**Group Psychoeducation Treatment**

**Integrity Measure (GPTIM) Manual**

**Introduction**

Practitioners delivering low intensity group psychoeducational interventions offer treatment for patients with mild-moderate depression and anxiety disorders. When delivering group psychoeducational content, practitioners employ a didactic style, which results in the practitioner becoming a ‘teacher’ and the service user becoming a ‘learner’. Self-help materials based on cognitive behavioural theory and principles provide the focus for treatment. The guided self-help clinical method emphasizes the skill of practitioners in utilizing psychoeducational materials and helping patients use them effectively to self-manage their symptoms. The competence of the practitioner in delivering low intensity treatment is crucial to ensure the progress/safety of the patient. Competence refers to the skill and appropriateness with which techniques/methods are delivered. The adherence of the practitioner is also crucial, as it refers to the extent they are delivering techniques/methods that are consistent with the therapy model and/or protocol. Measurement of the competency and adherence components combine to assess a practitioner’s overall TI.

**Treatment Using the COM-B as a Theoretical Guide**

In relation to the low intensity cognitive behavioral approach, consideration of behaviour change theory is pivotal. It is imperative that practitioners are able to consider the ways behaviour change underpins the low intensity method and apply this knowledge within treatment. The integrative model of behaviour and behaviour change for low intensity cognitive behavioural practitioners is the COM-B model (Michie et al, 2014). The model conceptualises the patient’s problem behaviour as resulting from the interaction of three components: (a) capability to perform behaviour change (b) the opportunity to carry out necessary behaviour change and (c) the motivation for behaviour change. Therefore when treating patients using low intensity treatment methods, the COM-B model can be used to inform, guide and influence PWP treatment delivery. Practitioners should utilise the COM-B model to inform and influence the gathering and synthesis of information to aid clinical decision-making and treatment planning. The manner in which this can be achieved is set out below:

**Capability**

Considerations about the patient’s capability to engage in behavior change should be built into the treatment plan. The practitioner should show evidence of providing low intensity materials, exercises, interventions and techniques that enable the patients to change their behavior/reasoning/executive functioning. The practitioner should aim to facilitate the patients in developing a good understanding of their common mental health problems and also of the mechanisms that must be targeted to create change to promote recovery.

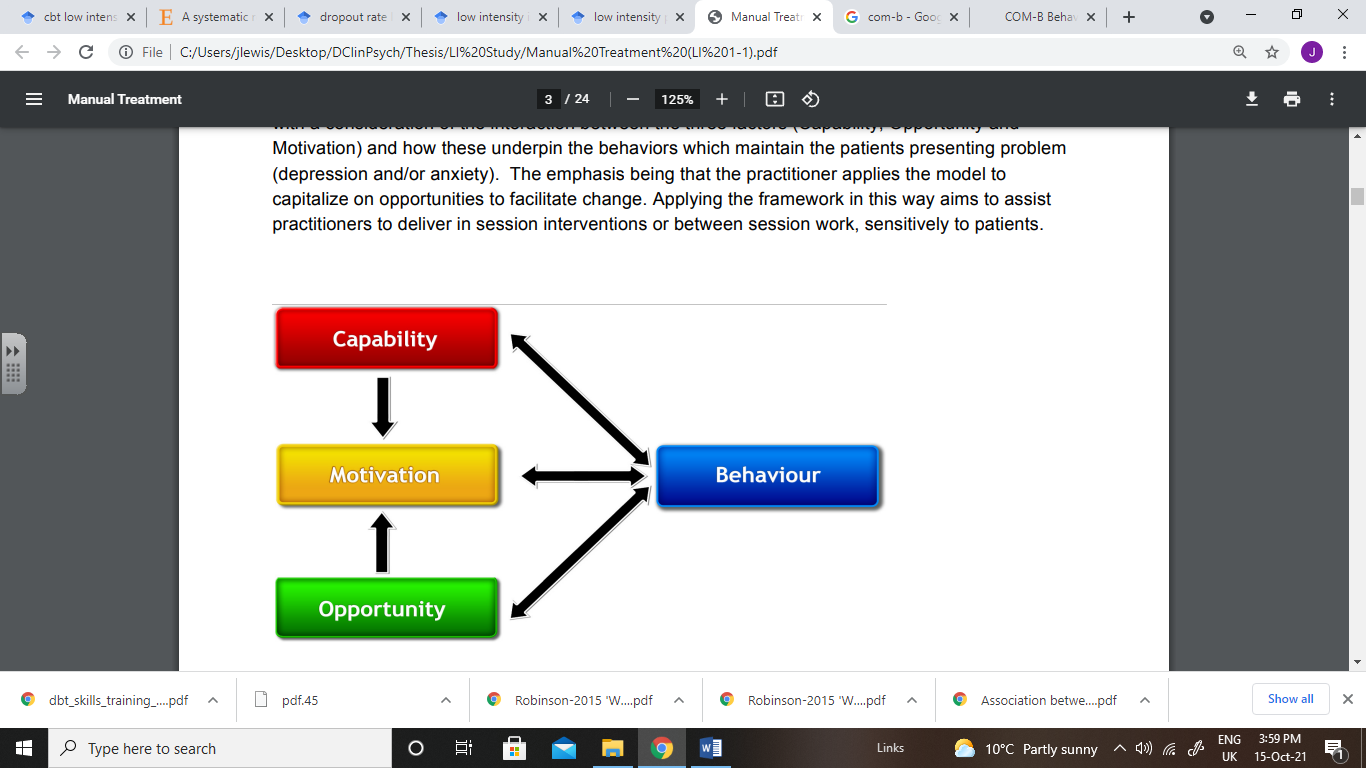
**Opportunity**

Consideration of the patientʼs opportunity to engage in behavior change should be integrated into the treatment plan. Practitioners should focus on supporting the patient to change factors in their environment (or their response to their environment) that would facilitate symptom change or lead to a reduction of the impact of their anxiety or depression.

**Motivation**

Practitioners should focus on addressing any issues with avoidance to enable effective engagement with self-management strategies i.e. in behavioral activation the focus would be on enhancing access to positive reinforcers. Alternatively, practitioners should aid patients in reduced cognitive/behavioral/emotional avoidance strategies that maintain their problem.

Raters should note the extent to which the practitioner applies the COM-B model to capitalise on opportunities to facilitate change. Application of the model is recognised as important as applying the framework assists practitioners to deliver in session interventions or between session work sensitively to patients.



**Low-Intensity Psychoeducational Group TI Measure Manual**

This manual outlines a scale for measuring the level of TI of low intensity cognitive behavioural practitioners during group treatment sessions. The scale contains 9 items which will enable raters to examine a range of adherence (3) and competency (6) components:

* Psychoeducational approach
* Psychoeducational needs
* Cognitive behavioural underpinning
* Agenda setting
* Effective use of time
* Engagement
* Psychoeducational communication
* Change methods presentation
* Between-session work guidance

The low intensity group psychoeducational integrity measure is a rating scale to be used by supervisors, trainers and managers to assess practitioner’s performance in treatment sessions. Practitioners can make use of the self to self-rate sessions to enhance reflections and development.

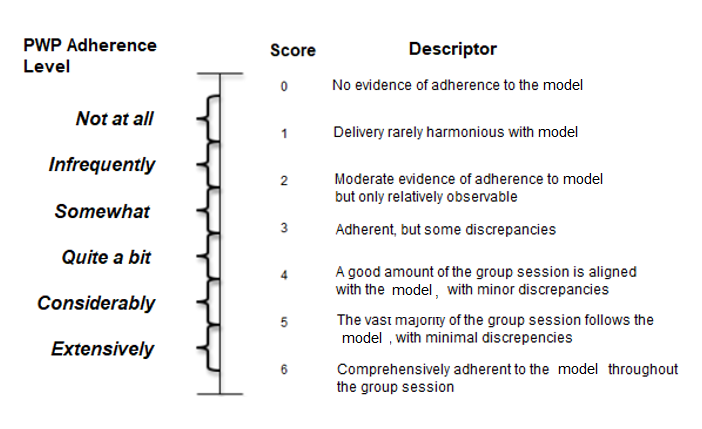
**Scoring**

The low-Intensity psychoeducational group TI measure uses two scoring scales to rate the facilitator competency of 6 areas and the facilitator adherence of 3 areas. Both scales utilise a 7-point Likert scale (0-6). For all items, raters must evaluate the extent to which an item is present/ (adherence/differentiation) and the skill with which the item is delivered (competency). The rating scales for both adherence and competence are defined in detail below. Furthermore, each items rating scale scores have been assigned specific descriptors to aid the rating process.

**Adherence/Differentiation Scale**

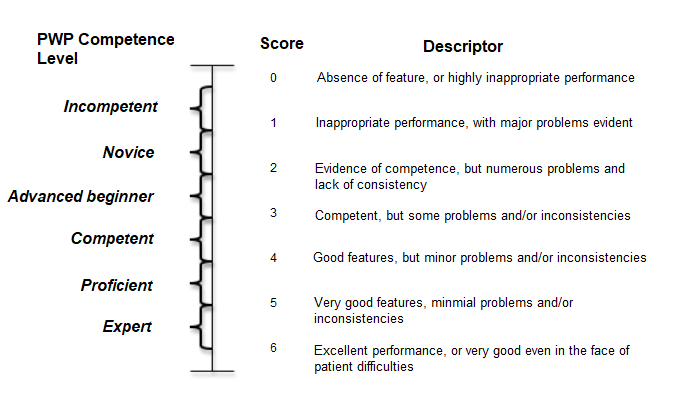
As outlined, the adherence/differentiation scale (below) provides a rating format to evaluate the extent to which a practitioner follows an item’s protocol. The higher ratings reflect behaviours that are more consistently in line with the expected protocol. Whereas, the middle range

scores reflect a practitioners inconsistent and variable fidelity to the protocol. The lowest scores indicate the complete or partial absence of the practitioner following the protocol.

For this rating scale, the starting point for practitioners is “0”. The rater should assign a number greater than “0” only if they observe examples of the item protocol behaviour. When applying the measure to managing stress sessions, raters should score facilitators according to their adherence to a cognitive behavioural model.

**Competency Scale**

The competency rating scale (below) provides a clear format by which to rate how skilled and appropriately the practitioner delivers the item in question. The higher ratings reflect a practitioner who displays a thoroughly adept delivery of the item, across the span of the group session. The middle range scores are reflective of practitioners who are observed to be adequately competent, but problems and inconsistencies are present at varying levels. The lowest scores reflect either the inappropriate delivery of the item or its complete absence. The highest score is often characterised by the application of competencies in the face of patient difficulties. However, it is possible to score a 6 in the absence of patient difficulties should the rater feel this provides the most accurate rating of the practitioners competence. For this rating scale, the starting point for each item should be “3”, as the raters should start by assuming that the practitioner will perform at a competent/average level.



**Scoring Guidelines**

In order to establish a consistent and reliable approach between raters, a set of clear scoring guidelines have been created which all raters should abide by. These guidelines should be followed when rating all of the items within the measure.

* All ratings should be based on the **performance of both facilitators as a pair**
* All items refer to the facilitator’s behaviour and therefore raters should consider what the therapist **actually does in the session** not what they might have intended to do
* As raters must make intricate distinctions among therapist behaviours, it is essential that the raters **listen and observe the session without distraction**
* Raters must also ensure they **rate what actually occurred**, not what they think ought to have occurred from their perspective. For example, ratings on one item should not have a bearing on others, raters liking/disliking of the practitioner should be irrelevant and how skilled the therapist believes the practitioner to be should be insignificant
* Raters must **use the rater’s manual during each rating**, as this will prevent rater drift and ensure that the process is more reliable and consistent
* Raters should only rate by selecting **whole numbers** and **must rate every item**
* All tapes and recordings are **confidential** and must be handled as if they were medical records. All ratings should be completed in an appropriate place away from individuals not involved in the study

**Adherence/Differentiation Items:**

**Was the right style of psychoeducational content used?**

**Items:**

**Psychoeducational approach**

**Psychoeducational needs**

**Cognitive behavioural underpinning**

**Psychoeducational Approach**

Psychoeducational groups are recognised as low-intensity interventions due to their concentration on providing mental health information. Whilst delivering groups, facilitators have minimal contact with patients (i.e. in a group didactic format over limited sessions) and present the information at a low-intensity level that is not overcomplicated. Facilitators also must ensure that a psychoeducational approach is clearly observable. Typically, this can take the form of providing information regarding psychological concepts (i.e. stress) and introducing strategies to alleviate the introduced psychological concepts (i.e. worry time). Although the inclusion of these is dependent on the session number, hallmarks of this approach should be noticeable throughout.

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| Psychoeducational Approach |
| * Are the facilitators clearly delivering the group using a psychoeducational approach? * Do the facilitators provide the patients with mental health information through their delivery of the content? * Are the typical hallmarks of a psychoeducational approach evident (i.e. introduction of psychological concepts, rationale regarding why change may be helpful, introduction of a change strategy)? |

**Psychoeducational Approach Scale**

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| Rating | Descriptor |
| 0 | No evidence of a psychoeducational approach used. |
| 1 | Sparse evidence of psychoeducational approach being used. Possibly only limited or some mental health information given, for example. |
| 2 | Facilitators evidence moderate use of the psychoeducational approach. This is only relatively observable, however. |
| 3 | Practitioners are observed using the psychoeducational approach, with some hallmarks noticeably present. Some discrepancies (i.e. not always clear or noticeable). |
| 4 | As above, but with a good amount of the session using a psychoeducational approach. Only minor discrepancies evident. |
| 5 | Large majority of session is based on the use of a psychoeducational approach, with only minimal discrepancies evident. Evidence of psychoeducational mental health information twinned with possible strategies (if suitable to session number). |
| 6 | As above, but no discrepancies and psychoeducational approach is comprehensively applied throughout the group session. |

**Psychoeducational Needs**

The facilitators of psychoeducational groups should ensure that the information they deliver is well-matched to the needs of the group. Importantly, those who attend psychoeducational groups are referred so they can access low-intensity interventions. Therefore, the content should be reflective of this. Facilitators should also deliver content which is relevant to the generalised needs of patient’s within psychoeducational groups, which typically relates to experiences of stress, depression and/or anxiety. Information that appears to cover more complex or unrelated difficulties will consequently not match the group aims. Facilitators should also ensure that earlier sessions focus on information giving, whilst later sessions concentrate on enabling change.

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| Item Rater Questions |
| * Do the facilitators deliver psychoeducational information at a low-intensity level? * Is the information they deliver overcomplicated or pitched incorrectly? * Do the facilitators deliver psychoeducational information that is related to the needs of the group (i.e. associated to stress, depression and/or anxiety)? * Is the content delivered in line with the stage the group is at on the course (i.e. information giving for earlier sessions, change methods for later sessions)? |

**Psychoeducational Needs Scale**

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| Rating | Descriptor |
| 0 | No evidence of facilitators matching psychoeducational information to group needs. Possibly inappropriate info delivered too early/too late. |
| 1 | Sparse evidence of practitioners matching psychoeducational information to the needs of the group. Limited attempts made, session may glaze over such concepts and possibly inaccurate if covered. |
| 2 | Practitioners evidence moderate matching of psychoeducational information to the needs of the group. This is only relatively observable however and is somewhat accurate (i.e. slightly relates to stress, depression and/or anxiety). |
| 3 | Practitioners match a reasonable amount of the psychoeducational information to the needs of the group but some discrepancies are evident (i.e. may be overcomplicated, pitched in the wrong session and/or at the wrong level). |
| 4 | Good amount of the session matching the psychoeducational information to the needs of the group. Only minor discrepancies evident. |
| 5 | Practitioners match large majority of psychoeducational information to the needs of the group (mostly relating to stress, depression and/or anxiety). Only minimal discrepancies evident. |
| 6 | As above, but no discrepancies and facilitators comprehensively matched psychoeducational information to the needs of the group throughout the session. Appropriate content delivered for the stage of the group. |

**Cognitive Behavioural Underpinning**

An important component of psychoeducational groups is that they are heavily underpinned by cognitive behavioural theory. Therefore, group facilitators must ensure that they deliver content related to this theory. Facilitators must also ensure that they do not deliver content from other theories in conjunction with or instead of cognitive behavioural concepts and/or theory. Typically, the theory is supported by the use of the five areas model, which formulates an individual’s difficult situation in relation to their thoughts, physical feelings, behaviours and mood. Whilst presenting, the facilitators may make reference to this model or areas of the model to reinforce the cognitive behavioural underpinning of the information covered. Facilitators may also make reference to aspects of cognitive behavioural theory which are not as explicit (i.e. referring to the inter-related nature of thoughts and behaviours etc.).

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| Item Rater Questions |
| * Do the facilitators discuss psychoeducational concepts that are underpinned by cognitive behavioural theory? * Do the practitioners inappropriately attempt to introduce or reference other theory? * Are the concepts that are covered underpinned by cognitive behavioural theory? * Do the facilitators reference the five areas model (thoughts, feelings, behaviours, mood, trigger) in relation to the content covered? * Do the facilitators make reference to aspects of cognitive behavioural theory in passing or in a less explicit manner? |

**Cognitive Behavioural Underpinning Scale**

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| Rating | Descriptor |
| 0 | No evidence of a cognitive behavioural underpinning. |
| 1 | Sparse evidence of practitioners underpinning the group session with cognitive behavioural theory. Some examples may be observable, but this may be limited to glazing over certain concepts and not covering them fully. |
| 2 | Practitioners evidence moderate underpinning of session with cognitive behavioural theory. These are relatively observable. |
| 3 | Practitioners underpin the session with cognitive behavioural theory but some discrepancies are apparent (i.e. partial use of another model, partial coverage of cognitive behavioural theory information). |
| 4 | As above, but with a good amount of the session underpinned by cognitive behavioural theory with only minor discrepancies evident. |
| 5 | Practitioners underpin the large majority of the session with cognitive behavioural theory. Most of the content appears related to the theory and only minimal discrepancies are evident (i.e. subtle misinformation or omission). |
| 6 | As above, but no discrepancies and cognitive behavioural theory comprehensively underpins the whole group session. |

**Competence Items:**

**How skillfully was the psychoeducational content delivered?**

**Items:**

**Agenda**

**Effective use of time**

**Engagement**

**Psychoeducational communication**

**Change methods presentation**

**Between-session work guidance**

**Agenda**

Low-intensity practitioners set an agenda to ensure that the key topics and information that need to be covered are done so in an efficient and time-ordered way. The agenda should aim to cover new concepts and/or concepts from the previous session, such as homework assignments. Facilitators should aim to demonstrate their ability to set, utilise and communicate a clear and structured agenda (with 2-4 items). The items included within the agenda must be appropriate, whilst also providing enough and not too much content for the allocated group time. This should result in a fluent and well-paced session overall. Importantly, practitioners will need to appropriately follow the agenda without shifting between different topics too quickly or slowly.

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| Item Rater Questions |
| * Was the practitioner fluent and well-paced in their adherence to the agenda? * Did the practitioner communicate the agenda clearly and succinctly? * Were the items included within the agenda appropriate? * Was the agenda followed in a clear and logical way? * Was time allocated efficiently to each of the items? |

**Agenda Scale**

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| Rating | Descriptor |
| 0 | No focus of the session agreed or provided. |
| 1 | Ineffective agenda setting as key information omitted (i.e. failure to plan to discuss between session tasks). Very vague agenda. No fluency. |
| 2 | Framing provided, but vague and numerous problems evident with important information missing (i.e. failure to plan to discuss between session tasks). Lacks fluency and patchy adherence to agenda. |
| 3 | Competent and effective agenda set, but somewhat lacking in fluency. Key appropriate standing items of low-intensity sessions planned and outlined. Adherence to agenda a little inconsistent. |
| 4 | Clear agenda outlined and fluently delivered. Key standing items of low-intensity sessions planned and outlined. Good subsequent adherence. |
| 5 | As above with very good fluency in agenda setting and consistent adherence throughout. Key standing items of low-intensity sessions planned and outlined. |
| 6 | As above, but with excellent features. Possibly even in the face of patient difficulties. |

**Effective Use of Time**

Low-intensity practitioners must ensure that they utilise the time available for the group session in accordance with the set agenda. Therefore, adequate control of the session must be exhibited. Facilitators should ensure that they do not rush pivotal aspects of the session. They should also display their ability to proficiently use the time allocated for the session and be seen to pace the session well (possibly referencing the time etc.). Effective pacing involves facilitating the flow of the group session through discreet start, middle and end phases. Facilitators must ensure that the pace of the session is appropriate for the group. Sessions should not go over the allotted time (unless due to unforeseen circumstances) and must neither be too fast or too slow. When switching between topics and/or agenda items, this should not be done too quickly, so as to ensure that the group is given enough time to understand the material adequately.

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| Item Rater Questions |
| * Does the session flow smoothly between discreet phases (start, middle and end)? * Was the time allocated to each part of the session appropriate for the items? May involve ensuring not too much time/not enough is allocated to any items. * Did the pacing seem appropriate for the group/low-intensity style? * Does the session go over the allotted time? |

**Effective Use of Time Scale**

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| Rating | Descriptor |
| 0 | No evidence of effective use of time or pacing evident. |
| 1 | Only slight attempts at effectively using time in the session. Does not flow between phases. Major problems evident. |
| 2 | Some evident attempts to effectively use time in the session and some flow apparent between phases evident, but this is inappropriate and inconsistent. |
| 3 | Facilitators make appropriate attempts to use time effectively by moving between discreet phases, allocating sufficient time for each agenda item and more. However, this is done inconsistently and some problems are evident. |
| 4 | Good use of time with appropriate pacing of the session according to agenda and evidence of other features (i.e. flowing smoothly) which are more consistent than not. Only minor problems or inconsistencies evident. |
| 5 | Very good and consistent use of time within the session according to the agenda. Evidence of smooth transitions between phases, references to time, possible overview of timings stated. Minimal problems and/or inconsistencies. |
| 6 | As above but whilst moving very smoothly between session phases, with some reference to the time and/or agenda. Considered an excellent display of effective use of time. |

**Engagement**

Facilitators should present materials in an engaging and enthusiastic manner to maintain the engagement of patients to aid their connection to the materials being presented. If facilitators are unable to facilitate their engagement, patients may become disillusioned with the process which may impact the intervention effectiveness. Furthermore, as the low-intensity format is defined as guided self-help, it is imperative that patients leave sessions feeling empowered and enthusiastic about employing the concepts independently. Facilitators should present with an enthusiastic manner, displaying a warm, empathic and compassionate approach. This may result in them referencing how difficult some experiences can be. Information should be pitched at an accessible level, which may involve explaining concepts in a range of ways. Facilitators should also capture the attention of the patients and present with confidence and/or flair.

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| Item Rater Questions |
| * Do the facilitators present the materials with confidence and/or flair? * Is there evidence of a warm, empathic and/or compassionate presenting style? * Does the practitioner present the content with enthusiasm? * Does the practitioner check regarding understanding? * Is the content paraphrased (if required) for the group and/or explained in a range of accessible ways? |

**Engagement Scale**

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| Rating | Descriptor |
| 0 | No attempt or evidence of practitioner presenting materials in an engaging way. |
| 1 | Very little attempt made by the practitioner to engage the group. Major problems evident. May appear unenthusiastic or uninterested. |
| 2 | Some inconsistent evidence of practitioner engaging the group. Problems evident in engaging patients with warmth, empathy and/or enthusiasm. |
| 3 | Apparent engagement of group, but inconsistent and some problems apparent. Some evidence of engaging patients warmth, empathy and/or enthusiasm. |
| 4 | As above, with good engagement of group, but minor problems and/or inconsistencies apparent. Possibly presents as confident, with some flair in delivery. |
| 5 | Very good engagement of group. Minimal inconsistencies apparent. Confidence, enthusiasm and flair apparent. Most information accessible. Evidence of paraphrasing or presenting information in different ways. |
| 6 | As above, but considered to be an excellent performance. Practitioner presents with engaging features throughout. May even manage to engage group in the face of patient difficulties. Confident throughout and flair is evident. Excellent engagement overall. |

**Psychoeducational Communication**

Throughout group sessions, facilitators will be required to deliver and be knowledgeable regarding psychoeducational information that are typically delivered as part of a cognitive behavioural low-intensity intervention. When communicating key psychoeducational concepts, they should always be clear and accurate. Clarity refers to the coherence and simplicity with which the facilitators deliver information to the patients. On the other hand, accuracy refers to the precision with which the practitioner delivers information to the patients. Some sessions will introduce psychoeducational content and others may refer to content that has been covered previously. Whilst communicating these concepts, facilitators should ensure that they relay information confidently, are clear and engaging an empathic regarding the possible impact of the information for patients.

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| Item Rater Questions |
| * Are concepts communicated with confidence? * Is the information that is delivered done accurately? * Does the practitioner show empathy when communicating concepts? * Is the practitioner clear and engaging in their delivery of the concepts? * Are patients given a chance to check their understanding? |

**Psychoeducational Communication Scale**

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| Rating | Descriptor |
| 0 | No evidence of appropriate psychoeducational communication. |
| 1 | Inappropriate performance. Observable lack of confidence in communicating concepts and a lack of empathy. Major problems evident. |
| 2 | Facilitators use some appropriate language (showing vague evidence of confidence and use of empathy), but numerous problems are apparent and features lack consistency. |
| 3 | Competent psychoeducational communication, but only somewhat confident in delivery and might only sometimes present information with clarity or present empathically. Some problems and inconsistencies apparent. |
| 4 | Clear communication of psychoeducational concepts with good features, but minor problems or inconsistencies evident. |
| 5 | Facilitators communicate psychoeducational content with confidence and display empathy. Communication clear and engaging. Patients given opportunity to check info. Only minimal problems or inconsistencies apparent. |
| 6 | As above, but considered an excellent performance throughout. May also be delivered in the presence of patient difficulties. No problems or inconsistencies. |

**Change Methods Presentation**

Facilitators of psychoeducational groups are required to include the clear and accurate presentation of change methods (i.e. thought diaries, behavioural activation planners etc.). As group sessions are based on self-help principles, such methods must be presented effectively, so patients can independently apply the techniques. Thus, there needs to be a change method apparent in the session that would help or does help the patient to self-manage their difficulties more. If applicable, the practitioner should also evidence revisiting and reiterating change methods. Practitioners should ensure that if they present change methods, this must be done with a rationale and must be communicated clearly and accurately. They must also consider the obstacles that the patients may come across when applying the methods, to ensure that the independent application of the techniques is more likely to be effective.

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| Item Rater Questions |
| * Did the practitioners present the methods in a clear manner? * Does the practitioner explain the rationale regarding the change methods? * Do the change methods seem linked to the content? * Do they discuss possible obstacles related to the change methods? * If required, are methods further broken down for patients to understand? |

**Change Methods Scale**

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| Rating | Descriptor |
| 0 | No evidence of within-sessions change methods being set or being explored. |
| 1 | Inappropriate setting up of and/or discussion of within-sessions change methods. Lack of rationale regarding methods discussed and they do not seem linked to the material. Obstacles not discussed and methods not broken down. |
| 2 | Attempts made to appropriately explore change methods, but inappropriate elements present (not clear, not engaging etc.). Some evidence of exploring a rationale and/or linking the task to sessions but may be problems with this. |
| 3 | Competent setting up of and/or discussion regarding change methods. Elements of competent delivery with regards to task rationale, session link, clarity, time etc. However, problems/inconsistencies with performance evident. |
| 4 | Good setting up of and/or discussion regarding change methods. As above, with good features and minor problems/inconsistencies. |
| 5 | Very good presentation of change methods in a clear and engaging manner. Rationale and link explored. Obstacles explored and methods breakdown covered (if required). Minimal problems evident. |
| 6 | As above, but an excellent performance and no problems/inconsistencies evident throughout. May have been delivered even in the face of patient difficulties. |

**Between-session Work Guidance**

Patient progress is reliant upon facilitators setting tasks to be completed outside of the group environment. The tasks should ideally involve the testing of a hypothesis, the incorporation of new perspectives, and may suggest some aspect of behaviour change. Practitioners must always explain the rationale behind the homework and this should be linked to the content. Guidance around these tasks may involve preparation, where practitioners explore the rationale behind their use and how they can be applied. Practitioners may provide guidance on tasks that have been applied and may need some refining. Practitioners should clearly set up between-session tasks; delivering a rationale, along with a straight forward explanation around its application. They must also consider the obstacles that patients may come across to ensure they fully support the independent application of the task. Tasks should also be broken down effectively so they are manageable and accessible for the patients.

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| Item Rater Questions |
| * Were between-session task obstacles discussed? * Did the facilitators effectively break down the tasks so they are manageable? * Were they presented in a clear manner? * Is there a clear rationale discussed? |

**Between-session Work Guidance Scale**

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| Rating | Descriptor |
| 0 | No evidence of between-session tasks being set and/or being explored. |
| 1 | Inappropriate setting up of and/or discussion of between-session tasks. Possible lack of rationale and lack of clear explanation. |
| 2 | Attempts made to appropriately set up homework task, but inappropriate elements. Some evidence of exploring a rationale may be problems with this. |
| 3 | Competent setting up of and/or discussion regarding between-session tasks. Elements of competent delivery with regards to task rationale, explanation, obstacles and session link. However, problems/inconsistencies evident. |
| 4 | Good setting up of and/or discussion regarding between-session tasks. As above, but with good features and minor problems/inconsistencies. |
| 5 | Very good setting up of and/or discussion of between-session tasks. Evidence of exploration of task rationale, a clear/engaging explanation around its application and obstacles. Minimal problems evident. |
| 6 | As above, but an excellent performance and no problems/inconsistencies evident throughout. May have been delivered even in the face of patient difficulties. |