the stigmatisation by society as a whole. Service users may therefore be sceptical about the usefulness of advance directives. Thomas and Cahill (2004) argue that “the idea that we can soothe the pain of greater compulsion with the balm of advance statements is simplistic” This is potentially massively problematic as it gives the appearance of enhancing service user rights whilst apparently having little significant impact on distress experienced. If this is the case, it is likely that interventions such as these are actually meeting the needs of professionals in their struggles with the ethics of involvement in sectioning, and not meeting the needs of service users.

5) Supportive acceptance of new role. A significant number of clinical psychologists are likely to accept the changes as a positive step for their own personal development as well as the profession as a whole. In the Cooke and colleagues (2002) survey 52% of clinical psychologists who responded to the attitude questionnaire were willing to become clinical supervisors if offered appropriate training. Clinical psychologists willing to accept the changes
may be motivated by the advantages of the new role identified above. Comments included on returned questionnaires support this. Psychologists referred to the advantages of a psychological understanding of service users' difficulties as an alternative to a medical framework. Less desirably, power and money issues were also identified as motivating factors, and concerns were raised that pay should be commensurate with the new role (Harper, 2005).

Clinical psychologists working in specialist areas could be involved in consultation processes with psychologists wishing to undertake the new role. Forensic psychologists, for example, may have particular experience with a number of the ethical issues involved. They may be more used to working with clients where motivation for engagement in therapy is external (for example fulfilling parole requirements, securing release from institutions) rather than internal factors (wishing to reduce subjective distress). Consultation with these professionals around issues of working with service users who are subject to compulsive psychological treatment may reveal possible resolutions to some of the ethical dilemmas raised by the Act.

Summary

In conclusion, a number of advantages and disadvantages have been identified relating to the proposed new role of clinical supervisor. These have focused on implications for our client work as well as clinical psychology as a profession. Possible reactions in terms of professional role choices were outlined. These ranged from direct activism against the proposals to full acceptance of the new role. My personal inclination towards person centred client work led me to favour rejecting the new role. This was mainly influenced by the ethical problems involved in compulsive treatment. Interventions should be aimed at increasing subjective wellbeing and not reducing objective medical symptoms which may not be prioritised by the service user themselves.
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Problem based learning reflective account: Year 1

March 2005

Year 1
On the day of the presentation I was very nervous. I was concerned that our presentation would not be up to a sufficiently high academic standard, that we would be unable to keep to time and that we had somehow missed the point of what the presentations were about. In particular, I was worried that other group presentations would be alike in some way that ours was not, and that this distinction would be obvious and would render our presentation incorrect in a concrete way. As I sat through the other presentations my anxiety was not diminished. I began to realise that our presentation was very different to other groups, and that this difference would be very obvious as soon as we began. I began to feel very uncomfortable and exposed. Had we missed the point? Our presentation was not funny! It seemed to me that the other groups had a strong comic theme, complete with panto-style props, and that they were enjoyable for the audience. I felt embarrassed that our presentation would seem conservative and orthodox in contrast to the creativity displayed by other groups and began to question the value of our presentation for the audience. In discussion with the rest of our group after the presentation, we commented that we had felt like we had been too conservative and would try to be more entertaining next time.

With the benefit of hindsight and clinical experience, I now view our presentation quite differently. I consider my immediate reflections on the day of the presentations as resulting from a sense of conformity pressure. On reflection, I think that the content of our presentation, as well as how we chose to present it, says a lot about our group process. I will first discuss the dynamics of our group when preparing for the presentation and the effects on the presentation itself. I will look at theoretical models of group process which underlies my experience. My clinical work has also impacted on how I regard our presentation now. In particular, I have noticed clinically the importance of recognising how clients can affect us as therapists, which was the content of our presentation. I have also reflected on patterns in how I think about clients and formulate their difficulties and how this relates to our group presentation.
Two dominant issues were present in our initial group meetings. These were a feeling of anxiety that we felt we didn’t really know what we were supposed to be doing, and an awareness that there would be an extra member joining us after the first two weeks. Both these factors influenced our group a great deal. Kutter (1982) describes the group as a system or matrix, where the group itself is more than the sum of its parts. In his model of group process, he describes the group as a network of relationships complete with normal interpersonal processes such as transference. When I look back on our group meetings there are a few sessions which were significant in that there was a change in direction, accompanied by a sense of progression and learning. One of these changes was brought about by the effect of the last member joining our group. Kutter’s (1982) ‘segment theory’ of group process helps explain how this occurs. Each individual contributes a segment to the group, and the sum of these segments form a specific ‘internal structure’ with a ‘culture’ operating along certain rules. This changes all the time with the changes in each individual segment, as well as the extent to which each individual is currently engaged with the group process. For example, individuals with particular conflicts may enter the group with particular vigour if these conflicts become a group issue. This means that the level to which each individual segment is engaged affects who is vulnerable to transference at any one time. Kutter explains that when a new person enters the group, the extent to which their personality structure fits what is anticipated contributes to how much the group process is disturbed.

In our group, there had been a developing culture of resistance and confusion about the aims of the presentation. I had assumed the new member would be as uncertain as we were, and in my mind her role was to contribute to unpicking the task in a confused and disheartened way which matched our approach. However, unaware of these rules and rejecting our pressure to join us in our hopelessness, the new member brought a sense of enthusiasm and clarity to the group. This was a defining moment in our group process and changed some of the rules we had been operating under. In this way, the
additional individual segment disturbed our unhelpful group thinking and enabled us to move on as a group.

A second major shift in group thinking occurred during one of our early group discussions. One member of the group hit upon an idea which we were very enthusiastic about. We decided to turn the topic on its head, and rather than talking about ourselves as agents for change, we would discuss how the clients are likely to be agents of change for us. Looking back on it now, this was creative thinking on our part, and I think that my initial impression on the day of the presentations that we had not been creative enough was unjustified. Although the method of presentation was rather orthodox, the topic was creative. It was also very meaningful to us and so we were able to become increasingly enthusiastic and motivated.

Part of the reason the content of our presentation seemed so attractive to us at the time was probably because we could at last obtain relief from our anxiety that we didn't have a clear plan. Anxiety also had an important effect on our group in terms of how we chose to present our work. This can perhaps be best understood in terms of the psychoanalytical concept of defences. Modern psychoanalytical thinking views defences in terms of a reflection of our mode of coping with threatening affect in our internal world (Lemma, 2003). They can be seen as having costs and benefits and are sometimes creative solutions to internal psychic difficulties (Sinason, 2002). She argues that there are two types of defences, defences against problematic realities and defences towards a feeling of security and safety. In our group we had been anxious about producing a presentation of an acceptable academic standard and were coping with uncertainty about what was being asked of us. Our decision to formalise our presentation, to revert back to tried and tested methods of passing academic tasks was a defence against this anxiety. As scribe, it was particularly easy for me to formalise the task in this way, as the role required a certain amount of concise record keeping and administration. As a group, we divided up the tasks in a formal manner, driven by a strong sense of fairness that everyone should get equal time to
present their ideas in a way that was familiar to us and had proved successful in the past. We were also diligent about time keeping, regularly practising to make sure we were not running over time. Interestingly, we were all aware on the day of the presentations that other groups went over time, conflicting with our group 'rules' about fairness. This can also be understood in terms of our defensive formality. With the benefit of hindsight, we now have a better understanding that flexibility and creative thinking is highly valued within the course.

My clinical work since the PBL task has had a large impact on how I now view our presentation. The task was to consider the relationship to change, how it affected us and our clients and as I have described, we approached the task from the viewpoint of how our clients are likely to effect change in us as practitioners. Through my subsequent clinical experience, I feel I have now seen the application of theory in practice. The content of our presentation now holds deeper meaning, and through discussion with service users, I am increasingly enthused by this topic. As part of our presentation, we presented the work of Khan and Harkavy-Friedman (1997), who had researched the effects of client change on therapists. I have found many of these ideas relevant in my clinical work. In particular, the authors write that clients may be a source of inspiration for therapists in terms of their resilience in the face of extreme difficulties. I have found this particularly true in my work with one woman, who has overcome extremely difficult circumstances with a courageous attitude which I have found inspirational and admirable. This has led me to reflect on how our clients can motivate us as therapists to approach our own difficulties with a sense of self belief, resilience and courage. Khan and Harkavy-Friedman (1997) discuss the value of learning simple things from our clients, which may lead to a behavioural change such as taking up a new hobby. I have found learning about the lifestyles of clients from diverse backgrounds very interesting and often surprisingly different from my first impressions.
During our presentation, we discussed the role of service users in effecting change at an organisational level. I recently attended a training event on personality disorders on my clinical placement and was able to learn a great deal from the experiences of a service user who presented her experiences of psychological therapy. This increased my awareness of the crucial importance of service user input into service direction. It was clear from this presentation that the experiences of service users are absolutely fundamental to providing a useful, meaningful therapeutic service in order to effect change.

Finally, the process of evaluating our presentation affected how I view my own clinical style. I wondered whether using formality as a defence against anxiety was evident in my clinical work. On reflection, I feel that in my interaction style with clients this defence was not evident. My interactions tend to be more relaxed and include an element of humour which was not evident in our presentation. However, in my own thinking about the client and in supervision I realised that I have been very formal and conservative in my approach to thinking about working therapeutically with the client. I had been suppressing creative thinking in an attempt to find the ‘correct’ way to work with clients. As a result of my anxiety in terms of clinical competence at this early stage of training, I am aware that I rely heavily on a conservative approach as I am preoccupied with learning what I ‘should’ be doing. This stems from anxiety that there must be one fixed, rigid way of doing psychological therapy. I have learned that even at this skills learning stage, it is important to think creatively about working with clients, whilst still following evidence based research closely. It is interesting that while in our presentation we showed creativity in content but not interaction style, the reverse has been true of my clinical work.

As a result of these reflections, would our presentation be approached differently if we were to do it again? Although our conservative style may have had negative consequences in that it may have held less audience
appeal, it served an important purpose in that it reduced our anxiety and enabled us to become task focused. We learned a great deal about the evidence behind clients as agents of change for therapists, and this has been deepened through our clinical experience. Furthermore, as these defences are deeply established in us as individuals, we are likely to continue to use this defence when faced with similar demands. However, I have been able to consider the importance of understanding this tendency to formalise my thinking in a concrete way to deal with anxiety. This has resulted in an increased awareness to ensure that I am able to value creative thinking in my clinical work.

References


Problem based learning reflective account: Year 2

March 2006

Year 2
During initial discussions concerning how our group might choose to approach this second problem based learning exercise; it became clear that a sense of wanting to conform to the larger group norm was present within our group. This originated from the day of the presentations of the first exercise, when our group had felt a communal sense of exposure. This was because unlike the other groups, we had chosen a very formal mode of presentation which appeared bourgeois and conservative in comparison to other groups. Over time we had reflected upon this, and had realised that our presenting style reflected both the serious nature of the topic we had chosen to present, as well as our individual and group defences against anxiety (Lemma, 2003).

Perhaps wanting to avoid this sense of being exposed, our group decided to approach the second problem based learning exercise in a less formal manner. Presenting the material in a creative way was prioritised from the outset, and this was agreed upon before we had even fully engaged with the task. Although this had the effect of diminishing our anxiety about presenting to the larger group (in that we felt sure that this time our groups’ presentation would fit the norm) it also affected our attitude towards the task. Our focus from the outset on the presentation meant that we became outcome focused, and did not attend to process issues in as much depth as we had previously. We were also keen to make our presentation as entertaining as possible. This light heartedness had an interesting effect on the process of preparing the presentation. Rather than enlivening the experience, I felt unenthusiastic about it. I was keen to do whatever was necessary to further the progression of our group towards the presentation which we had planned from the early stages. We worked steadily towards completing these tasks, and did not alter anything from our initial idea. The project quickly felt stale and unexciting. This was frustrating in that in attempting to enliven the outcome of our groups work, we had limited the process by which it could be accomplished. Interestingly, this was also reflected in the feedback we received. Two reviewers commented that we had not included any reflections about the process of the exercise.
Looking back with the benefit of hindsight, I have reflected on the affect of taking this approach on my clinical therapeutic work. I wonder whether being over focused on the outcome of my work has precluded me from engaging fully with the process. In my therapeutic work I am greatly influenced by the writings of Carl Rogers (e.g. Rogers, 1961) His humanistic therapy is particularly resonant for me, because I feel it is consistent with the spiritual principles I have been brought up with. The humanistic emphasis on man’s intrinsic drive towards bettering themselves, healing and coping, is consistent with universalistic Quaker beliefs. Rogers regards ‘genuineness’ within the therapeutic relationship as fundamental to maximising this aim (Rogers, 1961). It became evident to me that my tendency to focus on outcome which was so notable in the problem based learning exercise had become a pattern of my training in general. This reflects the level of anxiety associated with being assessed, which inevitably results in a bias towards outcome. However, my experience of the problem based learning exercise was that becoming too task focused resulted in a reduction in both creative thinking and awareness of the changing dynamics in the present moment. As Rogers considers the therapeutic relationship to be an important mediator of change, an impoverished relating style impacts negatively on therapeutic outcome by association. I felt that it was important to unpick this further in order to reduce the negative impact of this current pattern on my work. I explored these issues in supervision and have started to place increased emphasis on process issues in my clinical work.

Part of the reason that I felt unenthused by the problem based learning exercise was a result of my lack of experience with the client group concerned. The exercise focused on the experience of Mr and Mrs Stride. Mrs Stride was described as a woman who has learning disabilities, falling within the mild range. Mr Stride attended a school for children with special educational needs. Mr and Mrs Strides’ children had been taken into care, following concerns that they could not be adequately cared for by Mr and Mrs Stride. This was on account of Mr Stride’s violent behaviour towards Mrs Stride which had been witnessed by the children. We decided to
approach the task by splitting the group into two halves according to which placement each person was on. The decision to split the group was taken with the aim of allowing the work to be divided (again reflecting the outcome focus within our group). This divide became further pronounced as the work continued and the presentation was constructed. In our final presentation, this divide was also evident. We chose to present our work in a role play of two interviews for clinical training, with one interviewee focusing on the child elements of the case, and the other interviewee focussing on the learning disability issues. Presenting our work in this way meant that we did not need to resolve the issue in terms of making recommendations as to whether the children should remain in care. I feel this reflects our reluctance to appear as 'experts' in an area in which we felt we had little experience. However, when asked by another group to make clear our views on this issue, it was interesting that there was a group consensus that the children should be returned to their family.

With the benefits of completing a six month placement in a child and family service, I feel that my feelings regarding this vignette have changed. I am still completely inexperienced in working with adults with learning disability, and will no doubt be further influenced by my next placement which will involve working with this group.

However, at present it is my view that the children in this vignette would be better placed within their family of origin than with foster carers. My decision is therefore the same as on the day of the presentation. However, with the benefit of experience I am now more certain and confident in this decision. Three main factors influenced my decision initially. Firstly, an intrinsic belief that children are best cared for by their primary attachment figures wherever possible. The negative affects of disruption of attachment relationships is well documented in the literature (e.g. Bowlby, 1969). This was further emphasised by my tendency to wish to endorse Rogers' ideas about the human instinct towards growth. Secondly, I was influenced during our preparation for the presentation by an article I read by Tim Booth (2001)
which suggested that parents with learning difficulties were often subjected to ‘overzealous’ risk assessments, and that these assessments were characterised by a ‘presumption of incompetence’ and a ‘deficiency perspective’. A number of studies have suggested that a worryingly small number of children of parents with learning disabilities are living with their family of origin. This suggests that having a learning disability may be being considered (effectively) reason in itself to remove the children into local authority care (via unequal treatment in the legal system). The result is that ‘unnecessary harm is being done’ (McConnell & Llewellyn 2000b in Booth, 2001).

Thirdly, the feeling within our group was that the family within the vignette were in touch with a number of professional systems, and that not enough was being done to promote the use of the family’s own coping systems. In particular, we felt that increasing the grandparents contact with the family was one area which had not been sufficiently explored. This could potentially increase the family’s support without increasing external professional contact.

My experience working within a child and family service has resulted in an increased sense in the applicability of these concepts to this case. Few would argue with the idea that children are best cared for by their primary attachment figures wherever possible (i.e. in the absence of abuse or neglect). However, the intensity of this bond in the presence of abuse and neglect came as a surprise to me. During my placement I attended a Social Service Liaison Meeting where a complex abuse case was discussed. What struck me most about the case was that despite the best efforts of the professionals involved, the child made frequent attempts to get home in order to see his abusive mother. This case, as well as other cases which involved children who did not have any available attachment figures in their lives, prompted me to reflect upon the critical importance of good attachment relationships for emotional well being. The difference between intellectual competence and emotional / relational competence became
increasingly important in my reflections. This intensified my feeling that involving the grandparents in ensuring that the children’s concrete needs were met and that they were not exposed to domestic violence would be one avenue by which the family could be helped to stay together.

During my child placement, I was able to observe and use a solution focused approach in my clinical work. This experience affected how I viewed the vignette in countering the tendency towards a deficiency perspective. In solution focused therapy the client is encouraged to use ‘problem free talk’ which helps to illuminate strengths and positives within the family system. Berg and Steiner (2003) describe how exceptions exist within every problem when the difficulty is either absent or less severe. Focusing on these occasions allows exploration of what it is that is different when things are better, in order to increase and enhance these occasions. Additional techniques involve construction of a more preferred future, whereby preferable futures are constructed within the session in order that the client is able to make the necessary concrete changes to their own lives. Working within this therapeutic model has had a pronounced affect on my clinical work. In particular, I feel that working in this way creates a sense of hope and optimism and allows the client to gain a sense of distance from their problems. During my child placement, I have observed the use of solution focused therapy in promoting change within a number of problematic family systems to very good effect. This has effected how I view clinical problems, and again I am struck by how the Stride family have coping systems in place which are not fully utilised. These should be maximally explored before external measures are used.

Finally, in the six months since we completed the exercise, we have received teaching in assessing parenting skills in adults with learning disabilities. In addition I have been trained in child protection procedures. One issue that came out of the teaching on parenting skills in this group is that there is no definition of ‘effective parenting’ and clinicians must rely on their own clinical judgement. On the other hand, it struck me during the child
protection training that most parents were considered to be ‘good enough’ parents if there was no indication of physical, emotional, sexual abuse or neglect. If the absence of abuse is therefore sufficient criteria for people without learning disabilities, it should also be sufficient for those with learning disabilities. Performing parenting assessments in addition to an alertness to indicators of abuse or neglect is therefore endorsing the ‘presumption of incompetence’ and ‘deficiency perspective’ outlined in Booth (2001). Clinical psychologists should be aware of this when deciding whether or not to carry out such assessments.

In summary, I feel that my attitude towards the problem based learning exercise in itself, as well as the content of our presentation has changed as a result of my subsequent clinical experience. In particular, combining a solution focused approach to family work with my own tendency towards humanistic principles has enabled me to develop a better understanding of the importance of reflecting on the process of therapy itself.

References


Problem based learning reflective account: Year 3

March 2006

Year 3
On my first reading of the problem based learning exercise the group would be undertaking, I was pleased to find that there were a number of issues raised in the vignette that fell within an area I have a particular interest in. Although my experience of working with older adults was (and still is) limited, I felt that the focus on cross cultural issues and migration were potentially very interesting. During our initial discussion of the vignette as a group, we found that we had all identified the cultural elements of the case to be particularly interesting, and we were enthusiastic about taking this as a directional focus for the presentation. We discussed at the time how this focus seemed to reflect the research interests of individuals within the group, as well as a recurrent emphasis on diversity at the course level.

Our approach to the exercise: content and process.

The case vignette itself described the difficulties experienced by an elderly Pakistani man who had experienced separation and loss on many levels. The vignette described psychological difficulties resulting from the experience of a recent bereavement. In addition to the grief inherent in this loss, it became clear in our discussion of the case that there were other losses that were also important in this case. In particular, we felt that issues relating to the cultural losses involved in migration, as well as losses associated with the developmental ageing process. The subject of the vignette had also experienced the recent loss of other important relationships as other family members had chosen to return to Pakistan. Whether these additional losses compounded the losses associated with the grieving process was unclear. We felt strongly as a group that we would like to explore the impact of cultural factors on the individual’s psychological experience of these losses. We chose to present a systemic formulation of the case, as we felt that this would allow us to consider the different levels of influence on the case. We decided we would each choose a different level at which to formulate as reflected our personal interests, from the micro (individual) to the macro (societal) level.
In order to explore our approach to the task, and our reflections on it with the benefit of hindsight, I have chosen to use Belbin's description of various team roles that can operate within a group. These are descriptions arising from 9 years of research in within the sphere of occupational psychology (Belbin, 2003). The team roles are descriptions of personality traits, intellectual styles, and behaviours that were observed in managers approaching various tasks.

During our initial discussion of the new PBL task, we adopted roles that are identified by Belbin as 'action-oriented roles'. This reflected our common objective of minimising stress and anxiety around the task. Once we had decided on the goal of our presentation, different group members took different roles in planning the task. These roles are described by Belbin as 'implementer' (described as typically turning ideas into practical actions), 'completer finisher' (described as painstaking and conscientious, responsible for ensuring delivery on time) and 'monitor evaluator' (characterised as strategic and discerning). Our group decision that we would all take responsibility for a different level of the systemic formulation according to our own specialist interests meant that we all effectively placed ourselves within a 'specialist role'. This is described as a team role whose contribution lies in the provision of specialist knowledge. The role is characterised as being 'single-minded and self-starting'. There are drawbacks associated with this team role, which include a tendency towards over focusing on technicalities as well as providing a limited, narrow contribution.

Reflecting on these roles we took as individuals, our group lacked 'people oriented roles'. This meant that we did a lot of work independently. This may have limited our experience of group cohesion, mutual learning and enjoyment. However, this style of working had a number of associated benefits, including the opportunity to pursue our own special interests, which resulted in a higher level of knowledge acquisition from our individual literature searches. In addition we also gained a lot of knowledge from hearing about the work of the other group members. As a result we felt
proud of our presentation and felt that we were imparting valuable knowledge to our colleagues in other groups. There were also drawbacks to this approach, however. A greater focus on discussion and creative thinking might have resulted in an increased sense of group cohesion that may have increased our satisfaction with the process as well as the product of our work.

The way our group approached the task suggests we had fallen victim to a common teaming problem identified by Scholtes (1988) as the 'rush to accomplishment'. One drawback of concentrating on the preparation of the presentation materials is that we didn’t get to fully explore each other’s contributions and share as much as we might have done regarding the individual research we had done. Although we felt satisfied with the presentation itself, I wonder how we would have felt had we not received positive feedback. This can be seen as another drawback of focusing on performance rather than enjoyment and the process of the exercise.

In the light of these reflections, I have questioned how well we have worked as a group. Personally, my feeling is that we generally work well as a team, that there is a strong sense of social cohesiveness within the group and that we are supportive of each other and minimise stress and anxiety. However, upon reflection, I feel that the way we have chosen to minimise stress and anxiety is to take a very task-oriented approach to the PBL exercises we have undertaken throughout our training. As a group, we haven’t considered the effectiveness of this strategy, and evaluated it in comparison to other methods we could have adopted. For example, would an enhanced feeling of social support (which may have resulted from a more creative approach) have reduced our anxiety and stress levels further still? I am aware that as a group, we tend to experience positivity and enthusiasm at times when we are pursuing humorous and creative ideas in approaching the problem. Interestingly, these are often viewed by the group as being tangential and we invariably decide to return to the task at hand, which often involves a complete rejection of the creative ideas we have generated.
Thinking about how this occurs, it seems we often sabotage our original and creative ideas, by elaborating upon them to the extent that they become unworkable. This is unfortunate as the original concept is therefore rejected as it has become caught up in a ‘ridiculous’ embellishment. Reflecting upon this within our group, we discussed how seriously we view our areas of special interest and wonder whether this sabotaging strategy could be viewed as an attempt to protect this from being minimised by humour. This has led me to reflect upon how I view my clinical work, and indeed my training as a whole. The seriousness with which I approach my clinical work could be viewed in the same way. Although I feel that this attitude is crucial in maintaining a respectful therapeutic relationship, I have questioned if I am overly protective of this quality, and sabotage avenues that are more original or creative as a result. Minimizing my anxiety around working creatively within the therapeutic alliance may increasingly become important as I gain clinical experience.

**Implications for further development within our group**

In drawing these conclusions, I realise I have assumed that we all have the same objectives within our group. Our eagerness to approach the task in an action-oriented way and to stick to ‘tried and tested’ group norms suggests that we do, however this has never been explicitly explored within our group.

Do we all have the same objectives? Having decided that we could have learned more from each other, we could prioritise this as our goal in our other tasks together. One avenue that remains unexplored within our group is the opportunities for distinguishing between course requirements and our own priorities as an autonomous group. (Interestingly, feedback given by the cohort as a whole suggested that the presentation aspect of the PBL process was restrictive in that focusing on preparation for this limits the
opportunities for discussing issues raised by the work we have done. This suggests that the ‘product focus’ in our group, mirrors that of other groups within the larger cohort. It is interesting that as a cohort we have seemingly prioritised the presentation as the main objective, perhaps reflecting our experiences of education and training up to this point).

Group norms are established regardless of whether or not they are explicitly discussed (Scholtes, 1988). As a group we have not discussed changes that we would like to make in how we approach tasks. If we were to make changes in terms of our priorities this could best be accomplished through an open discussion about our objectives as a working group. Scholtes (1988) argues that ‘cooperative interdependence’ optimises task performance, so that the success of each member’s outcomes is determined by the actions of the other members. This raises interesting questions regarding how we have chosen to evaluate our work together in terms of our priorities. Do we all have the same priorities, and what would need to change to reflect a change of focus towards task accomplishment from performance to learning, interest and enjoyment?

Influences on clinical practice

The content of the work I personally undertook for the presentation has informed my clinical work, especially with relation to the literature review regarding stresses involved in migration, social isolation of migrants and the centrality of the concept of ‘Hijra’ to Islam. Hijra (meaning to migrate or abandon) is considered a positive, motivating and purifying force within Islam. Movement plays a central role within Islamic beliefs. Migration therefore may be considered to have unique implications for those with a strong Islamic faith. During the course of my placement I have worked with two individuals who have migrated from other countries, for various reasons. These issues raised by the PBL have been useful in exploring belief symptoms underlying positive and negative reactions to post-migratory experiences. In addition to these cases, research relating to factors
influencing stress reactions to migration has informed my work in developing a self help mental health promotion course aimed at Tamil individuals seeking support within a community setting.

In summary, aspects of my professional learning have influenced my clinical practice directly in my work with two individuals affected by similar issues to those raised in the vignette. More generally, reflecting on the way we have worked as a group and has led me to realise that we may have been too focused on the task at the expense of the process. Thinking about my own role within the group, I have reflected upon my own tendency to avoid creativity at times, perhaps fearing that the subject matter will be trivialised as a result. I have considered how my future clinical work could develop in this area, to include the opportunity for creating original solutions. It is likely that my confidence to work more creatively will develop as a result of increased clinical experience. These reflections have led me to consider how our group has developed over the course of our training and the assumptions we have made about how we can work efficiently and what our priorities are for optimising learning experiences in general. The challenge now is to consider how recognising assumptions we have made and our shifting priorities will affect how we work together for the final stage of our training.

References


Case discussion Group Process Account Summaries

Names and identifying information have been changed in the following summaries to preserve anonymity.
Case discussion group process account summary: Year 1

Edwards (1997) (in Shipton, 1997) describes two main models of supervision. The didactic model involves the use of rational reasoning of conscious thought processes and emphasises the teaching of theory and technique. The second model is more subjective and experiential, with an emphasis on the therapist's feelings as well as unconscious thought processes. The case discussion groups are an example of a combination of these two methods. In our group, there was a lot of emphasis on theory and some teaching of techniques. Feelings arising in the trainee bringing the case as well as group affect were considered to be of equal importance, reflecting the fact that the group facilitator worked within a psychodynamic model.

The supervisor/supervisee relationship can be understood as a model for the therapeutic relationship between the supervisee and the client. Conceptualising supervision in this way raises interesting questions regarding the dynamics of discussing cases within a group setting. Here the multiple relationships between the individual bringing the case and the other members of the group offer a diverse collection of relational experiences, whereby some relationships may better mirror the therapeutic relationships in discussion than others. My perception of these experiences was affected by whether I was presenting, or hearing a case. The affect of the development of relationships within the group resulted in increased emotional content, which were understood in terms of processes of transference and countertransference. In conclusion, my experience of the case discussion groups fits many of the experiences of supervision outlined in the literature. I experienced the group as a safe space which provided space to think clearly about clients, gain a new perspective, and revise emotional information which had been previously ignored. It also provided an opportunity to learn additional theoretical information and techniques for therapy.
References

Case discussion group process account summary: Year 2

My experience of the case discussion group in the second year differed from the first year both in terms of content and dynamics. This was evident from the outset, with the change in facilitator from an established member of the course team, to an experienced clinical psychologist working in the area. The inclusion of an ‘outsider’ within the group resulted in an interesting dynamic which had a major impact on the group. In addition, as second year trainees we had different expectations and priorities than those we had had in the first year. The change in facilitator and the development of our training led to an implicit focus on professional development. At times, issues relating to this were openly discussed, but more often than not I felt this was underlying our discussions in an implicit way.

A comparison is made between a therapeutic group I co-facilitated on placement and the development of group relations within our case discussion group. In both cases, as the group developed members became increasingly responsible for providing the support and containment for each other, and the co-facilitating professionals became increasingly superfluous. According to Tuckman (1983) (in Yalom, 1983), this dynamic is an important milestone within group dynamics and is an important indicator of group progression into a more stable phase, whereby individual conflicts are more resolved.

A number of hypotheses relating to how the group resolved conflicts relating to the development of a professional identity were identified. This led to the suggestion that including trainees from other professional groups may have a beneficial impact on clinical psychology trainees.

References:

Clinical Dossier

The clinical dossier contains summaries of five case reports written whilst on placement. Complete versions of the case reports can be found in volume II. An overview of clinical experience follows, which describes each of the five clinical placements undertaken during training.
Case Report Summaries

Names and identifying information have been changed in the following summaries to preserve anonymity.
Adult Mental Health Case Report Summary

The assessment and treatment of a 40 year old woman presenting with anxiety using a cognitive behavioural model

Presenting problem: Mrs Jane Roberts was referred to the CMHT by her GP. She was described as having a long history of generalised anxiety disorder. It became evident during the assessment that the client was experiencing intense anxiety in social situations as a result of an underlying fear that she would lose control of her bowels or be sick in public. As a result of her anxiety she had restricted her social activities. This was having an adverse affect on her mood and self esteem as well as causing her to have relationship difficulties.

Initial formulation: Jane’s symptoms did not fit neatly into a specific anxiety disorder as outlined in ICD-10 (World Health Organisation, 1994). An idiosyncratic psychological formulation for anxiety informed the intervention. Predisposing factors included a background history of anxiety as well as a family history of mental health difficulties. Precipitating events included the experience of an ear infection which had caused giddiness and nausea. This led to Jane’s belief that she was likely to vomit in public. Her difficulties were being maintained by her social withdrawal and use of safety behaviours which were preventing her from discovering that her fears were unlikely to occur. This was also reducing her confidence in her abilities to cope with such circumstances, should they occur. Good relationships with her family and her own resilience in overcoming previous experiences of panic were identified as positive protective factors.

Intervention: Three overall treatment aims were identified from the formulation. These were: 1) to reduce anxiety (in particular to prevent escalation of anxiety following awareness of initial symptoms); 2) to reduce
Jane’s reliance on safety behaviours; and 3) to apply what has been learned to increase self esteem.

These treatment aims were achieved using the Wells (1997) CBT model for anxiety disorders. Psychoeducation regarding the nature of anxiety was provided. This was followed by the use of cognitive restructuring and behavioural experiments to target specific problematic beliefs and behaviours. The client was able to generalise the new skills which had been learned to address other areas of difficulty, including low self esteem. Finally a relapse prevention plan was developed.

**Reformulation:** The original formulation was appropriate for understanding Jane’s difficulties. However, additional information which was disclosed over the course of the intervention was incorporated into the formulation and informed the intervention. In particular, additional information relating to core beliefs was incorporated. An intrinsic sense of self disgust as well as beliefs regarding whether she was acceptable to others were considered to be at the root of concerns that she would be sick in the presence of other people and that they would find her disgusting. She had developed dysfunctional assumptions that she would be accepted as long as she did not put other people out in any way. Being ill in front of others was considered to be a violation of this rule as she felt other people would have to clear up after her and would become unwell themselves. She was also concerned that they would think she was disgusting, confirming her core belief. Her perceived lack of control over whether she would be ill in front of others resulted in her marked anxiety. Her hypervigilance to physical symptoms can be understood in terms of attempting to control whether she was likely to be ill. Additional critical incidents and other social concerns were also identified over the course of therapy.

**Outcome:** The outcome of the therapy was measured using the BAI (Beck & Steer 1991). At baseline, Jane’s score indicated ‘severe’ anxiety. Mid point measures indicated a reduction in anxiety to ‘mild’ levels. Follow up scores
indicated that Jane was suffering from 'minimal' anxiety. Additional indications that Jane’s difficulties had improved were that she was able to take an increasingly metacognitive stance to her thinking (indicating distance from her negative thoughts). She also reported subjective improvement in mood and a reduction in frequency and severity of anxiety. Jane had also increased her social activities.

**Evaluation:** Jane showed significant improvement in her anxiety symptoms as shown by the BAI scores, her report of decreases in episodes and severity of anxiety, and her increased social activity. Jane had achieved a metacognitive understanding of her difficulties which should enable her to continue to make progress and to deal effectively with future difficulties. Additional work on core beliefs which the author felt were underlying Jane’s difficulties was not possible as a result of her resistance to the idea that these sorts of beliefs were related to her current difficulties. The author felt that this may increase the likelihood of relapse. However, Jane had developed good skills in dealing with negative thoughts at a surface level and this may be sufficient to coping with negative moods. A greater emphasis on the importance of core beliefs earlier on in the therapy may have allowed Jane to perceive this aspect of the intervention as less threatening.

**References:**


The use of integrative therapy for the treatment of depression in a Christian woman: Incorporating religious beliefs as evidence against negative automatic thoughts.

Presenting problem: Mrs. Sarah Richards was referred for psychological therapy by the consultant psychiatrist of the CMHT. She was described as having recurrent depressive disorder. It was evident from the initial assessment that the client held very strong religious beliefs. She described an episode of severe depression which had resulted in a sense of vulnerability to future episodes, which was of great concern to her. She also felt her confidence and self esteem had been markedly reduced as a result of this depressive episode, and told me that she no longer considered herself as someone who could cope in life. During this episode of depression, the client had been unable to continue to work as a teacher at a secondary school. She had also reduced her attendance at church and was not able to go out socially. At the time of our first meeting, the client viewed herself as ‘recovered’, although she described finding work a constant struggle. She was still experiencing periods of extremely low mood and negative thinking.

Initial formulation: Sarah was predisposed to depression on account of the formation of problematic core beliefs regarding the importance of a strong work ethic and self improvement. This was significant as it may have made Sarah vulnerable to feelings of failure when she took time off work to recover from the first depressive episode. In addition Sarah experienced frequent illnesses as a child, resulting in a core belief that she was weak, a characteristic which was apparently abhorrent to her family. Her difficulties were precipitated by several bereavements and a period of increased stress at work, which resulted in a loss of confidence regarding her ability to teach, as well as a reduction in her social activities. Her religious conviction was also reduced, following her experience of a traumatic assault. This was important as her religious beliefs usually helped her to overcome psychological distress.
Her difficulties were maintained by high self expectations, a cognitive style which was characterised by catastrophic thinking, and a negative cycle of thoughts and behaviours. Specifically, this involved attempts to protect herself from feeling that she was unable to cope and not working hard enough by taking on additional responsibilities and activities. Unfortunately this resulted in an increased sense of failure when she was unable to perform these additional activities in a way which met her high standards. In addition, she held rigid beliefs that she shouldn’t suffer from depression since she was a Christian, which was increasing her sense of failure.

**Intervention:** An integrative therapeutic approach was utilised in the intervention with this client. This involved a Christian model of CBT which encouraged the use of biblical teachings as evidence against negative automatic thoughts and challenging core beliefs. This model also targets emotional difficulties and cognitions which are particularly problematic for this group (Williams, Richards & Whitton, 2002). Additional therapeutic models which were used within this integrative approach were person centred therapy (Rogers, 1959 in Kirschenbaum & Henderson, 1990) and attachment therapy (Holmes, 2001). The intervention focused on three areas. These were: 1) the development of a therapeutic space which facilitates self growth according to person-centred theory (Rogers, 1959, in Kirschenbaum & Henderson, 1990). 2) Psychoeducation regarding the role of cognitive thinking style and behaviours in maintaining low mood and negative cognitions. Sarah was assisted in reducing the maintaining factors, using a CBT framework. 3) Cognitive restructuring of negative automatic thoughts (in initial sessions) and core beliefs (in later sessions) using conventional CBT techniques in addition to techniques adapted to incorporate religious beliefs.

**Reformulation:** The importance of Sarah’s beliefs regarding motherhood were incorporated into the original formulation. Sarah was troubled by the fact that she id not feel she wanted to have children. This deeply troubled her as she felt that she should want to have children as a Christian and a happily
married woman. Since this was not the case, she considered herself to be intrinsically selfish. This issue was further complicated by Sarah’s need to be a perfect mother, in order to protect herself from her other negative core beliefs about herself. Furthermore, she viewed having children as the only acceptable way she could reduce her community responsibilities and give up work without being viewed as weak. She was therefore caught up in a conflict involving two negative core beliefs (‘I am selfish’ and ‘I am weak’) which she could not resolve without heightening her awareness of the other core belief.

Outcome and Evaluation:
The intervention was successful in that her scores on the BDI-II (Beck & Steer, 1996) improved overall, whilst behaviours and cognitive errors which maintained her difficulties reduced. She also reported a subjective increase in her confidence and mood and said she was able to stop taking on additional responsibilities ‘on impulse’. Using integrative therapy was successful in this case and was appropriate because of Sarah’s diverse beliefs and therapeutic needs. A purely cognitive framework which did not allow for the integration of Sarah’s religious beliefs would have been of limited therapeutic value as religious teachings were the most important source of evidence against negative automatic beliefs for Sarah. The use of an integrative model was useful as it enabled attachment and existential issues to be addressed.

References:


Child and Young People Case Report Summary

Extended assessment of a 15 year old young man with psychotic-like symptoms

Presenting problem: Mr Sam Pritchard, a 15 year old adolescent, was referred to the Child and Family Mental Health Service, presenting with depression and psychotic symptoms. He reported seeing a character that was partially human but also animal like. In addition he experienced de-realisation and de-personalisation. He had cuts on his arms and chest, and was at times uncertain as to whether he had self-harmed or had been harmed by the animal character he saw.

Initial formulation: Sam’s difficulties were complex and severe. A detailed psychological assessment was necessary in order to understand the influence of the many factors involved. The initial formulation is presented. Areas which required additional assessment were also identified. A detailed risk assessment was also carried out.

Predisposing factors included an insecure attachment style. Sam had been described as dyspraxic when he was seven and had suffered a head injury aged twelve. A psychometric assessment formed part of the extended assessment in order to assess his cognitive functioning. The complex nature of Sam’s emotional and attachment difficulties suggested possible experience of childhood trauma (e.g. Carr, 1999). This was identified as an additional area requiring further assessment.

Precipitating factors included Sam’s experience of the termination of a significant relationship with his girlfriend. A detailed assessment of antecedents precipitating his hallucinatory and de-realisation experiences was also required.
Maintenance factors included a family and peer system which valued eccentricity. Sam’s hallucinatory experiences were therefore socially rewarded. Further assessment of the meaning of the hallucinations to Sam was required, in order to try to identify ways of reducing distress, and to increase his sense of control over these experiences (Nelson, 1997).

Protecting factors: Sam had good relationships with friends and his mother. The fact that he had completely stopped his self harm, was a positive sign that he had the internal resources to manage intense affective experience (Berg & Steiner, 2003) Exploration of the coping skills which Sam had developed to replace self harm formed part of the extended assessment.

Action plan: The aim of the extended assessment was to gain further information in the areas highlighted above. It was hoped that the assessment would allow the team to decide on suitable treatment options for Sam. Sources of information included psychometric assessment, clinical interview with Sam and his mother, structured questionnaires, information gathering from school and a brief therapy trial of CBT.

Extended assessment results: Sam did not respond well to a brief trial of CBT. He did not feel that the model fitted his experience. He expressed an interest in psychodynamic theory, was well read in this area, and was keen to apply a psychodynamic framework to his emotional difficulties.

A psychometric assessment was carried out in order to investigate areas of specific cognitive difficulties. In particular, Sam reported concerns regarding his memory. The Wechsler Intelligence Scale for Children, fourth edition (WISC-IV) was used to assess Sam’s cognitive functioning (Wechsler, 2003). Additional tests included the Wechsler Objective Numerical Dimensions (WOND) and the Wechsler Objective Reading Dimensions (WORD) (Wechsler, 1993, 1996).
Results from the WISC-IV indicated exceptionally high verbal intelligence. Scores for the perceptual reasoning index, working memory and processing speed indices all fell within the average range. WORD results indicated significant difficulties with spelling. His reading abilities were above average. WOND results indicated significant numeric difficulties.

**Psychological measures**

Sam and his mother completed psychological questionnaires. These results revealed that he was suffering from severe depression. Additional measures suggested that Sam’s difficulties were having a significant negative impact on his daily life. These findings were supported by reports from his school teachers, who were concerned about his poor attendance and wanted to withdraw him from two GCSE courses, against Sam’s wishes. His specific learning problems were emphasised by Sam’s teachers. It became apparent that Sam was perceived by the school as someone who had much greater and more generalised difficulties than he actually had.

**Extended formulation and recommendations for intervention:** Information from the assessment above fundamentally changed the formulation. The focus shifted from an emphasis on the most worrying ‘psychotic like’ symptoms, to issues of low self esteem and identity factors.

Additional predisposing and precipitating factors identified through the extended assessment include the impact of being identified as a pupil in need of special educational assistance as a result of dyspraxia. Sam felt his teachers and peers thought he was stupid. He experienced his inability to express himself in written work as extremely frustrating. His early problems with reading increased this sense of frustration and isolation.

Additional maintaining factors were also identified. Sam’s high verbal intelligence had been given insufficient attention at school, who had focused
on his difficulties. This had resulted in a confusing experience for Sam whereby his own experience of being intellectually able was inconsistent with his teachers' views. This sense of inconsistency between his subjective experience and the information he was receiving externally, may have compounded his dissociative experiences.

Sam found his inability to express himself through written work extremely frustrating. He was very bored at school as a result. Sam said his hallucinations were more frequent and more disturbing when his mind was not occupied. He had avoided the unpleasant experiences at school by frequent non attendance. Unfortunately that had resulted in the school withdrawing him from two GCSE courses which reinforced his negative view of himself and enhanced his intellectual frustration.

Additional protective factors which were identified through the assessment were his high intelligence and reflective capacity. Together with his interest in philosophy and psychodynamic theory, these factors were considered to indicate he would make good use of psychological therapy.

**Recommendations:** A psychotherapeutic approach which incorporated psychodynamic theory was recommended for Sam. This was because of his interest and enthusiasm for this type of therapy, his rejection of a CBT framework, and the appropriateness of this type of therapy in addressing his significant difficulties with his sense of identity and forming emotionally satisfying relationships.

**References:**


People with Learning Disabilities Case Report Summary

The use of brief psychodynamic psychotherapy with a man who has a mild learning disability on issues around his experience of abuse.

Presenting problem: Mr. Arnold Hayes, a man with mild learning disabilities, was referred to the psychotherapy service following an allegation of sexual abuse. Arnold introduced the issue of his abuse during the first session when describing important relationships. He described this relationship in positive terms and was experiencing significant confusion and ambivalence towards the abuser (a man his own age). Since losing this relationship (enforced upon him for his protection by his social care workers), he had felt terribly lonely. Arnold’s ambivalence towards his abuser meant that he was at risk of putting himself in a vulnerable position and ongoing risk assessments were necessary.

Initial formulation: The model of formulation used was based on Malan’s ‘Two Triangles’ for Brief Dynamic Therapy (Malan, 2001). It is suggested that a persons’ psychopathology can be understood in terms of the ‘triangle of conflict’ and the ‘triangle of person’. The ‘triangle of conflict’ represents a hidden feeling, the anxiety which is experienced as a result, and the defence used to protect the individual from the hidden feeling. The ‘triangle of person’ is related to the triangle of conflict as the hidden feeling is directed towards one or more categories in the triangle of person.

The triangle of conflict
Arnold’s anxiety was hypothesised to be fear of rejection. This was evident from the outset of therapy in his early arrival to each session. The hidden feeling was anger towards those who had abandoned him in his past. He defended against this by blaming himself and his excessive over politeness and willingness to please.
The Triangle of person

Past / Early relationships (P)

Arnold had experienced a significant number of losses during his early childhood. These were objectified by his mother’s rejection of him when she separated from his father. Arnold experienced terrible loneliness and grief as a result of this. His subsequent need for love and attention is hypothesised to be at the root of his difficulties.

These early experiences led to a deeply held fear of abandonment. This fear was evident in his anxiety and distress as a child. In the past, Arnold defended against his need for emotional care and support by projecting this emotional need onto his sister. His caring for her was therefore a way of acting out the satisfaction of his own needs. The triangle of conflict outlined above can therefore be traced back to his early experiences.

Other (or the current situation)

Arnold’s presenting difficulties were feelings of anxiety and loneliness. It was hypothesised that this anxiety was the felt emotion arising from deeply held emotions that he was not able to acknowledge at the beginning of therapy. In particular, I felt that Arnold was very angry at the losses he had experienced, but was not able to express this loss owing to his dependence on the professionals involved in his care. As a result his outward manner was acquiescent, but he showed visible signs of anxiety.

Transference relationship (T)

During the early stages of therapy when the initial formulation was made, there were indications of resistance towards therapy representing feelings of hopelessness. This can be understood as a representation of the core conflict and his fear that he would be rejected.

Intervention: The treatment aims were a combination of Arnold’s expressed goal of reducing his feelings of loneliness, and a resolution of the loss and
grief highlighted in the formulation as a result of his disrupted attachments and experiences of abuse. The three aims of therapy were 1) to identify the hidden feeling underlying the defence and anxiety according to Malan’s (2001) theory. In Arnold’s case this meant to facilitate the recognition of anger and grief underlying his anxiety that he would be rejected and his defensive use of excessive acquiescence. 2) to use therapeutic interpretations in order to work towards the resolution of past losses, and 3) to work towards a more coherent narrative through exploring and reconstructing past memories (Malan, 2001). This increases a sense of coherence between the past, present and future self. This was achieved through referring back to past conflicts (such as Arnold’ experience of repeated rejection and loss) and tracing their influence through to the present conflict (his inability to express at anger at caregivers for fear of losing the care he was dependent on).

Reformulation: An additional issue which was added into a reformulation of Arnold’s difficulties was whether Arnold had a good understanding of signals of others’ distress. His own experience of abuse had invalidated his sense that his own signals of distress would be heeded. This had occurred because his abuser repeatedly ignored signs that Arnold wanted the abuse to stop. At a deeper level, the verbal reassurance he had received from the abuser had invalidated his own sense of his feelings being correct. As an individual with a learning disability he had repeatedly experienced others correcting him and had developed an understanding of himself as someone who was likely to be wrong. He was therefore trusted the abusers assurances that what they were doing was okay and that his feelings were wrong. Arnold had learned to ignore his own feelings and instincts.

Outcome and evaluation: The outcome of the therapy was measured using the ‘Glasgow Anxiety Scale for people with an Intellectual Disability (GAS-ID) (Mindham & Espie, 2003) Initial and final session scores were compared. Arnold’s score at the time of his first session was 24, which was above the cut off of 13, which indicates the presence of anxiety disorder. His score at the final session was 19 indicating that although his levels of anxiety had
reduced he required further psychotherapeutic intervention in order to reduce his anxiety. The use of brief dynamic therapy was useful in this case in preparation for longer term psychotherapeutic work.

References:


Advanced Competencies Case Report Summary

The use of CBT to prevent relapse and to reduce negative affect in a 28 year old man diagnosed with psychotic depression

Presenting problem: Mr. Richard Evans was referred to the CMHT by his GP as he was experiencing depression, anxiety and psychotic symptoms. He was diagnosed with psychotic depression. Richard responded well to medication and experienced a rapid reduction in psychotic symptoms. He was then referred for psychological therapy for relapse prevention.

Initial formulation: A number of factors may have predisposed Richard to his current difficulties. Both his mother and father had experienced episodes of depression in the past, suggesting a biological vulnerability. The emotional environment within Richard’s family may have contributed to a predisposition towards his depression and psychotic symptoms. His families’ high standards and high expectations of their children have contributed to Richards’ high self expectations, concrete thinking and perfectionism. A competitive relationship with his younger brother has predisposed him to a tendency towards a reliance on being the best to maintain self esteem.

Richard’s psychotic breakdown was precipitated by increased levels of stress associated with the completion of his PhD. In addition he found it difficult when he his application to undertake a PGCE was rejected as a result of a bad reference from his tutor. This came as a shock to Richard as he had thought he was well regarded within the department. This seems to have led to extensive rumination about how he was perceived by others, and he became convinced that everybody thought he was “weird”. He was also concerned
about his inability to detect negative evaluation by others. As a result of this, he developed the negative assumption that if he was not praised by others, it was because they didn’t like him.

Richard’s psychological difficulties were being maintained by a series of maladaptive thinking errors, safety seeking behaviours, and exposure to reinforcement of faulty negative core beliefs.

Despite the difficulties within Richard’s family dynamics, Richard felt that his family were supportive and wanted the best for him. He also felt that he would be able to rely on him to support him through his difficulties. He also felt that there were positive aspects to his relationship with his brother, who would help him to increase his social activities.

Although Richard’s psychological insight was not particularly advanced, he was very intelligent and motivated to pursue therapy. He reported that he had found the CBT techniques he had learnt through the self help literature effective and felt that CBT would be useful in helping him to understand his difficulties and develop alternative strategies to manage his mood.

**Intervention:** the intervention was focused around four areas. These were:

1) The development of an understanding of how negative cognitions and problematic behavioural patterns are linked to negative affect, and to enhance skills in monitoring negative automatic thoughts and identifying thinking errors which increase negative affect (Beck, 1976). This was achieved through psychoeducation and collaborative discussions to facilitate socialisation to the CBT model. In addition, the intervention focused on developing Richard’s capacity to recognise negative automatic thoughts and to learn to evaluate the evidence for, and validity of these thoughts. This was achieved through the use of thought records and cognitive restructuring techniques during therapy. Richard also learned to use behavioural experiments as a means of testing out cognitions which are maintaining negative affect.
2) Enhancement of Richard’s quality of life by assisting him to increase his level of day time activity. This was achieved through the identification of specific goals and problem solving how to overcome obstacles to these goals.

3) Restructuring of problematic core beliefs which were underlying Richard’s negative automatic thoughts and problematic maintenance behaviours.

4) Development of a “relapse signature” (Birchwood et al, 2000) so that Richard is able to notice early signs of relapse. Strategies to be used in the event of relapse to prevent further deterioration of mental health were also identified.

Richard disclosed that he had a history of substance misuse mid way through the intervention. He also revealed that he was smoking cannabis at the time of the intervention. Since cannabis use is associated with higher relapse rates in psychosis (Rey & Tenant, 2002), exploration of the affects of this was included in the intervention. Motivational Interviewing techniques were incorporated into the intervention (Miller & Rollnick, 2002).

Reformulation: As a result of the late disclosures, it was necessary to constantly update the formulation. Therefore although the original formulation is still relevant, a number of additional factors are important in understanding Richard’s difficulties. Richard’s late disclosure of substance misuse is important both in the maintenance of his difficulties as outlined above, and also in predisposing him to his experience of psychotic depression. Additional information regarding core beliefs and dysfunctional assumptions which were identified over the course of the intervention were also incorporated into the reformulation.
**Outcome and Evaluation:** Richard reported a subjective improvement in mood, which was supported by a reduction in anxiety and depression scores on the Hospital Anxiety and Depression Scale (Zigmond & Snaith, 1983). Richard had made good progress in using verbal reattribution techniques to challenge negative automatic thoughts. He was able to identify thinking errors and to test the validity of negative thoughts and construct alternative balanced thoughts. The metacognitive sense of distance he obtained from these techniques seemed to be most useful to Richard. His use of behavioural experiments and cognitive restructuring had also reduced his conviction in his core beliefs which were causing negative affect.

Behavioural changes also indicated improvement in Richard’s psychological well being. This included increased social activity, reduction in safety seeking behaviours in social situations, and the termination of cannabis use for six months as a behavioural experiment to see whether it is necessary to ease his social anxiety. Using cognitive behavioural therapy was successful in this case in reducing negative affect and in equipping Richard with skills to enhance his ability to avoid relapse.

**References:**


Overview of clinical experience

A summary of clinical experience gained on core placements as well as an advanced competencies placement.
Adult Mental Health Core Placement Summary

Dates: 3rd November 2004 – 23rd September 2005
Base: Psychology Service.
Presenting Problems: Bereavement, phobias, anxiety, depression, PTSD, disorder, low self esteem, depression, panic disorder, difficulties associated with physical health problems, traumatic brain injury, memory and concentration problems, OCD and psychosis.
Assessments: Assessment for treatment interviews with clients, WAIS-III, AMIPB, WITAR, Hayling Brixton, CORE, MOCI, Fear Questionnaire, Revised Impact of Event Scale, Beck Depression Inventory, Beck Anxiety Inventory and thought diaries.
Interventions: Cognitive-behavioural model was predominantly utilised in all interventions with clients. One client was treated using a solution focused approach. A CBT model which had been adapted for use with clients holding particular religious beliefs was also utilised. Cognitive-behavioural models and psycho-education were utilised in a group for individuals with depression. The author co-facilitated this group with a specialist CBT practitioner, and was involved in the setting-up and evaluation of the group.

Child and Young People Placement Summary

Base: Child and Adolescent Mental Health Service.
Presenting Problems: Anxiety, ADHD, Autism, depression, family relationship difficulties, simple phobias, cerebral palsy, conduct disorder, attachment difficulties and a client with psychotic-like symptoms.
Assessments: Assessment for treatment interviews with clients, WISC-IV, WIPPSI-III, WOND, WOLD Strengths and Difficulties Questionnaire, Beck Depression Inventory, Beck Anxiety Inventory.
**Interventions:** Solution focused therapy was the main therapeutic model utilised with these clients. Cognitive Behavioural Therapy was also used in some cases. Family therapy and systemic approaches were also used.

**People with Learning Disabilities Placement Summary**

**Dates:** 23rd March to 22nd September 2006  
**Base:** Learning Disabilities Team.

**Presenting Problems:** Anxiety, relationship difficulties, depression, difficulties related to childhood sexual abuse, anger management, difficulties with social skills and assertiveness.

**Assessments:** Assessment for treatment interviews with clients, WAIS-III, Vineland, Mini PASAD, Glasgow Anxiety Scale for people with intellectual disabilities, Glasgow depression scale for people with intellectual disabilities.

**Interventions:** Brief psychodynamic psychotherapy and cognitive-behavioural models were mainly used. A psychoeducational and cognitive behavioural group package was designed by the author and a speech and language therapist for use with individuals who wished to improve social skills and assertiveness. This was co-facilitated and evaluated by the author, the speech and language therapist and a key worker from a voluntary sector organisation.

**Advanced Competencies Placement: (Advanced CBT Adult Mental Health) Placement Summary**

**Dates:** 11th October 2006 - 23rd March 2007  
**Base:** Community Mental Health Team, Mother and Baby Inpatient Unit.

**Presenting Problems:** Anxiety, depression, psychosis, psychotic depression, conversion disorder, unresolved grief, bipolar disorder, post natal depression, post natal psychosis, attachment problems, and challenging behaviour.
Assessments: Assessment for treatment interviews with clients, Hospital Anxiety and Depression Scale, Pregnancy Related Beliefs Questionnaire, Parent Self-rating of Abilities and Confidence, Parental Stress Index, Beck Depression Inventory, Beck Anxiety Inventory, risk assessments and thought diaries.

Interventions: A cognitive-behavioural model was utilised in all interventions. Systemic approaches were occasionally utilised with clients on the mother and baby unit. The author compiled an assessment package and designed a group for women with peri-natal mental health problems and their partners for use on the ward. In addition, service delivery work formed a large part of the placement. In particular, the author was part of the steering group for the Tamil Mental Health Promotion Project which involved the design, implementation, piloting and evaluation of six workshops designed to promote positive mental health. These were designed in consultation with members of the Tamil community and were delivered through interpreters.

Older Adults Placement Summary

Base: Community Mental Health Team, Older Adult's Service
Presenting Problems: Anxiety, depression, psychosis, dementia, fear of falling, difficulties in adjusting to physical health problems, bereavement and relationship difficulties.
Assessments: Assessment for treatment interviews with clients, Beck Depression Inventory, Beck Anxiety Inventory, risk assessments and thought diaries. Psychometric assessments for dementia were also carried out.
Interventions: Therapeutic interventions were carried out using a cognitive behavioural model. One intervention utilised a solution focused therapeutic approach. Psychodynamic and systemic theory informed formulations. A psychoeducational presentation was made to a group of older adults with physical health difficulties.
Research Dossier

The research dossier contains a research logbook summarising research activity during the three year course, a service related research project, the abstract of a qualitative research project completed with a group of other clinical psychology trainees and the major research project.
<table>
<thead>
<tr>
<th></th>
<th>Research Log Checklist</th>
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<td>1</td>
<td>Formulating and testing hypotheses and research questions</td>
<td>X</td>
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<tr>
<td>2</td>
<td>Carrying out a structured literature search using information technology and literature search tools</td>
<td>X</td>
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<tr>
<td>3</td>
<td>Critically reviewing relevant literature and evaluating research methods</td>
<td>X</td>
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<tr>
<td>4</td>
<td>Formulating specific research questions</td>
<td>X</td>
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<tr>
<td>5</td>
<td>Writing brief research proposals</td>
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<tr>
<td>6</td>
<td>Writing detailed research proposals/protocols</td>
<td>X</td>
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<tr>
<td>7</td>
<td>Considering issues related to ethical practice in research, including issues of diversity, and structuring plans accordingly</td>
<td>X</td>
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<td>8</td>
<td>Obtaining approval from a research ethics committee</td>
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<td>9</td>
<td>Obtaining appropriate supervision for research</td>
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<td>10</td>
<td>Obtaining appropriate collaboration for research</td>
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<td>11</td>
<td>Collecting data from research participants</td>
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<td>12</td>
<td>Choosing appropriate design for research questions</td>
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<td>13</td>
<td>Writing patient information and consent forms</td>
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<td>14</td>
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<td>15</td>
<td>Negotiating access to study participants in applied NHS settings</td>
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<td>16</td>
<td>Setting up a data file</td>
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<td>17</td>
<td>Conducting statistical data analysis using SPSS</td>
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<td>18</td>
<td>Choosing appropriate statistical analyses</td>
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<td>Choosing appropriate quantitative data analysis</td>
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<td>Summarising results in figures and tables</td>
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<td>22</td>
<td>Conducting semi-structured interviews</td>
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<td>23</td>
<td>Transcribing and analysing interview data using qualitative methods</td>
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<tr>
<td>24</td>
<td>Choosing appropriate qualitative analyses</td>
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<td>25</td>
<td>Interpreting results from quantitative and qualitative data analysis</td>
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<td>26</td>
<td>Presenting research findings in a variety of contexts</td>
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<td>27</td>
<td>Producing a written report on a research project</td>
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<td>Defending own research decisions and analyses</td>
<td>X</td>
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<tr>
<td>29</td>
<td>Submitting research reports for publication in peer-reviewed journals or edited book</td>
<td>X</td>
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<tr>
<td>30</td>
<td>Applying research findings to clinical practice</td>
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Service Related Research Project

How the psychology service is perceived by members of the Community Mental Health Team. A qualitative study.

June 2005

Year 1
Abstract

How the psychology service is viewed by members of the community mental health team may affect referrals, working relationships, and client's accessibility to psychological interventions. Attitudes towards the psychology service were explored using semi-structured interviews and analysed qualitatively. 8 members of two community mental health teams were interviewed. 5 themes were identified. These were: 'the usefulness of the psychology service', 'increasing client access to psychology', 'referring to psychology', 'Provision of psychological intervention: Boundaries between psychology and other services 'and 'psychology as internal / external to the team'. These themes included current sources of satisfaction and dissatisfaction with the service as well as suggestions for possible improvement. Misconceptions were identified regarding who psychologists work with, what they are likely to do and how referrals are organised. These were discussed in relation to current service developments.

Introduction

The psychology service in question is in the process of a number of operational transitions. It has traditionally operated separately from the Community Mental Health Team but is becoming increasingly integrated within it. In addition, closer links are to be drawn between the psychology service and the psychotherapy department. This integration has been formalised through a re-organisation of referral routes so that all referrals are routed through the CMHT.

There are several possible influences on who the team refers to the psychology service. These include team perceptions of the type of clients seen by psychology, and the nature of psychological interventions. The psychology case load is therefore likely to be directly affected by perceptions
within the team about what constitutes an appropriate referral. Other considerations which constitute part of this decision process need to be identified, in order to identify possible misconceptions.

Attitudes towards the service may also influence the extent of psychological thinking and use of psychological models and techniques within non-psychology team members. This is important in terms of increasing client access to psychological methods, indirectly, through working with other professional groups. Clarity regarding the psychology service may increase the likelihood of CMHT staff approaching psychological staff for supervision and training. This may raise the profile of psychology as an alternative to the medical model of mental 'illness'. Increasing access to psychology services is in accordance with NICE Guidelines (Department of Health, 2002)

The aim of this study is to evaluate how psychology is perceived informally by members of the CMHT. Surveying referrers perceptions of psychology service has been used as part of service evaluation in other studies (e.g. Abrahams & Udwin, 2002). Specific aims were to:

1) investigate whether the psychology service was perceived to useful and valuable.

2) identify possible improvements which could be made to the service.

3) explore perceptions of psychology which may affect types of referrals to the service.

It was hypothesised that perceptions would be mainly positive, but that waiting list times would be identified as a problem with the service. However, the study was designed primarily as an exploration of staff attitudes in order to inform service changes and to identify possible training needs around the nature of the psychology service.
Method

Setting: Community mental health care in the area is delivered by two teams. The two teams operate independently, but are managed and based together.

Participants: Out of a possible 16 members of clinical staff, 8 participants were recruited for the study from the two CMHTs covering the region. Half of these were from the west team (4), 3 were from the east team and one participant worked across both teams. Participants were recruited according to their job title. The sample included a consultant psychiatrist, community psychiatric nurses and social workers as well as a support worker.

Design: The study utilised an independent measures design. All participants were interviewed using a semi-structured interview designed specifically for this study. This is in accordance with guidelines outlined by Joffée and Yardley (2004) (in Marks & Yardley, 2004). The interview consisted of 7 open ended questions (Appendix A). Possible prompt questions were also included for each question.

Procedure: Each participant was interviewed for between 8 and 20 minutes by the author. Open ended questions were asked and were sometimes followed by prompt questions, if the participant had not covered these specific topics in their answer. Clarifications were also sought. The interviews were audio-recorded and subsequently transcribed verbatim for analysis.

Results

A wide range of views and opinions were expressed in the interview. These were analysed using thematic analysis using an inductive coding method (whereby themes originate from the raw data itself and not from existing theoretical frameworks) (Joffée & Yardley, 2004). Comments from the transcripts were labelled according to the ideas expressed. Manifest and
latent content was arranged into themes. Similar ideas were then clustered together, across transcripts. These were then grouped into themes and sub themes. This procedure was repeated by the same author, as recommended by Joffee & Yardley (2004). These authors suggest that although the same subjective biases are likely to be present at both stages, repeating the procedure provides a kind of 'test-retest reliability'.

The 5 identified themes are presented in table 1. Each theme is described below with examples taken from the transcripts.

*Table 1: Overview of identified themes*

<table>
<thead>
<tr>
<th>Theme label</th>
<th>Theme description</th>
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<tr>
<td>1. Is the psychology service useful?</td>
<td>Outcome of psychological intervention, approachability, helpfulness and use of psychologists</td>
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<tr>
<td>2. Increasing client access to psychology</td>
<td>Propagation of psychological ideas through supervision of non-psychology staff, continuing professional development of non psychology staff, decreasing waiting list, prioritising patient care.</td>
</tr>
<tr>
<td>3. Referring to psychology</td>
<td>Profiles of appropriate referrals to psychology: complex, severe,</td>
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4. Provision of psychological intervention: Boundaries between psychology and other services

Conflation of psychology with psychotherapy, Psychological provision outside of psychology service. Special services vs. special client groups.

5. Psychology as internal / external to the team

Access to psychological information and training. Participation in meetings and decisions. Advantages and disadvantages of operating internally / externally to the team.

**Theme 1: Is psychology a useful service?**

These comments provided an overall impression of the service and of the psychologists who worked within it. Many of the comments reflected a positive evaluation of psychology:

‘*They are approachable and helpful*’ (interview 7).

However, negative views were also expressed, often less directly:

‘*They are a bit aloof sometimes*’ (interview 3).
For most, the psychology service was perceived as getting good results with clients who were referred by the team:

‘they seem to get results which is nice... they do move people on and we’ve had some quite challenging people!’ (interview 4)

Theme 2: Increasing client access to psychology

Supervision provided by psychologists was consistently valued by participants. Those participants who had received psychological supervision expressed high levels of satisfaction with this part of the service. In addition to providing guidance in dealing with complex cases, there was an understanding that psychology offered a unique perspective in conceptualising ‘mental illness’. Psychologists were described as offering:

‘Flexible thinking outside of the box. (psychologists) don’t get closed in to a model’ (Interview 1).

Others reported some ambivalence about the usefulness of not using a medical model in dealing with mental distress:

‘its good to think there are effective, ways of working, beyond the medicine really. Although I know that without the drugs psychology wouldn’t always be able to help really’ (interview 7)

Some members of staff who were not receiving supervision expressed an interest in it, with the intention of applying basic psychological therapy techniques in their work. ‘I think that a lot of nurses would value being supervised by psychology in order to deliver better psychological therapies themselves. So there is probably a lot of stuff that we could try to do a bit more of under their supervision’ (Interview 2)
Many were aware of a conflict in how they would like psychologists' time to be used. Supervision and consultation was valued but offset against the problem of a lengthy waiting list. Most participants suggested that client care should be the highest priority, and many suggested that psychologists' time should be mainly used in the provision of direct client care, even at the expense of supervision of staff:

'I think client work should be the priority. Having said that I really value other psychological input, like supervision and training(...) I really do sometimes wonder about the relative percentages(...). I mean I see 25-30 patients a week, and I wonder 'is the balance right?' If we're talking about a full time equivalent, how much should be patient care and how much should be other supplementary things? (...) I think when the waiting list gets this long, thinking, okay, let's concentrate on client care for a bit'. (Interview 6)

*Theme 3 Referring to psychology*

These comments provided a profile of team perceptions of the type of clients psychologists work with. Most participants felt that psychologists worked with serious cases generally, and that simple cases were a waste of psychology time. Furthermore, there was some agreement that these cases should first be seen by other staff and referred to psychology if they required further interventions beyond that which CPN's could offer.

'‘the individual would be very severely mentally ill. Their difficulties would be tackled in the first instance by me, as far as I could do, before I would refer them on’ (Interview 1).

‘the commonest reason (for referring someone to psychology) would be that they needed support beyond what the CPN’s could offer’ (interview 6).
This is suggestive of an implicit skills hierarchy, and some comments support this perception in terms of describing the longer training time undergone by psychologists. However, others suggested that psychologists' increased capacity to provide interventions with those who had not responded well to other staff members' efforts was a result of a different conceptualisation and approach. The skills psychologists offered were not therefore necessarily considered to be more sophisticated than those used by non-psychology staff.

'there could be a different way of tackling the problem that I hadn't thought of, or that something, that perhaps is very simple, is a way through' (interview 1).

In reference to referring to psychology, the difficulty of waiting times was commonly highlighted. Managing this waiting time was perceived as a common difficulty.

'I don't think its fair on another member of staff to be holding people for 18 months while they wait for psychology. Nurses have got other things to do.' (interview 3).

Many participants commented that they felt assessment appointments should be prioritised to alleviate the problem of inappropriate referrals having to wait a long time to be subsequently re-routed. There was also a feeling that the psychology assessment itself was an effective intervention promoting change.

Finally, there was a great deal of confusion about how referrals are organised by psychology. Some believed more severe cases were prioritised, some suggested specific disorders were prioritised, and one participant suggested that 'luck' was involved (interview 8).
Theme 4: Provision of psychological intervention: Boundaries between psychology and other services.

The differences in service provision between psychology and other therapeutic outlets were generally confused. In particular psychology and psychotherapy were conflated. Although CBT was mentioned primarily as the main intervention tool, some comments suggested confusion about whether psychology interventions worked best at the point of ‘crisis’, ‘discovering the root causes’ of difficulties or when the client was ‘ready’ although what constituted this readiness was unclear. The conflation between psychology and psychotherapy is evident in the following statement:

'If someone has a history of abuse, I mean if its going to be one of these long sort of recapitulations rather than draw the line, this is how you can cope now... (psychologists contribute by) enriching patients lives with a psychodynamic perspective.' (interview 6)

A number of participants expressed confusion about the differences between psychology, psychotherapy and specific psychological interventions offered by non-psychology staff. This resulted in referrals routed according to practical considerations - for example, to the service with the shortest waiting list at the time.

There was disagreement regarding how psychology should operate in terms of offering specialist services. Some participants highlighted particular client groups, organised according to diagnosis, who were not offered specialist treatment within the psychology service. This was a major source of dissatisfaction with the psychology service. These included individuals who had been diagnosed with Asperger’s syndrome and those with eating disorders (Interview 4 and 5). In contrast to this view, other participants suggested that rather than organise services for specialist groups, specialist interventions should be offered for common psychological difficulties,
across diagnostic categories. One participant felt that this should be organised across all services providing psychological interventions:

‘I personally wouldn’t want specialist services organised around diagnostic groups. I want to be able to refer according to the identified needs as part of the care plan. So if someone needs anxiety management they can have it, there is a clear referral route, regardless of diagnosis. Which is why I’m not keen on ‘specialist treatment for this, specialist treatment for that’ because if you do it the other way you can bring them in anyway’ (interview 6)

**Theme 5: Psychology as internal / external to the team**

There was a general consensus that a fuller integration of psychology within the team would be beneficial. These benefits were acknowledged in terms of patient care, but also in the continuing professional development of nonpsychology staff through increased access to psychological information and training.

‘I would like(...) if their education forum was open to everybody to dip into coz I think that would be useful to learn from. Not only to dip in to but to contribute as well.’ (Interview 1)

‘I think having a psychologist, full time, attached to the team is what we need. I really think that. Someone who knew our patients and took work on directly for the team would be good’. (Interview 8)

**Discussion**

The themes drawn from the data suggest an overall satisfaction with the psychology service which was viewed as useful to patients in terms of outcome, and useful to staff in continuing their professional development. A
number of problems with the organisational structure of the service were highlighted. These included problems with the waiting list and how to manage clients while they were waiting and lack of provision for certain specialist client groups. Confusion regarding referral decisions and service boundaries were also evident. Interestingly, the profile of a typical psychology referral which emerged was of someone suffering from severe and chronic difficulties. There was some indication that psychologists were perceived to hold sophisticated skills to tackle these difficulties. Participant’s also recognised that the intervention may be simple and that it was emergent from an alternative conceptualisation of mental distress rather than a superior skills and knowledge base. This is important in terms of equality within the team and a sense of trans-disciplinary value.

The themes identified here answer the aims of the study, to investigate whether the psychology service was perceived to be useful and valuable by members of the CMHT. Additional aims were to explore perceptions of psychology which may affect referrals and to identify possible improvements. The profile of a typical psychology referral drawn from the data is useful in understanding who psychologists are perceived to help. The confusion surrounding how referrals are prioritised, and when to refer to psychology is problematic and the psychology service should clarify these issues with the CMHT. With closer integration between the psychotherapy and psychology departments, this will become increasingly important. Failure to clarify referral criteria jeopardises the access of some clients to the psychology service.

Additional suggestions made by participants were that psychological training events should be accessible to other professionals as part of a team approach to mental distress. Formal access to informal consultation from psychology would also be valued. One possibility might be to hold a psychology ‘surgery’ where non psychology staff could discuss appropriateness of referrals and gain access to psychological information to guide their work. This would be particularly helpful for staff who were not receiving
supervision from psychology, and would be more time efficient than ongoing supervision. This may also help to increase perceptions of approachability within the team. Clarification of referral criteria may assist waiting list problems without having to increase the number of assessments carried out. These issues also have wider professional and political implications in terms of how decisions regarding service provision should be made and by whom. Involving members from other professional groups in these decisions allows for increased creativity in service planning. It is also likely to increase involvement in, and understanding of psychology services amongst non-psychology staff. These benefits could be increased by involving service users in these decisions (Thornicroft & Tansella, 2005).

Limitations of the study include possible anonymity concerns which may have affected disclosure of negative evaluations. This is possible as the interviewer was a member of the psychology team. This may have decreased frankness. Furthermore, the affect on the interviewer of hearing the participants’ views is important, as the interviewers reactions may have influenced subsequent disclosure. The interviewer felt anxious to correct misconceptions held about the psychology service and to clarify issues concerning referral routes. Although this was not verbally acknowledged within the interview itself, it is possible that participants were aware of the effect of their comments. These interactions therefore may have introduced a bias into subsequent disclosure, reflecting relationship dynamics between the interviewer and the participant.

The specific nature of the study means that results are not generalisable to other psychology services. The small sample and the qualitative methodology did not allow investigations into affects of job role and experience of psychological intervention on perceptions. Additional research could investigate non psychology professionals perceptions of the nature of work carried out by psychologists as this was commonly misconceived within this team, and is often misunderstood by clients in initial contact with psychology. Client expectations regarding psychological services may reflect
beliefs held by staff working with them prior to referral. This may reflect wider implications of multidisciplinary working and highlights the importance of cohesive understanding of job roles and service provision within the team.

References:


Appendices:

Appendix I) Interview questions
Appendix II) Ethical Scrutiny form
Appendix III) Confirmation that results were conveyed to the service.
Appendix I: Interview questions.

1) How much contact have you had with the psychology service, and what is your overall impression of it?

2) What do you think psychologists do?

3) What sort of issues do you think about when you are considering referring someone to psychology?

4) What do you value most about the psychology service?

5) What do you wish was different about the psychology service?

6) If there were more psychologists, how would you like the extra resources to be used?

7) Are there any areas in service provision where you think input from psychology would not be appropriate?
Appendix ii:

Ethical Scrutiny form

University of Surrey

PSYCHD CLINICAL PSYCHOLOGY

Service Related Research Project

Ethical Scrutiny Form

The nature of the proposed project is such that I am satisfied that it will not require scrutiny by the trust's ethical committee.

Name of Field/Placement Supervisor: .................
Signature of Field/Placement Supervisor: .................

Name of Trainee: .......................................
Title of SRRP: ...........................................

Date: 7/7/05

https://www.surrey.ac.uk/psychology/psychology/psychology/ethics/ethical-scrutiny-form

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Appendix iii:

Confirmation that results were fed back to the service.

Katy Robyant, PsychD Clinical Psychology Trainee.
First year small-scale research project.

I can confirm that during the course of her first year adult mental health placement under my supervision, Katy fed back and discussed with me the results of her small-scale research project.

Consultant Clinical Psychologist
Lead Supervisor
Qualitative Research Project Abstract

Newspaper constructions of risk following protests about the publication of cartoons depicting the Prophet Mohammed: A discourse analysis.

Objectives: This study analysed newspaper reporting of an incident in March 2006 when a Danish newspaper published “cartoons” depicting the Islamic prophet Mohammad. Representations of Muslims and Islam were explored in response to this incident, with a particular focus on the depictions of risk and threat conveyed within British newspapers.

Method: A qualitative research methodology was employed. Specifically, newspaper extracts (including text and images) relating to representations of threat and risk were selected from papers of varying political affiliations, before being subjected to a detailed discourse analysis. This involved exploration of the text’s discursive organisation and possible functional orientations. A critical discursive psychology approach was undertaken, integrating elements of previously distinct discursive and Foucauldian discourse analytic traditions, within a social constructionist framework.

Results: Two predominant themes emerged. These were: ‘the separation of the majority Muslim community from the ‘extremists’” and ‘the protestors as wild individuals bringing Armageddon on the West’. Extracts of texts and images were discussed in relation to these themes.

Conclusions: The study concluded by considering the way in which the British media generally portrayed Muslims in a negative light, reinforcing notions of risk/danger through use of simplistic text and imagery supporting these positions. In doing so the current findings were contrasted alongside wider literature from the field with regard to the study’s potential limitations.
Major Research Project

Psychological distress of asylum seekers in immigration removal centres

July 2007

Year 3
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Appendices

Appendix I: Questionnaire
a) Questionnaire for detainees.

b) Explanation of differences between questionnaires for detainees and asylum seekers living in the community.

c) Consent form.

d) Information sheet for detainees.

e) Information sheet for the community group.

Appendix II: Confirmation of approval for access and Ethical approval.
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b) South East Multi Centre Research Ethics Committee Approval letter

c) School of Human Sciences Ethical approval letter.

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Appendix IV: Statistical Information
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b) Cronbach’s alphas for scales and subscales

c-d) HADS skewness and kurtosis scores

e) IES-R skewness and kurtosis scores

f-h) IES-R subscale skewness and kurtosis scores
Abstract

Objective To compare depression, anxiety and Post Traumatic Stress Disorder (PTSD) symptoms amongst asylum seekers living in four immigration removal centres (IRCs) with a comparison group of asylum seekers living within the community.

Method Participants were from 43 different countries and comprised detained asylum seekers (n=67), detainees who were previously imprisoned in the UK (n=30), and a community sample of asylum seekers (n=49). Participants completed the Hospital Anxiety and Depression Scale (HADS), the Impact of Events Scale Revised (IES-R) and the Post Traumatic Cognitions Inventory (PTCI). Demographic information and information relating to previous trauma exposure was also collected.

Results High rates of anxiety, depression and PTSD symptoms were reported by all three groups. Detained asylum seekers had significantly higher scores on all three measures compared with asylum seekers living within the community. A substantial number of individuals in detention had clinically significant scores. Detention experience was the highest predictor of anxiety and depression, and was the second most significant predictor of PTSD symptoms after exposure to interpersonal trauma. Individuals who had experienced interpersonal trauma and were in detention for over one month had higher levels of depression and anxiety than those who had been detained for less than one month.

Conclusion Individuals detained in IRCs are highly vulnerable to psychological distress. The findings from this study suggest that immigration detention may be a risk factor in itself for anxiety, depression and PTSD. Further research into the impact of immigration detention on mental health is needed.
Introduction

The aim of this research project is to investigate the psychological well-being of individuals who are living within Immigration Removal Centres (IRC’s). In particular, the experience of symptoms relating to high prevalence disorders such as anxiety and depression as well as post traumatic stress disorder (PTSD) will be compared amongst asylum seekers within IRCs and those seeking asylum that are living within the community. The rationale for this research will therefore include the following: 1) A review of evidence regarding mental health difficulties in asylum seekers 2) theories of PTSD which suggest that both pre and post traumatic experiences contribute to aetiology; 3) critique of the model 4) additional post migration factors which impact on asylum seekers in particular, and finally 5) studies investigating the impact of detention on mental health as a specific post migration experience. Firstly, the background and context behind detention in IRC’s is explained below.

Background and context of immigration detention.

Immigration Removal Centres (IRC’s) in the UK are secure environments where non-legal immigrants falling into various different categories are detained. They are unique in that individuals are held within these centres for an indefinite period whilst awaiting the outcome of administrative processes regarding their permission to stay in the UK. The majority are deemed by the Home Office to have exhausted their legal processes and are awaiting deportation to their country of origin or to a third country. However, some individuals are awaiting the outcome of legal processes and appeals on existing claims, or initiate fresh claims whilst in detention. Another group which may be detained in IRC’s are other foreign nationals who have previously been imprisoned in the UK (BID, 2007, Home Office, 2007). A large proportion of individuals who are living within IRC’s therefore claim to be fleeing persecution within their country of origin. By definition, asylum seekers are claiming to have experienced traumatic events in their country of origin. The process by which they travel to the UK may also have involved traumatic experiences. A large proportion of individuals living within IRC’s could therefore be described as a vulnerable group,
susceptible to the mental health difficulties which are associated with both experiencing traumatic events and detention. Despite this, few studies have investigated the psychological well-being of individuals who are detained within IRC’s. This is owing to restricted access to this group. An additional problem is that any research within this area tends to be highly politicised and therefore subject to bias.

1. Mental health difficulties in asylum seekers.

Asylum seekers are fleeing persecution from within their country of origin. Research suggests that asylum seekers and displaced persons worldwide report high rates of pre-migration trauma (e.g. Sinnerbrink et al, 1997). In a meta-analysis of world-wide studies investigating the mental health of refugees (including internally displaced persons, asylum seekers and stateless persons), Porter and Haslam (2005) found high rates of psychopathology amongst refugees worldwide compared with non-refugee controls. Effect sizes varied according to methodological variations, as well as a number of refugee characteristics and pre and post displacement factors. The authors report that although psychopathology amongst refugees occurs across multiple dimensions, a considerable amount of research has construed varying symptoms as indicative of post traumatic reactions.

PTSD and major depression has been found amongst post-conflict populations (Steel et al 2004). A number of studies have found high rates of symptoms associated with these disorders in asylum seeker populations (Drozdek et al 2003, Silove et al 1997 and Silove et al 1998). In addition there is evidence of a dose-response relationship between extent and severity of trauma and likelihood of developing PTSD (Mollica et al 1998, Steel et al, 1999). A high rate of mental health problems is reported in displaced individuals who have suffered oppression, torture and organised violence (Goldfield et al, 1988). Research has shown that asylum seekers suffer increased psychological disturbance compared with immigrants (Silove et al., 1998). This is unsurprising considering the increased likelihood of experiencing traumatic events in
this group, which is the biggest risk factor for developing PTSD (e.g. Steel et al, 1999, Steel, Silove, Phan et al, 2006).

Studies which have specifically looked at the relationship between experience of torture and PTSD symptoms have also shown this population to be particularly vulnerable. According to Steel and colleagues (2004), most studies have found incidence of torture rates at between 20% and 40% in asylum seeker populations (e.g. Silove et al 1993, Silove et al 1997). Torture is associated with high rates of psychological disturbance including depression, anxiety, PTSD and associated symptoms including sleep disturbance, nightmares, impaired concentration and memory (Steel, et al 2004). This pattern of psychological fallout from torture appears to occur across cultures regardless of differences in cultural, political and historical context (Steel et al, 2004). There is therefore a considerable body of evidence which suggests that there is a high prevalence of mental health difficulties amongst displaced people. This has most commonly been construed as a post-traumatic reaction to acute stressors associated with refugee experiences (Porter & Haslam, 2005).

2. Theories of Post traumatic Stress Disorder

In order to understand why asylum seekers might be at greater risk of developing PTSD, it is necessary to consider how this disorder develops and is maintained. In a review by Brewin and Holmes (2003), the considerable overlaps inherent in models of PTSD are outlined. Three recent models are emphasised by the authors as having the greatest explanatory power in accounting for the wide-ranging clinical symptoms and experimental findings. These are 1) Emotional Processing Theory (Foa & Rathbaum, 1998) 2) Dual representation theory (Brewin et al, 1996) and 3) Ehlers and Clark’s cognitive model (Ehlers & Clark, 2000). The Ehlers and Clark, (2000) model is outlined below. This model has been chosen as it has been successfully applied in the treatment of individuals with PTSD (Ehlers & Clark, 2000; Ehlers et al, 2005). The model subsumes many aspects of the other two models relevant for detention experiences.

This model was developed as a clinical tool. It emphasises the role of cognitive appraisals in the development and maintenance of PTSD. The premise of the model is that PTSD occurs as a result of maladaptive processing of traumatic events, and is maintained subsequently as a result of problematic negative reappraisals. In addition a second process involves malfunctions in cognitive apparatus, specifically autobiographical memory and associative memory which occur as a result of the way traumatic events are processed. This results in a fragmented trauma memory, which contains insufficient contextualising information to discriminate the event from current and future events. It is also characterised by strong associative components and perceptual priming. The combination of these factors results in a subjective sense of current, serious threat. In order to alleviate anxiety and reduce this sense of threat, a series of behavioural and cognitive strategies are utilised which prevent adaptive reappraisal of cognitions and habituation to anxiety.

The first process thought to underlie the development of PTSD refers to the way the traumatic event and its “sequelae” are appraised (Ehlers & Clark, 2000 pg 320). Although individuals will differ in the way they interpret these events, the overall result is a sense of ongoing and serious threat. The threat can either be external (the authors provide the example of a belief that the world is a dangerous place) or internal (that the individual is unable to cope). Foa and Rothbaum’s (1998) model also focuses on the role of negative cognitions in the development of PTSD symptoms. They emphasised the importance of negative schemas relating to the ability of the self to cope, as well as ideas relating to the safety and predictability of the world. Misattributions and negative appraisals of the trauma sequelae also may underlie this process. These relate to the individuals subjective experience of PTSD symptoms as well as their own and others’ behaviours and perceptions of coping. These negative cognitions produce negative emotions, which in turn may result in maladaptive behaviours such as social withdrawal which contributes to the maintenance of psychological disturbance (Beck, 1976). The first process underlying the onset and maintenance of PTSD is therefore negative appraisals of the trauma and its sequelae,
which can be influenced by factors occurring at the time of the trauma itself or subsequently.

The second process underlying PTSD according to the model is related to the way in which the trauma is represented in; a) autobiographical and b) associative memory. The authors suggest that both the fragmentary nature of the trauma memory which can prevent intentional recall as well as the involuntary experience of aspects of the trauma memory (such as flashbacks and the experience of strong affect in the absence of recollection for detail) account for many of the distressing symptoms experienced in PTSD. In addition to the experience of flashbacks, trauma memories are often inadequately contextualised within time and space and are therefore not well integrated with other autobiographical memories. Problems arising from characteristics of associative memory are also related to the experience of a sense of current danger. Cues which trigger reliving experiences are likely to be numerous and are less likely to be semantically linked to the trauma than temporally linked to it. These cues may include physical cues similar to those which occurred at around the same time as the onset of the traumatic event. They may also include emotional states experienced by the individual at the time or other internal cues which trigger involuntary re-living when they reoccur after the event. Re-living experiences may therefore appear to occur 'out of the blue' and the trigger may be difficult to ascertain. This is likely to reduce the individual’s sense of control over their emotional experience and also to reinforce the sense of current threat.

In addition, the authors propose that the S-S and S-R associations which structure associative memory are particularly strong when formed during traumatic experiences. Associative learning is a primitive form of memory which has the survival - oriented function of allowing organisms to predict likely ominous occurrences (Shanks, 1995). In addition, there is “strong perceptual priming” which means there is “a reduced perceptual threshold for these stimuli” resulting in an increased likelihood of noticing these cues (Ehlers & Clark, 2000 pg 326). The authors also note that poor stimulus discrimination occurs in implicit memory (Baddeley, 1997 in Ehlers & Clark, 2000) which results in an increased likelihood of generalisation. Vaguely similar stimuli
trigger involuntary re-experiencing regardless of the extent of similarity of the context in which the stimuli occurs. These characteristics of the way traumatic events are represented within autobiographical and associative memory results in distressing PTSD symptoms such as the experience of strong negative affect as well as reliving experiences. The authors suggest that these disturbances form the second route by which individuals experience a sense of ongoing threat, since they are characterised by strong negative affect (often principally involving fear) in the absence of contextual information which orient the experience in the past. Therefore the second process by which PTSD is developed and maintained involves problematic processing of trauma memories associative learning mechanisms.

According to the model there is a significant degree of interaction between these two processes. This maintains the sense of current threat. For example, negative appraisals lead selective retrieval of memories which confirm the appraisals, preventing the individual from remembering information which contradict these appraisals. Failure to remember details can also reinforce negative appraisals regarding degree of coping, or (as the authors suggest), the belief that something even worse may have occurred during the trauma which cannot be recalled. Re-experiencing strong affect may also reinforce idiosyncratic negative appraisals. The authors also recognise the importance of background factors, including prior beliefs, prior experience of trauma and characteristics of the traumatic event itself as impacting on onset and maintenance of PTSD symptoms.

PTSD is similarly maintained by the adoption of safety behaviours as a way of coping with the disturbing symptoms experienced. These maintain PTSD in that they may produce an increase in symptoms themselves (e.g. thought suppression techniques which actually increase the likelihood of thought intrusion Wegner 1989). Avoidance strategies which are aimed at avoiding thinking about the memory are particularly problematic in PTSD in that they prevent integration of the trauma memory with autobiographical memories so that they remain decontextualised from time and space.
3. Critique of the model: how well can it account for the experience of asylum seekers?

The Ehlers and Clark model of PTSD is useful in that it is able to explain a number of the features of the disorder which are specific to PTSD. This includes both emotional/affective and cognitive components such as memory difficulties and the experience of flashbacks. The model is associated with a model of therapy which has been shown to be effective in treating PTSD (Ehlers et al., 2005). PTSD models have largely been developed to explain an individual’s response to a singular traumatic event, representing typical presentations to clinical services. It may therefore be less useful in explaining the experience of asylum seekers and refugees, who are more likely to have experienced multiple (or repeated) traumatic events, as well as other psychologically damaging experiences. There is limited scope for the inclusion of other traumatic events within the model, which can be understood in terms of pre- and post traumatic experiences which influence negative cognition and affect. The cumulative effect of experiencing multiple traumas is not addressed by the model. The model does suggest that exposure to subsequent events which render the original event more meaningful, or include associated stimuli, can lead to delayed onset of PTSD. However, a comprehensive account of the effects of multiple traumas is not provided.

Displaced individuals worldwide have been described as having suffered multiple traumatic events. In addition, they have often experienced significant bereavements and other losses, disrupted networks and "personal exhaustion resulting from life threat" (Dohrenwend, 1992, in Silove et al. 1993 pg 607). The additional difficulties experienced by this group are not addressed specifically by models of PTSD. For those individuals who leave their country of origin, the psychological impact of migration itself may further degrade mental health (e.g. Bhugra, 2004; Ng, 2006).

The experience of loss of being uprooted and disconnected from one’s culture has been shown to have a large psychological impact in itself. Culture offers protection from stressful events through the provision of social support, identity and a shared vision of the future (deVries, 1996). When individuals experience traumatic events such as bereavements within a cultural context, traditions and customs help
individuals to structure behaviour, control emotions, and increase access to social support. Uprooted people are disconnected from these protective mechanisms. In some cases, displaced individuals may also have experienced degradation or disintegration of their culture as a result of war or genocide. De Vries (1996) argues that this decreases an individual’s locus of control and invalidates personal identities. The cultural context in which the trauma occurs is fundamental to understanding its effects on individuals within it. He describes trauma as “the product of a combination of the severity of the stress and the supportive capabilities of the environment” (pg 409). The Ehlers and Clark (2000) model does not address the role of culture in understanding how PTSD develops and is maintained.

Some authors have argued that the Western concept of PTSD is in itself a limited concept which is not applicable to the experience of individuals from non-western societies (e.g. Bracken et al, 1995, Silove, 1999, Summerfield, 2001). They point out that the psychiatric diagnostic category of PTSD is individualistic, and assumes a universalism in symptoms across cultures. They argue that this ignores the fact that prevalence of symptoms and how they are understood varies across cultures. PTSD symptoms are largely intra-psychic, reflecting Western concepts of psychological distress. In other cultures which are less individualistic, difficulties with relations to others are emphasised over intra-psychic events (Bracken et al, 1995). This influences distress associated with trauma. Similarly to deVries (1996), the authors emphasise the importance of understanding the social and political dimensions of trauma, especially in non-Western groups.

Mezey and Robbins (2001) contest this, arguing that PTSD is a valid and useful psychiatric category. They emphasise that there is accruing evidence of biochemical, neuroanatomical and phenomenological characteristics which differentiate PTSD from other conditions. This is particularly true of memory distortions and other cognitive abnormalities which are associated with PTSD. Rather than viewing PTSD as a western construct which is not applicable to other cultures, they point out that the fact that it is used internationally suggests it is a useful diagnostic category. Difficulties relating to conceptualizations of chronic trauma experiences should be resolved through further refinement of the diagnostic categories. Similarly to Porter and
Haslam (2005) the authors highlight that PTSD should not be considered to be the only psychiatric response to trauma. Post traumatic reactions to repeated chronic trauma are often more chronic and severe. This has led to the development of other descriptions such as complex PTSD as well as the ICD-10 diagnostic category of ‘enduring personality change after catastrophic experience’ (WHO, 1992).

In summary, the Ehlers and Clark model does not specifically address the influence of chronic, repeated traumas. It also ignores cultural factors. The usefulness of the concept of PTSD in itself has also been questioned, particularly in relation to non-Western groups. The usefulness of expanding current conceptualisations to incorporate the experience of those who suffer severe chronic psychopathology as a result of repeated traumas has been discussed as these would increase the applicability of this model to groups more likely to have experienced multiple traumas. However, keeping these limitations in mind, the model is still useful in understanding how PTSD develops and is maintained, and is linked to a clinically effective treatment protocol (Ehlers et al 2005).

4. The importance of post trauma factors in development and maintenance of PTSD

Similarly to Foa and Rathbaum ‘s (1998) model and Brewin and colleagues’ (1996) model, Ehlers and Clark (2000) incorporate the impact of experiences which occur after the trauma has occurred. The Ehlers and Clark model incorporates post trauma factors in the development and maintenance of PTSD, through the mediating influence of cognitive appraisal as well as availability of associated stimuli..

Post trauma stressors have been shown to be influential in the development of post traumatic stress disorder (PTSD). Brewin and colleagues (2000) demonstrated that social support following a traumatic event was the most significant of 14 risk variables (which included trauma severity) in the subsequent development of PTSD. In a study which investigated the antecedents to post traumatic stress in war traumatised Tamil asylum seekers in Australia, pre migration trauma accounted for 20% of the variance in post traumatic stress symptomatology, whilst post traumatic
events contributed 14%. This suggests that both traumatic and post-traumatic events contribute to the development of symptoms (Steel et al., 1999). Asylum seekers are therefore at increased risk of developing PTSD as a result of increased likelihood of exposure to traumatic events as well as increased exposure to post trauma stressors.

There is some evidence that aspects of the asylum procedure itself are a particularly stressful post-migratory factor (Sinnerbrink et al., 1997). 40 asylum seekers attending a community welfare centre in Sydney suggested that salient aspects of the asylum procedure (such as barriers to work, social and healthcare services as well as the process of pursuing asylum claims) compounded psychological difficulties. Compared with refugees, asylum seekers reported higher levels of post-migration stress on account of their insecure residency status. Uncertainty regarding residency status was found to contribute to mental health problems in asylum seekers in Toronto (Matas, 1992 in Silove McIntosh & Becker, 1993). Approximately 70% of 200 asylum-seekers reported anxiety and depression symptoms and 58% stated that their symptoms had worsened since arriving in Canada. Furthermore, suicidal preoccupations were observed in 63% of asylum seekers who had resided in Canada for over 5 years, but in less than 20% of those who had arrived within the previous two years. Delay in processing residency applications (measured in terms of period of residency in Canada) was directly associated with suicidal thoughts. Although these findings may be explained by the psychological effects of living with the uncertainty of asylum status, it is also possible that the emotional impact of the trauma only became apparent over time. Taken together however, these studies suggest that specific post migratory stressors encountered by individuals undergoing the process of claiming asylum are related to increased mental health symptomatology, and that uncertainty regarding residency status may be particularly problematic.

This is complicated by the fact that trauma memories have been shown to be more likely to be incomplete as a consequence of the way they are processed in memory (Brewin & Holmes, 2003). In a Canadian study conducted by Rousseau and colleagues (2002), qualitative analysis of cases considered during Canadian legal asylum proceedings indicated that decision makers were misinterpreting inconsistencies and incomplete trauma memories as evidence of malingering, and that
post traumatic symptoms themselves were considered to show that the evidence was falsified. Rousseau and colleagues (2002) also reported that decision makers and court officials displayed vicarious traumatisation (occurring as a result of overexposure to trauma stories) which resulted in avoidance of hearing details of traumatic events and a lack of empathy with the asylum seeker. Given the seriousness of the consequences of such decisions, such experiences are likely to be regarded as extremely stressful to the individuals concerned. In a study comparing post migratory stress in refugees, asylum seekers and immigrants, Silove and colleagues (1998) showed that the 'refugee determination process' (including interviews by immigration officials and fears of being sent home) was regarded as stressful by asylum seekers.

In a study which investigated the impact of the asylum process itself on Iraqis living in the Netherlands, Laban and colleagues (2004) found that duration of asylum procedure was an important risk factor for mental health problems. The authors also reported increased anxiety, depression and somatoform disorders in individuals who had lived in the Netherlands in excess of two years, compared with refugees that had arrived within the preceding 6 months. Post migratory stressors are therefore impacting negatively on this population, who are already vulnerable to mental health difficulties caused by increased exposure to traumatic events. Consistent with these findings was the observation of high rates of PTSD symptomatology in both groups.

**Immigration detention as a specific post trauma stressor**

As outlined above, asylum seekers and refugees are at an increased risk of exposure to both pre and post migratory stressors, and there is considerable evidence that rates of mental health difficulties are high in this group. There is one particular group of asylum seekers who suffer additional post migratory stressors which may impact on their mental health status; those who are detained in the host country.

Detained asylum seekers are exposed to an increased array of post migratory pressures as a result of the detention process itself as well as the detention centre environment. These include loss of liberty, uncertainty regarding return to country of origin, social isolation, abuse from staff, exposure to the forceful removal of detainees, riots and
exposure to hunger strikes and self harm amongst other difficulties (Fazel & Silove, 2006; Pourgourides, Sashidharan & Bracken, 1996, Keller, 2003).

Using the Ehlers and Clark model, it is possible to hypothesise that detention could have an impact on the maintenance and development of PTSD if it affected levels of negative appraisals of the traumatic event and its sequelae. In addition, the environment within detention centres may contain cues which trigger re-experiencing of former traumatic experiences if that experience involved imprisonment, or harassment by security or government officials or the police. Conversely it is possible that if these cues occur during detention in the absence of traumatic events, these cues will become less strongly associated with the trauma through extinction processes. This may result in a reduction in PTSD symptomatology.

Another reason why detention could potentially impact on PTSD symptoms is through the mediating variable of reduced social support. Lack of perceived social support has been shown to be associated with PTSD symptoms (Brewin et al, 2000). Detained individuals may also be socially isolated by language and cultural barriers. The environment may also constitute a ‘negative social environment’ in that it is characterised by the perceived criticism and indifference to the asylum seeker’s plight. Negative social support is more highly predictive of PTSD symptomatology than a lack of social support (Ullman & Filiopas, 2001; in Brewin & Holmes, 2003). In addition, beliefs and assumptions about the safety of the world and the benevolence of others may be refuted by detention experiences. These types of beliefs are related to an increase in PTSD symptomatology (Dunmore et al 1999; Janoff-Bulman, 1992). The situation is further complicated by the fact that detainees face the threat of imminent deportation. This may complicate appraisals of current threat which are characteristically confused in PTSD. Research into the mental health of asylum seekers detained abroad has revealed heightened levels of mental health symptoms in this group. This evidence is reviewed below.
5. Research into the mental health of detainees.

Research into the mental health of detainees began in Australia, and it is in this country that the most extensive work has been carried out. At the time of the research, detention in Australia was particularly problematic in that that it was introduced as mandatory practice for all asylum seekers (including children) arriving by boat or without valid documentation. Detention centres in Australia were largely situated in remote areas which meant that contact with individuals living outside of detention (including family members, members of the ethnic community as well as Australian compatriots) was severely restricted (Silove et al, 1993) (This policy of mandatory detention has since been reversed, Fazel & Silove, 2006).

Evidence regarding the psychologically damaging effects of detention in this group began to accumulate following the publication of a participant-observer account by an Iraqi doctor held in detention (Sultan & O’Sullivan, 2001) as well as clinical observations and accounts published by mental health specialists (Mares et al in Fazel and Silove, 2006). These accounts suggested that the mental health of vulnerable individuals who were detained was compromised as a result of the perceived injustice of detention as well as exposure to traumatic events within the detention centre. Mental health specialists and clinicians observing increased mental health difficulties in detainees described a “pressure cooker effect” whereby the restricted and monotonous environment of the detention centre, coupled with a lack of contact with individuals living outside of detention resulted in “mounting despair, suspicion and frustration” (Silove et al, 1993 pg 609). The authors described that detainees expressed confusion as to why they were imprisoned despite not being suspected of having committed a criminal offence. Many individuals were further isolated by language barriers which increased feelings of isolation and loneliness. In addition, an inquiry by the Human Rights and Equal Opportunity Commission found mental distress to be common amongst detainees. Incidence of self harm and suicide attempts were also recorded. The report emphasises the psychological harm caused by indefinite detention as well as harsh conditions; unnecessary and inappropriate use of force; and harassment by staff. This contributed to an extremely tense environment resulting in frustration, despondency and depression amongst detainees. (Human
Rights and Equal Opportunity Commission, 1998, in Silove & Steel, 2001). These reports are limited by methodological constraints in that they are largely anecdotal, or were carried out within a highly politicised context.

In the Sultan and O'Sullivan (2001) study, observations made by the author at the time of detention were further supported by semi structured interviews with 33 detainees. These were carried out in collaboration with the second author, a clinical psychologist working at the same detention centre. The authors described high levels of psychological disturbance amongst detainees. 85% showed signs of chronic depression and 65% reported suicide ideation. Symptoms of psychosis were also observed. They suggest that psychological difficulties observed amongst detainees increase through four successive stages, which closely follows the asylum process. In all but the final stage, progression into the next successive stage is thought to follow a negative outcome from decision points on asylum applications. The authors describe an increasing sense of hopelessness and despair, accompanied by severe depressive reactions including hunger strikes, self harm, psychotic symptoms and psychomotor retardation. The inclusion of semi structured interviews in this study is useful in that it increases the validity of the findings.

Evidence which is of a more systematic nature is presented by Thompson and colleagues (1998), in a study that compared a group of 25 detained Tamil asylum seekers with a parallel community based group. As well as suffering from higher levels of physical symptoms, detained asylum seekers were more depressed, suicidal and suffered more extreme post-traumatic panic. This group also reported exposure to a greater number of trauma categories. However, levels of pre-migration trauma did not account entirely for the differences, which may suggest that the conditions of detention contributed to the difficulties experienced by detainees. Although this study is limited by its small sample size, the results are important in providing quantitative evidence of the harmful effects of detention. A similar study which investigated the effects of detention on Afghan asylum seekers in Japan conducted in 2002-2003 compared levels of anxiety, depression and PTSD in asylum seekers who had been previously detained with those who had never been detained (Ichikawa et al 2006).
They reported higher levels of depression, anxiety and PTSD symptoms amongst former detainees compared with those who had never been detained. There were no differences in exposure to pre-migration traumas, or other characteristics which may confound this association. Furthermore, multiple regression analysis revealed that the adverse effects of detention were independent, together with greater trauma and living alone.

This study was limited by sample size (only 18 out of a total of 55 participants had been detained); and also by the fact that measures were completed subsequent to release rather than during the period of detention. However, this study is useful in that it provides evidence of the adverse effect of detention in a third country. Considering that detention policies and environments differ between countries, there is therefore evidence that the practice of detention is adverse in itself, regardless of how the circumstances surrounding detention and the specific detention environment is manifest.

Stronger evidence that detention causes psychological harm in this group is provided by a study which looked at rates of symptoms of depression, anxiety and PTSD in detained asylum seekers compared with follow up rates after release. In this study which looked at the effects of detention amongst asylum seekers in the USA, Keller and colleagues (2003) found that time in detention was directly related to symptomatology. High levels of symptoms of depression, anxiety and PTSD symptoms were observed amongst detainees, with significant reductions in symptoms observed at follow up in those who had been released. By contrast, individuals who had not been released showed deterioration in mental health, displaying increased symptomatology than at baseline. This study also suggested that those suffering from mental health problems were more likely to be detained. Although there are confounding variables which complicate the relationship between the effects of detention and mental health, the incorporation of follow up data within the design increases the validity of this association.

Further evidence of the longer term relationship between detention in Australia and mental health has been provided by a recent study based on a population of Mandaen
refugees (Steel, Silove, Brooks et al, 2006). Using snowball sampling techniques, the authors recruited 241 participants (constituting an estimated 60% of this population living in Sydney) and assessed PTSD, major depressive disorder and stress factors which were related to past trauma, detention and temporary protection (temporary legal status in Australia). The authors demonstrated statistically that past immigration detention and temporary protection contribute independently to mental health difficulties. Consistent with Keller and colleagues (2003), length of detention was associated with greater difficulties. On average, the harmful effect of detention persisted for 3 years (Steel et al, 2006).

In addition, the harmful effects of detention on children and adolescents have been studied. A small number of studies have suggested that detention is harmful to the mental health and development of children (Mares & Jureidini, 2004; Steel et al 2004; Sultan & O'Sullivan, 2001). The authors suggest that this occurs as a result of the impoverished detention environment in itself, as well as the harmful effects on the mental health and parenting capacity of parents in detention. In the sample described in Mares and Jureidini (2004), all children had at least one parent with a mental health problem.

As a result of increasingly sophisticated study designs as well as the employment of advanced statistical methods, good evidence of the harmful effects of detention on asylum seeker and refugee populations in different countries has accumulated. This suggests that the harmful effects of detention are not restricted to the specific policies of detention employed by different countries. However, it cannot be assumed that detention in the UK is comparable to that within the Australia or in the US without specific research investigating this, as both asylum policy and the detention environment itself is variable.

**Detention within the UK**

To date, only three studies have investigated the effects of detention within the UK on the mental health of asylum seekers. This is in spite of growing concern amongst clinicians that detention within the UK is psychologically harmful (Salinsky, 1997;
Arnold et al., 2006, Fazel & Silove, 2006; Cutler, 2005). Arnold and colleagues (2006) reported on the outcome of medical examinations of 56 failed asylum seekers who were either currently being held or had been recently released from, four UK detention centres. Arnold (2006) describes examinees who displayed unmet physical health needs as a result of serious physical illnesses. Unmet health needs resulting from the experience of pre-migration torture as well as the commencement of hunger striking whilst being detained in the UK were also evident. With regards to mental health difficulties, 33 out of 56 patients fulfilled ICD10 criteria for PTSD or depression (Arnold et al., 2006).

Bracken and Gorst-Unsworth (1991) document the cases of 10 asylum seekers who the authors provided care for whilst they were detained (in their capacity as clinicians working for the ‘Medical Foundation for the Care of Victims of Torture’). They describe a ‘high level of psychological disturbance in all cases’, characterised by intense fear and anxiety, sleep disturbance and nightmares, irritability and frustration as well as profound hopelessness, concerns about their own mental health, suicidal ideation and suicide attempts (Bracken & Gorst-Unsworth, 1991 pg 658).

The above two studies are useful in that they document the experiences of clinicians working with detainees in the UK. However, similarly to the early evidence accrued in Australia, these studies are subject to sampling biases in that they only include participants who required clinical intervention. The first study to formally investigate the effects of detention within the UK was carried out by Pourgourides and colleagues (1996). This qualitative study aimed to gain an in-depth understanding of why individuals who had been detained were presenting to NHS services with such high rates of depression, anxiety, self harm and psychosis upon release, and to investigate how the symptoms arose. Interviews with 15 male former detainees as well as focus group discussions were analysed within a grounded theory approach. Participants within focus groups included former detainees; support groups; professional advisors, health professionals as well as campaign groups who had contact and expertise in this area. This study provided rich qualitative data which adds substantially to the understanding of how and why mental health problems arise in this group. Particularly relevant findings are outlined below.
The authors highlight a number of specific difficulties encountered by this group which adversely effects mental health. Lack of information available to detainees regarding the status of their application, what is likely to happen to them and when it is likely to occur increases anxiety and depression, and contributes to the hopelessness and helplessness reported by detainees. Furthermore, the lack of positive possible outcomes adds to this sense of hopelessness.

The authors write about the decontextualisation of detainees experiences and conclude that this leads to a sense of loss of identity. In addition, relevant aspects of detainees’ experiences are denied by immigration, resulting in a feeling that their existence is therefore denied. Loss of relationships, familiar surroundings, control over every aspect of their own life and status add to this sense of loss of identity. Detainees reported concerns that they were losing autobiographical memory as well as fears concerning their mental health which contributes to this. Additional problems included an inability to utilise normal coping strategies as a result of detention centre restrictions and the detention environment representing a meaningless space, seemingly ‘between worlds’ denying detainees the opportunity to place their experiences within a meaningful framework. Detainees are therefore preoccupied by time and experience extreme boredom and frustration as well as a sense of futurelessness. The situation is compounded by a profound sense of injustice and ambivalence towards the host country as a result. Finally the authors describe the high incidence of hopelessness, depression and despair as normal reactions to an abnormal situation and regard the detention experience itself as an ongoing trauma (Pourgourides et al., 1996).

This study is valuable in that it provides extensive information regarding the subjective experience of detainees held within detention centres in the UK. However, operational changes occurring within IRC’s may have affected detention experiences since this study was carried out. Although more recent reports of clinical observations do support these findings, they are again limited in scientific validity as they are largely anecdotal. One example of a recent observational account is provided by Reverend Larry Wright, formally an internal chaplain at Yarl’s Wood Immigration
Removal Centre, UK. This report suggests that detainees experience physical, psychological and behavioural disturbances as a result of long-term detention experiences (Wright, 2006). He also described his experiences at weekly suicide and self harm meetings, noting that staff reported the most frequent symptoms experienced by detainees as: “Despair, boredom and lethargy, erratic sleeping patterns, night terrors, imagined voices or visualisations, weight loss or weight gain, fixation on health concerns, feelings of being victimised by detention and immigration staff, apathy and low self esteem, poor self hygiene, self-isolation, sudden emotional outbursts, suicidal urges and sexuality issues” (Wright, 2006 pg.4). The indefinite nature of detention was considered to compound psychological difficulties. This commentary suggests that the findings reported by Pourgourides and colleagues (1996) are still relevant and that further investigation of this would be useful.

One final study which investigated the impact of indefinite detention in a specific sample is described by Robbins and colleagues (2005). Between December 2001 and March 2005, a number of foreign nationals were subject to indefinite detention within UK prisons as they were considered a threat to national security. The study analysed the reports written by various professionals involved in the cases regarding 8 detainees, held at Belmarsh prison. Reports were mostly written by consultant psychiatrists and a consultant clinical psychologist. However, information provided by physicians, social workers and occupational therapists was also incorporated into the findings. The experiences of three of the detainees’ spouses were also analysed. All 8 detainees were found to be suffering significant levels of clinical depression and anxiety which had shown deterioration during the period of detention. A number of cases were also diagnosed as having PTSD, and all participants had experienced significant traumatic events. Levels of suicidal ideation and self harm were also high. In one case, psychotic symptoms were observed, having developed since the individual had arrived at Belmarsh. His condition improved within a short period following release. The experiences of three female spouses of detainees were congruent with these findings. These women all had clinical depression, one showed signs of PTSD, and another a phobic anxiety state. The psychological disturbance reported by the women fluctuated with changes to their husband’s conditions. The authors describe these difficulties to surpass those as those that one might expect to find in women whose spouses were
incarcerated in normal circumstances, with a definite release date. Findings indicated that indefinite detention per se was damaging to psychological wellbeing. Taken together these small studies and descriptive reports suggest that indefinite detention of asylum seekers within the UK is psychologically harmful, as has been demonstrated abroad. However, to date there have been no quantitative studies within UK detention centres.

**Aims and hypotheses**

The aims of the current study are therefore to investigate the experiences of detainees held within immigration centres within the UK using quantitative methods. These findings can then be compared with studies outlined above which have suggested that indefinite detention is psychologically damaging in other countries. A further aim is to compare a subgroup of detainees with a community sample in order to investigate whether there are differences in rates of anxiety, depression and PTSD between detainees and a community sample.

It is hypothesised that:

1) There will be higher rates of depression, anxiety and PTSD symptoms in detainees than in the comparison group of asylum seekers living in the community.

2) There will be a positive correlation between psychological symptoms and length of time in detention.

3) Negative cognitions regarding the self, the world and self blame mediate the impact of detention on mental health.
Method

Setting: Detained participants were recruited from within four Immigration Removal Centres. Two of these were high security centres and hold a large number of ex prisoners, all of whom are male. Detainees are allowed access to communal areas such as the library and recreational facilities for certain periods during the day and have to return to their rooms at set times for a roll call. This means that individuals have to return to their rooms for several hours in the middle of the day. Although the environments in these two centres are not identical, they are similar in that they are based on a prison design, with individual cells and uniformed staff. At one of the centres, incidents of problematic behaviour (which included self harm or threats of self harm) were managed by the individual being removed to a seclusion unit within the centre. This unit comprises of individual, empty cells. Detainees held in the seclusion unit were monitored by a guard, until they were deemed to be no longer a risk to themselves or others.

The other two centres hold male and female detainees, and also each have a family wing (and hence detain children of any age, with their parents). One of these centres also holds detainees whose cases are being managed under the ‘fast track’ system. This means that they are considered to be cases which are less complex and so are dealt with more quickly. Detainees are therefore likely to have been detained for shorter periods within this centre. This centre also detains a number of individuals who have already been detained in other centres, but are awaiting deportation. This centre has a more open environment and detainees have free access to all areas (except the family wing) during the day. Within all the centres, recreational activities are organised, but were not well attended. There is also a library in each centre and English language classes were held. The majority of detainees appeared to spend their time waiting in corridors, staying in their rooms or the library, or trying to get access to the administrative facilities necessary to contact lawyers and immigration officials about their cases. There was a high demand for assistance from staff with these sorts of administrative-legal requests and very limited availability.
All centres have visitors from religious groups who come in to provide religious services and pastoral care. In one centre, religious services were offered in one part of the building which is separate from the other rooms. As access around the building is restricted, individuals can return to their rooms at a choice of one of two time points. In practical terms, opting to practice their religion meant detainees had to stay for an extra few hours away from their rooms. Some individuals told the author that they therefore felt they did not feel this was a viable option. In all the centres, healthcare is provided on site and is privately run. Access to NHS services is only available when the healthcare available within the centre is considered to be inadequate, and a referral to secondary levels of healthcare is required.

**Community setting:** the community comparison sample was recruited from 7 different community centres, day centres and drop in centres for asylum seekers and refugees. Most offered meals, and recreational activities, although some also offered advocacy services.

**Participants:** Detained participants (n = 97) were recruited through opportunity sampling. Most detained participants were male (n = 69) There were 28 female participants. Approximately 75% of detained participants who were approached agreed to participate in the study.

Of these, two separate groups could be distinguished. The first group (n = 67) were detained asylum seekers, some of whom had exhausted legal processes (failed asylum seekers) and were awaiting deportation (n = 21). Some detainees were uncertain about their status at the time of the study, and some planned to initiate new claims. Detained asylum seekers ages ranged from 15-58, with a mean of 29.5 (SD = 8.86). (The age of the youngest participant was disputed by immigration officials, who claimed he was over 18).

A second group of detainees were individuals who had formerly been imprisoned in the UK (subsequently referred to as former prisoners). These individuals (n = 30) did not have legal immigration status, and some of these were seeking asylum. Some of these were awaiting deportation and had not claimed asylum (n = 4), others were also
awaiting deportation because their applications had failed (n = 4). This group had an age range of 22-50, with a mean of 32.41 (SD = 7.63).

A comparison group (n = 49) of asylum seekers were recruited via opportunity sampling from 7 different community drop-in centres. Of these, some were failed asylum seekers (n = 3). Within this group, 27 were male and 20 were female, 2 did not report their gender. All participants were over 18. Average age was 34.96 years (SD = 11.15 years) and ranged from 18-66. Approximately 60% of those approached in the community setting agreed to participate in the study.

Overall there were (n = 146) participants. Most were male (n = 96) and 48 were female. Average age was 31.86 years (SD = 9.70 years) and ranged from 15 to 66. Participants were from 43 different countries.

**Design:** The study utilised a cross-sectional, questionnaire methodology. Detained asylum seekers were compared with detained former prisoners as well as the comparison group of asylum seekers living within the community.

**Procedure:** Participants were recruited from the library and other communal areas in IRC's via opportunity sampling. Participants were approached by the author and the study was explained to them. Those wishing to participate in the study were asked to complete a questionnaire in English. Within the detention centres, approximately 75% agreed to participate. Approximately 60% agreed to participate in the comparison group. Although participants were encouraged to fill in the questionnaire by themselves, the majority chose to complete the questionnaire with the aid of the author owing to literacy and language confidence issues. In these cases the author asked the participants the questions and filled in their responses on their behalf. Participants completed all the questions, except in cases where they did not feel they had sufficient English language comprehension, or did not consider themselves to have experienced a traumatic event. In these cases participants did not complete the Impact of Events Scale or the Post Traumatic Cognitions Inventory.
Measures: The questions contained four measures. These were 1) The Hospital Anxiety and Depression Scale (Zigmond & Snaith, 1983) 2) The Impact of Events Scale-Revised (Weiss, 1996) 3) The Post Traumatic Cognitions Inventory (Foa et al 1999) 4) Biographical section consisting of questions relating to demographics, religion, social support, previous trauma history and previous imprisonment. A copy of the questionnaire can be found in appendix I.

1) **The Hospital Anxiety and Depression Scale (Zigmond & Snaith, 1983).**

This 14 item questionnaire measures mild degrees of mood disorder. It provides a measure for anxiety (HADS-A, sum of 7 items) as well as for depression (HADS-D, sum of 7 items). Originally designed for use in populations with physical health problems, it has since been used in a variety of research and clinical settings. The authors suggest that it requires only limited ability to read or reasonable aural comprehension (if it is read to the client). Each question has four possible answers and scores range from 0-3 indicating that symptoms are either not present at all or are present at 3 levels of severity. For HADSD and HADSA subscales, scores falling within the range of 0-7 are considered normal, 8-10 fall within the borderline range and scores of 11 or above indicates probable presences of mood disorder (Snaith, 2003).

In a review by Bjelland and colleagues (2002) of 747 papers which had used the scale, the HADS was found to have good reliability and validity. Correlations between anxiety and depression subscales were found to be between 0.40 and 0.74 (with a mean of 0.56). For the HADS-A subscale, Cronbach's alpha's ranged from 0.68 to 0.93 (mean 0.83). For HADS-D, Cronbach's alpha's of between 0.67 and 0.90 were reported (mean 0.82). Correlations between the HADS and other commonly used questionnaires ranged from between 0.49 to 0.83.

2) **The Impact of Events Scale-Revised (Weiss, 1996).**

This 22 item questionnaire measures posttraumatic disturbance. It is based on the Impact of Events Scale (IES) (Horowitz et al, 1979) which measures intrusion and
avoidance symptoms related to the experience of any specific stressful event. The IES-R measures hyperarousal in addition. The original 4-point scale scoring system was used which asks respondents to indicate whether they experienced the symptom at all (0), rarely (1) sometimes (3) or often (5) within the last week. The sum of the subscale scores is used as an indicator of total stress. This was used so that valid comparisons can be made to the IES (for which norms are available) as well measuring hyperarousal symptoms (in the IES-R). An additional advantage to using this original revision of the IES-R is that the original instruction to report how often symptoms occur was maintained. The later version of the IES-R measures extent of subjective distress at the presence of symptoms, a more complex concept for individuals who do not speak English as a first language. 7 items measure intrusion, 8 items measure avoidance and 7 items measure hyperarousal (Weiss, 1996). For the IES, scores of between 0-8 are subclinical, scores from 9-25 are within the mild range, scores of between 26-43 are within the moderate range and scores greater than 44 are indicate severe levels of disturbance (Horowitz et al, 2007).

The IES has been shown to have good reliability and validity. In a recent review of studies using the IES, Sundin and colleagues (2002) reported Cronbach’s alphas of between 0.72 and 0.92 for the intrusion subscale (mean 0.86) and 0.65 to 0.90 for the avoidance subscale (mean 0.82). This indicates satisfactory reliability. The authors also report good content validity (mean correlation between the two subscales was 0.63, suggesting relative independence).

The IES-R has also been shown to have good reliability. Cronbach’s alphas for intrusion ranged from 0.87 to 0.92, avoidance alphas ranged from 0.84 to 0.86. The third scale (hyperarousal) alphas ranged from 0.79 to 0.90 (Briere, 1997). In terms of validity, the authors of the IES-R report results of the validity of the two IES subscales (Weiss & Marmar, 1997). The hyperarousal subscale has been shown to have good predictive validity (Briere, 1997).
3) **The Post Traumatic Cognitions Inventory (Foa et al 1999)**

This 36 item self-report questionnaire is designed to measure negative cognitions in relation to traumatic events. The mean of 21 items are summed to form the 'negative cognitions about the self' (SELF) subscale. The mean of 7 items are summed to form the 'negative cognitions about the world'(WORLD) subscale, and the mean of 5 items measure 'self blame'(BLAME).

The test has been shown to have good reliability. Cronbach’s alphas for the total PTCI score was 0.97. The authors report Cronbach’s alphas of 0.97, 0.88 and 0.86 for SELF, WORLD and BLAME respectively. The authors also report good validity, as the PTCI is correlated with measures of depression, general anxiety and PTSD. The association between PTCI scores and PTSD remained significant when depression was controlled for (Foa et al, 1999).

4) **Biographical section.**

This section was compiled by the researchers in order to collect demographic information as well as information regarding relevant previous experiences. This included a list of traumatic events listed in the Posttraumatic Diagnostic Scale (Foa, 1995). In addition questions relating to age, gender, length of time in detention, length of time in the UK, previous imprisonment, religion, perceived support from staff, family and friends and asylum status were included. This section was designed for the purpose of this study.

**Home Office approval of access and ethical approval for the study**

Approval for access to detention facilities was granted by the Immigration Nationality Directorate of the Home Office. Ethical approval was granted by South East Multi-Centre Research Ethics Committee, who specialise in granting approval for research in prison settings. Ethical approval was also granted by the School of Human Sciences Ethics Committee at the University of Surrey. Evidence of this can be found in Appendix II.
Results

Data analysis

Missing data

Where data was missing for individual questionnaire items which were part of a subscale score, they were replaced with the mean as recommended by Howell (2002). This occurred in all cases except where missing items constituted in excess of 20% of the total number of subscale items. However, as 20% usually constituted between one and two items, the more conservative option was chosen. This meant that the mean was used to replace missing data in cases where there was only one missing item for the HADSD and HADSA subscales; the IESH, IESI and IESA subscales; as well as the BLAME and WORLD subscales. Up to 4 missing items were replaced by the mean for the SELF subscale. Cases where missing data constituted greater levels were excluded.

Data screening

The data was screened in order to test it met assumptions of parametric tests. Graphs were assessed visually to ascertain whether data was skewed. The Kolmogorov-Smirnov test was used to assess whether deviations from normality were skewed, as recommended in Field (2000). Kolmogorov-Smirnov test statistics are shown in table A in appendix IV. Outliers were identified and were removed where they were found to be invalid responses. The reliability of measures was assessed by obtaining Cronbach’s alphas for overall scales and subscales. These can be found in table B in appendix IV.
Statistical analysis

Data were analysed using the Statistical Package for Social Sciences (SPSS Inc., Chicago, Illinois, USA) version 14.0. The data was analysed using t-tests and Analysis of Variance (ANOVA). Equivalent non-parametric tests were used where assumptions were not met (as identified by the Kolmogorov-Smirnov test for normality, and the Levene test for homogeneity of variance). Additional analysis included the use of correlations and regression analysis.

Participants were split into three groups for data analysis. These were as follows:

**Group 1:** Detainees who were either engaged in the process of seeking asylum, were planning to initiate new claims, or were failed asylum seekers whose claims had been rejected.

**Group 2:** Detainees who had previously been imprisoned within the UK, but did not have the right to live in the UK. Some of these individuals were seeking asylum.

**Group 3:** Asylum seekers and failed asylum seekers who are living within the community, and who have never been detained.

Descriptive characteristics

The demographic characteristics of all participants were analysed. A summary of these findings are shown in table 1. Levels of trauma are shown in table 2. Frequencies of answers relating to the biographical section of the questionnaire are shown in appendix III.
Table 1. Demographic characteristics of participants

<table>
<thead>
<tr>
<th>Demographic</th>
<th>Total sample (n = 146)</th>
<th>Detained asylum seekers (n = 67)</th>
<th>Detained former prisoners (n = 30)</th>
<th>Community comparison (n = 49)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>96 (66.6%)</td>
<td>48 (71.6%)</td>
<td>21 (66.7%)</td>
<td>27 (57.4%)</td>
</tr>
<tr>
<td>Female</td>
<td>48 (33.3%)</td>
<td>19 (28.4%)</td>
<td>9 (30%)</td>
<td>20 (42.6%)</td>
</tr>
<tr>
<td>Religion</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Muslim</td>
<td>56 (39.7%)</td>
<td>28 (43.1%)</td>
<td>9 (30%)</td>
<td>19 (41.3%)</td>
</tr>
<tr>
<td>Christian</td>
<td>71 (50.4%)</td>
<td>30 (46.2%)</td>
<td>18 (60%)</td>
<td>23 (50%)</td>
</tr>
<tr>
<td>Sikh</td>
<td>2 (1.4%)</td>
<td>2 (3.1%)</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Hindu</td>
<td>2 (1.4%)</td>
<td>1 (1.5%)</td>
<td>1 (3.3%)</td>
<td>0</td>
</tr>
<tr>
<td>Buddhist</td>
<td>5 (3.5%)</td>
<td>1 (1.5%)</td>
<td>1 (3.3%)</td>
<td>3 (6.5%)</td>
</tr>
<tr>
<td>Jewish</td>
<td>1 (0.7%)</td>
<td>0</td>
<td>1 (3.3%)</td>
<td>0</td>
</tr>
<tr>
<td>None</td>
<td>4 (2.8%)</td>
<td>3 (4.6%)</td>
<td>0</td>
<td>1 (2.2%)</td>
</tr>
<tr>
<td>Practicing religion</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>107 (77.5%)</td>
<td>45 (70.3%)</td>
<td>26 (86.7%)</td>
<td>36 (81.8%)</td>
</tr>
<tr>
<td>No</td>
<td>31 (22.5%)</td>
<td>19 (29.7)</td>
<td>4 (13.3%)</td>
<td>8 (18.2%)</td>
</tr>
</tbody>
</table>
Table 2: Frequencies of types of traumatic events for the total sample and across groups

<table>
<thead>
<tr>
<th>Trauma type</th>
<th>Total sample (n = 146)</th>
<th>Detained asylum seekers (n = 67)</th>
<th>Detained former prisoners (n = 30)</th>
<th>Community comparison (n = 49)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accident / fire/ explosion</td>
<td>34 (24.8%)</td>
<td>20 (29.9%)</td>
<td>3 (12.5%)</td>
<td>11 (23.9%)</td>
</tr>
<tr>
<td>Natural disaster</td>
<td>9 (6.6%)</td>
<td>6 (9%)</td>
<td>0</td>
<td>3 (6.5%)</td>
</tr>
<tr>
<td>Non sexual assault by a known assailant</td>
<td>13 (9.5%)</td>
<td>6 (9%)</td>
<td>2 (8.3%)</td>
<td>5 (10.9%)</td>
</tr>
<tr>
<td>Non sexual assault by a stranger</td>
<td>37 (27%)</td>
<td>25 (37.3%)</td>
<td>4 (16.7%)</td>
<td>8 (17.4%)</td>
</tr>
<tr>
<td>Sexual assault by a known assailant</td>
<td>7 (5.1%)</td>
<td>4 (6%)</td>
<td>1 (4.2%)</td>
<td>2 (4.3%)</td>
</tr>
<tr>
<td>Sexual assault by a stranger</td>
<td>12 (8.8%)</td>
<td>7 (10.4%)</td>
<td>0</td>
<td>5 (10.9%)</td>
</tr>
<tr>
<td>Military combat or a war zone</td>
<td>47 (34.3%)</td>
<td>29 (43.3%)</td>
<td>2 (8.3%)</td>
<td>16 (34.8%)</td>
</tr>
<tr>
<td>Sexual contact as a child</td>
<td>9 (6.6%)</td>
<td>3 (4.5%)</td>
<td>0</td>
<td>6 (13%)</td>
</tr>
<tr>
<td>Imprisonment</td>
<td>51 (37.2%)</td>
<td>29 (43.3%)</td>
<td>11 (45.8%)</td>
<td>11 (23.9%)</td>
</tr>
<tr>
<td>Torture</td>
<td>41 (29.9%)</td>
<td>26 (38.8%)</td>
<td>6 (25%)</td>
<td>9 (19.6%)</td>
</tr>
<tr>
<td>Life threatening illness</td>
<td>18 (13.1%)</td>
<td>9 (13.4%)</td>
<td>1 (4.2%)</td>
<td>8 (17.4%)</td>
</tr>
<tr>
<td>Other traumatic event</td>
<td>63 (46%)</td>
<td>36 (53.7%)</td>
<td>10 (41.7%)</td>
<td>17 (37%)</td>
</tr>
</tbody>
</table>

Table 2 shows a larger number of traumatic experiences in both asylum seeking groups compared with detained former prisoners. There are also greater levels of personalised attacks compared with non personal attacks. Overall, the mean number of categories experienced by detained asylum seekers is 2.99 (SD = 1.73).
Amongst asylum seekers living within the community the mean number of trauma categories is 2.17 (SD = 1.16). The mean number of trauma categories in former prisoners is 1.67 (0.87). A non parametric test was used to see if this difference was significant, as the data did not meet the assumptions of parametric tests. The Levene test for homogeneity of variance was significant \( L(2,134) = 4.91 \ p<0.01 \) In addition, the Kolmogorov-Smirnov statistic for number of trauma categories experienced was \( K-S(137) = .233 \ p<0.01 \). The Kruskall Wallis test showed that there was a significant difference between the three groups in the number of trauma categories experienced \( \chi(2) = 15.83 \ p<0.01 \). Mann-Whitney U tests were used to further investigate these differences. Detained asylum seekers had experienced trauma falling into a significantly greater number of categories than asylum seekers who were living within the community \( (z = -2.66, p<0.01) \). The difference between asylum seekers who were detained and former prisoners who were detained was also significant \( (z = -3.58, p<0.01) \). There was no significant difference between detained former prisoners and asylum seekers living within the community \( (z = -1.64 p=1.01) \).

**Hypothesis 1**

The first hypothesis was that there would be higher rates of depression, anxiety and PTSD symptoms in detainees than in the comparison group of asylum seekers living in the community. Descriptive statistics for depression anxiety and PTSD scores are shown below. Figures regarding skewness and kurtosis for HADSD, HADSA and IES-R scales and subscales can be found in tables C-H in appendix iv.
Hospital Anxiety and Depression Scale Scores

Table 3: Depression (HADSD) scores and Anxiety (HADSA) scores for the total sample and for the three groups.

<table>
<thead>
<tr>
<th></th>
<th>Total sample</th>
<th>Detained Asylum seekers</th>
<th>Detained former prisoners</th>
<th>Community comparison</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>HADSD</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>N</td>
<td>138</td>
<td>66</td>
<td>30</td>
<td>42</td>
</tr>
<tr>
<td>Mean (SD)</td>
<td>11.76 (4.58)</td>
<td>13.54 (4.58)</td>
<td>11.37 (3.81)</td>
<td>9.24 (3.85)</td>
</tr>
<tr>
<td>% (n) normal range</td>
<td>17.4% (n = 24)</td>
<td>9.1% (n = 6)</td>
<td>13.3% (n = 4)</td>
<td>33.3% (n = 14)</td>
</tr>
<tr>
<td>% (n) borderline range</td>
<td>23.9% (n = 33)</td>
<td>15.2% (n = 10)</td>
<td>20% (n = 6)</td>
<td>40.5% (n = 17)</td>
</tr>
<tr>
<td>% (n) clinical ‘caseness’</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>58.7% (n = 81)</td>
<td>75.8% (n = 50)</td>
<td>66.7% (n = 20)</td>
<td>26.2% (n = 11)</td>
</tr>
</tbody>
</table>

| **HADSA**                |              |                         |                           |                      |
| N                        | 140          | 65                      | 30                        | 45                   |
| Mean (SD)                | 12.86 (5.52) | 14.08 (4.98)            | 12.82 (5.35)              | 11.12 (5.98)         |
| % (n) normal range       | 18.8% (n = 26)| 9.4% (n = 6)            | 20% (n = 6)               | 31.8% (n = 14)       |
| % (n) borderline range   | 15.9% (n = 22)| 18.8% (n = 12)          | 6.7% (n = 2)              | 18.2% (n = 8)        |
| % (n) clinical ‘caseness’|
|                          | 65.2% (n = 90)| 71.9% (n = 46)          | 73.3% (n = 22)            | 50% (n = 22)         |
**Distribution of HADSD scores.**

A Kruskall Wallis test was used to test the significance of HADS scores. This non parametric test was chosen because the Kolmogorov-Smirnov statistic was significant for this scale within the comparison group (K-S (42) = .160, p<0.01). The Kruskall Wallis test produced a significant result in the comparing HADSD scores between the three groups (χ(2) = 24.45, p<0.001).

Post-hoc tests are not available for the Kruskall Wallis (Field, 2000). In order to compare the differences between groups, the Mann-Whitney U test was used. As the use of multiple tests can raise the possibility of making a type I error, a bonferroni correction was applied (as suggested by Howell, 2002). This resulted in a reduced significance level of 0.01. Results of the Mann Whitney tests showed that detained asylum seekers had significantly higher HADSD scores than the community comparison group (z = -4.68, p<0.001). The same test was used to compare depression in detained asylum seekers and detained former prisoners. This difference in HADSD scores was not significant at the p<0.01 accepted level. (z = -2.23 p<0.03). Finally, comparisons were made between detained former prisoners and asylum seekers living within the community using the same test (z = -2.78, p<0.01).

**Distribution of HADSA scores.**

ANOVA was used to test the significance of these scores. F (2,137) = 4.00 p=0.02

Post Hoc tests were used to compare differences between sets of two groups. As the sample sizes were unequal, the Games-Howell test was used (as recommended in Field, 2000). There was a significant difference between detained asylum seekers and asylum seekers living in the community. The mean difference was 2.96 (SE = 1.09) p=0.02. There was no significant difference between detained asylum seekers and detained former prisoners (mean difference = 1.26 (SE = 1.16) p=0.52. There was also no significant difference between detained former prisoners and asylum seekers living in the community (mean difference =1.7 (SE = 1.32) p = 0.41.
Impact of Events Scale-Revised scores

Table 4: IES-R scores for the total sample and for the three groups

<table>
<thead>
<tr>
<th></th>
<th>Total sample</th>
<th>Detained asylum seekers</th>
<th>Detained former prisoners</th>
<th>Community comparison</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>N</strong></td>
<td>95</td>
<td>42</td>
<td>23</td>
<td>30</td>
</tr>
<tr>
<td><strong>Mean (SD)</strong></td>
<td>63.47</td>
<td>68.02</td>
<td>67.03</td>
<td>54.35</td>
</tr>
<tr>
<td></td>
<td>(22.96)</td>
<td>(20.23)</td>
<td>(21.27)</td>
<td>(25.69)</td>
</tr>
</tbody>
</table>

The IES-R scores were compared using ANOVA. Statistically significant differences were observed between the three groups. $F (2,92) = 3.66$ $p=0.03$. Results on post hoc comparison's using the Games-Howell test showed that detained asylum seekers had significantly higher IES-R scores than asylum seekers living within the community (mean difference = 13.67 (SE = 5.64) $p<0.05$. There was no significant difference between detained asylum seekers and detained former prisoners (mean difference = 0.99 (SE = 5.42) $p=0.98$. There was also no significant difference between former prisoners and asylum seekers in the community (mean difference = 12.68 (SE = 6.46) $p=0.13$.

The original version of the IES comprises of two of the three subscales in the IES-R. IES scores were computed by adding the IES-A and IES-I subscales. Unlike the IES-R, norms are available for the IES (Horowitz et al, 1979). Distributions of scores on the IES were analysed to assess whether scores reached clinically significant levels. Amongst the detained asylum seeker group, 4.8% ($n = 2$) scored within the mild range (scores of 9-25), 35.7% ($n = 15$) scored within the moderate range (scores of 26-43) and 59.5% ($n = 25$) scored within the severe range (>44). Detained former prisoners also scored highly. 4.3% ($n = 1$) scored within the mild range, 26.1% ($n = 6$) scored within the moderate range and 69.6% ($n = 16$) scored within the severe range. Amongst the community comparison group, 3.2% ($n = 1$) had subclinical scores (0-8), 22.6% ($n = 7$) had scores indicating mild difficulties, 41.9% ($n = 13$) had moderate difficulties and 32.3% ($n = 10$) scored within the severe range.
ANOVA was used to compare the differences between groups on IES scores. This was also found to be significant $F(2,94) = 5.38$ $p<0.01$. Post Hoc comparisons using Games-Howell revealed a statistically significant difference between detained asylum seekers and asylum seekers living within the community (mean difference =10.46 (SE = 3.63) $p<0.02$. There was also a significant difference between detained former prisoners and asylum seekers living within the community (mean difference = 10.68 (SE = 4.19) $p<0.04$). There was no significant difference between detained asylum seekers and detained former prisoners (mean difference = -0.23 (SE = 3.6)$p=1.00$.

**IES-R Subscale scores**

The IES-R is composed of three subscales. These measure intrusion (IES-I), avoidance (IES-A) and hyperarousal (IES-H).These scores are displayed in tables 6-8.

**Table 5: IES-I scores for the total sample and for the three groups**

<table>
<thead>
<tr>
<th></th>
<th>Total sample</th>
<th>Detained asylum seekers</th>
<th>Detained former prisoners</th>
<th>Community comparison</th>
</tr>
</thead>
<tbody>
<tr>
<td>IES-I</td>
<td>N</td>
<td>108</td>
<td>49</td>
<td>23</td>
</tr>
<tr>
<td></td>
<td>Mean (SD)</td>
<td>21.11 (8.84)</td>
<td>22.06 (8.26)</td>
<td>22.24 (9.55)</td>
</tr>
<tr>
<td>IES-A</td>
<td>N</td>
<td>100</td>
<td>43</td>
<td>25</td>
</tr>
<tr>
<td></td>
<td>Mean (SD)</td>
<td>22.51 (8.85)</td>
<td>24.7 (7.66)</td>
<td>24.76 (7.17)</td>
</tr>
<tr>
<td>IES-H</td>
<td>N</td>
<td>106</td>
<td>46</td>
<td>24</td>
</tr>
<tr>
<td></td>
<td>Mean (SD)</td>
<td>19.39 (19.5)</td>
<td>20.71 (8.37)</td>
<td>19.69 (8.17)</td>
</tr>
</tbody>
</table>

IES–I scores were analysed using ANOVA. There was no significant difference between groups on this subscale. $F (2,105) 1.42 p=0.25$. Scores on the IES-A scale were not normally distributed. The Kolmogorov-Smirnov test indicated that this was significant ($K$-$S(100) = .113$, $p<.01$). Since the assumptions of using parametric tests were therefore not met, the Kruskall Wallis non-parametric test was used to assess whether IES-A scores between groups were significant. $\chi(2) = 10.83$ $p<0.01$
Differences between group IES-H scores were analysed using ANOVA and were found to be not significant. $F (2,103)=1.329$ $p=0.27$. Mann-Whitney U tests were carried out in order to analyse where the differences between group scores on IES-A occur. There was a significant difference between detained asylum seekers and asylum seekers living in the community ($z = -3.02$ $p<0.01$) and between detained former prisoners and asylum seekers living in the community ($z = -2.62$ $p<0.01$). These were significant at the bonferroni adjusted level of 0.01. There was no significant difference between detained asylum seekers and detained former prisoners ($z = -0.006$, $p=0.99$).

This analysis of subscale scores shows that there was a significant difference on the IES-A subscale scores between groups, but that differences on the IES-I and IES-H subscales were not significant.

These results show significant differences between HADSD, HADSA, IES-R and IES scores obtained in detained asylum seekers, detained former prisoners and asylum seekers living within the community. Analysis of differences between detained asylum seekers and community asylum seekers showed that the higher scores for HADSD, HADSA, IES and IES-R were statistically significant. No significant differences were observed between the three groups on individual subscale scores, with the exception of IES-A.

In order to determine how much of the variance in HADSD, HADSA and IES-R scores can be explained by detention, multiple regression analyses were carried out with each of the three total scores as the dependent variables. A forward (forced entry) method was used with HADSD, HADSA and IES-R as the dependent variable (on three separate tests) and with group, age, gender, and previous experience of personalised trauma as predictor variables. Detention experience was found to be the largest predictor of variance on HADSD, HADSA and IES scores amongst asylum seekers. All results from multiple regression analyses were checked for multicollinearity by assessing correlations and collinearity diagnostics. The Durbin Watson test statistic was also obtained and assessed to ensure independence of residuals (Field, 2000).
Depression

In a regression model which regressed group, age, gender and previous experience of personalised trauma onto detention, 20.6% of the variance was accounted for (R\(^2\) = .206, F(5,116) = 6.02 p<0.01. Detention group was the most significant predictor of depression score, when comparing asylum seekers who were detained with asylum seekers in the community. Gender was also significant, indicating that women experience greater levels of depression.

**Table 6: Coefficients for multiple regression of group, gender, personalised trauma, and age onto HADSD scores**

<table>
<thead>
<tr>
<th>Predictor variable</th>
<th>B (SE)</th>
<th>Beta</th>
<th>T</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Constant</td>
<td>7.40 (2.27)</td>
<td>3.25</td>
<td>&lt;01*</td>
<td></td>
</tr>
<tr>
<td>Group 1 vs 3</td>
<td>4.02 (0.90)</td>
<td>0.43</td>
<td>4.47</td>
<td>&lt;01*</td>
</tr>
<tr>
<td>Group 2 vs 3</td>
<td>1.41 (1.17)</td>
<td>0.12</td>
<td>1.21</td>
<td>0.23</td>
</tr>
<tr>
<td>Gender</td>
<td>2.41 (0.84)</td>
<td>0.24</td>
<td>2.87</td>
<td>0.01*</td>
</tr>
<tr>
<td>Personalised trauma</td>
<td>-0.29 (.79)</td>
<td>-0.03</td>
<td>-0.36</td>
<td>0.72</td>
</tr>
<tr>
<td>Age</td>
<td>-0.18 (0.04)</td>
<td>-0.04</td>
<td>-0.43</td>
<td>0.66</td>
</tr>
</tbody>
</table>

Anxiety

Using the same methods and variables, the model accounted for 10.7% of the variance in HADSA scores (R\(^2\) = 0.127, F (5,118) = 3.45, p<0.01. Differences between detained asylum seekers and the comparison group accounted for the largest amount of variance. No other predictors were significant, although the results show there is a trend for elevated HADSA scores amongst females.
Table 7: Coefficients for multiple regression of group, gender, personalised trauma, asylum label and age onto HADSA scores

<table>
<thead>
<tr>
<th>Predictor variable</th>
<th>B (SE)</th>
<th>Beta</th>
<th>T</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Constant</td>
<td>11.72 (2.86)</td>
<td></td>
<td>4.10</td>
<td>&lt;01*</td>
</tr>
<tr>
<td>Group 1 vs 3</td>
<td>2.85 (1.15)</td>
<td>0.25</td>
<td>2.48</td>
<td>&lt;01*</td>
</tr>
<tr>
<td>Group 2 vs 3</td>
<td>1.28 (1.48)</td>
<td>0.25</td>
<td>0.87</td>
<td>0.39</td>
</tr>
<tr>
<td>Gender</td>
<td>1.08 (2.04)</td>
<td>0.17</td>
<td>1.89</td>
<td>0.06</td>
</tr>
<tr>
<td>Personalised trauma</td>
<td>-1.39 (1.00)</td>
<td>-0.12</td>
<td>-1.39</td>
<td>0.17</td>
</tr>
<tr>
<td>Age</td>
<td>-0.04 (0.05)</td>
<td>-0.07</td>
<td>-0.73</td>
<td>0.47</td>
</tr>
</tbody>
</table>

PTSD symptoms

The same predictors accounted for 16.1% of the variance in IES-R scores. (R2 = 0.16, F (5,77) = 2.95 p=0.02. None of the predictors were independently significant however.

Table 8: Coefficients for multiple regression of group, gender, personalised trauma, asylum label and age onto IES-R scores

<table>
<thead>
<tr>
<th>Predictor variable</th>
<th>B (SE)</th>
<th>Beta</th>
<th>T</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Constant</td>
<td>69.53 (13.62)</td>
<td></td>
<td>5.11</td>
<td>&lt;01*</td>
</tr>
<tr>
<td>Group 1 vs 3</td>
<td>9.91 (5.75)</td>
<td>-0.21</td>
<td>1.72</td>
<td>0.09</td>
</tr>
<tr>
<td>Group 2 vs 3</td>
<td>13.51 (7.03)</td>
<td>0.23</td>
<td>-1.92</td>
<td>0.06</td>
</tr>
<tr>
<td>Gender</td>
<td>9.35 (5.41)</td>
<td>0.18</td>
<td>1.73</td>
<td>0.09</td>
</tr>
<tr>
<td>Personalised trauma</td>
<td>-9.03 (4.98)</td>
<td>-0.19</td>
<td>-1.81</td>
<td>0.07</td>
</tr>
<tr>
<td>Age</td>
<td>-0.40 (0.27)</td>
<td>-0.17</td>
<td>-1.53</td>
<td>0.13</td>
</tr>
</tbody>
</table>

The same predictors were regressed onto IES scores (Table 9). The total IES score is the sum of the avoidance and intrusion subscales but without the hyperarousal subscale. The same predictors are able to account for more of the variance (20%) in IES scores (R2 = .20 F(5,79) = 3.96, p<0.01.

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Table 9: Coefficients for multiple regression of group, gender, personalised trauma, asylum label and age onto IES scores

<table>
<thead>
<tr>
<th>Predictor variable</th>
<th>B (SE)</th>
<th>Beta</th>
<th>T</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Constant</td>
<td>50.93 (8.97)</td>
<td>0.25</td>
<td>5.68</td>
<td>&lt;0.01*</td>
</tr>
<tr>
<td>Group 1 vs 3</td>
<td>7.88 (3.77)</td>
<td>0.29</td>
<td>2.09</td>
<td>0.04*</td>
</tr>
<tr>
<td>Group 2 vs 3</td>
<td>11.43 (4.6)</td>
<td>0.29</td>
<td>2.47</td>
<td>0.02*</td>
</tr>
<tr>
<td>Gender</td>
<td>4.97 (3.55)</td>
<td>0.14</td>
<td>1.40</td>
<td>0.17</td>
</tr>
<tr>
<td>Personalised trauma</td>
<td>-7.94 (3.27)</td>
<td>-0.25</td>
<td>-2.43</td>
<td>&lt;0.02*</td>
</tr>
<tr>
<td>Age</td>
<td>-0.27 (0.17)</td>
<td>-0.17</td>
<td>-1.58</td>
<td>0.12</td>
</tr>
</tbody>
</table>

These multiple regression models suggest that detention experience is the most significant predictor of depression, anxiety and IES scores when comparing asylum seekers who have been detained with those who live in the community.

**Hypothesis 2**

The second hypothesis was that there would be a correlation between psychological symptoms and length of time in detention. Number of days in detention was calculated by summing the total number of days individuals had spent both in the current detention centre and previous immigration detention. Days spent in prison in the UK (for the former prisoner group) were not added into this calculation. The mean number of days in detention was 66.09 (SD = 78.06). The median number of days was 30. For the detained asylum seeker group, mean length of detention was 51.32 (SD = 68.72). The median number of days was 25. Former prisoners had been in immigration detention for a mean length of 100.20 (SD = 88.41) days, with a median length of 75 days.

Total days in detention was not normally distributed as it was positively skewed. Skewness = 1.76(SE 0.246), kurtosis = 3 (SE 0.488). Skewness and kurtosis was also assessed visually on a histogram. A Kolmogorov-Smirnov test was performed to test the significance of deviation from normality of this distribution, and was found to be
statistically significant (K-S (96)= 0.22 p<0.001). The data was therefore transformed using a log transformation as recommended in Howell (2002).

Pearsons’correlations were obtained for total days in detention and scores on the HADSD, HADSA and IES-R scales. The correlation matrix is shown in table 10.

**Table 10: Pearson’s correlations for total days in detention, HADSD, HADSA and IES-R scores.**

<table>
<thead>
<tr>
<th></th>
<th>HADSD</th>
<th>HADSA</th>
<th>IES-R</th>
<th>Days in detention</th>
</tr>
</thead>
<tbody>
<tr>
<td>HADSD</td>
<td>Pearson correlation 0.69</td>
<td>0.54</td>
<td>-0.03</td>
<td></td>
</tr>
<tr>
<td></td>
<td>p-value (2-tailed) &lt;.01*</td>
<td>&lt;.01*</td>
<td>0.75</td>
<td></td>
</tr>
<tr>
<td></td>
<td>N 136</td>
<td>136</td>
<td>93</td>
<td></td>
</tr>
<tr>
<td>HADSA</td>
<td>Pearson correlation 0.69</td>
<td>0.59</td>
<td>0.002</td>
<td></td>
</tr>
<tr>
<td></td>
<td>p-value (2-tailed) &lt;.01*</td>
<td>&lt;.01*</td>
<td>0.99</td>
<td></td>
</tr>
<tr>
<td></td>
<td>n 136</td>
<td>94</td>
<td>94</td>
<td></td>
</tr>
<tr>
<td>IES-R</td>
<td>Pearson correlation 0.54</td>
<td>0.59</td>
<td>0.05</td>
<td></td>
</tr>
<tr>
<td></td>
<td>p-value (2-tailed) &lt;.01*</td>
<td>&lt;.01*</td>
<td>0.69</td>
<td></td>
</tr>
<tr>
<td></td>
<td>n 94</td>
<td></td>
<td>64</td>
<td></td>
</tr>
<tr>
<td>Days in detention</td>
<td>Pearson correlation -0.03</td>
<td>0.002</td>
<td>0.05</td>
<td></td>
</tr>
<tr>
<td></td>
<td>p-value 0.75</td>
<td>0.99</td>
<td>0.69</td>
<td></td>
</tr>
<tr>
<td></td>
<td>n 93</td>
<td>94</td>
<td>64</td>
<td></td>
</tr>
</tbody>
</table>

Scores on HADSD, HADSA and IES-R are all correlated. Days in detention is not correlated with scores on these scales.

In order to further investigate the relationship between time in detention and HADSD, HADSA and IES-R scores, time in detention was split into two groups around the median (30 days). Individuals who had experienced interpersonal attacks (sexual and non sexual attacks by a known assailant or a stranger; previous experience of torture) were compared with individuals who had not experienced interpersonal trauma (but who had experienced other traumatic events). Mean scores on HADSD, HADSA and IES are shown in table 11. Mean scores on IES-R subscale scores are shown in table 12.
Table 11: Mean HADSD, HADSA and IES-R scores for detainees who had interpersonal trauma compared with those who had not experienced interpersonal trauma (IP trauma).

<table>
<thead>
<tr>
<th></th>
<th>N</th>
<th>Mean</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>HADSD</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Experience of IP</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>trauma</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Under 30 days</td>
<td>26</td>
<td>12.73</td>
<td>3.79</td>
</tr>
<tr>
<td>Over 30 days</td>
<td>25</td>
<td>14.2</td>
<td>4.44</td>
</tr>
<tr>
<td>No experience of</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>IP trauma</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Under 30 days</td>
<td>22</td>
<td>13.5</td>
<td>4.77</td>
</tr>
<tr>
<td>Over 30 days</td>
<td>17</td>
<td>10.37</td>
<td>4.70</td>
</tr>
<tr>
<td><strong>HADSA</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Experience of IP</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>trauma</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Under 30 days</td>
<td>26</td>
<td>13.59</td>
<td>4.56</td>
</tr>
<tr>
<td>Over 30 days</td>
<td>25</td>
<td>15.03</td>
<td>4.46</td>
</tr>
<tr>
<td>No experience of</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>IP trauma</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Under 30 days</td>
<td>21</td>
<td>13.86</td>
<td>4.28</td>
</tr>
<tr>
<td>Over 30 days</td>
<td>17</td>
<td>11.13</td>
<td>6.94</td>
</tr>
<tr>
<td><strong>IES-R</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Experience of IP</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>trauma</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Under 30 days</td>
<td>19</td>
<td>67.57</td>
<td>13.98</td>
</tr>
<tr>
<td>Over 30 days</td>
<td>18</td>
<td>74.65</td>
<td>16.96</td>
</tr>
<tr>
<td>No experience of</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>IP trauma</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Under 30 days</td>
<td>14</td>
<td>61.99</td>
<td>26.25</td>
</tr>
<tr>
<td>Over 30 days</td>
<td>9</td>
<td>66.11</td>
<td>26.95</td>
</tr>
</tbody>
</table>
Comparison of means suggests that length of detention may have a differential impact on detainees according to previous trauma experiences. Individuals who had experienced personalised traumatic events showed elevated scores on all measures of psychological distress in the second month of detention compared to individuals who had been detained for less than one month. With regards to HADSD and HADSA scores, the reverse was true of individuals with no reported experience of personalised trauma (although these scores remain very high). IES-R scores were also slightly higher in detainees who had been detained for over one month in this group.

In order to test whether there was an interaction between length of time in detention and experience of interpersonal trauma, a factorial ANOVA was carried out on the dependent variables of HADSD scores, HADSA scores and IES-R scores.

The results show that there is no significant main effect of detention length on HADSD scores ($F(1,86) = 2.75, p = .38$). The main effect of experience of interpersonal trauma on HADSD scores was also non significant ($F(1,86) = 2.64, p = .108$). However, there was a significant interaction effect between interpersonal trauma and length of time in detention ($F(1,86) = 5.97, p = .017$). This shows that individuals who had experienced interpersonal trauma and longer detention scored higher than those who had experienced interpersonal trauma and had been in detention for less than one month.

For HADSA scores there is no significant main effect of detention length ($F(1,85) = .351, p = .56$) The main effect of interpersonal trauma is also not significant ($F(1,85) = 2.84, p = .096$). The interaction effect is approaching significance ($F(1,85), 3.74, p = .056$).

The same test was taken on IES-R scores. This showed that there was no significant main effect, either for detention length ($F(1,56) = 1.04, p = .31$); or for experience of interpersonal trauma ($F(1,56) = 1.66, p = .20$). There was also no significant interaction ($F(1,56) .07 p = .78$).
Table 12: Mean IES-R subscale scores for detainees who had interpersonal trauma compared with those who had not experienced interpersonal trauma (IP Trauma).

<table>
<thead>
<tr>
<th>IES Subscale</th>
<th>N</th>
<th>Mean</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>IESI</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Experience of IP trauma</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Under 30 days</td>
<td>23</td>
<td>22.12</td>
<td>6.91</td>
</tr>
<tr>
<td>Over 30 days</td>
<td>19</td>
<td>24.46</td>
<td>8.17</td>
</tr>
<tr>
<td>No experience of IP trauma</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Under 30 days</td>
<td>16</td>
<td>20.17</td>
<td>10.29</td>
</tr>
<tr>
<td>Over 30 days</td>
<td>9</td>
<td>22.89</td>
<td>9.65</td>
</tr>
<tr>
<td>IESA</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Experience of IP trauma</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Under 30 days</td>
<td>20</td>
<td>26.12</td>
<td>6.21</td>
</tr>
<tr>
<td>Over 30 days</td>
<td>18</td>
<td>26.29</td>
<td>7.95</td>
</tr>
<tr>
<td>No experience of IP trauma</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Under 30 days</td>
<td>14</td>
<td>20.87</td>
<td>7.37</td>
</tr>
<tr>
<td>Over 30 days</td>
<td>11</td>
<td>22.42</td>
<td>8.57</td>
</tr>
<tr>
<td>IESH</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Experience of IP trauma</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Under 30 days</td>
<td>21</td>
<td>19.25</td>
<td>6.69</td>
</tr>
<tr>
<td>Over 30 days</td>
<td>18</td>
<td>23.57</td>
<td>6.82</td>
</tr>
<tr>
<td>No experience of IP trauma</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Under 30 days</td>
<td>16</td>
<td>19.13</td>
<td>20.03</td>
</tr>
<tr>
<td>Over 30 days</td>
<td>10</td>
<td>20.36</td>
<td>9.78</td>
</tr>
</tbody>
</table>

Since overall IES-R scores and subscale scores did not indicate an interaction effect, comparisons were made between individuals who had been detained for over one
month and those who had been detained for less than one month, amongst individuals who had experienced interpersonal trauma. A bonferroni corrected significance level of \( p < 0.02 \) was applied. Differences between avoidance scores were not significant \( (t(36) = -0.07, \ p=0.94) \), nor were differences on intrusion scores \( (t(40) = 0.98, \ p = 0.34) \). The difference between hyperarousal scores amongst those who had experienced personalised trauma and had been detained for less than one month compared to those who had been detained in excess of one month was close to the corrected significance level \( (t(37) = -1.99 \ p=0.054) \), and represents a trend.

**Hypothesis 3**

The third hypothesis was that post traumatic cognitions mediate the impact of detention on mental health. In order to test this hypothesis, scores on the PTCI were compared across groups. Three subscales constitute the total PTCI score (TOTAL). These are negative cognitions about the self (SELF), negative cognitions about the world (WORLD) and self-blame (BLAME). All items within each subscale are summed before dividing by the number of items in that subscale. Higher scores reflect higher endorsement of negative beliefs. Sample sizes are lower for PTCI scores. This is because some participants did not complete the final measure because they were interrupted before completing the questionnaire, or had insufficient English language ability to understand the more complex concepts.
Table 13 Total score on the PTCI and for the three subscales for the total sample and across groups

<table>
<thead>
<tr>
<th></th>
<th>Total sample</th>
<th>Detained asylum seekers</th>
<th>Detained former prisoners</th>
<th>Community comparison</th>
</tr>
</thead>
<tbody>
<tr>
<td>TOTAL</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>N</td>
<td>81</td>
<td>41</td>
<td>14</td>
<td>26</td>
</tr>
<tr>
<td>Mean (SD)</td>
<td>131.68</td>
<td>142.8</td>
<td>125.80</td>
<td>117.34</td>
</tr>
<tr>
<td></td>
<td>(40.11)</td>
<td>(41.78)</td>
<td>(42.80)</td>
<td>(31.11)</td>
</tr>
<tr>
<td>SELF</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>N</td>
<td>85</td>
<td>41</td>
<td>16</td>
<td>28</td>
</tr>
<tr>
<td>Mean (SD)</td>
<td>3.65</td>
<td>4</td>
<td>3.62</td>
<td>3.15</td>
</tr>
<tr>
<td></td>
<td>(1.47)</td>
<td>(1.53)</td>
<td>(1.54)</td>
<td>(1.20)</td>
</tr>
<tr>
<td>WORLD</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>N</td>
<td>87</td>
<td>43</td>
<td>16</td>
<td>28</td>
</tr>
<tr>
<td>Mean (SD)</td>
<td>5.43</td>
<td>5.66</td>
<td>5.45</td>
<td>5.07</td>
</tr>
<tr>
<td></td>
<td>(1.18)</td>
<td>(1.15)</td>
<td>(1.45)</td>
<td>(1.01)</td>
</tr>
<tr>
<td>BLAME</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>N</td>
<td>85</td>
<td>43</td>
<td>14</td>
<td>28</td>
</tr>
<tr>
<td>Mean (SD)</td>
<td>3.56</td>
<td>3.82</td>
<td>3.14</td>
<td>3.41</td>
</tr>
<tr>
<td></td>
<td>(1.48)</td>
<td>(1.61)</td>
<td>(1.39)</td>
<td>(1.27)</td>
</tr>
</tbody>
</table>

Total scores on the PTCI scale were not normally distributed. The Kolmogorov-Smirnov test indicated that this was significant (K-S (81) = 0.109, p<0.02). The Kruskall Wallis non-parametric test was used to assess whether differences between groups were significant. χ(2) = 6.85 p=0.03. This shows that there is a significant difference on TOTAL scores overall between groups. Mann-Witney U tests were used to further investigate these differences. Once again a bonferroni correction was made to minimise the chances of making type I errors. The adjusted significance level was p<0.02. There was a significant difference between TOTAL scores between detained asylum seekers and asylum seekers who lived in the community (z = -2.61, p < 0.01). There was no significant difference between detained asylum seekers and detained former prisoners (z = -1.12, p = 0.26). There was also no significant difference between detained former prisoners and asylum seekers within the community (z = -0.82 p = 0.41).
The Kruskall Wallis test was also used to compare differences on the subscales. The differences between SELF scores were not significant ($\chi^2(2) = 4.96$, $p = .084$). There was also no significant difference between scores on the BLAME scale ($F(2,82) = 1.43$, $p = .25$). ANOVA was used to make this comparison as the data was normally distributed on this subscale. A significant difference was found however on WORLD scores between groups, using the Kruskall Wallis test ($\chi^2(2) = 5.94$, $p = .05$). Mann-Whitney U tests were used to differentiate between groups. There was a significant difference between asylum seekers in detention and asylum seekers in the community ($z = 2.36$, $p < .02$). No significant differences were found between detained asylum seekers and detained former prisoners, ($z = -0.46$, $p = .64$) nor between detained former prisoners and asylum seekers in the community ($z = -1.55$, $p = .12$).

Hierarchical regression

In order to test whether the adverse effects of detention on mental health are mediated by cognitions, hierarchical regression analysis was carried out using forced entry. This was possible because the data met necessary assumptions. Namely that both predictor (group membership) and dependent variable (HADSD, HADSA and IES-R scores) were associated with each other, and with the mediating variable (PTCITOTAL scores) (Baron & Kenny, 1986).

In step 1 group was entered as the predictor variable and HADSD, HADSA and IES-R were entered as dependent variables in turn. The model was not significant for HADSA scores, ($F$ change$(2,78) = 2.23$, $p = .12$), nor for IES-R scores ($F$ change $(2,62) = 2.31$, $p = .11$). Hierarchical regression was therefore not carried out for scores on these measures.

The same model was significant for IES scores however. This regression model onto IES scores was therefore included as it produces interesting findings which may be useful for further research. (The results should be interpreted with caution however since the effect was not found on the revised scale). In this model, group accounted for 9.7% (R-squared = .09), of variance in IES scores ($F$ change $(2,63) = 3.39$, $p<.05$).
The regression model for HADSD scores was also significant. Group accounted for 16.1% (R-squared = .16) of the variance in HADSD scores (F Change (2,78) = 7.46 p<0.01.

In step 2, PTCITOTAL scores were entered. An additional requirement to test for mediation effects, is that the proposed mediating variable to be related to the dependent variables, above the effect of the predictor variable. This assumption was met for HADSD scores. The R-square value for the second model was 0.18 (F change (1,77) = 20.48, p<.01). Similarly, the addition of the PTCI scores in model 2 accounted for additional variance in IES scores (R square = 0.33, F change (1,62) = 21.29 p<0.01. Differences between the two models for HADSD scores and IES scores can be seen in tables 14 and 15 below.

Table 14: Coefficients for hierarchical regression onto HADSD scores

<table>
<thead>
<tr>
<th>Predictor variable</th>
<th>B (SE)</th>
<th>Beta</th>
<th>T</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Constant</td>
<td>9.48 (0.82)</td>
<td></td>
<td>11.6</td>
<td>&lt;.001*</td>
</tr>
<tr>
<td>Group 1 vs 3</td>
<td>4.13 (1.08)</td>
<td>0.45</td>
<td>3.84</td>
<td>&lt;.001*</td>
</tr>
<tr>
<td>Group 2 vs 3</td>
<td>1.88 (1.33)</td>
<td>0.17</td>
<td>1.41</td>
<td>0.16</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Predictor variable</th>
<th>B (SE)</th>
<th>Beta</th>
<th>T</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Constant</td>
<td>3.55 (1.50)</td>
<td></td>
<td>2.37</td>
<td>0.02</td>
</tr>
<tr>
<td>Group 1 vs 3</td>
<td>2.84 (1.00)</td>
<td>0.31</td>
<td>2.83</td>
<td>0.006*</td>
</tr>
<tr>
<td>Group 2 vs 3</td>
<td>1.46 (1.19)</td>
<td>0.13</td>
<td>1.23</td>
<td>0.22</td>
</tr>
<tr>
<td>PTCITOTAL</td>
<td>0.05 (0.01)</td>
<td>0.44</td>
<td>4.53</td>
<td>&lt;0.001</td>
</tr>
</tbody>
</table>

The inclusion of PTCI scores into model 2 slightly lowers the significance of the effect of the first group comparison onto HADSD scores, and is therefore partially mediating this effect. However, this difference is very low and has little meaningful significance.
Table 15: Coefficients for hierarchical regression onto IES scores

**MODEL 1**

<table>
<thead>
<tr>
<th>Predictor variable</th>
<th>B (SE)</th>
<th>Beta</th>
<th>T</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Constant</td>
<td>37.05(3.12)</td>
<td></td>
<td>11.7</td>
<td>&lt;.001*</td>
</tr>
<tr>
<td>Group 1 vs 3</td>
<td>9.92 (4.18)</td>
<td>0.32</td>
<td>2.38</td>
<td>0.02*</td>
</tr>
<tr>
<td>Group 2 vs 3</td>
<td>10.58 (5.15)</td>
<td>0.28</td>
<td>2.06</td>
<td>0.04*</td>
</tr>
</tbody>
</table>

**MODEL 2**

<table>
<thead>
<tr>
<th>Predictor variable</th>
<th>B (SE)</th>
<th>Beta</th>
<th>T</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Constant</td>
<td>14.25(5.66)</td>
<td></td>
<td>2.52</td>
<td>0.01</td>
</tr>
<tr>
<td>Group 1 vs 3</td>
<td>4.96 (3.79)</td>
<td>0.16</td>
<td>1.39</td>
<td>0.20</td>
</tr>
<tr>
<td>Group 2 vs 3</td>
<td>9.01 (4.49)</td>
<td>0.24</td>
<td>2.01</td>
<td>0.05*</td>
</tr>
<tr>
<td>PTCITOTAL</td>
<td>0.19 (0.04)</td>
<td>0.50</td>
<td>4.61</td>
<td>&lt;0.001</td>
</tr>
</tbody>
</table>

The inclusion of PTCI scores into model 2 renders the effect of the first group comparison on IES scores non significant, and is therefore mediating this effect. The effect of the second group comparison is slightly lowered, and PTCI scores can therefore be said to be a partial mediator of this effect. As outlined above, regression analyses were checked to ensure that assumptions of independence of errors and multicollinearity were met (Field, 2000).
Discussion

Overview

Asylum seekers arriving in the UK have faced a number of traumatic events and adversities. The additional post migratory event which has been examined in this study is detention within an Immigration Removal Centre (IRC). Main findings relating to each hypothesis in turn will be addressed and interpreted according to previous research and theory. Clinical implications of findings are highlighted. Identification and discussion of methodological problems, generaliseability, and other limitations of the study follows. Further questions and suggestions for further research are made as they arise.

1) Levels of psychological distress in asylum seekers in detention, detained former prisoners, and asylum seekers in the community

The results from this study demonstrate very high levels of psychological distress amongst all three groups. Clinically significant levels of anxiety, depression and PTSD symptoms were found in both groups of asylum seekers (including those who are detained and those who are living in the community). This is consistent with other research which has shown displaced individuals internationally to be vulnerable to mental health problems (Porter and Haslam, 2005). Similarly to other studies, depression and PTSD symptoms were common (Drozdek et al 2003, Silove et al 1997 and Silove et al 1998). Also consistent with other studies (e.g. Sinnerbrink et al 1997), is the finding that both detained asylum seekers and asylum seekers living in the community had experienced high levels of trauma. In particular, experience of interpersonal trauma was common amongst both groups, which has been shown to be more highly related to PTSD than other types of traumatic events (Mollica et al, 1998). Previous experience of torture, was found in both groups of asylum seekers, which has been found to be closely related to subsequent development of PTSD (Goldfield et al, 1988). Higher levels of depression, anxiety and PTSD were found amongst detainees.
than asylum seekers living within the community. This may suggest that detention contributes to mental health difficulties.

It is also possible that individuals who are already experiencing mental health problems are more likely to be detained. Decisions regarding who is detained are made by immigration officials who are not trained in mental health assessment. A report by Amnesty International has suggested that this decision appears to be arbitrary (Amnesty International, 2005). It is possible that individuals who are suffering from mental health problems may appear more hostile towards immigration officials as a result of mental health difficulties which may go unrecognised as such. In addition, they may be more likely to provide a less coherent account of their circumstances, which also could influence their likelihood of being detained. Asylum seekers in the detained group had also experienced traumatic events falling into a greater number of categories than both other groups. Therefore, it is possible that highly traumatised individuals are presenting themselves in a manner which increases their chance of being detained, because mental health difficulties are not identified by immigration officials. This speculative hypothesis has not been tested within this study, as a prospective design would be necessary. However, the results suggest that this could be usefully investigated in further research.

High levels of depression, anxiety and PTSD symptoms were also found amongst detained former prisoners. These results are interesting in that this group had experienced less trauma (and particularly less interpersonal trauma) which may suggest a negative impact of the detention experience in itself. Detained former prisoners reported lower levels of depression, anxiety and PTSD symptoms compared to detained asylum seekers, but higher rates compared to asylum seekers living within the community. This is an important finding as it suggests that both groups who were detained suffered worse mental health outcomes than asylum seekers living within the community, even though detained former prisoners had lower rates of trauma exposure. The impact of being detained amongst asylum seekers was assessed in the multiple regression analyses, which demonstrated that being detained was the most significant predictor of depression, anxiety and PTSD symptoms when gender,
experience of interpersonal trauma and age were included. This suggests that
detention in itself is negatively impacting on mental health. Across the three groups,
females were more likely to be at risk of depression. There is also a trend in the data
for females to report higher anxiety. With regards to PTSD symptoms, experience of
detention was the most significant predictor in both group comparisons, after
experience of interpersonal trauma. This is consistent with previous research which
shows that experience of traumatic events is the most significant predictor of the
development of PTSD amongst asylum seeker populations.

High rates of psychological distress amongst both of the detained groups is consistent
with other studies which have found high prevalence of mental health problems
amongst detainees and former detainees in the USA (Keller et al 2003), Australia (e.g.
Thompson et al, 1998; Steel et al, 2006), and Japan (Ichikawa et al 2006). The
findings of this study are also consistent with qualitative findings from the UK
(Bracken & Gorst-Unsworth, 1990, Pourgourides et al 1996), which demonstrate
psychological distress amongst detainees. High incidence of mental health disorders
was found in a study by Arnold and colleagues (2006) that used clinical diagnostic
criteria to assess cases.

In summary, incidence of depression, anxiety and PTSD symptoms was high across
all three groups. Asylum seekers who were detained suffered the worst mental health
outcomes. Detained asylum seekers scored more highly than asylum seekers living
within the community on all three clinical measures. Hypothesis one was therefore
supported.

Subscale analysis showed that the largest difference between all three groups in terms
of PTSD were in avoidance symptoms with detained asylum seekers reporting higher
avoidance than detained former prisoners, and that detained former prisoners showed
higher avoidance than asylum seekers within the community. The difference between
avoidance symptoms in detained asylum seekers and asylum seekers living within the
community were significant. The higher rates of PTSD symptoms amongst former
prisoners who were detained compared with asylum seekers living within the
community is particularly interesting, given that this detained group had experienced
less trauma categories. The non-significant difference in PTSD scores between both detained groups demonstrates that levels of PTSD between these groups are more homogenous. This adds further evidence to the hypothesis that the detention experience in itself may contribute to PTSD symptomatology. This raises very interesting questions regarding the detention experience as a traumatic event in itself. Further research is needed to investigate whether intrusion and avoidance symptoms include content related to detention experiences specifically (such as the experience of arrest, or traumatic events which occurred during detention). Comments made by detainees to the author during data collection suggest that this is not uncommon.

There are a number of clinical implications of these findings. Firstly, these results show clinically significant levels of mental health problems amongst all three groups. Eligibility for NHS services however is restricted within this population. Even amongst asylum seekers living within the community, individuals whose applications have failed are not necessarily eligible for NHS services. Amongst detainees, only those who require secondary care are treated within the NHS. Within mental health services this is likely only to apply to those who require sectioning under the Mental Health Act. This is a significant problem given the findings that there are high levels of mental health difficulties amongst detainees. In addition, mental health services need to be aware of the potential for high levels of distress amongst those individuals who are released from detention, and that post traumatic stress symptoms may be related to adverse detention experiences in addition to pre-migratory traumatic events.

These findings can be understood within existing models of PTSD which have identified the contribution of post-trauma experiences on the development and maintenance of PTSD (e.g. Ehlers & Clark, 2000). As outlined above, the model stipulates that development and maintenance of PTSD occurs as a result of two processes. These are: 1) negative appraisal of the trauma and its sequelae and 2) cognitive malfunctions relating to associative and autobiographical memory. The combination of these events results in the sense of current threat which characterises PTSD. Detention experiences may be impacting on both of these processes, if the detention environment increases the risk of negative appraisals of previously experienced traumatic events or its sequelae, and also if it provides salient cues which
trigger re-living experiences. In addition, experience of being detained, as well as traumatic events occurring during detention may constitute a new traumatic event. As experience of traumatic events is the biggest risk factor for the development of PTSD symptoms, this would increase the risk of the development of PTSD. The possible influence of detention on these two processes is discussed in relation to the two further hypotheses addressed in this study.

2) The relationship between time in detention and psychological distress

One finding which is inconsistent with other studies is that there was no significant relationship between time in detention and mental health symptoms. This was found in both Australian and US samples (e.g. Steel et al 2006; Keller et al, 2003). There are a number of possible explanations for this difference. Firstly, conditions are likely to vary considerably in immigration centres between countries and it possible that UK centres are less adverse. However, this is unlikely to entirely account for the difference in findings, as comments made to the researcher suggest conditions of detention were not regarded to be as problematic as the loss of liberty in itself. Findings from the qualitative study outlined in Pourgourides and colleagues (1996) suggest that cognitive and emotional experiences related to detention were more detrimental than environmental conditions. Furthermore, adverse events occurring in detention in Australia and the US (such as exposure to hunger striking, witnessing forced removals of individuals and failed removals e.g. Silove et al 1993; Keller et al, 2003) are also reported within UK IRCs (Pourgourides et al, 1996; Cutler 2005).

A more likely explanation for these differences is the fact that time in detention is more closely linked to the asylum procedure within Australia than within the UK. Sultan and O'Sullivan (2001) outline stages of decline in mental well being which are closely related to experience of rejection at salient legal points involved in asylum procedure in Australia. This also suggests that it may be the case length of time in detention is correlated with perceived threat of deportation. Within the UK, the asylum system is more complex. Length of time in detention is not so closely related to imminence of deportation, or to salient stages in asylum procedure. The sample in
this study included individuals within the 'fast track' system. This system aims to process claims quickly, and individuals within this system may have been detained for relatively short periods of time but the threat of imminent deportation is greater.

A third possible reason why an association was not found may be a result of the shorter median time in detention in this sample. Individuals within the Keller and colleagues (2003) study had been detained a median of 5 months prior to baseline interview whereas the median length of time in detention within this sample was 30 days. Furthermore, levels of mental distress were very high amongst those who had only been detained for a short time. The limited variance reduces the likelihood of finding an association. This is consistent with the above speculative hypothesis that it is possible that those with greater mental health difficulties are more likely to be detained. Given the high levels of PTSD symptoms amongst detainees (including those with lower levels of trauma) it is possible that the actual event of being placed in detention constitutes a traumatic event in itself, causing significant mental health difficulties from the outset. This speculative hypothesis should be investigated in future research.

Findings from this study do suggest however that length of time in detention may have a differential effect on individuals, according to whether or not they have experienced interpersonal trauma. The presence of an interaction effect between these two variables shows that amongst those who have experienced interpersonal trauma, depression and anxiety was higher in those who had been detained over one month compared with those who had been detained under one month. This is suggestive of a cumulative impact of detention on mental health amongst those who have experienced interpersonal traumatic events. Interestingly, this was not the case for PTSD symptoms. The hyperarousal symptoms of PTSD were particularly problematic amongst those who had experience interpersonal trauma, and there was a trend for higher scores in those detained for longer. In order to further investigate the cumulative effect of detention, a repeated measures design methodology should be used. Incorporating follow up data (as in Keller, 2003) would allow the opportunity to investigate persistence of the effects of detention after release, as well as investigating
whether PTSD symptoms associated with the detention experience in particular are associated with the development of the disorder.

Clinically, these findings are useful in identifying individuals who may be at particular risk of suffering from anxiety and depression. (It should be noted however that levels of psychological distress were high in both those who had, and had not experienced interpersonal trauma). Individuals who have been detained and are referred to mental health services should be assessed for PTSD, and these results suggest that individuals who have experienced interpersonal trauma and have been detained for a long time may be particularly at risk of hyperarousal symptoms.

These findings are also consistent with the Ehlers and Clark (2000) model of PTSD. The trend for higher rates of PTSD symptoms in individuals who had been in detention may be theoretically explained by the presence of additional exposure to salient stimuli, which increases malfunctions in cognitive processes which underlie re-living experiences. This theory could be used to speculatively explain the finding that hyperarousal was higher amongst those who had experienced personalised trauma and had been detained for longer than one month. It is possible that length of detention is associated with increased exposure to stimuli which trigger PTSD symptoms in those who have previously experienced forms of interpersonal violence such as torture. Torture is likely to have occurred within a prison setting. The model explains that stimulus-response associations are particularly strong when formed during traumatic experiences, are highly generalised, and that hypervigilance to cues associated with the trauma occurs in individuals with PTSD. Further research is required to investigate the independent influences of these factors.

Limitations within this model, and other western models of PTSD are evident in understanding the experience of asylum seekers in detention. In particular, the models do not account for the cumulative effects of traumatic events. In addition, the model understands PTSD as occurring as a result of decontextualisation of time and space, resulting in a sense of current threat. The model therefore assumes that this sense of current threat is a misperception. For individuals who are living in detention, a sense
of current threat may not be a misperception, but a reality. This is owing to well founded fears of being deported into unsafe areas, in addition to the current threat posed by the detention centre environment itself. This includes the influence of adverse events which may render individuals unsafe. This raises a number of very interesting theoretical questions relating to understanding both the cumulative effects of trauma as well as the influence of objective current danger on threat perception of past events. Findings from the Keller and colleagues (2003) study which showed that the adverse effects of detention persisted for an average of three years suggests that experience of multiple traumatic events may be particularly problematic in the maintenance of PTSD. The development of models of PTSD in circumstances of multiple traumas would be relevant for a wide range of populations including asylum seekers and displaced individuals, as well as those involved in ongoing conflict or interpersonal violence occurring within long term relationships.

3) The role of post traumatic cognitions in PTSD symptoms

Findings from this study showed increased levels of negative post traumatic cognitions amongst those asylum seekers who had been detained than asylum seekers living within the community. Subscale analysis showed that negative cognitions about the world were higher in detained asylum seekers compared with those living within the community. This is understandable given that these cognitions relate to vulnerability as a result of external factors, mirroring the differences in the external environment between the two groups. This study also supports the hypothesis that negative cognitions are mediating the effects of detention on the intrusion and avoidance symptoms of PTSD amongst both groups of asylum seekers.

These findings have important clinical relevance in treating PTSD amongst asylum seekers who have and have not been detained. Assessment of negative cognitions may be useful in identifying potential areas of maintenance of distress. Further research which looked at the persistence of these beliefs following release from immigration detention may also be useful for clinical intervention purposes.
According to the Ehlers and Clark (2000) model the first process underlying the development and maintenance of PTSD is negative appraisal of the traumatic event and its sequelae. This theory would therefore predict higher levels of negative appraisals amongst those who reported higher PTSD symptoms (detained asylum seekers in this study). The observed mediation effect of negative cognitions amongst asylum seekers who had been detained contributes further support for the important role of negative cognitions in PTSD. Higher PTCI scores were also mediating the relationship between detention experience and depression; however this effect was too small to be clinically meaningful. This adds further support for the discriminative validity of the PTCI in measuring PTSD.

**Limitations of research**

This research is useful in that it is the first quantitative study to investigate mental distress amongst those who are detained in immigration detention in the UK. However, there are a number of limitations and methodological constraints with the study. These are outlined below.

**Difficulties encountered during data collection**

A number of difficulties in data collection were experienced by the researcher. This resulted in the loss of data from one centre where the reliability couldn’t be assured as a result of the close proximity of staff members at the time of questionnaire completion. Data collection was terminated early at one of the centres as a result of heightened security. This meant that additional data had to be collected from a different centre, where individuals had been detained for shorter periods. This added to the problems of a lack of variance in the length of detention time. This prevented the opportunity to investigate adverse affects of mental health on individuals detained for significant lengths of time. Changes to government policies which occurred during the time of the study also affected the sample, in that there were higher levels of former prisoners than had been anticipated.
An additional problem is that the detained sample may have been subject to a recruitment bias. This is because of problems encountered by the researcher relating to access to detainees within the IRCs, owing to security restrictions. This meant that most of the recruitment took place within the library. Detainees using the library were more likely to have good English and higher literacy levels. They may therefore have had a higher level of education than other detainees. This is problematic as higher educational level was associated with poorer mental health amongst refugees in meta analysis (Porter and Haslam, 2005). It is therefore possible that levels of distress reported by participants in this study were not representative of the target group, and represents an over-estimation of distress. Conversely however, this sample bias may have resulted in conservative levels of distress being recorded as individuals with more significant mental health problems may have been more likely to stay in their rooms. This was acknowledged anecdotally by staff members at the centres as well as by members of detainee support groups who visit distressed detainees at their request. Furthermore, owing to the unique population studied, the results lack generaliseability. Even amongst other detained samples, care should be taken to consider the differences between detention environments and policies operating in different countries which may confound the effects. However, the main findings are consistent with other international studies which have shown a negative impact of immigration detention in a number of different countries. The fact that detention environments and policies differ considerably between countries, and that this effect has been observed in every study adds support to this.

Another problem which may have impacted on the results is that a riot occurred at one of the centres following a period of data collection. This may have increased symptom scores either on this day, or on subsequent days when data collection occurred at other centres where detainees had been moved to. However, adverse detention experiences are likely to contribute substantially to the reasons why detention may adversely affect mental health, and therefore it is impossible to control for the effect of these events whilst investigating this question. Furthermore, although the study environment was uncontrolled, the study has high ecological validity in that participants were actually detained at the time, rather than providing information retrospectively.
Validity and Reliability

Owing to the unique population in this study, the validity of the measures used may be reduced. Participants came from a very diverse sample (originating from 43 different countries) although some measures have been validated for use amongst different ethnic groups, these do not exist for the majority of the individuals who took part in this study. Although this is a limitation, the robustness of the IES is widely established (Sundin & Horowitz, 2002). This is also the case for the HADS (see Bjelland et al, 2002 for a review). The reliability of the results may also have been affected by the fact that a number of participants were read the questionnaire owing to low levels of literacy. Steps were taken to minimise this effect as far as possible. Participants were encouraged to complete the questionnaire by themselves wherever possible, and where assistance was required, the same researcher read out the questionnaire. As literacy levels were low, it is also possible that items may have been misunderstood. As a result of the wide diversity of cultural groups represented in the study, individual items may have held different meaning for different groups which may have affected the results. In addition, the unique nature of the detention environment may have affected how items were understood. The extent to which these factors affect the validity and reliability of the results cannot be ascertained for certain. However, with the exception of the self blame subscale, most of the scales showed good reliability. This is an indication that questionnaire items were consistently and reliably understood. The reasons why the self-blame subscale should perform worse than others is unclear. One possibility is that the notion of personal blame is not consistently understood across individualistic and collectivist cultures.

In addition to variations in cultural meanings and language, completing the questionnaire with the help of another person may have influenced reports of distress. This may have resulted in under reporting of distress as a result of embarrassment or shame. This is particularly problematic with reporting incidence of sexual trauma or torture. It is also possible that over reporting of symptoms may have occurred, if it was considered that this might influence an asylum application. This is thought to be unlikely however, as a result of the measures taken to avoid this. These were that participants were made aware in the participant information sheet that the
questionnaires were anonymous and that the researcher was not connected to staff at the IRC or the Home Office IND. Furthermore, asylum seekers in detention had already explained the nature of their traumatic experiences, as well as their distress, to a number of different immigration officials as well as staff at the centre without effect, and were therefore unlikely to perceive any advantage in over reporting symptoms.

Related to this is the problem of using scales which are designed to consider the impact of events after the event has occurred (and usually presumably from a place of subsequent safety). The use of these measures in situations where individuals are currently experiencing traumatic events, and are not subjectively or objectively in a place of safety is clearly problematic. However, the IES was chosen because it is the most widely used and robust measure available at the current time. Future research investigating the impact of objective current threat and repeated trauma on the maintenance of PTSD is needed, and could involve development of tools designed for use in these contexts.

Confounding factors

Complex problems abound in differentiating between the effects of detention, the threat of deportation, previous experience of trauma and the asylum procedure in itself. It was not possible to make these distinctions within this study. An additional problem is that the number of days in detention is a crude measure of levels of adverse detention experiences. Further research which differentiates between these variables is required. Nonetheless, this study was useful in that it is the first study to investigate incidence of mental health problems amongst individuals held in IRCs and identifies these individuals as a particularly vulnerable group. It was also useful in that it suggested that the effect of detention may impact on individuals differently according to pre-existing risk factors. Further research is now required to further investigate the many factors which result in high levels of psychological distress in this group.
Summary of limitations of current theories and suggestions for further research

This study adds to a growing international literature investigating the effects of trauma on displaced individuals (e.g. Porter and Haslam, 2005). Limitations to current theories of post trauma reactions have been identified as they arose, and are summarised here.

Current theories have been criticised for ignoring cultural differences in post traumatic reactions (Bracken et al, 1995, Silove, 1999, Summerfield, 2001) as well as the additional adverse effects of cultural loss in itself (de Vries, 1996). De Vries (1996) writes about the importance of cultural understandings in allowing the individual to make meaning of their experiences. Detained individuals are potentially even more vulnerable to this loss as they are living within a depersonalised context which makes it difficult to place experiences within a meaningful framework (Pourgourides et al, 1996). This may be particularly problematic amongst individuals who are experiencing difficulties in anchoring past experiences within a temporal framework, as is characteristic of re-living experiences in PTSD. The interaction between this type of environment, and appraisals traumatic events and its sequelae (particularly perceptions of coping) is worthy of further investigation.

Another problem with current models of PTSD is the apparent assumption that individuals experiencing PTSD are objectively safe from the original source of threat, or indeed other threats to life and identity. This is less likely to be the case amongst displaced individuals. The sense of ‘current threat’ which characterises PTSD is therefore not necessarily a misperception. Research into the effects of objective current threat on perceptions of threat would be usefully incorporated in psychological understandings of post traumatic reactions. Additionally, research into the effects of multiple traumatic events compared with single events should also be included.

This highlights the significance of the underlying debate regarding the usefulness of the PTSD diagnosis amongst worldwide populations more generally. Models assuming that traumatic events are not commonplace, that perceptions of current threat are misinterpretations, and that negative appraisals regarding the ability of the
self and the system to cope with the dangerousness of the world are not objective, may be less applicable in the non western world. Post traumatic reactions may therefore be viewed as normal (rather than disordered) reactions, and individuals who have shown remarkable resilience in coping with extreme events are pathologised.

However current models of PTSD emphasise two independent processes, as well as an interaction between these two, which produce and maintain PTSD symptoms. The first process concerns a cognitive appraisal process which may incur significant cross cultural variations as outlined above. The second process involving malfunctions in cognitive apparatus such as autobiographical memory and high levels of associative learning are more universal. Given the significant levels of distress caused by re-living experiences; and the evidence for the effectiveness of the clinical therapy developed from the Ehlers and Clark model; PTSD may be a clinically useful concept. Further research which led to the development of models which incorporated both cultural factors as well resilience factors within this framework would be particularly useful.

Conclusion

This study has investigated levels of psychological distress amongst asylum seekers detained in immigration removal centres in the UK, compared with asylum seekers living in the community. Former prisoners detained in immigration centres were also included in the study. The results show clinically significant levels of anxiety, depression and PTSD in all three groups. Asylum seekers in detention had higher scores on all three clinical measures compared with asylum seekers in the community. Overall, time in detention was not related to clinical symptoms, as levels of depression, anxiety and PTSD symptoms were high amongst detainees who had been detained for any length of time. This may suggest that individuals who are suffering mental health difficulties are more likely to be detained. Length of time in detention was associated with higher levels of anxiety and depression symptoms amongst those who had previous experience of interpersonal trauma. This effect was not observed with regards to PTSD symptoms however. There was a trend for elevated hyperarousal symptoms of PTSD amongst those who had experienced interpersonal trauma and had been detained for over one month compared with individuals who had also
experienced interpersonal trauma but had been detained for a shorter period. Experience of detention was the most significant predictor of depression, anxiety and PTSD symptoms suggest that experience of detention may have an independent adverse effect on mental health. Finally, post traumatic cognitions were higher amongst detained asylum seekers than asylum seekers in the community supporting models of PTSD which suggest negative cognitions underlie the maintenance and development of PTSD.

Taken together, these findings support international evidence that immigration detainees are a particularly vulnerable group, experiencing high levels of psychological distress. It is therefore of great concern that access to mainstream NHS services is restricted for this group. Furthermore, there is evidence to suggest that detention in immigration removal centres may contribute to mental health difficulties faced by this group. Additional research in this area is needed in order to further investigate the damaging effects of this policy to the mental health of asylum seekers in the UK.
References


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Appendices:

Appendix I: Questionnaire
   a) Questionnaire for detainees.
   b) Explanation of differences between questionnaires for detainees and asylum seekers living in the community.
   c) Consent form
   d) Information sheet for detainees
   e) Information sheet for the community group.

Appendix II: Confirmation of approval for access and Ethical approval.
   a) Letter approving access from the Home Office
   b) South East Multi Centre Research Ethics Committee Approval letter
   c) School of Human Sciences Ethical approval letter.

Appendix III: Demographic Information
   a) Days since leaving country of origin
   b) Frequencies of responses to beliefs and support questions

Appendix IV: Statistical Information
   a) Kolmogorov-Smirnov statistics
   b) Cronbach’s alphas for scales and subscales
   c-d) HADS skewness and kurtosis scores
   e) IES-R skewness and kurtosis scores
   f-h) IES-R subscale skewness and kurtosis scores
Appendix I Questionnaires

a) Questionnaire for detainees.

Version 3 16/08/2006

NAME OF DETENTION CENTRE ............................................................................

HOSPITAL ANXIETY AND DEPRESSION SCALE

PLEASE READ EACH ITEM AND CIRCLE THE REPLY WHICH COMES CLOSEST TO HOW YOU HAVE BEEN FEELING IN THE PAST WEEK. DON’T TAKE TOO LONG OVER YOUR REPLIES: YOUR IMMEDIATE REACTION TO EACH ITEM WILL PROBABLY BE MORE ACCURATE THAN A LONG THOUGHT OUT RESPONSE.

I FEEL TENSE OR WOUNDED UP
Most of the time
A lot of the time
Time to time, occasionally
Never

I STILL ENJOY THE THINGS I USED TO ENJOY
Definitely as much
Not quite so much
Only a little
Not at all

I GET A SORT OF FRIGHTENED FEELING LIKE SOMETHING AWFUL IS ABOUT TO HAPPEN
Very definitely and quite badly
Yes but not too badly
A little, but it doesn’t worry me
Not at all

I FEEL AS IF I AM SLOWED DOWN
Nearly all of the time
Very often
Sometimes
Not at all

I GET A SORT OF FRIGHTENED FEELING LIKE ‘BUTTERFLIES IN THE STOMACH’
Not at all
Occasionally
Quite often
Very often
I HAVE LOST INTEREST IN MY APPEARANCE
Definitely
I don't take as much care as I should
I may not take quite as much care
I take just as much care as ever

I CAN LAUGH AND SEE THE FUNNY SIDE OF THINGS
As much as I always could
Not quite so much now
Definitely not as much now
Not at all

I FEEL RESTLESS AS IF I HAVE TO BE ON THE MOVE:
Very much indeed
Quite a lot
Not very much
Not at all

WORRYING THOUGHTS GO THROUGH MY MIND
A great deal of the time
A lot of the time
From time to time but not too often
Only occasionally

I LOOK FORWARD WITH ENJOYMENT TO THINGS
As much as I ever did
Rather less than I used to
Definitely less than I used to
Hardly at all

I FEEL CHEERFUL
Not at all
Not often
Sometimes
Most of the time

I GET SUDDEN FEELINGS OF PANIC
Very often indeed
Quite often
Not very often
Not at all

I CAN SIT AT EASE AND FEEL RELAXED
Definitely
Usually
Not often
Not at all

I CAN ENJOY A GOOD BOOK OR RADIO OR TV PROGRAMME
Often
Sometimes
Not often
Very seldom
1) How long have you been held here?
   _____ Days _____ Months _____ Years

2) Have you been detained in another immigration removal centre before this?
   YES / NO (please delete)
   a) IF YES, how long were you there for?
      _____ Days _____ Months _____ Years

3) Since arriving in the UK, have you been held in prison?
   YES / NO (please delete)
   a) IF YES, how long were you there for?
      _____ Days _____ Months _____ Years

4) How long has it been since you left your country of origin?
   _____ Days _____ Months _____ Years

5) Are there other people here who you know from your country of origin?
   YES / NO

6) How many other people here speak a language which you are able to speak comfortably?
   0 / 1-5 / 6-10 / 11-20 / over 20 (please delete)

7) What religion are you?
   Muslim / Christian / Jewish / Hindu / Sikh / Buddhist/Other (please delete)

8) Are you practicing your religion here?
   YES / NO
   a) IF NOT, why not?
      Don’t wish to / Don’t have the opportunity to / other reason

9) Do you understand why you are here?
   YES / NO
10) To what extent do you feel you are being supported
   a) by professional staff?
      A lot / a little / not at all (please delete)
   b) by friends or family?
      A lot / a little / not at all (please delete)

11) To what extent do you feel that your case is being managed justly?
      A lot / a little / not at all (please delete)

12) Were you detained in your country of origin before arriving in the UK?
      YES / NO
      a) IF YES, during detention were you subject to ill-treatment?
         YES / NO

13) Are you MALE / FEMALE (please delete)

14) How would you describe your ethnic origin?

15) Which country have you come from?

16) How old are you? ______ Years.

17) What is your status?
    Awaiting deportation (not seeking asylum) / awaiting deportation (asylum application failed) / Awaiting initial asylum decision / appeal process / awaiting appeal decision / other (specify)

Have you experienced any of the following traumatic events? (tick all which apply)

1) **Serious accident, fire or explosion**
2) **Natural disaster**
3) **Non-sexual assault by a family member or someone you know (for example, being mugged, physically attacked, shot, stabbed or held at gunpoint)**
4) Non sexual assault by a stranger (for example, being mugged, physically attacked, shot, stabbed or held at gunpoint)
5) Sexual assault by a family member or someone you know (for example rape or attempted rape)
6) Sexual assault by a stranger (for example rape or attempted rape)
7) Military combat or a war zone
8) Sexual contact when you were younger than 18 with someone who was 5 or more years older than you
9) Imprisonment (for example prison inmate, prisoner of war, hostage)
10) Torture
11) Life threatening illness
12) Other traumatic event

**IMPACT OF EVENTS SCALE**

**INSTRUCTIONS:** Below is a list of comments made by people after stressful life events. Please circle each item indicating how frequently these comments were true for you DURING THE PAST SEVEN DAYS with respect to the event. If they did not occur during that time, please mark the 'not at all' column.

<table>
<thead>
<tr>
<th>Number</th>
<th>Description</th>
<th>Not At all</th>
<th>Rarely</th>
<th>Sometimes</th>
<th>Often</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Any reminder brought back feelings about it</td>
<td>0</td>
<td>1</td>
<td>3</td>
<td>5</td>
</tr>
<tr>
<td>2</td>
<td>I had trouble staying asleep</td>
<td>0</td>
<td>1</td>
<td>3</td>
<td>5</td>
</tr>
<tr>
<td>3</td>
<td>Other things kept making me think about it</td>
<td>0</td>
<td>1</td>
<td>3</td>
<td>5</td>
</tr>
<tr>
<td>4</td>
<td>I felt irritable and angry</td>
<td>0</td>
<td>1</td>
<td>3</td>
<td>5</td>
</tr>
<tr>
<td>5</td>
<td>I avoided letting myself get upset when I thought about it or was reminded of it</td>
<td>0</td>
<td>1</td>
<td>3</td>
<td>5</td>
</tr>
<tr>
<td>6</td>
<td>I thought about it when I didn’t mean to</td>
<td>0</td>
<td>1</td>
<td>3</td>
<td>5</td>
</tr>
<tr>
<td>7</td>
<td>I felt as if it hadn’t happened or wasn’t real.</td>
<td>0</td>
<td>1</td>
<td>3</td>
<td>5</td>
</tr>
<tr>
<td>8</td>
<td>I stayed away from reminders of it</td>
<td>0</td>
<td>1</td>
<td>3</td>
<td>5</td>
</tr>
<tr>
<td>9</td>
<td>Pictures about it popped into my head</td>
<td>0</td>
<td>1</td>
<td>3</td>
<td>5</td>
</tr>
<tr>
<td>10</td>
<td>I was jumpy and easily startled</td>
<td>0</td>
<td>1</td>
<td>3</td>
<td>5</td>
</tr>
<tr>
<td>11</td>
<td>I tried not to think about it</td>
<td>0</td>
<td>1</td>
<td>3</td>
<td>5</td>
</tr>
<tr>
<td>12</td>
<td>I was aware that I still had a lot of feelings about it, but I didn’t deal with them</td>
<td>0</td>
<td>1</td>
<td>3</td>
<td>5</td>
</tr>
<tr>
<td>13</td>
<td>My feelings about it were kind of numb</td>
<td>0</td>
<td>1</td>
<td>3</td>
<td>5</td>
</tr>
<tr>
<td>14</td>
<td>I found myself acting or feeling like I was back at that time</td>
<td>0</td>
<td>1</td>
<td>3</td>
<td>5</td>
</tr>
<tr>
<td>15</td>
<td>I had trouble falling asleep</td>
<td>0</td>
<td>1</td>
<td>3</td>
<td>5</td>
</tr>
<tr>
<td>16</td>
<td>I had waves of strong feelings about it</td>
<td>0</td>
<td>1</td>
<td>3</td>
<td>5</td>
</tr>
<tr>
<td>17</td>
<td>I tried to remove it from my memory</td>
<td>0</td>
<td>1</td>
<td>3</td>
<td>5</td>
</tr>
<tr>
<td>18</td>
<td>I had trouble concentrating</td>
<td>0</td>
<td>1</td>
<td>3</td>
<td>5</td>
</tr>
<tr>
<td>19</td>
<td>Reminders of it caused me to have physical reactions such as sweating, trouble breathing, nausea or a pounding heart</td>
<td>0</td>
<td>1</td>
<td>3</td>
<td>5</td>
</tr>
</tbody>
</table>
20) I had dreams about it 0 1 3 5
21) I felt watchful and on-guard 0 1 3 5
22) I tried not to talk about it 0 1 3 5

POST TRAUMATIC COGNITIONS INVENTORY

We are interested in the kinds of thoughts which you may have had after a traumatic experience. Below are a number of statements that may or may not be representative of your thinking. Please read each statement carefully and tell us how much you AGREE or DISAGREE with each statement.

People react to traumatic events in many different ways. There are no right or wrong answers to these statements.

1) Totally disagree
2) Disagree very much
3) Disagree slightly
4) Neutral
5) Agree slightly
6) Agree very much
7) Totally agree

1. The event happened because of the way I acted.
   1 2 3 4 5 6 7

2. I can’t trust that I will do the right thing
   1 2 3 4 5 6 7

3. I am a weak person
   1 2 3 4 5 6 7

4. I will not be able to control my anger and will do something terrible
   1 2 3 4 5 6 7

5. I can’t deal with even the slightest upset
   1 2 3 4 5 6 7

6. I used to be a happy person but now I am always miserable
   1 2 3 4 5 6 7

7. People can’t be trusted
   1 2 3 4 5 6 7

8. I have to be on guard all the time
   1 2 3 4 5 6 7

9. I feel dead inside
10. You can never know who will harm you

11. I have to be especially careful because you never know what can happen next

12. I am inadequate

13. I will not be able to control my emotions, and something terrible will happen

14. If I think about the event I will not be able to handle it

15. The event happened to me because of the sort of person I am

16. My reactions since the event mean that I am going crazy

17. I will never be able to feel normal emotions again

18. The world is a dangerous place

19. somebody else would have stopped the event from happening

20. I have permanently changed for the worse

21. I feel like an object, not like a person

22. Somebody else would not have gotten into this situation

23. I can’t rely on other people
24. I feel isolated and set apart from others
25. I have no future
26. I can't stop bad things from happening to me
27. People are not what they seem
28. My life has been destroyed by the trauma
29. There is something wrong with me as a person
30. My reactions since the event show that I am a lousy coper
31. There is something about me that made the event happen
32. I will not be able to tolerate my thoughts about the event, and I will fall apart
33. I feel I don't know myself anymore
34. You never know when something terrible will happen
35. I can't rely on myself
36. Nothing good can happen to me anymore

THANK YOU VERY MUCH FOR COMPLETING THIS QUESTIONNAIRE
b) **Explanation of differences between questionnaires for detainees and asylum seekers living in the community.**

The questionnaire used for asylum seekers within the community was identical to the questionnaire for detained participants except for the following items in the biographical section: Question 9 was omitted, questions 1 and 2 were re-worded to reflect the differences in experience. Questions 1 and 2 appeared as the following on the questionnaire for asylum seekers living in the community:

1) How long have you been in the UK?
   _______Days _______Months _______Years

2) Have you been detained in an immigration removal centre before now?

   YES / NO (please delete)
c) Consent Form.

Version 3
16/08/06

Title of Project: Assessing indicators of psychological distress experienced by asylum seekers held in immigration removal centres.

Name of Researcher: Katy Robjant

CONSENT FORM

1. I confirm that I have read and understand the information sheet dated 16th August (version 3) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily

   Please initial box

2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, up until the time when I hand in the questionnaire. I understand that withdrawing from the study will have no affect on my medical or legal rights.

   Please initial box

3. I agree to take part in the above study.

   Please initial box

----------------------------------  -----------  ------------------
Name of Participant               Date         Signature

Name of Person taking consent     Date         Signature
(if different from researcher)

----------------------------------  -----------  ------------------
Name of Researcher                Date         Signature
d) Information Sheet for detainees.

Version 3 16/08/2006

Participant Information Sheet (detainee group).

You are invited to take part in this study because you are being held in an immigration removal centre. The study is being carried out by a group at the University of Surrey. The aim is to assess the mental well being of people living here. This will be compared with people who live in the community, to see whether there is any difference. Another aim of the study is to find out which factors make living in detention better or worse.

If you decide to take part you will be asked to fill in a questionnaire. This will take about 35-40 minutes. This will not have your name on it and will only be seen by the people involved in the study. It will not be seen by Immigration Officials or the people who work here. It is confidential and will be destroyed once the study is over. You can choose to withdraw from the study up until the point that you hand over the questionnaire, with no effect on your circumstances. Once you have given the finished questionnaire to the researcher it won’t be possible to withdraw because your questionnaire cannot be identified from the others.

The investigators of this study are in no way connected to the Immigration Officials, or the people who work here. Taking part in this study will have no effect on your asylum application, and cannot help with your release. If you decide that you don’t want to take part, that will also have no effect on your release. Immigration officials will not see the questionnaires. There are no risks involved in taking part in the study. The findings of the study will be used to suggest questions for future research. They will also be distributed amongst charities interested in these issues.
Participant Information Sheet (community group)

You are invited to take part in this study, which is being carried out by a group at the University of Surrey. The aim is to compare the mental wellbeing of people living within immigration removal centres with people who live in the community. Another aim of the study is to find out which factors make living in detention better or worse.

If you decide to take part you will be asked to fill in a questionnaire. This will take about 35-40 minutes. This will not have your name on it and will only be seen by the people involved in the study. It is confidential and will be destroyed once the study is over. You can choose to withdraw from the study up until the point that you hand over the questionnaire, with no effect on your circumstances. Once you have given the finished questionnaire to the researcher it won’t be possible to withdraw because your questionnaire cannot be identified from the others.

The investigators of this study are in no way connected to Immigration Officials. Taking part in this study will have no effect on an asylum application. Immigration officials will not see the questionnaires. There are no risks involved in taking part in the study. The findings of the study will be used to suggest questions for future research. They will also be distributed amongst charities interested in these issues.
Appendix II: Confirmation of approval for access and Ethical approval.

a) Letter approving access from the Home Office

Dear Ms Robjant,

RESEARCH INTO PSYCHOLOGICAL WELLBEING OF DETAINEES

This is to confirm that IND has agreed to facilitate your research project into the psychological wellbeing of immigration detainees. In particular, we have agreed that you will be given access to the Immigration Removal Centres concerned. As mentioned previously, arrangements for your visits to the individual Centres should be made direct with the on-site Immigration Service managers, whose contact details you have been provided with separately.

Yours sincerely

Head of Detention Policy

Ms Katy Robjant
Department of Clinical Psychology
University of Surrey
Guildford

Our Ref
Your Ref
Date
12 July 2006
b) South East Multi Centre Research Ethics Committee Approval letter

11 September 2006

Ms Katy Robjant
Trainee Clinical Psychologist
University Of Surrey
Department of Clinical Psychology
University of Surrey
Guilford
GU2 7XK

Dear Ms Robjant

Full title of study: Assessing indicators of psychological distress experienced by asylum seekers held in Immigration removal centres.

REC reference number: 06/MRE01/75

Thank you for your letter of 29 August 2006, responding to the Committee’s request for further information on the above research and submitting revised documentation.

The further information was considered by the Chairman.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised.

Ethical review of research sites

The Committee has designated this study as exempt from site-specific assessment (SSA). There is no requirement for Local Research Ethics Committees to be informed or for site-specific assessment to be carried out at each site.

Conditions of approval

The favourable opinion is given provided that you comply with the conditions set out in the attached document. You are advised to study the conditions carefully.

Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

<table>
<thead>
<tr>
<th>Document</th>
<th>Version</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Application</td>
<td></td>
<td>18 July 2006</td>
</tr>
<tr>
<td>Protocol</td>
<td>vers 2</td>
<td>18 July 2006</td>
</tr>
</tbody>
</table>

The Central Office for Research Ethics Committees is responsible for the operational management of Multi-centre Research Ethics Committees.
Research governance approval

You should arrange for the R&D department at all relevant NHS care organisations to be notified that the research will be taking place, and provide a copy of the REC application, the protocol and this letter.

All researchers and research collaborators who will be participating in the research must obtain final research governance approval before commencing any research procedures. Where a substantive contract is not held with the care organisation, it may be necessary for an honorary contract to be issued before approval for the research can be given.

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (duly 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

With the Committee's best wishes for the success of this project

Yours sincerely

Canon Ian Ainsworth-Smith
Chair

Email: jane-martin@stmrec.fsnet.co.uk

Enclosures: Standard approval conditions

Copy to: Professor Terry Desombre, University of Surrey

University of Surrey

208
Dear Katy

Reference: 56-PSY-06
Psychological distress in asylum seekers in detention in the UK. A Qualitative study

Thank you for your submission of the above proposal.

The School of Human Sciences Ethics Committee has given a favourable ethical opinion.

If there are any significant changes to this proposal you may need to consider requesting scrutiny by the School Ethics Committee.

Yours sincerely

Kate Davidson
Dr Kate Davidson
### Table A: Days since leaving country of origin

<table>
<thead>
<tr>
<th></th>
<th>Detained asylum seekers</th>
<th>Detained former prisoners</th>
<th>Community comparison</th>
</tr>
</thead>
<tbody>
<tr>
<td>N</td>
<td>57</td>
<td>27</td>
<td>41</td>
</tr>
<tr>
<td>Mean (SD)</td>
<td>1393 (1217)</td>
<td>3090 (3122)</td>
<td>1482 (1066)</td>
</tr>
<tr>
<td>Median</td>
<td>1460</td>
<td>1915</td>
<td>1275</td>
</tr>
<tr>
<td>Skewness (SE)</td>
<td>0.77 (0.32)</td>
<td>1.65 (0.45)</td>
<td>0.54 (0.37)</td>
</tr>
<tr>
<td>Kurtosis (SE)</td>
<td>0.15 (0.62)</td>
<td>2.31 (0.87)</td>
<td>-0.5 (0.72)</td>
</tr>
</tbody>
</table>

### Table B: Frequencies of responses to beliefs and support questions

<table>
<thead>
<tr>
<th>Question</th>
<th>Total sample (n = 146)</th>
<th>Detained asylum seekers (n = 67)</th>
<th>Detained former prisoners (n = 30)</th>
<th>Community sample (n = 49)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Understand why here?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>NA</td>
<td>52 (77.6%)</td>
<td>25 (86.2%)</td>
<td>NA</td>
</tr>
<tr>
<td>No</td>
<td></td>
<td>15 (22.4%)</td>
<td>4 (13.8%)</td>
<td></td>
</tr>
<tr>
<td>Support from staff</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A lot</td>
<td>33 (22.6%)</td>
<td>12 (17.9%)</td>
<td>8 (26.7%)</td>
<td>13 (32.5%)</td>
</tr>
<tr>
<td>A little</td>
<td>51 (34.9%)</td>
<td>27 (40.3%)</td>
<td>9 (30%)</td>
<td>15 (30.6%)</td>
</tr>
<tr>
<td>Not at all</td>
<td>45 (30.8%)</td>
<td>23 (17.9%)</td>
<td>10 (33.3%)</td>
<td>12 (24.5%)</td>
</tr>
<tr>
<td>Support from friends / family</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>A lot (38.4%)</td>
<td>A little (23.3%)</td>
<td>Not at all (31.5%)</td>
<td>Don't know (15.1%)</td>
</tr>
<tr>
<td>----------------------</td>
<td>--------------</td>
<td>------------------</td>
<td>--------------------</td>
<td>-------------------</td>
</tr>
<tr>
<td>Is case being</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>managed</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>justly?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A lot</td>
<td>12 (8.2%)</td>
<td>1 (3.3%)</td>
<td>3 (10%)</td>
<td>8 (16.3%)</td>
</tr>
<tr>
<td>A little</td>
<td>42 (28.8%)</td>
<td>17 (25.4%)</td>
<td>7 (23.3%)</td>
<td>18 (36.7%)</td>
</tr>
<tr>
<td>Not at all</td>
<td>61 (41.8%)</td>
<td>32 (47.8%)</td>
<td>19 (63.3%)</td>
<td>10 (20.4%)</td>
</tr>
<tr>
<td>Don’t know</td>
<td>22 (15.1%)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Detention in</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>country of origin?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>51 (34.9%)</td>
<td>27 (40.3%)</td>
<td>6 (20%)</td>
<td>18 (38.8%)</td>
</tr>
<tr>
<td>No</td>
<td>79 (54.1%)</td>
<td>38 (56.7%)</td>
<td>22 (73.3%)</td>
<td>19 (36.7%)</td>
</tr>
<tr>
<td>Subjected to</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ill treatment?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>42 (73.7%)</td>
<td>23 (82.1%)</td>
<td>5 (83.3%)</td>
<td>14 (60.9%)</td>
</tr>
<tr>
<td>No</td>
<td>15 (26.3%)</td>
<td>5 (17.9%)</td>
<td>1 (16.7%)</td>
<td>9 (39.1%)</td>
</tr>
</tbody>
</table>
Appendix IV

Table A: Kolmogorov-Smirnov statistics for the overall sample.

<table>
<thead>
<tr>
<th>Variable</th>
<th>Kolmogorov-Smirnov statistic</th>
<th>Df</th>
<th>P-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>IES</td>
<td>.086</td>
<td>97</td>
<td>.074</td>
</tr>
<tr>
<td>IES-R</td>
<td>.077</td>
<td>95</td>
<td>.200</td>
</tr>
<tr>
<td><strong>Subscales:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>IESI</td>
<td>.077</td>
<td>108</td>
<td>.118</td>
</tr>
<tr>
<td>IESA</td>
<td>.113</td>
<td>100</td>
<td>.003</td>
</tr>
<tr>
<td>IESH</td>
<td>.059</td>
<td>106</td>
<td>.200</td>
</tr>
<tr>
<td>HADSD</td>
<td>.073</td>
<td>138</td>
<td>.068</td>
</tr>
<tr>
<td>HADSA</td>
<td>.067</td>
<td>140</td>
<td>.200</td>
</tr>
<tr>
<td>PTCI ALL</td>
<td>.109</td>
<td>81</td>
<td>.019</td>
</tr>
<tr>
<td>PTCI SELF</td>
<td>.107</td>
<td>85</td>
<td>.018</td>
</tr>
<tr>
<td>PTCI WORLD</td>
<td>.107</td>
<td>97</td>
<td>.016</td>
</tr>
<tr>
<td>PTCI BLAME</td>
<td>.071</td>
<td>85</td>
<td>.200</td>
</tr>
</tbody>
</table>

Table B: Cronbach’s alphas for scales and subscales

<table>
<thead>
<tr>
<th>Scale/Subscale</th>
<th>Cronbach’s Alpha</th>
</tr>
</thead>
<tbody>
<tr>
<td>HADS</td>
<td>.67</td>
</tr>
<tr>
<td>HADSA</td>
<td>.65</td>
</tr>
<tr>
<td>IES</td>
<td>.82</td>
</tr>
<tr>
<td>IESR</td>
<td>.89</td>
</tr>
<tr>
<td>IESI</td>
<td>.77</td>
</tr>
<tr>
<td>IESH</td>
<td>.76</td>
</tr>
<tr>
<td>IESA</td>
<td>.71</td>
</tr>
<tr>
<td>PTCI ALL</td>
<td>.92</td>
</tr>
<tr>
<td>PTCI SELF</td>
<td>.92</td>
</tr>
<tr>
<td>PTCI WORLD</td>
<td>.73</td>
</tr>
<tr>
<td>PTCI BLAME</td>
<td>.59</td>
</tr>
</tbody>
</table>
### Table C: HADSD scores

<table>
<thead>
<tr>
<th></th>
<th>Total sample</th>
<th>Detained asylum seekers</th>
<th>Detained former prisoners</th>
<th>Community comparison</th>
</tr>
</thead>
<tbody>
<tr>
<td>N</td>
<td>138</td>
<td>66</td>
<td>30</td>
<td>42</td>
</tr>
<tr>
<td>Mean (SD)</td>
<td>11.76 (4.58)</td>
<td>13.54 (4.58)</td>
<td>11.37 (3.81)</td>
<td>9.24 (3.85)</td>
</tr>
<tr>
<td>Median</td>
<td>11.5</td>
<td>13.5</td>
<td>11.5</td>
<td>9</td>
</tr>
<tr>
<td>Skewness (SE)</td>
<td>0.10 (0.21)</td>
<td>-0.27 (0.30)</td>
<td>-0.99 (0.43)</td>
<td>0.62 (0.37)</td>
</tr>
<tr>
<td>Kurtosis (SE)</td>
<td>0.48 (0.41)</td>
<td>-0.42 (0.58)</td>
<td>1.50 (0.83)</td>
<td>0.08 (0.72)</td>
</tr>
<tr>
<td>Minimum</td>
<td>0</td>
<td>2</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>Maximum</td>
<td>21</td>
<td>21</td>
<td>17</td>
<td>16</td>
</tr>
</tbody>
</table>

### Table D HADSA scores:

<table>
<thead>
<tr>
<th></th>
<th>Total sample</th>
<th>Detained asylum seekers</th>
<th>Detained former prisoners</th>
<th>Community comparison</th>
</tr>
</thead>
<tbody>
<tr>
<td>N</td>
<td>140</td>
<td>65</td>
<td>30</td>
<td>45</td>
</tr>
<tr>
<td>Mean (SD)</td>
<td>12.86 (5.52)</td>
<td>14.08 (4.98)</td>
<td>12.82 (5.35)</td>
<td>11.12 (5.98)</td>
</tr>
<tr>
<td>Median</td>
<td>13</td>
<td>15</td>
<td>13.5</td>
<td>11</td>
</tr>
<tr>
<td>Skewness (SE)</td>
<td>0.04 (0.21)</td>
<td>-0.18 (0.30)</td>
<td>-0.59 (0.43)</td>
<td>0.82 (0.35)</td>
</tr>
<tr>
<td>Kurtosis (SE)</td>
<td>0.23 (0.41)</td>
<td>0.67 (0.59)</td>
<td>-0.49 (0.83)</td>
<td>1.43 (0.70)</td>
</tr>
<tr>
<td>Minimum</td>
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<td>0</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Maximum</td>
<td>31</td>
<td>29</td>
<td>20</td>
<td>31</td>
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Table E: IES-R scores

<table>
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<th></th>
<th>Total sample</th>
<th>Detained asylum seekers</th>
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<th>Community comparison</th>
</tr>
</thead>
<tbody>
<tr>
<td>N</td>
<td>95</td>
<td>42</td>
<td>23</td>
<td>30</td>
</tr>
<tr>
<td>Mean (SD)</td>
<td>63.47 (22.96)</td>
<td>68.02 (20.23)</td>
<td>67.03 (21.27)</td>
<td>54.35 (25.69)</td>
</tr>
<tr>
<td>Median</td>
<td>67</td>
<td>70</td>
<td>69.14</td>
<td>51.5</td>
</tr>
<tr>
<td>Skewness (SE)</td>
<td>-0.48 (0.25)</td>
<td>-0.45 (0.37)</td>
<td>-0.77 (0.48)</td>
<td>0.10 (0.43)</td>
</tr>
<tr>
<td>Kurtosis (SE)</td>
<td>-0.36 (0.49)</td>
<td>-0.48 (0.71)</td>
<td>1.42 (0.94)</td>
<td>-0.62 (0.83)</td>
</tr>
<tr>
<td>Minimum</td>
<td>3</td>
<td>23</td>
<td>9</td>
<td>3</td>
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<tr>
<td>Maximum</td>
<td>106</td>
<td>106</td>
<td>104</td>
<td>101</td>
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Table F: IES-I Scores

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<th>Community comparison</th>
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<td>N</td>
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<td>49</td>
<td>23</td>
<td>36</td>
</tr>
<tr>
<td>Mean (SD)</td>
<td>21.11 (8.84)</td>
<td>22.06 (8.26)</td>
<td>22.24 (9.55)</td>
<td>19.09 (9.04)</td>
</tr>
<tr>
<td>Median</td>
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<td>22</td>
<td>26</td>
<td>19.5</td>
</tr>
<tr>
<td>Skewness (SE)</td>
<td>-0.413 (0.23)</td>
<td>-0.374 (0.34)</td>
<td>-0.882 (0.48)</td>
<td>-0.140 (0.39)</td>
</tr>
<tr>
<td>Kurtosis (SE)</td>
<td>-0.57 (0.46)</td>
<td>-0.63 (0.67)</td>
<td>-0.05 (0.94)</td>
<td>0.48 (0.77)</td>
</tr>
<tr>
<td>Minimum</td>
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<td>0</td>
<td>0</td>
</tr>
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<td>Maximum</td>
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Table G: IES-A scores

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<th>Community comparison</th>
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<td>N</td>
<td>100</td>
<td>43</td>
<td>25</td>
<td>32</td>
</tr>
<tr>
<td>Mean (SD)</td>
<td>22.51 (8.85)</td>
<td>24.7 (7.66)</td>
<td>24.76 (7.17)</td>
<td>17.82 (9.87)</td>
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<td>27</td>
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<td>17</td>
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<tr>
<td>Skewness</td>
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<td>-0.34 (0.36)</td>
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<td>0.037 (0.41)</td>
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<tr>
<td>Kurtosis</td>
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<td>-1.11 (0.81)</td>
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<td>Minimum</td>
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<td>9</td>
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<td>Maximum</td>
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Table H: IES-H scores

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<th>Detained asylum seekers</th>
<th>Detained former prisoners</th>
<th>Community comparison</th>
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</thead>
<tbody>
<tr>
<td>N</td>
<td>106</td>
<td>46</td>
<td>24</td>
<td>36</td>
</tr>
<tr>
<td>Mean (SD)</td>
<td>19.39 (19.5)</td>
<td>20.71 (8.37)</td>
<td>19.69 (8.17)</td>
<td>17.52 (9.84)</td>
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<tr>
<td>Median</td>
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<td>21.5</td>
<td>20</td>
<td>16</td>
</tr>
<tr>
<td>Skewness</td>
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<td>0.23 (0.39)</td>
</tr>
<tr>
<td>Kurtosis</td>
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<td>0.74 (0.77)</td>
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<tr>
<td>Minimum</td>
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<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Maximum</td>
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<td>31.5</td>
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