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This file is a **sample synopsis for study reference** for MPCE-016 (Clinical Psychology), the project course of the IGNOU MA in Psychology (MAPC). It shows how a synopsis on the topic "Experiential Avoidance and Psychological Distress among Family Caregivers of Persons with Schizophrenia in [City]" can be laid out in the order that section 5.1 of the Handbook on Project for MPCE-016/026/036 (Discipline of Psychology, SOSS, November 2018 revision) asks for.

How it was made

The ignouproject.com editorial desk prepared this sample with AI assistance in November 2026. The structure follows section 5.1 of the Handbook, read in November 2026. Every reference was checked against its publisher or indexing record in November 2026. It is published under the editorial responsibility of BK Sahni, Shri Chakradhar Publication Pvt. Ltd. ignouproject.com is an independent service and is not affiliated with IGNOU.

How to use it

- Read it to see the shape of each part. Do not submit it, copy it or change a few words and submit it. The Handbook says the same of its own printed sample synopsis: it is not to be copied.
- Every item in [square brackets] is for your own facts: your name and enrolment details, your city and setting, your sample size, the studies you have read yourself, and the values you take from the test manuals you hold.
- Agree the topic, the sample and the tools with your guide before you write. Your synopsis must be your own work.
- Your real synopsis is typed on A4 in Times New Roman 12 with 1.5 spacing and can run to 15 to 20 pages (section 5.1). This sample is shorter because the literature review, the place and the figures are left for you.
- Submit it at your Regional Centre in your batch window with the papers section 5.2 lists, in this order: Appendix I proforma (with MPCE-016 written clearly in the course code box), Appendix II, Appendix III, Appendix IV consent letter, Appendix V bio-data if your guide is an other expert, a self-attested grade card copy showing MPC-005 and MPC-006, and the synopsis.
- Do not begin data collection until the synopsis is approved.

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SYNOPSIS

Experiential Avoidance and Psychological Distress among Family Caregivers of Persons with Schizophrenia in [City]

Master of Arts (Psychology), MAPC

MPCE-016: Project in Clinical Psychology

Name of the learner	[Your full name]
Enrolment number	[Your enrolment number]
Course code	MPCE-016, Project in Clinical Psychology
Study centre	[Name and code]
Regional centre	[Your Regional Centre]
Year	[Year of submission]
Name of the guide	[Guide's name, designation and institution]

Title page fields from section 5.1 of the Handbook on Project; the course code line is our addition, so the code you write on Appendix I is visible here too.

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1. Introduction

Schizophrenia is a long-term psychiatric illness, and in India much of the daily care of a person living with it is given by the family at home. A parent, spouse or sibling who carries this role often handles medication routines, relapse warning signs, hospital visits and the social cost of the illness at the same time. The emotional load of this role is described in the literature as caregiver burden, and it is commonly accompanied by symptoms of depression, anxiety and stress.

The present study looks at one psychological process that may explain why some caregivers are more distressed than others in similar situations: **experiential avoidance**. Hayes and colleagues (1996) described experiential avoidance as an unwillingness to remain in contact with unpleasant private experiences, such as thoughts, feelings, memories and bodily sensations, together with attempts to change their form or frequency. In later work the same process is described in its opposite form as psychological flexibility (Bond et al., 2011).

The two variables of the study are experiential avoidance, measured as a continuous score, and psychological distress, measured as continuous scores of depression, anxiety and stress. The study is placed in clinical psychology because it concerns the mental health of people who live alongside a severe mental illness, and because its findings bear on family interventions taught in the Clinical Psychology courses of the programme (MPCE-011 to MPCE-013).

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2. Review of Literature

Awad and Voruganti (2008) reviewed the burden that schizophrenia places on family caregivers and described it across emotional, practical and financial areas. In India, Aggarwal, Avasthi, Kumar and Grover (2011) studied the experience of caregiving in schizophrenia in a hospital sample, which shows that the question can be studied with Indian caregivers in an outpatient setting.

Kashdan, Barrios, Forsyth and Steger (2006) examined experiential avoidance as a generalised psychological vulnerability and compared it with coping and emotion-regulation strategies. Bond and colleagues (2011) developed the Acceptance and Action Questionnaire II and reported its psychometric properties across 2,816 participants in six samples, which made a short and standardised measure of the construct available.

Among families of persons with psychosis, Jansen and colleagues (2017) found that psychological flexibility was a significant predictor of caregiver distress after caregiver socio-demographic factors, the service user's symptoms, drug use and global functioning

were controlled; greater flexibility went with lower distress. More recently, Chakraborty, Mitra and Ray (2024) developed a present-moment awareness guided psychoeducation and tried it in a pilot study with five family caregivers of persons with remitted schizophrenia, drawing on the same acceptance-based model.

[Add here, in flowing paragraphs and not in bullets, the further studies you have read yourself, especially recent Indian studies of the last ten years. For each, give the author, year, objectives, sample, tools and findings, as section 5.1 asks, and end by stating the gap your study addresses.]

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3. Rationale of the Study

Most caregiver research describes how heavy the burden is. Fewer studies ask which psychological processes in the caregiver are linked with higher distress and could be changed through intervention. Experiential avoidance is such a process: it is measurable, it can be addressed through acceptance-based approaches, and it has been examined far less often in Indian caregivers of persons with schizophrenia than burden itself. A relationship study between experiential avoidance and distress in [City] would show whether this process deserves a place in family work at [type of setting, for example the psychiatry outpatient department of a general hospital].

The study collects primary data on two continuous psychological constructs. It does not estimate how common distress is, and it does not compare caregivers by gender alone, both of which section 5.1 of the Handbook excludes.

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4. Methodology

4.1 Research problem

Is experiential avoidance related to psychological distress among family caregivers of persons with schizophrenia in [City]?

4.2 Objectives

- To study the relationship between experiential avoidance and psychological distress among family caregivers of persons with schizophrenia.
- To study the relationship of experiential avoidance with each of depression, anxiety and stress.
- To examine whether experiential avoidance predicts psychological distress in these caregivers.

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4.3 Hypotheses (null form)

- H01: There is no significant relationship between experiential avoidance and psychological distress among family caregivers of persons with schizophrenia.
- H02: There is no significant relationship between experiential avoidance and each of depression, anxiety and stress among these caregivers.
- H03: Experiential avoidance does not significantly predict psychological distress among these caregivers.

Section 5.1 asks for either null or alternative hypotheses, not both. This sample uses the null form.

4.4 Operational definitions

- Experiential avoidance: the total score on the Acceptance and Action Questionnaire II (Bond et al., 2011); a higher score shows more experiential avoidance.
- Psychological distress: the total and subscale scores on the Depression Anxiety Stress Scales, 21-item version (Lovibond & Lovibond, 1995), scored as the manual directs.
- Family caregiver: [your definition, for example the family member who lives with the person and has given most of the daily care for at least six months].

4.5 Sample

[N, decided with your guide; state how you arrived at it] family caregivers of persons diagnosed with schizophrenia by the treating team, selected by purposive sampling at [name the hospital or clinic and the city]. Inclusion: aged [age range]; living with the person; giving care for at least [period]; able to read the language of the tool version used. Exclusion: [for example caregivers who report receiving treatment for a mental illness themselves]. Background details (age, relationship to the person, duration of care, family type) are recorded on a demographic sheet and used only to describe the sample.

4.6 Research design

A correlational research design with a single measurement point.

4.7 Tools for data collection

- Acceptance and Action Questionnaire II (AAQ-II; Bond et al., 2011): seven items rated on a seven-point scale from 1 (never true) to 7 (always true); one factor; higher scores show greater experiential avoidance. [Add the reliability and validity figures from Bond et al. (2011), and the source of any translated version you use.]
- Depression Anxiety Stress Scales, 21-item version (DASS-21; Lovibond & Lovibond, 1995): 21 items in three subscales of seven items each (depression, anxiety, stress), rated from 0 to 3 for the past week. Henry and Crawford (2005) reported its construct validity and norms in a large non-clinical sample. [Add the reliability, validity and norm details you will report.]

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- Demographic sheet prepared for this study.

4.8 Procedure and ethics

Permission is sought from [the head of the department or the hospital authority] with the Appendix VII reference letter, and from the institutional ethics committee where the hospital requires it. Each caregiver is told the purpose of the study, gives written informed consent and may withdraw at any time. No patient record is consulted. Responses are anonymous and stored securely. A caregiver whose scores suggest marked distress is given [the contact of the hospital's psychology service or a helpline], as agreed with the department. Every visit is logged on the Appendix VIII sheet.

4.9 Data analysis

Descriptive statistics for every variable; a check of normality [for example the Shapiro-Wilk test]; Pearson's product moment correlation for H01 and H02 (Spearman's rank correlation if the data are not normal); simple linear regression for H03. Analysis in [software]. The level of significance is [0.05].

4.10 Expected chapter plan of the dissertation

Introduction; Review of Literature; Rationale of the Study; Methodology; Results and Discussion; Conclusion and Implications; Delimitations, Limitations and Future Suggestions; References; Appendices (section 7.0 order).

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[Add every study you cite in your own review, in APA style and in alphabetical order.]

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