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**Coping with criticism and praise; the emotional well-being of people  
with intellectual disabilities**

**Major Research Project & Clinical Research Portfolio**

**PART 1**

**(Part 2 bound separately)**

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**UNIVERSITY  
of  
GLASGOW**

**Submitted in part fulfilment of the requirements for the Degree of Doctor of  
Clinical Psychology**

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## **CHAPTER ONE**

### **Systematic Literature Review**

#### **The role of the social comparison process in psychological well- being of people with intellectual disabilities**

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## **Abstract**

**Background:** People with intellectual disabilities can often be subject to negative experiences such as bullying, discrimination and stigma. These experiences may impact on the beliefs they develop about themselves and the way in which they compare themselves to other people. Social comparison is the psychological process by which we evaluate ourselves in relation to others. In the general adult population, making negative comparisons with others has been associated with psychological difficulties. However, it also appears that social comparison can be used to protect self-esteem. This review draws together the literature surrounding the social comparison process in the psychological well-being of people with intellectual disabilities.

**Method:** Published studies were identified by conducting an electronic search of four databases, together with hand searches of key journals and reference lists. This identified six studies for review. Studies were rated for methodological quality using a structured quality rating scale.

**Results:** The studies reviewed investigated three psychological constructs related to psychological well-being; self-esteem, mood and self-worth. The different methods of investigation make it difficult to draw definitive conclusions. However, all the studies demonstrated an association between negative social comparison and negative psychological well-being. The person chosen for comparison, the impact of stigma and the dimensions used for comparison are important to this relationship.

**Conclusions:** It appears that social comparison has an important role in the psychological well-being of people with intellectual disabilities. This review highlights the complexities of measuring social comparison in this group and the need for further research.

**Keywords:** Intellectual disability, social comparison, psychological well-being, mental health

## **Introduction**

Being subjected to discrimination, bullying, and stigma can be a common experience for people with intellectual disabilities (Cooney et al, 2006). It has been suggested that this groups' devalued status within society and life experiences, may impact on the beliefs that they develop about themselves (Jahoda et al, 2009). Within the general adult population, negative self-beliefs are known to lead to vulnerability to psychological distress and have been implicated in various mental health difficulties including depression (Beck et al, 1979) and anxiety disorders (Clark & Wells, 1995).

The way in which negative life experiences influence the self-perceptions of people with intellectual disabilities is under investigation and the literature is currently developing. One strand of this literature adopts a symbolic interactionism perspective (Jahoda et al, 2009). The theory, originally developed by Mead (1934), emphasises the importance of social interaction with significant others in the development of beliefs about the self; we internalise a view of ourselves based on the way we are treated by other people. Therefore, being treated differently and negatively may lead to the development of self-beliefs of a similar nature. However, this relationship is not deterministic or straightforward. The meaning ascribed to events and the mechanisms that people use to cope with social difficulties can help protect the self-concept. Jahoda & Markova (2004) investigated perceptions of stigma in people with intellectual disabilities who were leaving long-term hospital care and the family home. In this study, the participants rejected a stigmatised self-image. The participants were aware that being treated in a stigmatised way was unfair and unjust, thereby helping them to reject a stigmatised identity. Beart et al (2005) reviewed the literature on identity in people with intellectual disabilities and concluded that a stigmatised social identity is not one that is generally endorsed by this group. Therefore, the way in which social interactions

and social experiences influence self-perceptions requires investigation. Other mechanisms which may have a role in protecting and maintaining a positive self- image require investigation; social comparison is one such process.

Social comparison is the process by which we evaluate ourselves in relation to others (Festinger, 1954). It is an active process in which an individual attempts to establish a relative sense of self in the world. Downward (positive) social comparison occurs when one evaluates oneself to be superior or on par with others. In upward (negative) social comparison, others are regarded as superior on valued dimensions of the self. Social comparison can be concerned with estimates of relative social rank (inferior-superior, weaker-stronger), and similarity-difference (Gilbert, Price & Allan, 1995). The evaluation of the self in relation to others can therefore be used to enhance ones self-concept and to make decisions on whether to challenge or submit in conflict situations. Social comparison is an active process as people have choices as to who they compare themselves with and on what dimensions. Positive social comparison can be associated with positive mental health whereas making negative comparisons can be associated with psychological difficulties and low self-esteem (Allan & Gilbert, 1995).

Although people have been shown to evaluate themselves in relation to others, social comparison can have negative implications for self-esteem and psychological well-being. White et al (2006) suggested that people who are uncertain of their self-worth and who do not have clear internal standards, are more likely to engage in social comparison to reduce uncertainty about their abilities, performance or other attributes. However, these people may be more vulnerable to the affective consequences of their comparisons and consequently this may affect their well-being (White et al, 2006). Allan & Gilbert (1995) developed a scale to measure social comparison using dimensions of social attractiveness, rank/ social status and group belonging. These authors used the Symptom Checklist- 90 Revised (SCL-90; Derogatis, 1983), which

assesses a broad range of psychological problems including depression and anxiety, to investigate the relationship between psychopathology and social comparison. The study used a student and a clinical sample. In the student sample all three dimensions of comparison (social attractiveness, rank/ social status and group belonging) were significantly correlated with measures of psychopathology. In the clinical group, social comparisons concerning rank and social attractiveness were more important than group membership. This study demonstrates that social comparison is associated with psychological well-being. However, the different dimensions appear to have a different salience for clinical and non-clinical groups.

It is pertinent to investigate the relevance of social comparison processes to people with intellectual disabilities given their devalued social status, experience of discrimination and the impact of their cognitive limitations. It may be that people with intellectual disabilities are more susceptible to making negative social comparisons as they may have fewer protective factors and less opportunity for downward comparisons (Jahoda et al, 2006). For example, in the general adult population having a limited range of roles in life and a limited range of social valued attributes, can make the impact of negative social comparisons more damaging (Swallow & Kuiper, 1988). In addition, being treated in a discriminatory or negative way may lead people to believe that they are inferior to others which may predispose them to make negative comparisons with others. This may also be associated with depressive ideation, as negative beliefs about the self are known to provide such vulnerability in the general adult population (Beck et al, 1979). However, there is also the suggestion that people with intellectual disabilities can use the social comparison process in an active way to protect their self-concept. Gibbons (1985) demonstrated that people with intellectual disabilities engage in downward social comparison with others they perceive as worse off than themselves, to protect their own self-concept. The use of social comparison for self-enhancement in

people with intellectual disabilities has been shown by Finlay & Lyons (2000). These authors found that people with intellectual disabilities can use a range of strategies such as emphasising similarities with people who did not have intellectual disabilities in order to protect their self-concept.

As yet there has been no attempt to draw together the literature surrounding the role of the social comparison process in the psychological well-being of people with intellectual disabilities. Therefore, it remains unclear how the social comparison process is utilised in this group, and whether it can be used protectively or is associated with psychological distress and poor psychological well-being. This systematic review will examine the way in which people with intellectual disabilities view themselves in relation to others and the impact of this on psychological well-being. It will look at the potential relationship between these two variables, in young people and adults with intellectual disabilities, and will also consider the direction of any relationship.

### **Review questions**

The question that will be addressed in this review is:

- Is there an association between social comparison and psychological well-being in young people and adults with learning disabilities?

The review will also consider the following sub questions:

- Is negative social comparison linked to poor psychological well-being?
- Is positive social comparison linked to enhanced psychological well-being?

## Search strategy

Publications from peer reviewed journals were identified using the following methods:

### Electronic search

The following electronic databases were searched: MEDLINE including MEDLINE in process (1950-22<sup>nd</sup> Oct 2010), EMBASE (1980-2010 week 41), PsycInfo (1967-Oct week 3 2010), Cochrane Library (1980- October 2010).

The following terms were matched onto Medical subheadings (MeSH) and combined for the electronic search: 'Social comparison' and 'Well being' and 'Learning Disability'. The following additional terms were also combined using a keyword search to ensure a thorough search of the literature:

(social adj2 comparison) *or* ((self or social) adj2 evaluati\*) *or* (self adj2 esteem)

*and*

(Well\* adj2 being) *or* (Psycholog\* adj2 (well\* or health or prob\* or difficult\* or distress)) *or* (Emotion\* adj2 (well\* or health or prob\* or difficult\* or distress )) *or* (Mental adj2 (well\* or health or prob\* or difficult\* or distress)) *or* depress\* *or* distress\* *or* vulnerab\*

*and*

(Learn\* adj2 disab\*) *or* (Mental\* adj2 (retard\* or disab\* or handi\* or defic\* or incap\*)) *or* (Intellect\* adj2 (disab\* or impair\* or handi\*)).

## **Hand search of key journals and relevant articles**

The contents pages of the following journals were hand- searched for relevant articles: Journal of Learning Disabilities (1997-2010), British Journal of Developmental Disabilities (1993-2010), Journal of Intellectual Disability Research (1996-2010), Journal of Applied Research in Intellectual Disabilities (2001-2010), American Journal on Mental Retardation/ American Journal on Intellectual and Developmental Disabilities (1997-2010), Mental Retardation/ Intellectual and Developmental Disabilities (2000-2010).

In addition, reference lists from relevant articles were checked and any relevant articles sourced.

## **Inclusion and exclusion criteria**

Studies were included if they investigated social comparison in people with intellectual disabilities. The studies chosen included people from adolescence (12 years plus) to adulthood. Studies utilising a quantitative methodology and which were published after 1980 were included. Those utilising qualitative methodologies and case studies were excluded. In addition, the review excluded studies with samples that did not have an intellectual disability, studies printed in languages other than English, book chapters, dissertations, conference presentations and unpublished manuscripts.

## **Article selection and results**

In the first instance article titles were read for relevance to the review topic. The abstracts of potentially relevant references were then selected and examined for relevance and the inclusion/ exclusion criteria applied. The full text was obtained for

articles deemed suitable and relevant. If it was unclear whether an article was relevant or suitable, the full text was obtained to ascertain its inclusion into the review. Following the initial title search, 113 abstracts were obtained and examined for relevance. This allowed 99 abstracts to be discarded. Of the remaining 14 abstracts, seven were duplicates and four did not meet the inclusion/ exclusion criteria. Therefore, the electronic search yielded three studies, for which full text articles were obtained. The hand search of reference lists and relevant journals yielded a total of seven potential articles, however, four were later excluded as they were deemed unsuitable in terms of design and relevance to the review question. Therefore, a total of six studies were selected for inclusion in the systematic review. A flowchart detailing the process of article selection is provided in Appendix B.

Table 1 details the electronic search and reasons for exclusion.

Table 1

*Electronic search and reasons for exclusion from review*

Database	Dates searched	Initial number obtained	Number excluded	Initial search using article title	Secondary search after obtaining abstracts		
				Reasons for exclusion	Number excluded	Reasons for exclusion	Full text articles to obtain
<b>MEDLINE (inc in process)</b>	1950-22/10/10	1128	1089 (kept 39)	Did not meet inclusion criteria = Not relevant = 773	36	Not relevant = 36	3
<b>EMBASE</b>	1980-2010 week 41	1495	1454 (kept 41)	Did not meet inclusion criteria= 436 Not relevant = 1081	37	Not relevant = 37	4
<b>PsycInfo</b>	1967- Oct week 3 2010	261	228 (kept 33)	Did not meet inclusion criteria= 22 Not relevant = 206	26	Did not meet inclusion criteria= 4 Not relevant = 22	7
<b>Cochrane</b>	1980- Oct 2010	46	46 (kept 0)	Not relevant = 46			0

## **Article quality and rating criteria**

This systematic review utilises a ratings scale developed specifically for this review. Established quality criteria such as the Consolidated Standards of Reporting Trials guidelines (CONSORT; Altman et al, 2001) are devised for controlled outcome studies and are therefore not appropriate for use in this review. However, existing and established guidelines such as those published by the Scottish Intercollegiate Guidelines Network (SIGN, 2008) were considered when developing the ratings scale and quality criteria. The use of a robust design was considered the most important factor in terms of the quality of the study. In this review, the measurement of the key variables (social comparison and psychological well-being) was also crucial to the quality of the study. Overall, each study was assessed on eight criteria relating to the design and method. Study design was assessed on a five point rating system (0-4), with higher scores reflecting greater quality and a more robust design. The other quality criteria, with the exception of the study question, are evaluated using a four point scale (0-3). The quality rating scale is shown in Appendix C.

In addition to the numerical scores, the studies had to meet particular criteria to be categorised as either 'excellent', 'good', 'adequate' or 'poor'. This system was chosen in order that the higher quality papers were accurately identified. It acknowledges both the key aspects of study design and measurement of the key variables as well as the overall methodological strengths of the research. Studies rated 'poor' were excluded from the review. A full description of the requirements for each category is included in Table 2.

Table 2

*Quality rating scale categories*

<b>Rating</b>	<b>Essential criteria</b>	<b>Score (maximum 24)</b>
Excellent	<ul style="list-style-type: none"> <li>• Longitudinal design</li> <li>• Key measures standardised for use with an ID population</li> <li>• Standardised assessment of IQ</li> <li>• At least one point on all other categories</li> </ul>	Minimum score 17
Good	<ul style="list-style-type: none"> <li>• Cross sectional design with a control group</li> <li>• Key measures standardised or adapted for an ID population</li> <li>• Standardised assessment of IQ or measure of adaptive functioning</li> <li>• At least one point on all other categories</li> </ul>	Minimum score 11
Adequate	<ul style="list-style-type: none"> <li>• Cross sectional design</li> <li>• At least one point on all other categories</li> </ul>	Minimum score 8
Poor	<ul style="list-style-type: none"> <li>• Failure to meet adequate rating</li> </ul>	Minimum score 0

**Data extraction**

Following completion of the electronic and hand searches and application of the inclusion/ exclusion criteria, six studies were identified for inclusion in the review. The papers were reviewed twice, firstly by the first author and subsequently by a second independent rater (another trainee Clinical Psychologist) to ensure reliability of the quality ratings. A Kappa statistic of 0.95 showed good inter-rater agreement. Appendix D shows the ratings given to the reviewed studies following application of the quality criteria.

The data extraction tables (tables 3, 4 & 5) provide details of the included studies, and their quality rating. The tables are arranged according to the variable of psychological well-being which they measure and can be referred to for information on study design, sample characteristics and measures.

The main findings and conclusions from each paper are in the results section below.

## **Results**

Six studies have been reviewed that consider the association between social comparison and the psychological well-being of people with intellectual disabilities. The categorical ratings of the reviewed studies resulted in five papers being rated as 'adequate' and one paper achieving a 'good' rating.

As the studies reviewed have focused on different constructs (e.g. self-esteem, mood, self-worth) to explore psychological well-being, the results relating to each of these constructs will be discussed separately. One study (Dagnan & Sandhu, 1999) is discussed in two sections. The methodological strengths and weaknesses of the studies will also be considered. Finally, the conclusions will be considered in relation to the review questions.

### **Measurement of social comparison**

Two different methods to investigate and measure social comparison in people with intellectual disabilities were used in the studies. Two studies by the same author (Szivos, 1991; Szivos- Bach, 1993) asked participants to complete the measure of well-being for someone else (or multiple other people), in addition to rating themselves.

Crabtree & Rutland (2001) used a similar methodology although each participant compared themselves to only one other person. The discrepancy between the scores for self and other(s) provides an idea of how the participants view themselves in relation to another person and, as such, has been used as a measure of social comparison. The remaining studies (Dagnan & Sandhu, 1999; Dagnan & Waring, 2004; MacMahon & Jahoda, 2008) utilised the Adapted Social Comparison Scale (ASCS; Dagnan & Sandhu, 1999); which was adapted from the Social Comparison Scale (Allan & Gilbert, 1995) developed for the general adult population. The ASCS has six items which make up three dimensions of comparison; rank/ achievement, social attractiveness and group belonging.

### **Measurement of psychological well-being**

**Self- esteem.** Self- esteem has been studied in relation to social comparison in three studies. Details of these studies can be found in Table 3. Research undertaken by Szivos (1991) and Szivos- Bach (1993) both considered the role of social comparison in the self- esteem of young people with mild to moderate intellectual disabilities. Both studies utilised the same participants and methodology and both received an ‘adequate’ rating. The 1991 study considered the social comparison process within the family environment, whereas the 1993 study investigated the comparison made between four figures both within and outwith the family. Self-esteem was measured in a scale developed for the study titled ‘the social comparison scale’. The scale used items from previously published self-esteem scales, and covered three dimensions considered important to self-esteem: i) power and significance, ii) virtues and values, and iii) competence. These studies also used a measure titled ‘the stigma scale’, which included items such as *‘I wish I were someone different’*, *‘in groups I feel the odd one out’* and *‘I worry what other people think of me’*. Social comparison was measured by asking the

participants to answer the self-esteem questions based on how they view themselves and also how they viewed their favourite sibling (Szivos, 1991). In the subsequent study, the participants compared themselves to i) their best friend in the class, ii) their sibling, iii) a specific non-disabled person not in their class, and iv) their ideal self.

The 1991 study found that participants saw themselves as similar to their siblings. However, there was a tendency for the participants to perceive themselves as inferior to an older sibling of the same sex but superior to a younger sibling of the opposite sex. The results also indicated a relationship between stigma and self-esteem and between feeling stigmatised and seeing oneself as inferior to their siblings.

Factor analysis of the social comparison scale and the stigma scale identified five factors: positive self (e.g. 'I have good ideas', 'I am happy'), social competence (e.g. 'I am helpful' and 'I am good at making friends'), being different (e.g. 'I wish I was different', 'my family are disappointed in me'), anxiety (e.g. 'I worry what people think of me'), and work competence (e.g. 'I am good at work'). The factor analysis showed that factors 1, 2 and 3 were not related to the comparisons that participants made with a sibling. However, anxiety (factor 4) was related to the comparisons that the participants made. Participants who were most anxious compared themselves more negatively to their siblings. There was also an effect of age and gender. The participants who compared themselves to a younger, same-sex sibling were more likely to compare themselves negatively and had higher levels of anxiety.

The author of this study proposes that comparing oneself to an older sibling enhances self-esteem. It is suggested that it is acceptable to compare oneself to an older sibling who may provide protection, advice and a role model whereas it may be functional/ protective to self-esteem to derogate a younger sibling who may have already have overtaken him or her in terms of developmental and social milestones.

Szivos (1993) found that participants saw themselves as similar to both friends and siblings. The results suggest that perceiving friends as similar to themselves may enhance their own self-concept. There was also evidence of a slight tendency for downward comparison with this group. However, the participants tended to see a non-disabled peer as superior to them. The perception of stigma, and a stigmatised self-image, was related to self-esteem. The students with the greatest awareness of stigma had the lowest self-esteem and felt the most different from others and their siblings (but not their friends). Those with the highest self-esteem and highest ideals showed the least awareness of stigma. The comparison target was important in the way that people compared themselves to others and their self-esteem. This study highlights the complexity of the social comparison process, as it was suggested that downward comparison may not only be implicated with enhanced self-concept, but may also have a negative effect on self-esteem. The study results suggest that participants with the lowest self-esteem found having a friend with a learning disability a source of shame and embarrassment, therefore it may be that comparing oneself to a friend viewed in this way could help to maintain low self-esteem.

Dagnan & Sandhu (1999) furthered the investigation of self-esteem and social comparison. This was the first study of social comparison to use scales for social comparison, depression and self-esteem that were developed for the general adult population, and adapted for people with intellectual disabilities (see Table 3 for details of the scales utilised). This study received an 'adequate' rating. Although the study used appropriate scales to measure social comparison and psychological well-being, the cross-sectional design did not include a control group. Dagnan & Sandhu (1999) found that depression was significantly negatively correlated with positive self-esteem and social comparison on the group belonging and social attractiveness dimensions of the social comparison scale. Positive self-esteem was positively correlated with

achievement/ rank dimension. The total self-esteem and total ASCS were significant positively correlated.

*Conclusions.* The studies reviewed indicate a relationship between self-esteem and social comparison. An association was found in several studies between positive social comparison and positive self-esteem, and negative social comparison and low self-esteem. It appears that social comparison can be used in complex ways and downward comparison is not only used for self-enhancement but can also have negative implications for self-esteem. There is however evidence that the different dimensions of social comparison have a different impact on self-esteem. Perceiving oneself as having greater status and social position in comparison to others seems to be associated with positive self-esteem. However, the different methods used in the studies makes establishing the relationship and developing conclusions challenging. The studies also highlight that there are various aspects to social comparison which seem to have an impact on the relationship. The source of comparison, in terms of relationship, age and gender, would appear to have an impact on self-esteem and requires to be investigated separately.

The studies suggest that social experience and stigma are factors important to the self-esteem of people with intellectual disabilities and the way in which they compare themselves to others. The internalisation of stigma into one's self-image appears to be detrimental to self-esteem.

Table 3  
*Studies measuring self- esteem in relation to social comparison*

Author, design	Quality rating score & category	Variables considered	Sample	Measures	Main results	Methodological issues
<b>Szivos (1991)</b>  Cross-sectional	<b>11</b>  <b>ADEQUATE</b>	Self- esteem, social comparison (with a sibling) and stigma.	50 adolescents (20 female, 30 males) from four further education courses which were attached to mainstream colleges.  Mean age= 18 years, 3 months	Measure of ID: BPVS (mean 50.96).  Social comparisons test. Devised for the study. Included 12 positive, 12 negative items. Presented visually. Participants were asked answer 'social comparison test' for themselves and their sibling. 3 scores: self-esteem scores, sibling scores, discrepancy scores.  The stigma scale: 10 item scale that was devised for the study. A high score denoted a positive self- image; not feeling stigmatised.	Those who had more experience of stigma had lower self- esteem. A relationship was also found between being stigmatised and considering themselves as inferior to their siblings.  Factor analysis identified 5 factors: positive self, social competence, being different, anxiety, work competence.	<b>Weaknesses</b> Asked to choose the sibling on the basis of liking and similarity- no surprise that there were few differences found between the participants and their siblings.  The use of the BPVS as a measure of intellectual ability.
<b>Szivos-Bach (1993)</b>  Cross-sectional	<b>11</b>  <b>ADEQUATE</b>	Self- esteem, social comparison and stigma.	Same sample as Szivos (1991).	Same measures as Szivos (1991) although procedure was different.  4 comparison figures: their best friend on the course, their sibling, a specific non-handicapped person not on their course, and their ideal self.  Stigma test- 3 factors found: feeling different, anxiety, poor in group concept.	- Non- disabled peer seen as superior to them. - Highest self-esteem & highest ideals- least awareness of stigma. - Perceive friends as similar to themselves- seems to enhance their own self- concept. - Greatest awareness of stigma had the lowest self- esteem and felt the most different from others and their siblings (but not their friends).	<b>Weaknesses</b> Wide variation of scores of BPVS reported (19-92) – throwing doubt on to the validity of this measure.
<b>Dagnan &amp; Sandhu (1999)</b>  Correlational	<b>14</b>  <b>ADEQUATE</b>	Social comparison, depression and self-esteem	The sample were recruited from four adult training centre (n= 43; 18 females, 25 males) Mean age: 35.1 years.	Measure of ID: BPVS  Zung depression Scale Rosenberg self-esteem scale. Social comparison scale.  All scales used a visually represented response format and adapted for PWLD.	-Depression was significantly negatively correlated with positive self- esteem and social comparison on group belonging & social attractiveness dimensions. - Positive self-esteem was positively correlated with achievement/ rank dimension. - Total scores of SE & SCS: significantly positively correlated.	<b>Weaknesses:</b> Small number of participants for factor analysis.  Sampling – adult training centres, Limits generalisation.  Use of BPVS as a measure of intellectual ability

**Mood.** Another construct used to investigate the psychological well-being of people with intellectual disabilities and its association with social comparison is mood or depressive symptomology. Both studies (Dagnan & Sandhu, 1999 and MacMahon & Jahoda, 2008) used similar scales in their studies. Details of these studies can be found in Table 4.

Dagnan & Sandhu (1999) found a significant negative relationship between the total scores of the Zung Depression Scale (Zung, 1965) and the ASCS. The social attractiveness and group belonging dimensions of the ASCS were also negatively related to depression scores. Overall scores and individual dimensions have an association with low mood. Regression analysis showed that the social attractiveness and group belonging dimensions were the only significant independent predictors of depression. Therefore, to perceive oneself as less socially attractive than others and excluded from the group are related to low mood.

MacMahon & Jahoda (2008) recruited a group of participants who had been diagnosed with clinical depression, and a matched comparison group. This paper was rated 'good', which reflects its attention to the appropriate measurement of the constructs and the inclusion of a matched control group. Additional elements to the ASCS were developed for this study to allow participants to choose their own source of comparison. This method allowed the researchers to identify who participants were using as a source of comparison. Participants were also asked about the value that they placed on each comparison. MacMahon & Jahoda also found an overall significant association between depression and negative social comparisons. Depressed participants were more likely to make negative social comparisons than the non-depressed group when comparing themselves to a general other (where a comparison target was not specified). This relationship was also found for an identified target (someone chosen by the participant). However, it was found that participants did not compare themselves

equally across the dimensions. The depressed group made more negative social comparisons on the social attractiveness and the achievement dimensions (when comparing self to a general other). This relationship only held true for the social attractiveness dimension when the identified target scores were examined.

Correlations of the within group scores showed a negative association between depression scores and the rank and achievement dimensions of the ASCS (for general other scores). However, there were no significant correlations with depression scores and ASCS subscales with the identified targets. This study also investigated the importance placed on each comparison made. Depressed individuals rated both positive and negative comparisons of similar importance. However, non-depressed participants had a tendency to rate positive comparisons as more important compared to negative comparisons. Support workers were the most common source of comparison. The authors comment that the comparison target chosen by the participants appeared to reflect their living circumstances rather than representing a strategy for self-enhancement.

The results of MacMahon & Jahoda's study showed that the social comparisons made by people with intellectual disabilities who are depressed differ from those who are not depressed. However, it cannot be determined by the correlational design whether social comparison is implicated in the development of depression or is a symptom of depression.

**Conclusions.** The two studies which use mood as a measure of psychological well-being adopted similar methods. There seemed to be an association between social comparisons and mood, specifically between negative social comparison and low mood. However, this relationship differed depending on the dimension of social comparison investigated. Both studies found that making comparisons on the social attractiveness

dimension was related to depression scores. Therefore, perceiving oneself as less socially able appears to be related to low mood.

It is of interest that the relationship between social comparisons and low mood was no longer significant when participants were able to choose their source of comparison (MacMahon & Jahoda, 2008). This may suggest that the way in which the social comparison process is used may differ with different sources of comparison. Although only investigated by one study, there are suggestions that the source of comparison and the importance placed on comparisons could be important to the relationship with depression.

Table 4  
*Studies measuring mood in relation to social comparison*

Author, design	Quality rating score & category	Variables considered	Sample	Measures	Main results	Methodological issues
<p><b>Dagnan &amp; Sandhu (1999)*</b></p> <p>Cross-sectional</p> <p>Correlational study</p>	<p><b>14</b></p> <p><b>ADEQUATE</b></p>	<p>Social comparison, depression, self-esteem</p>	<p>The sample were recruited from four adult training centre (n= 43;18 females, 25 males)</p> <p>Mean age: 35.1 years.</p>	<p>Measure of ID: BPVS</p> <p>Zung depression Scale</p> <p>Rosenberg self-esteem scale.</p> <p>Social comparison scale.</p> <p>All scales used a visually represented response format and adapted for PWLD</p>	<ul style="list-style-type: none"> <li>- Depression was significantly negatively correlated with positive self-esteem and social comparison on group belonging &amp; social attractiveness dimensions.</li> <li>- Social attractiveness and group belonging dimensions are negatively related to depression.</li> <li>- Total scores of Zung &amp; SCS: Sig negatively correlated.</li> <li>- Regression analysis - social attractiveness and group belonging were the only significant independent predictor of depression.</li> </ul>	<p>Weaknesses</p> <p>Small number of participants for factor analysis.</p> <p>Sampling – adult training centres, Limits generalisation.</p> <p>Use of the BPVS as a measure of intellectual ability</p>
<p><b>MacMahon &amp; Jahoda (2008)</b></p> <p>Cross-sectional</p> <p>Between groups design</p>	<p><b>19</b></p> <p><b>GOOD</b></p>	<p>Social comparison in depressed and non-depressed individuals</p>	<p>Total participants = 36 (20 males, 16 females)</p> <p>Depressed group identified by specialist mental health services (mean age= 43.72 yrs)</p> <p>The non-depressed group -recruited through day centres (mean age=36.61 yrs).</p>	<p>Measure of ID: WASI</p> <p>Depression - diagnosed using the PAS-ADD or DC-LD criteria.</p> <ul style="list-style-type: none"> <li>- Glasgow depression scale for people with learning disabilities (GDS-LD)</li> <li>- Zung depression scale</li> <li>- Rosenberg self-esteem scale</li> <li>- Adapted social comparison scale- further adaptations made for this study.</li> </ul> <p>- All measures are adapted for people with intellectual disabilities and have a visually represented response format.</p>	<ul style="list-style-type: none"> <li>- A significant association between depression and negative social comparisons.</li> <li>- The depressed group made more negative social comparisons the social attractiveness and the achievement dimensions.</li> <li>- A negative correlation was found between higher scores on GDS-LD and with the rank &amp; achievement dimension of the SCS.</li> <li>- No significant correlations with the GDS-LD and SCS subscales with the identified targets.</li> </ul>	<p>Weaknesses</p> <p>Issues with reliability of the identified target for social comparison scale.</p> <p>Difficulty matching the samples in terms of IQ &amp; age. Although no reason to think that these would be co-variates.</p> <p>Comments on the ecological validity in terms of the salience of comparisons.</p>

\* Dagnan & Sandhu (1999) is included in two sections of the review and in two tables. The results reported in each section examine different constructs.

**Self-worth/ belief.** The measurement of self-worth or self-belief is another construct investigators have used to study the relationship between social comparison and psychological well-being. Table 5 shows details of the studies examining self-worth and self-belief.

Crabtree & Rutland (2001; study 2) used the Self-Perception Profile for Children (SPPC; Harter, 1985) in their study of young people (ages 12- 16 years) with intellectual disabilities. This study achieved an 'adequate' rating when reviewed in relation to the quality criteria. The five dimensions of the SPPC (scholastic competence, social acceptance, athletic competence, physical appearance, behavioural conduct) were used to give a measure of global self-worth. All participants completed the SPPC for themselves. Some participants also completed the SPPC for a pupil in their class, a pupil from a mainstream school and a sibling. The discrepancy between the participants' scores and the SPPC scores of another person were used to measure social comparison. The results indicated that social comparison has an important role in the self- evaluations of young people with intellectual disabilities. The source of comparison had a significant effect on the student's perception of their physical appearance and athletic competence. Students' self-evaluations were lower when they were encouraged to compare themselves with an adolescent without an intellectual disability. Sibling social comparison had little effect on the self-evaluations. Therefore, this study highlights the importance of the source of comparison and when forced to compare themselves with a non-disabled peer this had negative implications for their self-worth.

Dagnan & Waring (2004) investigated the relationship between perceived stigma, negative evaluative beliefs and social comparison. This study was rated 'adequate' and gained strength from the scales used to measure the constructs of interest. In this study, the Evaluative Beliefs Scale (Chadwick et al, 1999) was used to

establish how participants view themselves. From a cognitive perspective, evaluative beliefs about the self e.g. 'I am a bad person' are thought to be important in the development of psychological distress. It was hypothesised that perceived stigma and negative evaluations would be associated with negative social comparison. The results indicated that there was an association between increased perception of stigma, negative evaluations and negative social comparison. Therefore, for people with intellectual disabilities negative evaluative beliefs were associated with feeling different; the perception of stigma was internalised. A regression analysis of the data found that evaluative beliefs mediated the predictive strength of stigma on social comparison. Both the self-self (views of the self) and self-other (views of other people) subscales from the Evaluative Beliefs Scale were correlated with the social attractiveness dimension of the ASCS. There was no relationship found with the other ASCS dimensions, suggesting that social attractiveness may be particularly salient. A relationship was also found when the total scores were examined.

***Conclusions.*** As the studies investigating self-beliefs used different methods, comparison between studies is not possible. However, findings suggest that making negative social comparisons can be associated with negative beliefs about oneself. The studies further our understanding of social comparison as a multi-dimensional construct. Key factors include the person used for comparison and the social attractiveness dimension.

This review provides further evidence highlighting the potential importance of social context and impact of stigma in the psychological well-being of people with intellectual disabilities. It may be that experiencing stigma or negative treatment from others can impact on ones sense of self, which in turn affects the social comparisons that they make.

Table 5  
*Studies measuring self- worth in relation to social comparison*

Author, design	Quality rating score & category	Variables considered	Sample	Measures	Main results	Methodological issues
<p><b>Crabtree &amp; Rutland (2001b)</b></p> <p>Between group cross- sectional design</p>	<p><b>8</b></p> <p><b>ADEQUATE</b></p>	<p>Social comparison, perceived self-competence</p>	<p>68 students (24 females, 44 males) with moderate intellectual disabilities recruited from special schools</p> <p>Age range: 12-16 years (mean 13.66).</p>	<p>Measure of ID: no measure complete as part of the study. Identified as moderate ID in terms of their school placement.</p> <p>Self- perception profile for children (SPPC). No reference made to this scale being suitable or adapted for PWID.</p> <p>SPPC rated for a pupil in their class, a pupil from a mainstream school or their brother or sister before rating themselves.</p>	<ul style="list-style-type: none"> <li>- Significant effect for condition.</li> <li>- Condition had a significant effect on the student's perception of their physical appearance, athletic.</li> <li>- Social comparison has an important role in the self- evaluations of adolescents with intellectual disabilities.</li> <li>- Self evaluations were lower when students were encouraged to compare themselves with an adolescent without an ID.</li> </ul>	<p>Weaknesses</p> <p>Recruitment process unclear.</p> <p>No mention of how measures were adapted</p> <p>No mention how randomisation was done.</p> <p>No opportunity for the students to chose a source of comparison- someone who was important to them.</p>
<p><b>Dagnan &amp; Waring (2004)</b></p> <p>Cross- sectional Correlational study</p>	<p><b>14</b></p> <p><b>ADEQUATE</b></p>	<p>Social comparison and evaluative beliefs and perceived stigma.</p>	<p>39 adults with intellectual disabilities recruited from days centres and a supported employment centre.</p> <p>21 males, 18 females</p> <p>Mean age= 38 years (range: 23- 65 years).</p>	<p>Measure of ID: BPVS</p> <p>Adapted social comparison scale. Presented visually.</p> <p>Stigma Scale- as used by Szivos</p> <p>Evaluative beliefs scale- not previously used with PWID. 3 subscales; negative evaluations made of oneself, perceived to be made by others, and the one makes about others. Presented visually for use in this study.</p>	<ul style="list-style-type: none"> <li>- A strong general relationship between perceived stigma and negative evaluative beliefs.</li> <li>- A weaker relationship was found between stigma and social comparison.</li> <li>- Stigma was a significant predictor of social comparison when regressed on its own, but is reduced to non-significant levels when considered alongside evaluative beliefs. Therefore, evaluative beliefs do mediate the predictive strength of stigma on social comparison.</li> </ul>	<p>Weaknesses</p> <p>Lack of control group and sampling may limit generalisations.</p> <p>One time point- correlational</p> <p>Use of BPVS as a measure of intellectual ability</p> <p>Internal reliability of the SCS was low. Comments that scale requires psychometric development.</p>

## **Methodological strengths and weaknesses**

There are a dearth of studies investigating social comparison and psychological well-being in people with intellectual disabilities, with only six studies of reasonable quality within a thirty year period. Moreover, the studies were all conducted at a single time point. The lack of longitudinal studies means that the causality of relationships cannot be established and the conclusions drawn need to reflect these limitations. The literature within the general population also highlights the lack of longitudinal research and the need to determine whether negative social comparison can be implicated as a cause of depression or whether depression leads to negative social comparisons (Thwaites & Dagnan, 2004). There is also a lack of research using a non-disabled control group, which would allow consideration of the differences, or similarities, between people with and without intellectual disabilities in the way in which the social comparison process is related to psychological well-being. Although the findings suggest similarities with the way in which the social comparison process operates in non-disabled people (Allan & Gilbert, 1995), a design with a matched control group would be able to establish this relationship in a more robust way.

The studies included in this review have employed different methods to measure social comparison. The ASCS, used by three of the studies, was adapted from the scale developed for the general population to ensure accessibility for people with intellectual disabilities. However, two recent studies (Dagnan & Waring, 2004; MacMahon & Jahoda, 2008) have commented on difficulties with the reliability of this scale. In addition, the Adapted SCS only consists of six items, of which group belonging is only measured by one item. Three of the studies examined social comparison by asking participants to rate another person for comparison with their self rating. Szivos (1993) reported that participants managed well when asked to discriminate between comparison

figures when rating them. However, it can be argued that asking participants to rate up to four figures may present difficulties. This method may also present further limitations as the participants are directed who to compare themselves to. For example, Szivos (1991) asked participants to choose a sibling to compare themselves to on the basis of liking and similarity. Therefore, it is not surprising that the results showed that the participants perceived themselves as similar to their sibling. Crabtree & Rutland (2001) gave the participants the opportunity to compare themselves with a range of people. However, there was no opportunity for the participants to choose the source of comparison. MacMahon & Jahoda (2008) allowed participants to choose a target for comparison, however, reported poor reliability on the identified target social comparison scale. These authors also commented on the salience of the comparison items to people with intellectual disabilities, and the need for future research to include items personally relevant to the participants. Overall, the manner in which social comparison is measured is inconsistent across studies and the research conducted to date suggests that there are significant challenges in the measurement of this construct in people with intellectual disabilities.

The measurement of psychological well-being also varied across the studies. This is a major challenge for the review process as it is difficult to compare the studies and develop conclusions. Several studies made reference to adaptations being made to ensure the materials could be used effectively by people with intellectual disabilities. However, the Crabtree & Rutland (2001) study made no reference to adapting the materials or whether they had been used with this population previously. In order to critically review the literature, it is important to be aware of these issues. A further issue raised by Dagnan & Sandhu (1999) is that caution is required when considering the relationship between self-esteem and social comparison, as the items used to measure self-esteem can be socially comparative in nature.

The methods employed to measure IQ also varied across studies. Four studies used the British Picture Vocabulary Scale (BPVS) to estimate IQ. As a measure of verbal comprehension, a degree of caution is required when using this as the sole basis to estimate IQ. Several authors have also reported difficulties in using this scale. Szivos-Bach (1993) found a wide variation of IQ scores using the BPVS (19-92) and questioned the validity of its use. MacMahon & Jahoda (2008) were the only study to use the Wechsler Abbreviated Scale of Intelligence (WASI; Wechsler, 1999). Although this measure is only based on two subscales it is likely to provide a more accurate estimate of IQ than the BPVS. Crabtree & Rutland (2001) did not complete any formal measure of IQ, and were not able to access this information from records. Their sample was identified as having a moderate intellectual disability based on their school placement, which is unlikely to be a reliable measure of the participants' level of ability.

Despite these limitations, the literature has developed in complexity over time, taking into consideration previous methodological difficulties and issues. The use of the ASCS in people with intellectual disabilities has become more sophisticated.

### **Overall conclusions**

This systematic review has been limited by a lack of research and differing methodologies in the published studies. The variation in the measurement of psychological well-being and social comparison poses particular difficulties when comparing the studies and drawing conclusions.

However, the studies are generally consistent in their conclusions in that there is an association between social comparison and psychological well-being in people with intellectual disabilities. There appears to be an association which relates negative social

comparison with poor psychological well-being. This relationship holds true when each construct (self-esteem, mood, self-belief) is examined separately. Although examined by fewer studies, this relationship appears to be bi-directional as several studies suggest that positive social comparison is related to enhanced psychological well-being. Ultimately, social comparison does appear to be a psychological process important to the psychological well-being of people with intellectual disabilities.

The literature calls attention to social comparison as a multi-dimensional concept and different aspects of comparison seem more salient than others in the relationship with psychological well-being. The social attractiveness dimension of the Adapted SCS has been found in several studies to have particular salience. Therefore, viewing others as more socially able (friendlier, less shy) is associated with poor psychological well-being. In a study of non-disabled students, Thwaites & Dagnan (2004) found that attributes associated with attracting others such as social skills and physical attractiveness to be particularly important to participants. Consistent with the findings from this review, Thwaites & Dagnan showed that making negative comparisons on these dimensions was associated with higher levels of depression. It would seem that having qualities of a social nature are important for psychological well-being. Findings suggest that the source of comparison is an important consideration, and that being required to undertake negative comparisons is associated with poor psychological well-being. The impact of gender, relationship and age of the comparison figure has been found to influence the way in which people make comparisons and the relationship with psychological well-being.

This review emphasises the role of social experience and stigma in the relationship with social comparison and psychological well-being. Perceptions of stigma appear to have negative implications for psychological well-being. One of the reviewed studies suggests that perception of stigma may have a mediating role in the relationship

between social comparison and psychological well-being, and may be important in the way in which people view themselves. Future investigations of the social comparisons of people with intellectual disabilities would be prudent to consider the role of stigma.

Overall this review has functioned to highlight the complexities, but also some of the difficulties, of measuring social comparison in people with intellectual disabilities. Although conclusions are difficult to draw given the limited research, it raises questions about the measurement of this construct in this population. It remains uncertain whether the existing methods are adequate to capture the process as it occurs in people with intellectual disabilities. It may be more telling to examine the social comparisons in a more ecologically valid way, to determine how the social comparison process operates in real-life contexts rather than be artificially constrained by a questionnaire format. This may further our understanding of who is chosen for comparison, on what dimensions comparisons are made, how frequently and the importance placed on them. Attention to such issues may offer a better insight into the relationship between social comparison and psychological well-being in people with intellectual disabilities.

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## **CHAPTER TWO**

### **Major Research Project**

#### **Coping with criticism and praise; the emotional well-being of people with intellectual disabilities**

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## **Lay summary**

**Background:** Experiencing stigma and negative treatment from other people can be a common experience for people with intellectual disabilities. This may lead them to feel badly or negatively about themselves. In addition, it may make them more sensitive to criticism from others and less likely to believe praise. In people without intellectual disabilities, being distressed by criticism has been associated with a vulnerability to mental health difficulties such as depression. However, it is not known how people with intellectual disabilities feel about and cope with criticism. This study compared the responses of people with and without intellectual disabilities to praise and criticism.

**Method:** The praise and criticism task (PACT) was developed for the study. In the PACT, participants were presented with ten scenes, with accompanying photos, in which they were asked to imagine someone saying something positive (praise) or negative (criticism). Following the presentation of each scene, participants were asked about their emotions, beliefs, thoughts and actions in response to the criticism and praise.

**Results:** People with intellectual disabilities were more likely to believe and be distressed by criticism. However, this group were also more likely to believe and experience positive emotions in response to praise. There were no differences found in the types of coping or thoughts in response to criticism.

**Conclusions:** The results may suggest that people with intellectual disabilities are more prone to believing others' views of them and incorporating this into how they view themselves. This sensitivity could make people more likely to develop mental health difficulties. However, there are also possibilities for positively influencing how people feel about themselves through social support and psychological interventions.

## **Abstract**

**Background:** Through their experiences of stigma and discrimination, people with intellectual disabilities may develop negative beliefs about themselves and compare themselves negatively to others. This may make them more sensitive to criticism from others. In addition, receiving praise may be discrepant with the self-views of people with intellectual disabilities and they may be less likely to benefit from praise. Being distressed by criticism has been associated with vulnerability to mental health difficulties in the general adult population. It is not known how people with intellectual disabilities perceive and experience criticism and praise.

**Method:** Two study groups were recruited; one with intellectual disabilities, one without. The praise and criticism task (PACT) was developed for the study. Participants were presented with ten scenes in which they were asked to imagine someone saying something positive (praise) or negative (criticism). Following the presentation of each scene, participants were asked about their emotions, beliefs, thoughts and actions.

**Results:** People with intellectual disabilities were more likely to believe and be distressed by criticism. Contrary to predictions, this group were also more likely to believe and experience positive affect in response to praise. No differences were found in the frequency of self-supporting thoughts or actions reported in response to criticism.

**Conclusions:** The results may represent a difference in the way people with intellectual disabilities develop their sense of self and may suggest that the self-perceptions of this group are more dynamic and reliant on the views of others. In theory, such sensitivity could make people more vulnerable to mental health difficulties. On the other hand, the possibilities for positive influence have implications for psychological and social interventions.

## **Introduction**

People with intellectual disabilities are more likely to experience negative life events than people without intellectual disabilities, which may contribute to the higher prevalence of mental health problems in this group (Esbenson & Benson, 2006). In particular, negative interpersonal experiences have been found to be more prevalent and cause greater stress than other negative events for people with intellectual disabilities (Bramston, Fogerty & Cummins, 1999; Hartley & McLean, 2005). Therefore, it may be that people with intellectual disabilities are sensitised to and, consequently, vulnerable to the effects of negative interpersonal experiences.

Negative interpersonal experiences such as discrimination and stigmatisation may result in people with intellectual disabilities developing a negative self-view. Dagnan & Waring (2004) found that discriminatory views can be internalised; being treated negatively was associated with a view of oneself as inferior and a view of one's social position as low in comparison to others.

Social comparison is the psychological process by which people evaluate themselves in relation to others (Festinger, 1954), and has been used to examine how people with intellectual disabilities view their relative social position. Negative social comparison has been associated with depression in people with intellectual disabilities (Dagnan & Sandhu, 1999, MacMahon & Jahoda, 2008). Dagnan & Sandhu (1999) suggest that people with intellectual disabilities can recognise and internalise others' negative views of them, and that this may lead to negative social comparisons. Although Dagnan & Sandhu's study included a non-clinical sample, the findings suggest that negative social comparison can be associated with distress in people with intellectual disabilities. In a study with a general adult population, Cheung, Gilbert &

Irons (2004) also found that viewing one's social position negatively can have detrimental effects on well-being and is associated with vulnerability to depression.

Gilbert & Miles (2000) suggest that a negative view of one's social position is a contributory factor in 'sensitivity to social put-down' i.e. being sensitive to criticism from others. Their study found that people who were more distressed by criticism reported higher ratings of depression and were more likely to make negative social comparisons. Attribution style was also an important factor. Those who viewed themselves as inferior to others were more likely to internalise criticism. Therefore, criticism may initially come from external sources but its effects may continue to be evident when it is internalised. Gilbert, Durrant & McEwan (2006) suggest that being sensitive to criticism originates from negative social experiences such as being bullied or subordinated; experiences that are common to people with intellectual disabilities. Although these processes have not yet been studied in people with intellectual disabilities, the implication is that through their negative interpersonal experiences people with intellectual disabilities are likely to be sensitive to and more distressed by criticism from others. Hartley & McLean (2009) found that perceptions of social situations were an important factor in psychological distress in people with intellectual disabilities. In particular, other people behaving unpleasantly, such as someone saying something negative about you to others, produced a high level of stress.

The ability to cope effectively with criticism can ameliorate its impact. To investigate responses to criticism, Whelton and Greenberg (2005) used a procedure where students were video-recorded being critical towards themselves, to which they later had to respond. They described a construct termed 'self-resilience' which they found was important in dealing with criticism. Self-resilient people were more able to recruit positive emotions of praise, confidence and anger (viewed as positive when

faced with criticism) in order to cope with this criticism. These authors suggest that a lack of self-resilience results in vulnerability to distress. It is not clear how greater exposure to criticism impacts on the ability of people with intellectual disabilities to cope when faced with criticism. It may be that through greater exposure to criticism their coping is better developed, thereby reducing distress when encountering criticism. Lunsky & Benson (2001), when investigating perceptions of social support, found that people with intellectual disabilities interpreted social interactions as more supportive and helpful than people without an intellectual disability. The authors suggest that people with intellectual disabilities may have developed a “sense of acceptance” based on their experiences of care and support leading them to respond to salient positive cues and neglect negative cues. Therefore, it is possible that these close relationships provide alternate, positive experiences that play a role in their perceptions of social interactions and positively influence their ability to cope. However, it is currently unclear how people with intellectual disabilities respond to praise and whether praise increases resilience. It is also uncertain whether praise is accepted and internalised by this group.

A failure to internalise praise may affect a person’s ability to defend themselves against criticism by being supportive to themselves. This has been associated with a vulnerability to distress (Whelton and Greenberg, 2005). It is possible that supportive comments or praise may be discrepant with the self-views of people with intellectual disabilities, and therefore may not be accepted or given significance. MacMahon & Jahoda (2008) found that people with intellectual disabilities who were depressed may recognise their strengths, but fail to attach significance to these strengths. This study highlights a possible maintenance factor in depression. However, it is possible that a vulnerability to low mood may be created through a lack of recognition of one’s positive characteristics. Given the current lack of research and difficulties drawing

conclusions from the current literature, it is of interest to study how praise is perceived and experienced by people with intellectual disabilities.

In summary, the literature suggests that negative treatment can lead to the development of negative views of oneself and consequently to negative comparisons of oneself in relation to others. Such views may result in a vulnerability to distress when faced with criticism. Being unable to cope effectively in the face of criticism may create a further vulnerability. Given the negative life experiences of people with intellectual disabilities, the question remains as to whether the coping of this group differs to their non-disabled peers. Therefore, this study aimed to compare the cognitive and emotional responses to criticism and praise in adults with and without intellectual disabilities. Differences between the two groups were anticipated. Due to their cognitive impairments and experience of social stigma, people with intellectual disabilities may be likely to have more experience of criticism than their non-disabled peers. Therefore, it was anticipated that this group would be more sensitive to criticism. The experience of receiving praise is less likely to match the self-views of people with intellectual disabilities, therefore, it was expected that they would be less likely to believe and value praise. This study also aimed to explore the ability of people with and without intellectual disabilities to generate self-supportive responses when faced with criticism, and consider the way in which they deal with criticism.

The following hypotheses were examined:

*Between group hypotheses:*

1. People with intellectual disabilities are more likely to believe criticism and to be distressed in response to criticism than people without intellectual disabilities.
2. People with intellectual disabilities are less likely to believe praise and experience positive affect in response to praise than people without intellectual disabilities.
3. People with intellectual disabilities are less likely to generate self-supportive thoughts in response to criticism than people without intellectual disabilities.

*Within group hypotheses:*

4. People who make negative social comparisons are more likely to experience negative affect when faced with criticism.

## **Methods**

Ethical approval for the study was obtained from The University of Glasgow Medical Faculty Ethics Committee. The ethical approval can be found in Appendix F.

### **Participants**

Twenty five adults with intellectual disabilities and 21 adults without intellectual disabilities were recruited to the study from Further Education colleges. However, six participants were excluded from the analysis. Four participants recruited to the

intellectual disability group were excluded as their WASI IQ scores fell within the low average or average range of cognitive functioning, therefore, it was unclear whether they had an intellectual disability. Another participant was excluded from this group as he struggled to engage with the study materials. One participant in the control group was excluded due to his WASI IQ score being within the borderline range.

Participants who were included in the study all met the following criteria: i) were aged 18-65 years, ii) had the ability to provide informed consent, iii) had sufficient receptive and expressive verbal ability to describe everyday events. Participants were excluded from taking part in the study if they: i) had a severe visual or hearing impairment which would make it difficult to engage with the study materials and/ or ii) had a diagnosis of autistic spectrum disorder as the social deficits associated with this diagnosis would be likely to make the research tasks challenging.

### **Recruitment Procedure**

Participants from both groups were recruited from Further Education colleges in the Glasgow area. Senior staff from interested college departments identified classes of students who had sufficient receptive and expressive language to describe everyday events. To assist with this, the following items from the Adaptive Behaviour Scale (ABS-RC:2) (Nihira, Leland & Lambert, 1993) were used: i) talks to others about sports, family, group activities, ii) sometimes uses complex sentences containing 'because', 'but', iii) answers simple questions such as 'What is your name?' or 'What are you doing?'. The researcher then presented information regarding the study to these classes for 5-10 minutes and provided written information. Students were invited to express

interest in participating in the study by contacting the researcher by reply slip, phone or email.

## **Measures**

The following measures were delivered to each participant in the order presented below:

**1. Background information sheet.** To ensure that the two groups were as closely matched as possible, information was gained from each participant on their: i) age, ii) gender, iii) living situation, iv) employment and v) postcode. Postcode was used to measure socio-economic status using the Carstairs Index (Carstairs & Morris, 1991). The Carstairs Index is composed of four indicators judged to represent material disadvantage in the population: low social class, lack of car ownership, overcrowding and male unemployment. A copy of the background information sheet can be found in Appendix G.

**2. Adapted social comparison scale (ASCS; Dagnan & Sandhu, 1999).** The ASCS was delivered to the participants to examine how they view themselves in relation to others on the domains of rank and achievement, social attractiveness, and perceived group membership. This scale was originally developed for the general adult population (Allen & Gilbert, 1995). Dagnan & Sandhu adapted the scale for people with intellectual disabilities and it has been successfully used in other studies with people with intellectual disabilities (MacMahon & Jahoda, 2008). Participants are presented with an incomplete sentence ('when I'm with other people I generally feel') followed by a series of bipolar constructs (worse than other people/ better than other people, not as good at things/ better at things, less friendly/ more friendly, less shy/ more shy, on your

own/ part of the group and different/ same), which the participants are asked to rate on a five point scale.

Following piloting, the ASCS was changed from a five to a three point scale, in order to make the response format more accessible (worse, the same, better). The final scores allocated were 0 (negative comparison), 2 (lateral comparison), 4 (positive comparison). In addition, a practice question was developed to allow participants to become familiar with the response format before starting the measure proper. The ASCS, practice question and delivery instructions are shown in Appendix H.

**3. Glasgow depression scale for people with a learning disability (GDS-LD; Cuthill, Espie & Cooper, 2003).** The GDS-LD is a 20 item questionnaire used to measure depression in people with intellectual disabilities. This was delivered to the participants to ensure that there were no significant differences in low mood between the two study groups, which could potentially be a confounding factor in terms of response to criticism and praise. The GDS-LD shows a strong correlation ( $r= 0.88$ ) with the Beck Depression Inventory II (BDI- II; Beck et al, 1996), and good test-retest reliability ( $r = 0.97$ ). A copy of the GDS-LD and the delivery instructions are shown in Appendix I.

**4. Praise and criticism task (PACT).** This task was devised for the purposes of this study. An existing body of work has used hypothetical vignettes to investigate the social-cognitive responses of people with intellectual disabilities to threat in interpersonal situations (Pert & Jahoda, 2008). This method was successful in engaging people with intellectual disabilities, and in eliciting their responses to social threat. Therefore, a similar method was considered appropriate in this study to ascertain responses to criticism and praise.

In the PACT, participants were presented with a self-referent scenario in which they were asked to imagine encountering a person who says something positive (praise) or negative (criticism) about them. Each hypothetical scenario was illustrated using three photographs and was presented in a story board format. The narratives were read to the participants by the researcher.

**4.1 Development of the PACT and piloting.** The content of the scenarios required careful consideration as they needed to have resonance in the lives of people both with and without intellectual disabilities.

The authors used the Sensitivity to Social Putdown Scale (SPD scale; Gilbert & Miles, 2000) to help identify the social criticism scenarios to be included in the PACT. The SPD scale is an assessment tool developed for a general adult population, which measures responses to common social criticisms. Additionally, discussion with the research collaborators, who have considerable clinical and research experience with people with intellectual disabilities, allowed twelve scenarios to be developed. Storyboards were developed for each scenario and the scenes were illustrated using photographs taken by the researcher.

These twelve scenarios were then piloted with three individuals (two with an intellectual disability and one without) prior to the main study commencing. The pilot established the following: i) which of the scenarios were salient to both groups, and ii) the benefits of using opened-ended, exploratory questions to assess emotions, thoughts and actions. Two scenarios were excluded as they lacked relevance to both groups. This resulted in ten scenarios deemed suitable for use in the research study, each with a critical and praise ending.

**4.2 PACT Final version.** Two parallel versions of the PACT were developed covering the same five themes: i) performance/ effort, ii) skill/ ability, iii) popularity, iv)

future goals and v) autonomy. The researcher narrated five stories with a criticism ending and five stories with a praise ending to each participant. The order of presentation ensured that the criticism and praise scenarios were delivered alternately. All scenarios and associated photographs can be found in Appendix J.

*Example of a criticism scenario:* “You are at college. You walk past a couple of people talking. You overhear them talking about you. You hear them say “Not many people get on well with her/ him” (*PACT popularity theme*).

*Example of a praise scenario:* “You are at home and (someone relevant to participant’s circumstances) is making dinner. She/ he asks for your help. When the dinner is ready, your (insert person) says “I couldn’t have done it without you. You were a lot of help” (*PACT performance/ effort theme*).

Following the presentation of each scenario participants were asked series of questions to establish their emotions, beliefs, thoughts and actions in response to criticism and praise:

1. Emotional response was ascertained by asking an open-ended question, ‘*How does that make you feel?*’ The degree of emotional response was then determined by asking ‘*Would you feel a wee bit (insert person’s response) or a lot (insert person’s response)?*’
2. Belief was ascertained by referring specifically to the criticism/ praise given in the scenario. For example ‘*Do you try hard enough?*’, ‘*Do you get on well with other people?*’ Degree of belief was established by asking ‘*How much do you think that?*’ (*some of the time/ a lot of the time*).
3. Thoughts were ascertained by asking an open-ended question that linked the emotional response to the scenario. For example ‘*Your tutor says you didn’t try*

*hard enough and you are feeling upset. What are you thinking?’* Participants who were unable to respond to the open-ended question were given a forced choice option: i) *‘They’re right, I can’t/ can do that’* or ii) *‘They’re wrong, I can/ can’t do that’*.

4. Actions in response to criticism were ascertained by asking participants, *‘Is there anything that you could do about this situation?’*. A ‘yes’ answer prompted a further open- ended question, *‘What could you do?’*.

**4.3 Delivery.** The PACT was delivered as a structured interview with the scenarios being presented by the researcher alongside the photographs. The response format was a combination of forced choice responses and open-ended questions, and all questions were asked in a tentative style that encouraged the participants’ intuitive response. Prompting was only done when necessary to ensure that the key information was obtained.

**5. Wechsler Abbreviated Scale of Intelligence (WASI; Psychological Corporation, 1999).** The two subset form of the WASI was delivered to provide an estimate of the participants’ general intellectual ability. Psychometric properties include a high level of internal reliability (0.96- 0.98), adequate test-retest reliability (0.88- 0.92) and good concurrent validity (0.87).

## **Procedure**

Once a participant had expressed interest in the study, an individual meeting with the researcher was arranged and written informed consent was obtained. All meetings took place in a private room at the participant’s college. Consent forms and

information sheets were adapted to be accessible for people with intellectual disabilities (Appendices K, L, M & N). The researcher usually met once with the participants to administer the measures. However, for some participants it was necessary to meet on two occasions. The administration time was approximately sixty minutes.

At the beginning of each meeting, time was spent establishing rapport with the participant and to help them feel at ease. It was made explicit to participants that there were no 'right' or 'wrong' answers to the questions. The WASI was completed at the end of each meeting as it does have 'right' and 'wrong' answers and therefore is contrary to the tone of the research process.

### **Power calculation**

There were no studies that compared the emotional and cognitive responses of people with and without intellectual disabilities to criticism and praise. In terms of the within group analyses, Dagnan & Sandhu (1999) investigated the association between social comparison and distress and found a negative relationship ( $r=-0.50$ ). Based on this previous research, the G Power software (Faul et al, 2007) was used to undertake a power calculation. For a power level of 0.80 at the 5% significance level using a one-tailed correlation, it was calculated that the total sample required would be 42 (21 in each group).

## Results

### Data coding and data analysis

Responses to the PACT were recorded on a response sheet during the interview. Responses were subsequently content analysed, and grouped into categories that characterised the different responses to each of the five open-ended questions. A second independent rater was asked to group the participants' responses into the categories developed for each question. The inter-rater agreement obtained was: i) emotions (criticism) Kappa= 0.97, ii) emotions (praise) Kappa= 0.92, iii) thoughts (criticism) Kappa= 0.91, iv) thoughts (praise) Kappa = 0.90 and iv) actions (criticism) Kappa= 0.93. The data obtained from the PACT was categorical, therefore, chi-square analysis was undertaken to measure group differences. Where the conditions for chi-square were not met, the Fisher's exact test was used.

### Participant socio- demographic data

Table 1 provides a summary of the sample characteristics and descriptive data on the measures administered. Statistical analysis was used to test for any significant differences between the groups. There were no significant differences between the groups on gender ( $X^2(1)= 0.90$ ,  $p= 0.34$ ). Age was not normally distributed, therefore, a Mann Whitney U test was used. The results were non-significant ( $U(38)= 194.5$ ,  $p= 0.52$ ), therefore, the groups did not differ significantly in age. Differences in deprivation category were tested using an Independent samples t-test. The results did not detect any significant differences;  $t(38)= -1.9$ ,  $p= 0.07$ . Chi-square analysis on the living situation data did not detect any group differences ( $X^2(3)= 2.9$ ,  $p= 0.40$ ), however, the employment data did show significant group differences ( $X^2(2)= 6.23$ ,  $p= 0.04$ ), with

more people in the non-intellectual disability group in paid work than in the intellectual disability group. This contrast was not unexpected, and overall the two groups were well matched.

### **Descriptive data from the depression, social comparison and IQ measures**

Both groups had a mean score of 8.5 for the GDS-LD and similar standard deviations (ID group= 5.98, Non-ID group= 6.18). Therefore, the groups did not differ in terms of reported symptoms of depression. The scores for ASCS did not differ between the groups ( $p= 0.775$ ), therefore the social comparisons of the groups did not differ. As expected, the non-intellectual disability group had significantly higher WASI IQ scores;  $t(38)=-13.12$ ,  $p= <0.001$ .

Table 1

*Sample characteristics*

<b>Socio- demographic data</b>		<i>ID group</i>	<i>Non- ID group</i>	<i>P- value</i>
<b>Gender</b>	<i>Male</i>	12	9	0.34
	<i>Female</i>	8	11	
<b>Age</b>	<i>Mean (SD)</i>	28.2 (12.06)	26.75 (13.18)	0.52
	<i>Range</i>	18- 54	18- 63	
<b>Deprivation score</b>	<i>Mean (SD)</i>	5.80 (1.15)	4.95 (1.63)	0.07
	<i>Range</i>	4- 7	2- 7	
<b>Living situation</b>	<i>Lives alone</i>	2	2	0.40
	<i>With family</i>	16	14	
	<i>Partner/ flatmate</i>	1	4	
	<i>Supported accom</i>	1	0	
<b>Employment</b>	<i>Paid</i>	2	9	0.04*
	<i>Voluntary</i>	4	3	
	<i>None</i>	14	8	
<b>Measures completed by participants</b>				
<b>GDS-LD</b>	<i>Mean (SD)</i>	8.5 (5.98)	8.5 (6.18)	1.00
	<i>Range</i>	1-23	0-25	
<b>Adapted SCS- Total score</b>	<i>Mean (SD)</i>	15 (4.38)	14.6 (4.4)	0.775
	<i>Range</i>	4-22	8-22	
<b>Adapted SCS- Rank/ achievement</b>	<i>Mean (SD)</i>	4.1 (2.2)	3.9 (1.5)	0.740
	<i>Range</i>	0-8	2-8	
<b>Adapted SCS – Social attractiveness</b>	<i>Mean (SD)</i>	8.5 (2.04)	8.2 (2.8)	0.702
	<i>Range</i>	4-12	4-12	
<b>Adapted SCS- Group belonging</b>	<i>Mean (SD)</i>	2.4 (1.79)	2.2 (1.58)	0.710
	<i>Range</i>	0-4	0-4	
<b>WASI</b>	<i>Mean (SD)</i>	62.5 (5.88)	101 (12.35)	<0.001*
	<i>Range</i>	55-74	86-133	

\* Significant difference

**Hypothesis 1: People with intellectual disabilities are more likely to believe and be distressed by criticism than people without intellectual disabilities**

Table 2 shows the data for the emotional responses and belief in criticism expressed by both groups.

**Beliefs:** The belief data were collapsed from the original three categories to simply 'yes' and 'no'. This was due to insufficient numbers in some cells to carry out the chi-square analysis with the full range of response options.

Analysis of the total scores showed a significant difference in belief in criticism between the two groups ( $X^2(1) = 3.87, p = 0.049$ ), with people in the intellectual disability group believing criticism more frequently. When the individual themes of criticism were tested, a significant difference was found in the popularity theme ( $X^2(1) = 13.33, p < 0.001$ ), with people in the intellectual disability group believing the criticism more frequently. The other themes showed no significant differences; performance ( $X^2(1) = 1.91, p = 0.168$ ), skill ( $X^2(1) = 1.37, p = 0.243$ ), future plans ( $X^2(1) = 2.24, p = 0.135$ ) and autonomy ( $X^2(1) = 0.40, p = 0.527$ ).

**Emotions:** The data for emotion in response to criticism was coded into two categories; internal negative (sad, depressed, down) and external (angry, annoyed, rejecting). Table 3 gives a definition and example of responses in these categories.

The total scores showed a significant group difference in the emotional response to criticism ( $X^2(1) = 22.33, p = 0.001$ ), with people in the intellectual disability group more frequently reporting an internal negative emotion in response to criticism. Examination of the individual themes of criticism showed significant group differences in the performance ( $X^2(1) = 3.75, p = 0.053$ ), popularity ( $X^2(1) = 5.58, p = 0.02$ ) and autonomy ( $X^2(1) = 8.64, p = 0.003$ ) themes; people with intellectual disabilities reported

more internal negative emotion in these themes. No significant group differences were found in the skill ( $X^2(1)= 3.08$ ,  $p= 0.08$ ) or future plans ( $X^2(1)= 3.31$ ,  $p= 0.069$ ) themes, although trends in the same direction were evident.

Therefore, the hypothesis that people with intellectual disabilities are more likely to believe and be distressed by criticism than people without intellectual disabilities is supported. In particular, people with intellectual disabilities are more likely to believe criticism about popularity than people without intellectual disabilities. This group was also more likely to report an internal negative emotion, such as sadness or upset, in response to criticism in the areas of performance, popularity and autonomy.

Table 2

*Responses when faced with criticism*

<b>Variable</b>	<b>Categorisation</b>	<b>ID group</b>	<b>Non- ID group</b>	<b>P value</b>
<b>Belief</b>	<i>No</i>	60	73	0.049*
	<i>Yes</i>	39	26	
<b>Emotional response</b>	<i>Internal negative</i>	72	39	<0.001*
	<i>External</i>	27	60	
<b>Thoughts</b>	<i>Self-supporting</i>	21	31	0.106
	<i>Other</i>	78	68	
<b>Coping</b>	<i>Active</i>	53	47	0.503
	<i>Passive</i>	37	38	
	<i>Protest</i>	10	15	

\* Significant difference

Table 3: Categorisation of open-ended questions

<b>Criticism</b>			
	<i>Categorisation</i>	<i>Definition</i>	<i>Examples</i>
<b>Emotions</b>	<i>Internal negative</i>	Negative emotion directed internally	Sad, depressed, upset, gutted
	<i>External</i>	Emotion directed externally	Annoyed, angry, not bothered
<b>Thoughts</b>	<i>Self-supporting</i>	Thoughts that are characterised by positive or supportive beliefs about oneself, abilities, skill, performance.	<p>“Was he even reading the right paper? When a task comes, I always put in the effort” (<i>Non-ID group participant, performance category</i>)</p> <p>“I do know my way around. She doesn’t know me well. I’m helpful and would be able to do it” (<i>ID group participant, skill category</i>)</p>
	<i>Other</i>	All other thoughts in response to criticism. These include negative views of one’s self, negative views of the other person and their intentions.	<p>“They don’t like me. I don’t have enough confidence” (<i>ID group participant, popularity category</i>)</p> <p>“I’m not good enough and I can’t do anything right. That just confirms it” (<i>Non-ID participant, future plans category</i>)</p>
<b>Actions</b>	<i>Active</i>	Responses that suggest efforts to change the situation. Including involving the criticiser or others to improve oneself through asking for help, getting other peoples opinions, accepting help.	<p>“Wait til the end of class. Ask what I could do to make myself better and find out where I went wrong”. (<i>Non-ID participant, performance category</i>)</p> <p>“Talk to (<i>tutor</i>). She would talk to the person”. (<i>ID group participant, future plans category</i>)</p>
	<i>Passive/ no response</i>	Responses that indicate a passive response or a choice to carry on regardless of criticism.	<p>“Wouldn’t say anything” (<i>ID group participant, performance category</i>)</p> <p>“Just ignore them. Don’t get involved” (<i>Non-ID group participant, popularity category</i>)</p>
	<i>Protest</i>	Negative response towards the person giving criticism- aggressive, passive aggressive or verbal retaliation.	<p>“Stand up for myself. Tell them I can do it” (<i>ID group participant, future plans category</i>)</p> <p>“Probably start a fight” (<i>Non-ID group participant, performance category</i>)</p>
<b>Praise</b>			
	<i>Categorisation</i>	<i>Definition</i>	<i>Example</i>
<b>Emotions</b>	<i>Positive</i>	Positive emotion	Happy, excited, good, confident
	<i>Unable to benefit</i>	Negative emotion or dismissive	Worried, anxious, not bothered
<b>Thoughts</b>	<i>Rejecting</i>	Thoughts characterised by negative views about the self and feeling that the praise is undeserved or not important. Thoughts that question the intentions of the person giving the praise.	<p>“Is she being sarcastic or over- exaggerating?” (<i>Non-ID participant, performance category</i>)</p> <p>“Are you sure about that? We might fall out and put a damper on it”. (<i>ID group participant, popularity category</i>)</p>
	<i>Accepting</i>	Thoughts characteristics by positive beliefs about oneself, abilities etc. Also, using praise in an positive manner bolster ones confidence or sense of self.	<p>“He can depend on me. Good knowing someone can trust me”. (<i>ID group participant, performance category</i>)</p> <p>“That would definitely be a major uplift for me. I would definitely feel valued” (<i>Non-ID group participant, performance category</i>)</p>

**Hypothesis 2: People with intellectual disabilities are less likely to believe and experience positive affect in response to praise than people without intellectual disabilities**

Table 4 shows the findings for emotional response and belief in praise.

**Beliefs:** The belief data was also analysed in two categories; ‘yes’ and ‘no’. A significant group difference in the total scores was found ( $X^2(1)= 3.81, p= 0.051$ ); people with intellectual disabilities reported believing praise more often than people without intellectual disabilities. The individual themes of praise showed a significant group difference in the autonomy theme ( $p=0.002$ ). However, no significant group differences were found in the performance ( $p=1.00$ ), skill ( $p= 0.677$ ), popularity ( $p= 0.311$ ) or future plans ( $p= 0.677$ ) themes.

**Emotions:** Participants’ emotional response to praise was coded into two categories: i) positive emotion and ii) ‘unable to benefit’. Table 3 gives a definition and examples of response in these categories. The total scores showed a significant group difference in the emotional response to praise ( $X^2(1)= 11.23, p= <0.001$ ), however, this difference was in the opposite direction than predicted. Therefore, people without intellectual disabilities reported an emotional response categorised as ‘unable to benefit’ more often than people with intellectual disabilities. The theme of autonomy showed a significant group difference ( $p= 0.003$ ). There were no significant differences between the groups on the performance ( $p= 0.487$ ), skill ( $p= 0.605$ ), popularity ( $p= 0.605$ ) or future plans ( $p= 1.00$ ) themes.

Therefore, the hypothesis that people with intellectual disabilities are less likely to believe praise and experience positive affect in response to praise than people without

intellectual disabilities is rejected. A significant group difference was found, particularly in the autonomy theme, however in the opposite direction than predicted.

Table 4

*Responses to praise*

<b>Variable</b>	<b>Categorisation</b>	<b>ID group</b>	<b>Non- ID group</b>	<b>P- value</b>
<b>Belief</b>	<i>No</i>	8	17	0.051*
	<i>Yes</i>	92	82	
<b>Emotional response</b>	<i>Positive</i>	96	80	0.001*
	<i>Unable to benefit</i>	4	19	
<b>Thoughts</b>	<i>Rejecting</i>	14	37	<0.001*
	<i>Accepting</i>	84	62	

\* Significant difference

**Additional analysis- thoughts in response to praise.** Additional analysis was conducted on the thoughts generated by both groups in response to praise. It appears that people with intellectual disabilities had more difficulty responding to an open-ended question in response to praise (ID group= 79%, Non-ID group= 97%). Thoughts were coded into two categories: i) rejecting and ii) accepting. Those who could not identify thoughts in response to the open-ended questions were able to answer a forced choice question. These responses were coded into the same framework. Table 3 gives a definition and example of thoughts in each category.

Table 4 shows the frequency of thoughts in response to praise for each group. An overall group difference was found ( $\chi^2(1)= 13.68$ ,  $p= <0.001$ ) showing that

participants without intellectual disabilities reported rejecting thoughts in response to praise more frequently than participants with intellectual disabilities. When the PACT themes were examined separately, no significant group differences were found in the performance ( $F(1)= 0.66$ ), skill ( $X^2(1)= 2.85$ ,  $p= 0.091$ ), future plans ( $X^2(1)= 0.44$ ,  $p= 0.507$ ) or the popularity ( $F(1)= 0.342$ ) themes. A significant group difference was found in the autonomy theme ( $X^2 = 14.15$ ,  $df = 1$ ,  $p= <0.001$ ). Therefore, people without intellectual disabilities are more likely to generate thoughts that reject praise than people with intellectual disabilities, particularly in the autonomy theme.

**Hypothesis 3: People with intellectual disabilities are less likely to generate self-supporting thoughts in response to criticism than people without intellectual disabilities**

The majority of participants in both groups managed to identify thoughts in response to criticism (ID group= 89%, Non-ID group= 99%). Those who could not identify thoughts were able to answer the forced choice question, and this answer was coded. The thoughts in response to criticism were coded into two categories: i) self-supporting and ii) other. Table 3 gives a definition of the categories and examples of the participants' responses.

Table 2 shows the frequency of thoughts reported in each group. Overall there were no significant group differences ( $X^2(1)= 2.61$ ,  $p= 0.106$ ) in the types of thoughts reported by each group in response to criticism. The individual themes of the PACT also failed to show any significant group differences; performance ( $X^2(1)= 3.584$ ,  $p= 0.058$ ), skill ( $X^2(1)= 0.065$ ,  $p= 0.798$ ), popularity ( $X^2(1)= 3.135$ ,  $p= 0.077$ ), future plans ( $X^2(1)= 0.936$ ,  $p= 0.333$ ) and autonomy ( $X^2(1)= 0.533$ ,  $p= 0.465$ ). However, the

differences found in the performance and popularity themes are showing a trend towards significance, with people in the non-intellectual disability group generating more self-supporting thoughts than people in the intellectual disability group.

Therefore, the hypothesis that people with intellectual disabilities are less likely to generate self-supporting thoughts in response to criticism than people without intellectual disabilities is rejected.

**Additional analysis- actions in response to criticism.** An analysis was undertaken on the actions that participants predicted taking in response to criticism. The data were coded into three categories: i) active, ii) passive and iii) protest. Table 3 describes the categorisations and gives examples. No overall significant group difference ( $X^2(2) = 4.50$ ,  $p = 0.503$ ) was found. The individual themes of the PACT also failed to show any significant differences between the groups; performance ( $X^2(2) = 4.656$ ,  $p = 0.097$ ), skill ( $X^2(2) = 2.133$ ,  $p = 0.344$ ), popularity ( $X^2(2) = 2.516$ ,  $p = 0.248$ ), future plans ( $X^2(2) = 3.314$ ,  $p = 0.191$ ) and autonomy ( $X^2(2) = 4.50$ ,  $p = 0.105$ ). Therefore, no group differences were found in the type of actions reported by the two groups in response to criticism.

#### **Hypothesis 4: People who make negative social comparisons are more likely to experience negative affect when faced with criticism**

**Social comparisons and depression:** Spearman's rank correlations were conducted for each group to investigate the relationship between social comparison and depression scores. The total ASCS scores showed a significant negative correlation with

depression scores for the intellectual disability group ( $\rho = -0.443$ ,  $p = 0.051$ ). The total scores of the ASCS of the non-intellectual disability group did not show a significant correlation with depression scores ( $\rho = -0.329$ ,  $p = 0.15$ ). When the subcategories of the ASCS were examined, the only significant correlation was found between the rank/achievement dimension of the ASCS and depression scores in the intellectual disability group ( $\rho = -0.678$ ,  $p = 0.001$ ).

**Social comparison and negative emotion in response to criticism:** The emotional response to criticism data from the PACT was analysed using the Kruskal-Wallis statistic. Three degrees of negative emotion (none, a bit, a lot) were compared with social comparison. This analysis was completed for each theme of the PACT. The only significant result found was in the future plans theme of the non-intellectual disability group. Therefore, those who reported more negative emotion about future plans, had more negative social comparisons ( $H(2) = 6.82$ ,  $p = 0.033$ ). The skills theme in this group showed a trend towards significance ( $H(2) = 5.73$ ,  $p = 0.057$ ). There were no other significant results or trends in the other themes for either of the groups.

It is difficult to conclude on the basis of these results whether to reject or retain the hypothesis as the different variables would appear to show different results. Therefore, the hypothesis that people who make negative social comparisons are more likely to experience negative affect when faced with criticism remains inconclusive.

## **Discussion**

This study has demonstrated that people with intellectual disabilities are more likely to believe and experience internal negative emotions (sadness, depression) in response to criticism compared to people without intellectual disabilities. Greater belief

in criticism may suggest that the participants with intellectual disabilities hold more negative beliefs about themselves. However, those with intellectual disabilities were also more likely to believe praise; which could lead one to believe they held a positive view of themselves. An alternate explanation could be that people with intellectual disabilities are more susceptible to social influence of a positive and negative nature. Their self-views may be more dynamic and they may be more prone to internalising the beliefs of others. This explanation would fit with the existing literature that has examined the self-views of people with intellectual disabilities.

A symbolic interactionist perspective has been proposed to explain the development of psychological difficulties in people with intellectual disabilities (Jahoda et al, 2009). This perspective was originally developed by Mead (1934), who proposed that self-beliefs were dynamic and that interactions with others are important in the construction of beliefs about the self; we develop an awareness of our self through our interactions with others. Dagnan & Waring (2004) demonstrated that stigma can influence the development of negative beliefs about the self. Jahoda et al (2009) have also proposed that interactions can positively impact on a person's sense of self. The current study may contribute to this understanding.

In addition, the findings of the current study may suggest an emotional vulnerability in the face of criticism by people with intellectual disabilities. In contrast, praise elicited positive emotions such as happiness or confidence in people with intellectual disabilities. However, people without intellectual disabilities were not affected by praise and were more likely to reject such comments. Whelton and Greenberg (2005) suggest that internalising praise may provide a buffer to stress. The current study also indicates that praise can be used in a positive way to bolster their sense of self. Therefore, these results may suggest that the underlying vulnerabilities of

the two groups differ. People without intellectual disabilities are less likely to internalise praise which may make them vulnerable to distress, whereas people with intellectual disabilities appear to be more sensitive to criticism. Alternately, it may be that the praise scenarios had less significance to the people without intellectual disabilities, and were not viewed as an achievement by this group.

Contrary to predictions, there were no significant group differences found in the frequency of self-supporting thoughts or in the types of coping reported. It may be that a bigger sample would allow the trends in the thoughts to reach significance. However, there were also difficulties coding the open-ended questions. Therefore, there may be subtle differences which are not identified by the categorisations. Given that the experience of receiving criticism is distressing for people with intellectual disabilities, it would be of interest to further investigate the thoughts underlying this distress. The most frequent type of coping reported by each group was active coping. Therefore, contrary to predictions, people with intellectual disabilities can suggest active ways to cope in the face of criticism. The way in which stressful situations are dealt with can influence the impact. In their study of coping with stressful social interactions, Hartley & McLean (2008) found that active coping was negatively associated with psychological distress in adults with intellectual disabilities.

Social comparisons were found to be negatively associated with depression scores in people with intellectual disabilities; a finding that replicates that of the existing literature (Dagnan & Sandhu, 1999; MacMahon & Jahoda, 2008). This relationship was not found to be significant in people without intellectual disabilities. Therefore, how people with intellectual disabilities view themselves in relation to others is important in terms of vulnerability to mental health difficulties; not just the self-views they possess. In terms of social comparison and responses to criticism, the future plans and skills

themes were important to participants in the non-intellectual disability group. Those who reported more negative emotion in response to criticism, reported more negative social comparisons. This finding may represent the life stage of many of the participants; college attenders. The absence of this finding in the group with intellectual disabilities may suggest that they have less sense of their future plans and life goals.

### **Clinical Implications**

This was an exploratory study and utilised a non-clinical sample, therefore, its application in clinical practice requires careful consideration. If the findings from the current study do, in fact, reflect a greater sensitivity to other people's views, then it suggests that this could heighten vulnerability to mental health problems. More positively, it also suggests that praise can be an important mechanism in promoting well-being. There may also be implications for therapeutic intervention.

Cognitive behaviour therapy (CBT) is a psychological intervention which emphasises the importance of views of the self in psychological difficulties (Beck et al, 1976). Such interventions have been adapted for people with intellectual disabilities (Whitehouse et al, 2006). The current study highlights the importance of beliefs about the self, others' view of the self and the impact of social experience. These factors have been highlighted as significant to the mental health of people with intellectual disabilities and for psychological intervention (Jahoda et al, 2006).

The current findings may suggest ways that can be influential when working to challenge negative self-views or support the development of positive views. Willner (2006) suggested that carers can have an important role in promoting engagement in CBT. However, given the possible influence of others' views, it may be that significant

others can have a more direct role in CBT to promote change. It may also highlight the value of behavioural experiments, such as gaining the views of others, as a therapeutic technique.

Supporting people with intellectual disabilities to cope with stress and difficult social experiences may be fruitful in terms of reducing distress. In this study, people with intellectual disabilities were able to generate responses suggestive of active coping, therefore, the promotion and development of this type of coping may be of value.

### **Limitations**

There are several methodological weaknesses with the study that require consideration when interpreting the findings. The PACT is a novel tool, and although it draws on effective approaches used previously, it means the study is essentially exploratory in nature. The use of open-ended questions allowed for natural, and possibly more valid, responses to be obtained than a forced choice response would allow. However, this approach presented challenges in terms of the data coding and analysis. It was important for the resulting categories to be meaningful, yet there also had to be enough data in each category to allow for formal statistical analysis to be undertaken. This meant that more subtle differences could not be drawn out. Future research with a larger number of participants would help ensure that the conclusions drawn are more robust and allow more subtle group differences to be identified. Alternately, a qualitative or ethnographic approach may allow for a more detailed examination of how criticism and praise is perceived in people with intellectual disabilities. In addition, in terms of the quantitative approach to measurement i.e. using degrees of emotion and belief (a bit, a lot), there was no preparatory task to ascertain the

participants' understanding of this type of scale. The analysis conducted in the current study collapsed 'no', 'a bit' or 'a lot' to either 'no' or 'yes', therefore, this issue did not effect the results or conclusions of the study. During the meeting participants did make spontaneous discriminations of their degree of belief and emotion, however, future use of the PACT may wish to include a preparatory or practice item to allow participants to become familiar with the materials and ascertain their understanding of this type of scale. Use of a visual scale should also be considered and integrated into the practice task.

The hypotheses were developed from the literature suggesting that people with intellectual disabilities have more experience of criticism and negative interpersonal experiences (Bramston, Fogerty & Cummins, 1999; Hartley & McLean, 2005). However, it is not known whether the participants involved in this study differed in terms of their social experiences. Future research should include a measurement of negative life experiences. In addition, both groups were recruited from colleges so that they had common experiences thereby helping the PACT scenarios make sense to both groups. However, this may also mean that the results cannot be generalised beyond people who attend further education.

### **Conclusions**

This study investigates a novel area of research; how people with and without intellectual disabilities perceive and experience criticism and praise. There seem to be differences between the groups which may represent a difference in the way people with intellectual disabilities develop their sense of self and beliefs about self in social situations. The results suggest that the self-perceptions of people with intellectual

disabilities are more dynamic and reliant on the views of others. In theory, such sensitivity could make people more vulnerable to mental health difficulties. Alternatively, the possibilities for positive influence have implications for psychological and social interventions.

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# APPENDICES

## Appendix A: Requirements for submission to Journal of Intellectual Disability Research

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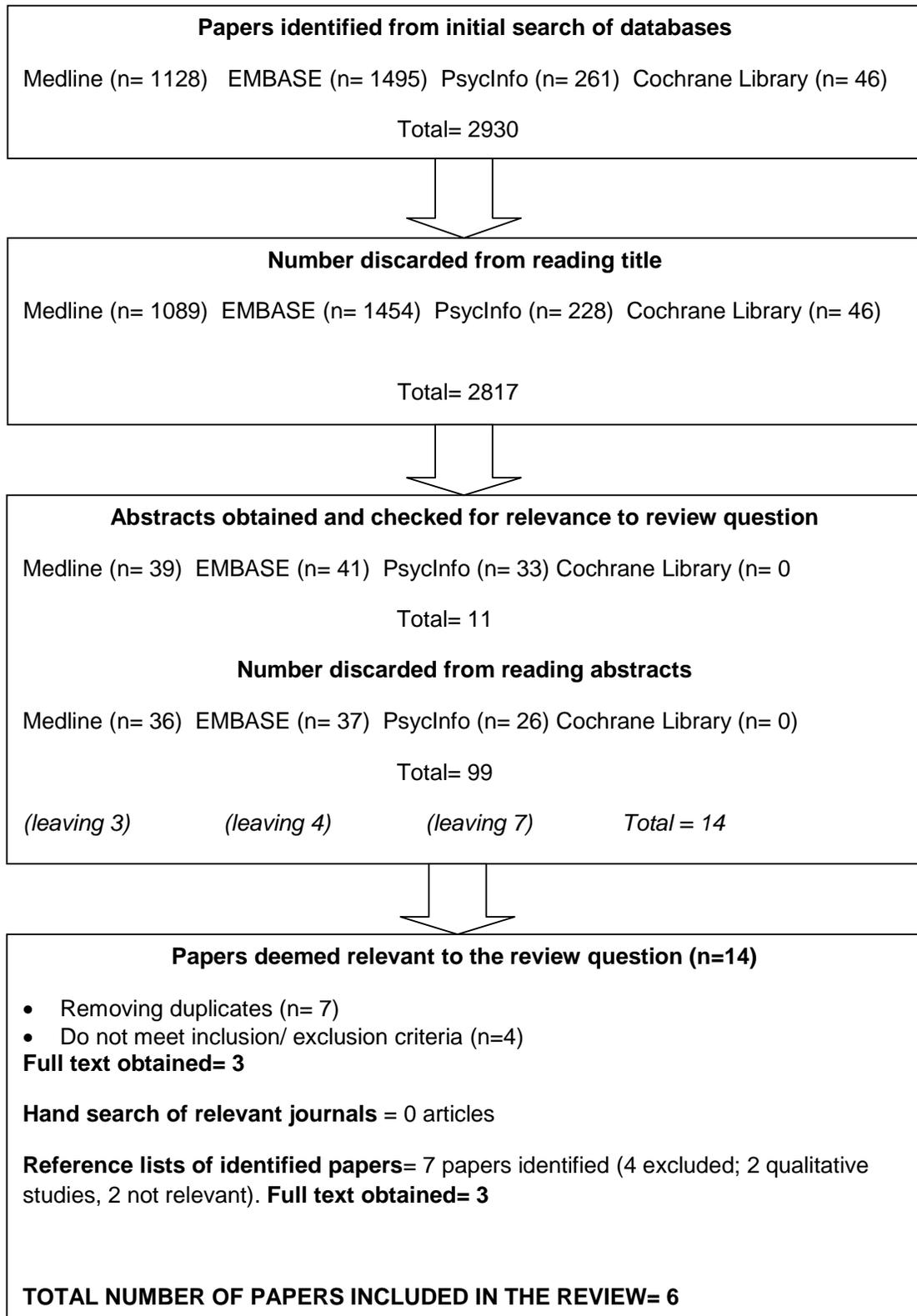
The Journal of Intellectual Disability Research is devoted exclusively to the scientific study of intellectual disability and publishes papers reporting original observations in this field. The subject matter is broad and includes, but is not restricted to, findings from biological, educational, genetic, medical, psychiatric, psychological and sociological studies, and ethical, philosophical, and legal contributions that increase knowledge on the

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Appendix B: Flow chart of process of article selection



### Appendix C: Quality criteria and ranking system

Item	Criteria	Score
<b>Study question</b>	Clear and focused	2
	Partially focused	1
	Unclear	0
<b>Study design</b>	Longitudinal	4
	Cross sectional design with Mental Age (MA) and Chronological Age (CA) matched control groups	3
	Cross sectional design with MA or CA matched control group	2
	Cross sectional design with no control group	1
	Inappropriate design or not enough detail	0
<b>Sampling methods</b>	Geographical cohort	3
	Random sample	2
	Convenience or volunteer sample	1
	Unclear how sample was obtained	0
<b>Sample characteristics</b>	Age, gender, living circumstances and level of ID reported	3
	Any 3 of the above reported	2
	Any 2 of the above reported	1
	Only 1 of the above reported	0
<b>Assessment of intellectual disability</b>	Standardised assessment of IQ (e.g. WAIS)	3
	BPVS or measure of adaptive functioning	2
	Review of case notes	1
	Not specified or no assessment	0
<b>Measurement of social comparison</b>	Measure designed and standardised for use with an ID population	3
	Measure standardised for use with a non-ID population, appropriate to design and for use with an ID population. Adapted for an ID population.	2
	Non-standardised measure appropriate to design and for use with an ID population	1
	Measure inappropriate to design and/ to population	0
<b>Measurement of psychological well being</b>	Measure standardised for use with an ID population	3
	Measure standardised for use with a non-ID population, appropriate to design and for use with an ID population. Adapted for an ID population.	2
	Non-standardised measure appropriate to design and for use with an ID population	1
	Measure inappropriate to design and/ to population	0
<b>Statistical analysis</b>	Statistical analysis appropriate to design, justification of use of para/ non-parametric statistics, and IQ analysed in relation to performance on measures	3
	Statistical analysis appropriate to design, and IQ analysed in relation to performance on measures	2
	Statistical analysis appropriate to design	1
	Inappropriate statistical analysis or not enough detail to rate	0

Appendix D: Quality rating applied to reviewed papers

<b>Study</b>	<b>Study question</b>	<b>Study design</b>	<b>Sampling</b>	<b>Sample characteristics</b>	<b>Assessment of ID</b>	<b>Measurement of social comparison</b>	<b>Measurement of psychological well-being</b>	<b>Statistical analysis</b>	<b>Total score/ Category</b>
<b>Szivos (1991)</b>	2	1	0	2	2	1	2	1	<b>11/ Adequate</b>
<b>Szivos- Bach (1993)</b>	2	1	0	2	2	1	2	1	<b>11/ Adequate</b>
<b>Dagnan &amp; Sandhu (1999)</b>	2	1	1	3	2	2	2	1	<b>14/ Adequate</b>
<b>Crabtree &amp; Rutland (2001; study 2)</b>	2	1	1	1	0	1	1	1	<b>8/ Adequate</b>
<b>Dagnan &amp; Waring (2004)</b>	2	1	1	2	2	2	2	2	<b>14/ Adequate</b>
<b>MacMahon &amp; Jahoda (2008)</b>	2	2	1	3	3	2	3	3	<b>19/ Good</b>

**Major Research Proposal**

Coping with criticism and praise; the emotional wellbeing of people with  
intellectual disabilities.

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Version 2

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## **Introduction**

People with intellectual disabilities are more likely to experience negative life events than people without intellectual disabilities, which may contribute to the higher prevalence of mental health problems in this group (Esbenson & Benson, 2006). In particular, negative interpersonal experiences have been found to be more prevalent and cause greater stress than other negative events for people with intellectual disabilities (Bramston, Fogerty & Cummins, 1999; Hartley & McLean, 2005). Therefore, it may be that people with intellectual disabilities are sensitised to and, consequently, vulnerable to the effects of negative interpersonal experiences.

Negative interpersonal experiences such as discrimination and stigmatisation may result in people with intellectual disabilities developing a negative self-view. In a study of stigma and psychological distress in people with intellectual disabilities, Dagnan & Waring (2004) found that discriminatory views can be internalised; being treated negatively was associated with a view of oneself as inferior and a view of one's social position/ rank as low in comparison to others. The implications of holding a negative view of one's social position/ rank have been studied in relation to the mental health of people with intellectual disabilities.

Social comparison is a psychological process in which people evaluate themselves in relation to others (Festinger, 1954), and has been used to examine how people with intellectual disabilities view their relative social position. Negative social comparison has been associated with depression in people with intellectual disabilities (Dagnan & Sandhu, 1999). Dagnan & Sandhu (1999) suggest that people with intellectual disabilities can recognise and internalise others' negative evaluations, and that this may lead to negative social comparisons. Although this study included a non-clinical sample, it suggests that negative social comparison can make people with intellectual disabilities vulnerable to distress. In a study with a general adult population, Cheung, Gilbert & Irons (2004) also found that viewing one's social position negatively can have detrimental effects on well-being and is associated with vulnerability to depression.

Gilbert & Miles (2000) suggest that a negative view of one's social position is a contributory factor in 'sensitivity to social put- down' i.e. being sensitive to criticism from others. Their study highlighted that people who were more distressed by criticism reported higher ratings of depression and were more likely to make negative social comparisons. Attribution style was also an important factor. Those who viewed themselves as inferior to others were more likely to internalise criticism. Therefore, criticism may initially come from external sources but its effects may continue to be evident when it is internalised. Gilbert, Durrant & McEwan (2006) suggest that being sensitive to criticism originates from negative social experiences such as being bullied or subordinated; experiences that are common to people with intellectual disabilities. The implication is that people with intellectual disabilities, through their negative interpersonal experiences, are likely to be sensitive to and distressed by criticism from others.

Hartley & McLean (2009a) found that perceptions of stressful social situations were an important factor in psychological distress in people with intellectual disabilities. In particular, situations that involved the intentional negative actions of others, such as someone saying something bad about you to others, produced a high level of stress. Hartley & McLean (2009b) also studied perceptions of stressful social interactions in people with intellectual disabilities who were depressed, and found that they were more sensitive to interpersonal criticism and rejection. In addition, the participants showed a propensity towards a negative attributional style (internal, stable and global). Therefore, the participants seemed to experience a high level of stress in response to interpersonal stressors. These findings have implications for the emotional wellbeing of people with intellectual disabilities and it is possible that when they receive criticism they will be more likely to attribute it to an internal cause.

People with intellectual disabilities may also be vulnerable to emotional distress if they cannot benefit from positive and supportive interpersonal experiences. Supportive comments or praise may be discrepant with the self views of people with intellectual disabilities, and therefore may not be accepted or given significance. MacMahon & Jahoda (2007) found that people with an

intellectual disability who were depressed may recognise their strengths, but fail to attach significance to these strengths. This study highlights a possible maintenance factor in depression. However, it is possible that a vulnerability to low mood may be created through a lack of recognition of one's positive characteristics. Moreover, a failure to internalise praise may affect a person's ability to defend themselves against criticism by being supportive to themselves, which may be associated with a vulnerability to distress (Whelton and Greenberg, 2005). These processes have yet to be studied in people with intellectual disabilities.

In summary, the literature suggests that negative treatment can lead to the development of negative views of oneself and consequently to negative comparisons of oneself in relation to others. These views may result in a vulnerability to distress when faced with criticism. Being unable to cope effectively may create a further vulnerability. Given the negative life experiences of people with intellectual disabilities, it would be prudent to develop an understanding of how this group cope with these experiences and whether it differs from those without intellectual disabilities. It is a novel research area to investigate the ability of this group to be self-supportive in the face of criticism. Given its role in emotional well-being, this is a viable research area.

### **Aims**

The aims of this study are to compare the cognitive and emotional responses to criticism and praise in adults with and without intellectual disabilities. Differences between the two groups are anticipated, due to the differing nature of their life experiences. People with intellectual disabilities, due to their cognitive impairments and experience of social stigma, are likely to have more experience of criticism. Therefore, it might be expected that this group are more likely to be sensitive to criticism. The experience of receiving praise is less likely to match the self-views and social experience of people with intellectual disabilities, therefore, they may be less likely to believe and value praise. This study also aims to explore the ability of people with

and without intellectual disabilities to generate self- supporting responses when faced with criticism.

## **Hypotheses**

The following hypotheses will be examined in relation to the above aims:

Between groups:

5. People with intellectual disabilities are more likely to believe criticism and to be more distressed in response to criticism than people without intellectual disabilities.
6. People with intellectual disabilities are less likely to believe praise and experience positive affect in response to praise than people without intellectual disabilities.
7. People with intellectual disabilities are less likely to generate self- supporting statements in response to criticism than people without intellectual disabilities.

Within group:

8. A tendency to believe criticism is associated with more distress.
9. A tendency to believe praise is associated with greater positive affect.
10. People who make more negative social comparisons are likely to experience more distress when faced with criticism.

## **Design**

This study will utilise a between groups comparison design to examine the differences in emotional and cognitive responses to criticism (hypotheses 1) and to praise (hypotheses 2) in people with and without intellectual disabilities. Within subjects analyses will examine the association between criticism and distress (hypothesis 4), praise and positive emotion (hypotheses 5), negative social comparison and distress (hypothesis 6). In addition, the ability to generate self- supporting statements will be explored (hypothesis 3).

## **Plan of investigation**

### ***Participants:***

Two non-clinical groups will be recruited; one group with an intellectual disability and a comparison group without an intellectual disability. The two groups will be as closely matched as possible in terms of gender, age, socio-economic status and living situation.

### ***Inclusion Criteria:***

Participants will be included in the study if they:

- Are an adult aged 18- 65 years.
- Have the ability to provide informed consent.
- Have sufficient receptive and expressive verbal ability to describe everyday events.

### ***Exclusion Criteria:***

People will be excluded from the study if they:

- Have a severe visual or hearing impairment as they are likely to have difficulty engaging with the study materials.
- Have a diagnosis of autistic spectrum disorder. The social deficits associated with this diagnosis may make the research tasks difficult for the participants.
- Have clinically significant psychiatric problems. Difficulties such as clinically significant anxiety, depression and psychosis are likely to influence responses to the study tasks.

### ***Recruitment Procedures:***

Participants for both groups will be recruited through colleges of further education in Greater Glasgow and Clyde. The researcher will contact the managers at colleges to gain permission to meet with students to discuss the research.

Recruitment will be conducted by approaching the manager or tutor who will be asked to identify pre-existing groups or classes who have sufficient receptive and expressive language to

describe everyday events. To assist with this, the following items from the Adaptive Behaviour Scale (ABS-RC:2) (Nihira, Leland & Lambert, 1993) will be used:

- Talks to others about sports, family, group activities.
- Sometimes uses complex sentences containing 'because', 'but'.
- Answers simple questions such as 'What is your name?' or 'What are you doing?'

The researcher will meet with groups of potential participants to provide verbal and written information on the study. All participants will be asked to contact the researcher if they wish to take part in the study.

### *Measures and experimental task*

To ensure that the two groups are closely matched as possible, information will be gained from each participant on their: i) age, ii) gender, iii) socio-economic status, iv) living situation, v) involvement of specialist mental health services, vi) diagnosis of autistic spectrum disorder.

Socio-economic status will be measured by the Carstairs Index, which is determined by postcode (Carstairs & Morris, 1991). It is composed of four indicators which are judged to represent material disadvantage in the population: low social class, lack of car ownership, overcrowding and male unemployment.

The following measures and experimental procedure will be used and delivered in the following order:

1. Social comparison scale (Allen & Gilbert, 1995).

This is a six item scale examining how people view themselves in relation to others on the domains of rank and achievement, social attractiveness, and perceived group membership. Dagnan & Sandhu (1999) adapted the scale for people with intellectual disabilities, reporting an alpha value of 0.58. This scale was utilised in MacMahon & Jahoda (2008) who reported an alpha value of 0.74. Participants are presented with an incomplete sentence ('when I'm with other people I generally feel') followed by a

series of bipolar constructs (worse than other people/ better than other people, not as good at things/ better at things, less friendly/ more friendly, less shy/ more shy, on your own/ joined in and different/ same).

2. Glasgow Depression Scale for People with a Learning Disability (GDS-LD; Cuthill, Espie & Cooper, 2003).

The GDS-LD is a 20 item questionnaire to measure depression in people with learning disabilities. It shows a strong correlation with the Beck Depression Inventory II (BDI-II;  $r = 0.88$ ), and good test- retest reliability ( $r = 0.97$ ) and internal consistency (Cronbach's  $\alpha=0.90$ ) have been demonstrated. Each question asks participants to reflect how they have been feeling over the past week and each question is asked in two parts. First, the participant is asked to choose between a 'yes' and 'no' answer. If the answer is 'no', then no further prompting for that question is required. If the answer is 'yes', the participants is asked if that is 'sometimes' or 'always'. The authors advise using a cut- off score of 13 when screening for depression (sensitivity to detect individuals with depression = 96%, specificity= 90%). The GDS- LD has been used successfully in other studies (MacMahon & Jahoda, 2008).

3. Praise and criticism task (PACT).

This task is being developed for the purposes of this study. The procedure is being developed following an existing body of work, in which hypothetical vignettes were successfully used to investigate the social- cognitive responses of people with intellectual disabilities to threat in interpersonal situations (Pert & Jahoda, 2008). In the PACT, participants will be presented with a self- referent scenario in which they are asked to imagine encountering a person who then says something positive (praise) or negative (criticism). The situations will be presented in a visual, story board format. There will be four criticism and four praise scenarios and the order of presentation of the scenarios will be random. Prompt questions will be used to establish the person's

belief and emotional response to the scenario. The PACT will require careful piloting. Participants will also be asked to rate the perceived power of the critic on a three point scale. However, this will be carefully piloted before use in the main study. Details of the proposed scenarios and proposed response format can be found in Appendix A.

4. Wechsler Abbreviated Scale of Intelligence (WASI) (Psychological Corporation, 1999). The WASI provides an estimate of general intellectual ability. Psychometric properties include a high level of internal reliability (0.96- 0.98), adequate test- retest reliability (0.88- 0.92) and good concurrent validity (0.87).

Careful piloting will be undertaken with a small number of individuals from both groups.

Piloting would hope to establish:

- if the PACT scenarios are salient and relevant to both groups,
- if the PACT response format is appropriate to answer the research questions,
- if the opened-ended exploratory question is an adequate way of assessing self-supporting statements,
- if an open-ended exploratory questions appears feasible, then a method of measuring and coding the responses will need developed, and
- the administration time for the research materials.

### *Justification of sample size*

There are no studies that compare the emotional and cognitive responses of people with and without intellectual disabilities to criticism and praise. In terms of the within group analyses, Dagnan & Sandhu (1999) investigated the association between social comparison and distress and found a negative relationship ( $r = -0.50$ ). Based on this previous research, the G Power software (Faul et al, 2007) was used to undertake a power calculation. For a power level of 0.80 at the 5% significance level using a one- tailed correlation, it was calculated that the required

total sample would be 42 (21 in each group). Consideration was given to possible changes in effect size.

### ***Settings and equipment***

The data collection will take place in the further education colleges where the participants are recruited. Access to the WASI (including score sheets and response booklets) will be required. When appropriate, responses will be recorded straight onto the response form. Meetings will also be recorded and transcribed verbatim, therefore, access to recording equipment will be required.

### ***Data analysis***

Data analysis will be carried out using The Statistical Package for Social Sciences (SPSS). The data will be examined to determine whether parametric analysis is appropriate. If appropriate, an analysis of co-variance (ANCOVA) will be used to examine the between group differences in belief in criticism, distress in response to criticism, belief in praise and positive affect in response to praise (hypotheses 1 & 2). An ANCOVA will allow the groups to be compared while taking into account the variability of low mood (as measured by the GDS-LS). Pearson's  $r$  correlations will be used to assess within group associations (hypotheses 4, 5 & 6). Content analysis will be used to analyse the responses from the open-ended question (hypothesis 3).

## **Health and Safety Issues**

### ***Researcher safety issues***

Data collection will comply with standard safety procedures and lone working procedures. The data collection will be conducted in a safe environment in the college where recruitment takes place. Meetings will take place during normal working hours and a member of staff will be made aware of the meeting.

### ***Participant safety issues***

All participants will be required to give informed consent prior to commencing the study and have the right to withdraw their consent at any time. All participants will be made aware of confidentiality issues from the outset. If any participant becomes distressed by the study materials, the researcher will take time to discuss the issues with the participant in the first instance. Where necessary and with the participant's consent, the researcher will help the participant access support from carers, family or other relevant services.

### **Ethical Issues**

Potential participants will be given written or recorded information describing the purpose of the study and will have the opportunity to discuss the study with the researcher. Consent will be gained in accordance with the Adults with Incapacity (Scotland) Act (2000) and all participants will be required to give written consent. Ethical approval will be sought from the relevant committee. Permission to recruit from further education colleges will be obtained by writing to the managers of the organisations. Data will be stored securely and in accordance with NHS IT directives.

A similar approach has been used in previous studies (Pert, 1999) with people with mild intellectual disabilities, many who have significant problems with aggression and anger. The approach has been engaging and of interest to the participants, without causing distress or upset. It is anticipated that the proposed experimental task will be met with similar acceptance, however, if any participant experiences distress in response to the study materials, the researcher will attempt to manage this in the first instance. If this support is insufficient, the researcher will help the participant access support from carers, family or other relevant services (with the participant's consent).

### **Financial Costs**

The estimated cost of this project is £166.75. This includes equipment (WASI response forms), stationary, and postage. It is anticipated that access to recording equipment will be available through the Department of Psychological Medicine, Glasgow University, therefore, this has not been included in the cost at this time.

### **Time-scale**

The timetable for the project is as follows:

10 <sup>th</sup> May 2010:	Proposal submitted
August 2010:	Submit proposal changes
September 2010:	Submit & obtain ethical approval
October- November 2010:	Pilot and begin recruitment
March 2011:	Complete recruitment
March 2011:	Data analysis
April- June 2011:	Write up
30 <sup>th</sup> July 2011:	Loose bound portfolio submission
September 2011:	Viva

### **Practical Applications**

Undertaking this study would allow consideration of how people with intellectual disabilities deal with criticism in comparison to people without intellectual disabilities. There are implications for teaching people to cope with adversity. This study would provide an indication of the ability of people with intellectual disabilities to accept and benefit from praise in comparison to people without intellectual disabilities. It would be valuable to assess these abilities in people with intellectual disabilities who are vulnerable to low mood and consider ways in which intervention could be applied. This study would also develop our understanding of the social comparison process in people with intellectual disabilities and its relationship to distress. Overall, the proposed study fits well with the research agenda to promote mental wellbeing and resilience in people with intellectual disabilities (Dagnan, 2008)

## Appendix A (MRP Proposal)

### Praise and criticism task (PACT) - draft

#### Criticism scenarios

The criticism scenarios are based on items from the Sensitivity to Put-down (SPD) Scale (Gilbert & Miles, 2000). This is a 20 item scale where participants have to rate how anxious/distressed and how angry/irritated (on a scale of 1-5) by each statement. Items from SPD scale that have been used to develop the PACT are:

1. Having your opinion dismissed as irrelevant
2. Being seen as inferior
3. Being called a derogatory name e.g. stupid, ugly
4. Being treated like a child

Possible critical scenarios:

1. Imagine you are at work/ college/ day centre. It's someone's birthday and you and a group of people are planning to go out for lunch to celebrate. Everyone is making suggestions about where to go to eat. When you suggest your favourite café someone responds "No way, your suggestions are always rubbish". (Having your opinion dismissed)
2. Imagine you are walking down the street with a friend. A stranger stops and asks you for directions. Before you can answer, your friend says "I'll tell them, there's no way you'd get it right". (Being seen as inferior)
3. Imagine you are making some dinner with the help of a friend. You knock over a bowl and its contents fall all over the floor. Your friend says "You're such an idiot". (Being called a derogatory name)

4. Imagine you are at work/ college/ day centre. There is an important visitor coming to visit the work/ college/ day centre. You volunteer to show them around. You are told that someone else will come with you to make sure that you do a good job. (Being treated as a child).

The content of the scenarios in the PACT need to be emotionally- laden and have resonance in the lives of people with and without intellectual disabilities. The piloting phase will establish if the current scenarios meet these requirements. During the piloting phase of the study, the validity of the above scenarios will be established. A small number of people from each group will be given the scenarios and asked to match them up with the statement that best describes the scenario depicted i.e. being treated like a child. This assessment will determine whether the devised scenarios are transparent and easily understood by the participants.

### **Response format**

#### ***1. Belief***

Belief in the statement will be ascertained by asking ‘Do you think this is true?’. If a participants answers ‘yes’ then they will be asked how much they believe the statement. Degree of belief will be rated using 3 point visual analogues; blocks of increasing size with the words ‘a wee bit’, ‘quite a lot’, ‘a lot’.

#### ***2. Emotional response***

Emotional response to criticism scenarios will be established by asking the participants “How upset would you feel?”. Response will be rated using 3 point visual analogues; blocks of increasing size with the words ‘a wee bit’, ‘quite a lot’, ‘a lot’

#### ***3. Self- supporting response***

The open-ended question “Is there anything you could say to yourself to make you feel better?” will be asked to explore the participants ability to generate self- supporting statements.

#### ***4. Perceived power of critic***

It is proposed that the participants will also be asked to rate the perceived power of the critic on a three point visual analogue scale. However, this will be carefully piloted before use in the main study.

#### **Praise scenarios**

Like the criticism scenarios, the development of the praise scenarios requires careful thought and piloting.

Possible praise scenarios:

1. Imagine you are at work/ college/ day centre. A new person starts and it's their first day. The boss/ staff/ tutor ask you show them around and introduce them to everyone. The boss/ staff/ tutor says, "This is (insert participants name), he/ she knows this place well and will make you feel welcome".
2. Imagine you are at a friend's house. Your friend is upset after breaking up with their boyfriend/ girlfriend. When you are leaving they say, "Thanks, you were a great help tonight. You are a really good listener".
3. Imagine you are at home. A friend comes to visit. They comment that they like a DVD that you have. You say that they can keep it as you have already watched it. Your friend responds "Thanks, you are always really generous".
4. Imagine you are at work/ college/ day centre. You and some others have been working on organising a special event for Christmas. The tutor/ staff/ boss approaches you and says, "You have worked really hard on that, I am proud of you".

## **Response format**

### ***1. Belief***

Belief in the statement will be ascertained by asking 'Do you think this is true?'. If a participant answers 'yes' then they will be asked how much they believe the statement. Degree of belief will be rated using 3-point visual analogues; blocks of increasing size with the words 'a wee bit', 'quite a lot', 'a lot'.

### ***2. Emotional response***

Emotional response to praise scenarios will be established by asking "How good would you feel?". Response will be rated using 3 point visual analogues; blocks of increasing size with the words 'a wee bit', 'quite a lot', 'a lot'.

### ***3. Perceived power of person giving praise***

It is proposed that the participants will also be asked to rate the perceived power of the critic on a three point visual analogue scale. However, this will be carefully piloted before use in the main study.

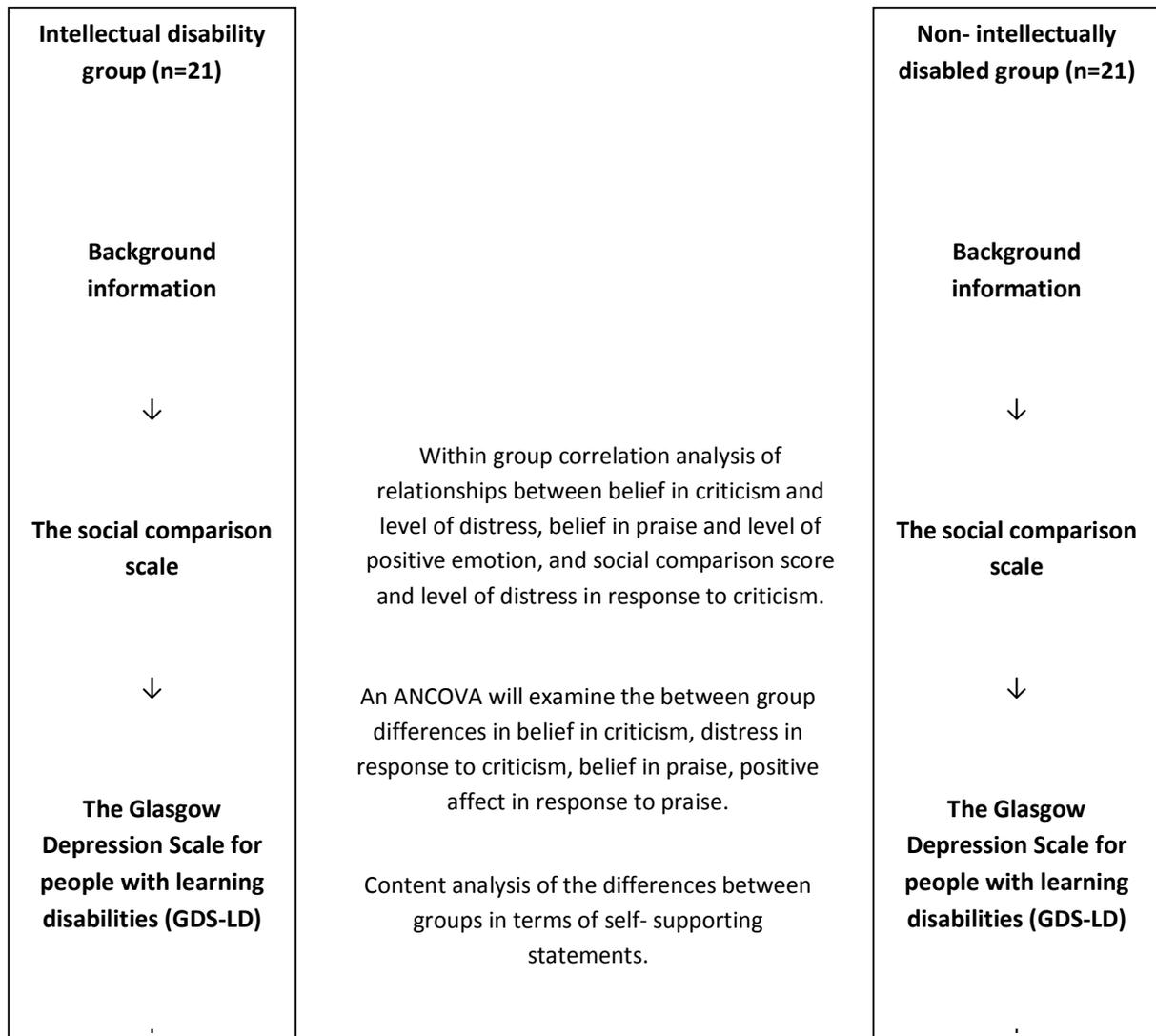
## Appendix B (MRP Proposal)

### Flow chart of project proposal

**Total participants (n= 42; 21 in each group)**

**Pilot phase (n= 4; 2 in each group)**

A pilot phase will be conducted to establish if the PACT and response format works well with both groups.



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10<sup>th</sup> December 2010

Dear Ms Ackland

**Medical Faculty Ethics Committee**

**Project Title: *Coping with criticism and praise; the emotional wellbeing of people with intellectual disabilities.***

**Project No.: FM07809**

The Faculty Ethics Committee has reviewed your application and has agreed that there is no objection on ethical grounds to the proposed study. They are happy therefore to approve the project, on condition that:

- *Disclosure Certificates are fully up to date.*

The ethics approval is also conditional upon the following:

- The research should be carried out only on the sites, and/or with the groups defined in the application.
- Any proposed changes in the protocol should be submitted for reassessment, except when it is necessary to change the protocol to eliminate hazard to the subjects or where the change involves only the administrative aspects of the project. The Ethics Committee should be informed of any such changes.
- If the study does not start within three years of the date of this letter, the project should be resubmitted.
- You should submit a short end of study report to the Ethics Committee within 3 months of completion.

Yours sincerely

Dr David Shaw  
Faculty Ethics Office

Appendix G: Background information sheet

<b>Name</b>	
<b>Gender</b>	<b>male/ female</b>
<b>DOB</b>	
<b>Address</b>	
<b>Postcode</b>	
<b>Carstairs Index</b>	
<b>Living situation</b>	<b>Living alone/ with family/ with partner or housemate/ group home</b>
<b>College course</b>	
<b>Regular activities/ hobbies</b>	
<b>PT employment</b>	
<b>Copy of results?</b>	<b>Yes/No</b>
<b>Group</b>	<b>Case/ control</b>
<b>Initial meeting</b>	<b>Date:</b> <b>Location:</b>
<b>Consent given</b>	<b>Date:</b>
<b>Participation in study</b>	<b>Date:</b> <b>Location:</b>
<b>Results sent</b>	<b>Yes/ No /Not applicable</b> <b>Date:</b>

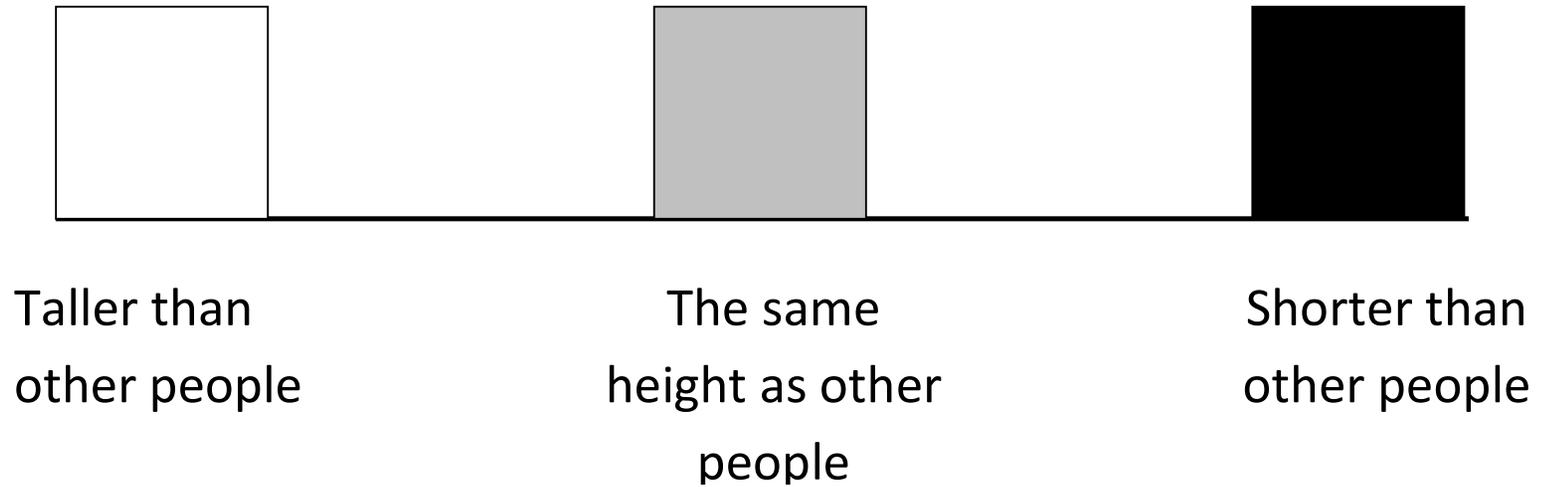
## Appendix H: Adapted Social Comparison Scale

### **Adapted social comparison scale instructions**

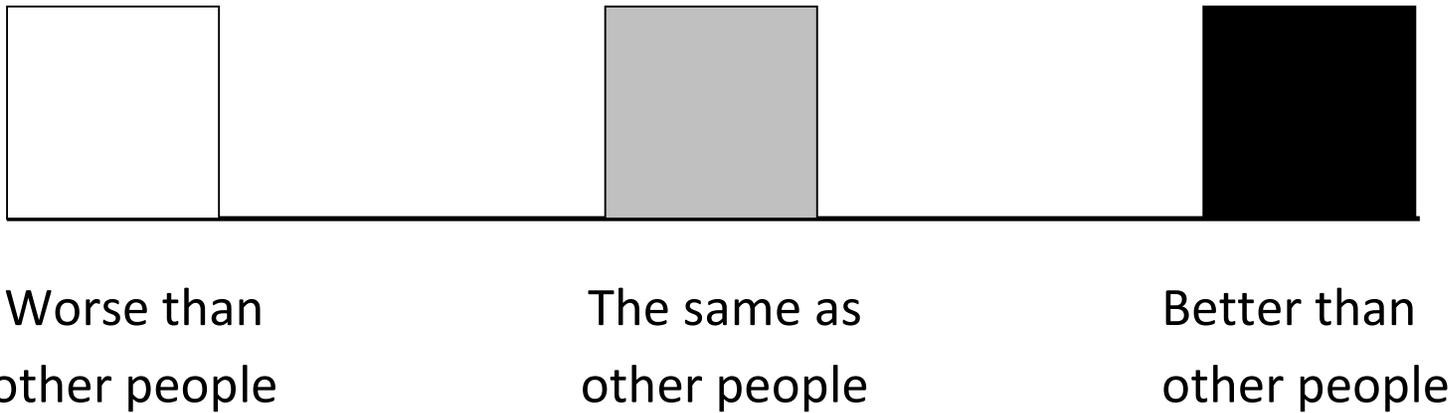
1. These questions are about how you feel when you are with other people. I will ask you to point to a block to show how you feel.
2. Let's do a practice. Show the example question and read out the question and responses. Ask the participant to point to the 'taller than' block, to the 'shorter than' block, and then to the 'same height' block. Then ask 'which block would a tall person point to?', 'which block would a short person point to?', and 'which block would they point to if they were the same height as other people'.
3. If the participant is unable to do this, then give the example 'if I was a short person, I would point to the block here', 'if I was the same height as other people, I would point to this block'. Then ask the participant 'which block would you point to if you were a tall person?'.
4. Continue with the questions 1-6.

Practice question

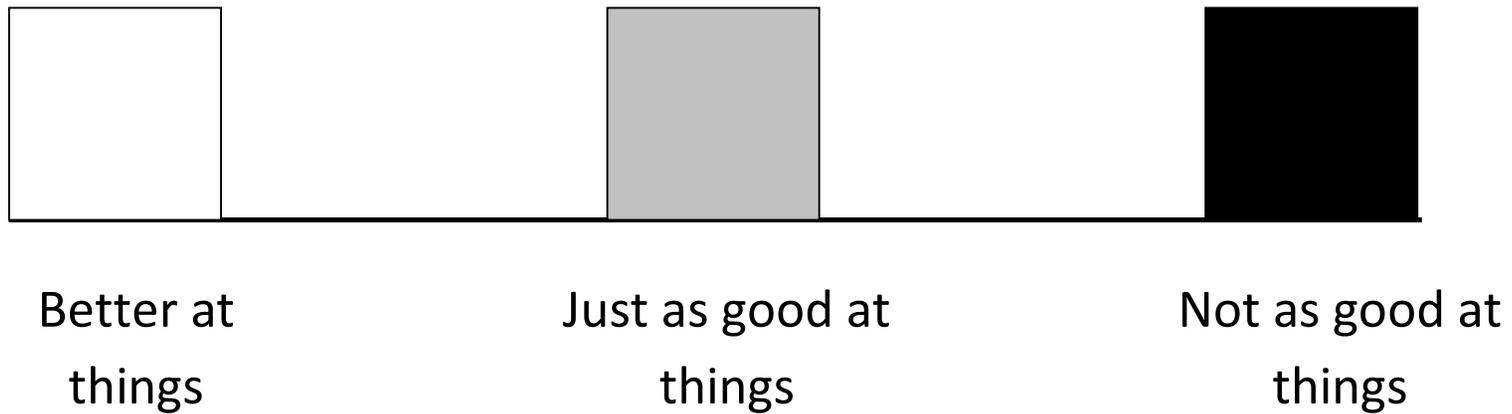
When I am with other people I generally feel:



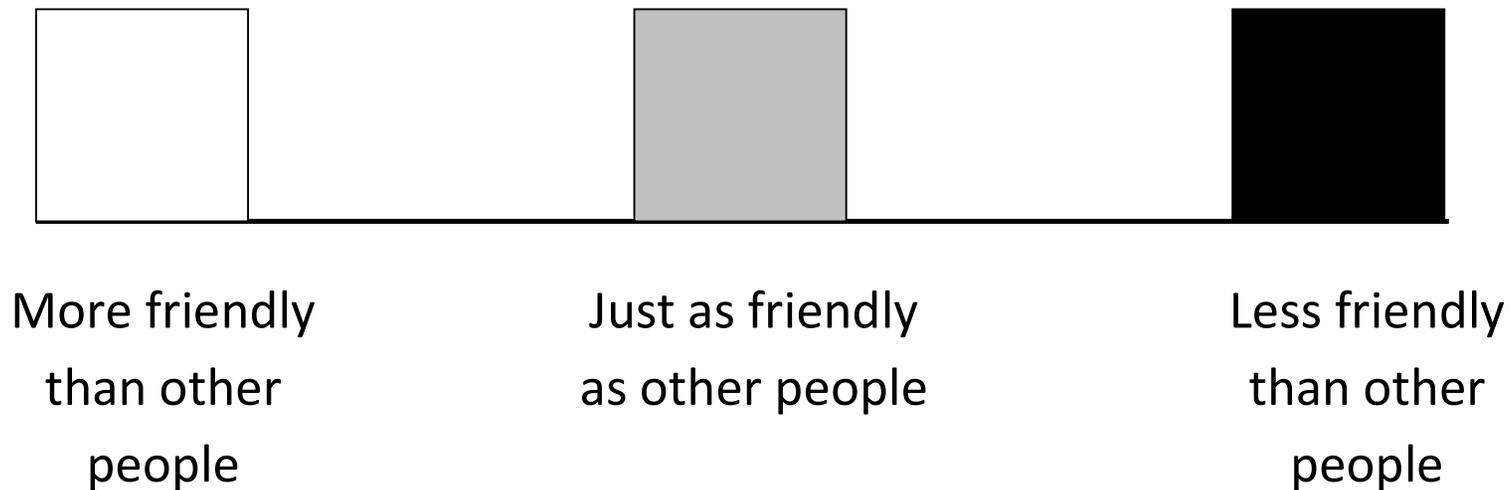
# 1. When I am with other people I generally feel:



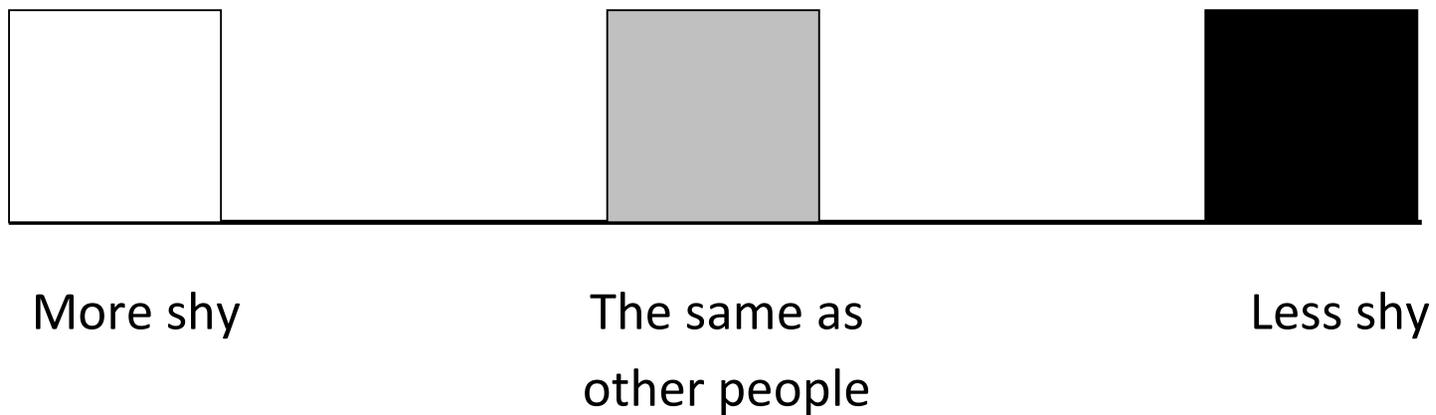
## 2. When I am with other people I generally feel:



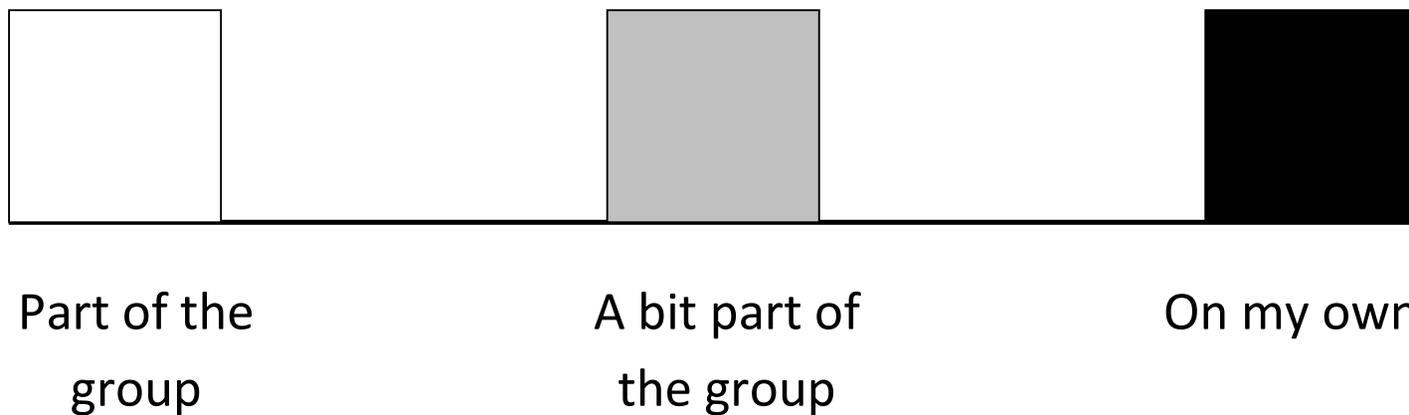
3. When I am with other people I generally feel: ... less friendly or more friendly?



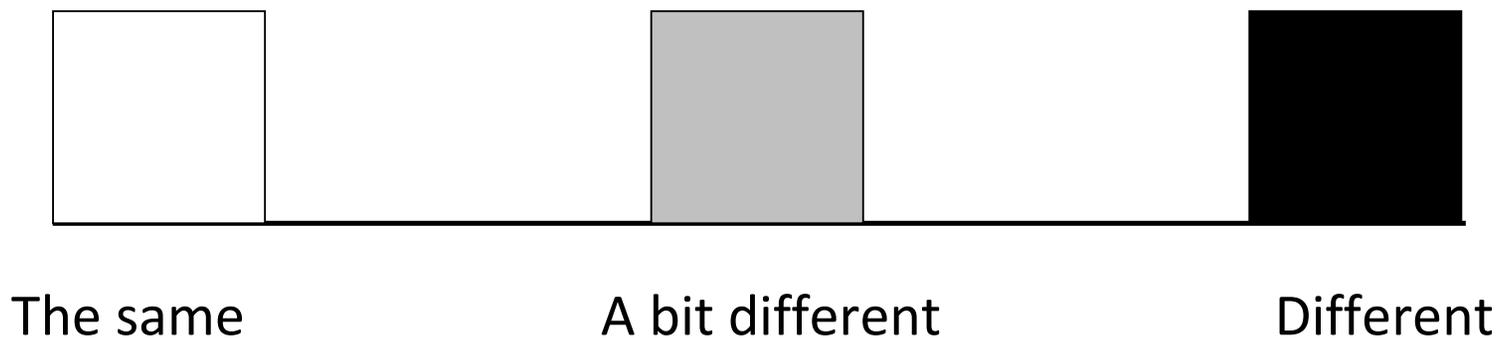
4. When I am with other people I generally feel:



# 5. When I am with other people I generally feel:



6. When I am with other people I generally feel:



<b>Date:</b>
<b>Participant number:</b>

**Interviewer score sheet**

**Adapted social comparison scale**

Q1. When I am with other people I generally feel... worse than other people or better than other people?

Worse than other people		the same as other people		Better than other people
0	1	2	3	4

Q2. When I am with other people I generally feel ... not as good at things or better at things?

Not as good at things		Just as good at things		Better at things
0	1	2	3	4

Q3. When I am with other people I generally feel ... less friendly or more friendly?

Less friendly than other people		Just as friendly as other people		More friendly than other people
0	1	2	3	4

Q4. When I am with other people I generally feel ... less shy or more shy?

Less shy than other people		Just as shy as other people		More shy than other people
4	3	2	1	0

Q5. When I am with other people I generally feel ... on my own or part of the group?

Part of the group		A bit part of the group		on my own
4	3	2	1	0

Q6. When I am with other people I generally feel ... the same or different?

The same		A bit different		Different
4	3	2	1	0

### **Screening/ preparation process**

- Show yes/ no symbols, and sometimes/ always
- Participants are asked some questions to assess their understanding of the response terms.
- Factual questions, unrelated to the scale, are asked to test the participant's ability to discriminate between 'yes' and 'no' (e.g. 'Do you live in Scotland?')
- and between 'sometimes' and 'always' (e.g. 'Do you have fish for tea?') and to understand the symbols (e.g. 'Which card means "always"?').

### **Preparatory instructions**

'Hello. My name is . . . . I would like to talk to you about how you have been feeling just recently. First, it would help if you could tell me something you did last . . . [provide day of the week]/about a week ago.' [Provide prompts as necessary or ask a carer to identify an anchor event.]

'I am going to ask you about how you have been feeling since [state anchor event last week]. Just between . . . and now, OK. There is no right or wrong answer - I just want to know how you have been feeling. If I don't explain things well enough, just ask me to tell you what I mean.

We will be using the pictures we looked at before.' [Recap on the meanings of these.]

### **Administrative instructions**

- Each question should be asked in two parts.
- First, the participant is asked to choose between a 'yes' and 'no' answer. Use the symbols, if necessary. If their answer is 'no', the score in that column ('0' or '2') should be recorded.
- If their answer is 'yes', they should be asked if that is 'sometimes' or 'always', and the score recorded as appropriate. Some respondents will be able to use the three-point scale from the start, others might learn the 'rules' as you proceed.
- Supplementary questions (*italics*) may be used if the primary question is not understood completely. If a response is unclear, ask for specific examples of what the participant means, or talk with them about their answer until you feel able to allocate it to a response category

**In the last week . . .**

	Never/ No	Sometimes	Always / a lot
1. Have you felt sad? <i>Have you felt upset?</i> <i>Have you felt miserable?</i> <i>Have you felt depressed?</i>	0	1	2
2. Have you felt as if you are in a bad mood? <i>Have you felt bad-tempered?</i> <i>Have you felt as if you want to shout at people?</i>	0	1	2
3. Have you enjoyed the things you have done? <i>Have you had fun?</i> <i>Have you enjoyed yourself?</i>	2	1	0
4. Have you enjoyed talking to people and being with other people? <i>Have you liked having people around you?</i> <i>Have you enjoyed other people's company?</i>	2	1	0
5. Have you made sure you have washed yourself, worn clean clothes, brushed your teeth and combed your hair?  <i>Have you taken care of the way you look?</i> <i>Have you looked after your appearance?</i>	2	1	0
6. Have you felt tired during the day?  <i>Have you gone to sleep during the day?</i> <i>Have you found it hard to stay awake during the day?</i>	0	1	2
7. Have you cried?	0	1	2
8. Have you felt you are a horrible person? <i>Have you felt others don't like you?</i>	0	1	2
9. Have you been able to pay attention to things (such as watching TV)? <i>Have you been able to concentrate on things (like television programmes)?</i> <i>What is your favourite [television programme]? Are you able to watch it from start to finish?</i>	2	1	0
10. Have you found it hard to make decisions? <i>Have you found it hard to decide what to wear, or what you would like to eat, or do?</i> <i>Have you found it hard to choose between two things?</i> <i>[Give concrete example if required.]</i>	0	1	2
11. Have you found it hard to sit still? <i>Have you fidgeted when you are sitting down?</i> <i>Have you been moving about a lot, like you can't help it?</i>	0	1	2
12. Have you been eating too little?  <i>Have you been eating too much?</i> <i>Do people say you should eat more/less?</i> [Positive response for eating too much OR too little is scored.]	0	1	2

13 Have you found it hard to get a good night's sleep?  [Ask questions to clarify information. If a positive response is given to one of the following, score positively.] <i>Have you found it hard to fall asleep at night?</i> <i>Have you woken up in the middle of the night and found it hard to get back to sleep?</i> <i>Have you woken up too early in the morning?</i> [Clarify time.]	0	1	2
14. Have you felt that life is not worth living?  <i>Have you wished you could die?</i> <i>Have you felt you do not want to go on living?</i>	0	1	2
15. Have you felt as if everything is your fault? <i>Have you felt as if people blame you for things?</i> <i>Have you felt that things happen because of you?</i>	0	1	2
16. Have you felt that other people are looking at you, talking about you, or laughing at you? <i>Have you worried about what other people think of you?</i>	0	1	2
17. Have you become very upset if someone says you have done something wrong or you have made a mistake? <i>Do you feel sad if someone tells you . . ./gives you a row?</i> <i>Do you feel like crying if someone tells you . . ./gives you a row?</i>	0	1	2
18. Have you felt worried? <i>Have you felt nervous?</i> <i>Have you felt tense/wound up/on edge?</i>	0	1	2
19. Have you thought that bad things keep happening to you? <i>Have you felt that nothing nice ever happens to you anymore?</i>	0	1	2
20. Have you felt happy when something good happened? [If nothing good has happened in the past week] <i>If someone gave you a nice present, would that make you happy?</i>	2	1	0

“Thank you for answering these questions. That was very helpful.”

“What are you going to do now? Have you any plans for the rest of the day?”

### Praise and Criticism Task

#### Performance theme (1):

**Scenario ID group:** You are at college and are asked to go to the shops to buy some things for a class task. When you get back, your tutor says

**Scenario Non-ID group:** You are at college and your tutor gives the class an assignment. You work on the assignment and hand it in. When you get it back, your tutor says

**Criticism:** “Everyone else managed fine but you’ve not tried hard enough”.

**Praise:** “Well done, you tried really hard”.



Picture 1



Picture 2



Criticism



Praise

**Performance theme (2):**

**Scenario (same for ID & Non-ID group):** You are at home and (someone relevant to participant's circumstances) is making dinner. She/ he asks for your help. When the dinner is ready, your (insert person) says

**Criticism:** "I'll do it myself the next time, you weren't much help".

**Praise:** "I couldn't have done it without you. You were a lot of help"



**Picture 1**



**Picture 2**



**Criticism**



**Praise**

**Skill theme (1):**

**Scenario ID group:** You are at college and you see someone trying to take a photograph of their friend. They can't seem to work the camera so you offer to take the photo. The person responds by saying

**Criticism:** "No thanks, you are rubbish at taking photos".

**Praise:** "Thanks, I have heard you are good at taking photos".



**Photo 1**



**Photo 2**



**Criticism**



**Praise**

**Skill theme (1):**

**Scenario Non-ID group:** You are at college using the computer. Someone on the computer beside you can't get the computer to work. You offer to help them. The person responds by saying

**Criticism:** "No thanks, you are rubbish at using computers".

**Praise:** "Thanks, I have heard you are good at using computers".



**Photo 1**



**Photo 2**



**Criticism**



**Praise**

**Skill theme (2):**

**Scenario ID group:** You are at college and you are told that there is an important visitor coming to visit the college. You volunteer to show them around. Your tutor tells you.

**Criticism:** “You don’t know your way around well enough. You will get lost”.

**Praise:** “Great. You are good at finding your way about”.



**Photo 1**



**Photo 2**



**Criticism**



**Praise**

**Skill theme (2):**

**Scenario Non- ID group:** You are at college. Your tutor asks someone to do a presentation at an open day to tell the visitors about your course. You volunteer and your tutor responds

**Criticism:** “I’ll find someone else. You’re not good at presenting in front of people”.

**Praise:** “Great. You have good presentation skills”.



**Photo 1**



**Photo 2**



**Criticism**



**Praise**

**Popularity theme (1):**

**Scenario (same for ID and Non- ID groups):** You are at college. You walk past a couple of people talking. You overhear them talking about you. You hear them say

**Criticism:** “Not many people get on well with her/ him”

**Praise:** “Everyone gets on really well with her/ him”



**Photo 1**



**Photo 2**



**Criticism**



**Praise**

## Popularity theme (2)

**Scenario (ID and Non-ID group):** You are at college, sitting talking with a group of friends about plans for the summer/ the weekend. Someone suggests going on holiday/ away for the weekend. You say you would like to go. Someone says

**Criticism:** “Maybe you should go with someone else. You are not really part of this group.”

**Praise:** “Great, you are a big part of this group, it wouldn’t be the same without you”.



Photo 1



Photo 2



Criticism



Praise

## Future plans (1)

**Scenario (same for ID group & Non- ID group):** A group of people at college are talking about their part time jobs. You say that you would like to get a weekend job. Someone in the group says

**Criticism:** “No one would want to give you a job”.

**Praise:** “There are lots of jobs you would be good at”



**Photo 1**



**Photo 2**



**Criticism**



**Praise**

**Future plans (2):**

**Scenario (same for ID group & Non- ID group):** You are at college talking to a group of people. You say that you would like to be in the student council. Someone in the group says

**Criticism:** “you would be rubbish at that; no one would listen to you”.

**Praise:** “you would be good at that; people would listen to you”.



**Photo 1**



**Photo 2**



**Criticism**



**Praise**

## Autonomy theme (1)

**Scenario ID group:** You need new clothes and want to go shopping with your friends. You go and ask your (someone relevant to participants situation) and she/ he says

**Criticism:** “You can’t manage to choose your own clothes”

**Praise:** “Yeah sure, you are good at managing to choose clothes”.

**Scenario Non- ID group:** You are at home and you want to redecorate your room/ the kitchen. You say to your (mum/ someone they live with/ friend) and she/ he says

**Criticism:** “I’ll help you with that. You can’t manage to make decisions about the house”.

**Praise:** You know what you’re doing. You are good at making decisions about the house”.



Photo 1



Photo 2



Criticism



Praise

**Autonomy theme (2)**

**Scenario (ID group):** You want to buy a new outfit for a party you have been invited to. You mention to your mum/ dad/ carer that you plan to do this at the weekend. They say

**Criticism:** “I’ll go with you. You can’t manage your own money”.

**Praise:** “Sure, I know you are good at managing your own money”.

**Scenario (Non-ID group):** You are at home talking to your Mum/ partner/ friend. You tell them a friend has asked to borrow money. They say

**Criticism:** “You should get advice about that. You’re not good at making decisions about money”.

**Praise:** “Ok. Well you know what you are doing. You are good at making decisions about money”.



**Photo 1**



**Photo 2**



**Criticism**



**Praise**

## **Coping with criticism and praise**

### **A research study**

#### **Information Sheet**

Please read this information sheet, or ask someone to read it



You can talk to your carers or family about the study. Ask them what they think about it.



My name is Lynn. I am studying at university.



#### **What is this about?**

I am doing a research study as part of my university course.

I am inviting you to take part.

#### **What will the study find out?**

I want to talk to people about how they feel about themselves. I also want to find out how they cope with different situations. This will help psychologists learn how to help people who have been treated badly by other people.

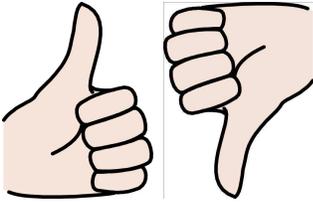
The starts in October 2010. It finishes in August 2011.

### **Why do you want me to take part?**

I am asking you to take part because you are an adult who attends college.

I hope that 42 people will take part in the study.

### **Do I have to take part?**



No. You decide if you want to take part.

It is OK to change your mind. You don't have to say why.

### **What will happen if I decide not to take part?**

It is OK to say no.

If you don't want to take part, this will not affect the care and support you receive. If you do not take part, it will not affect your grades in any way.

### **What do I have to do if I take part?**

I will meet you at college.

If you say yes, you will be asked to sign a consent form.

I will meet with you for about an hour. If this seems too long for you, you can choose to have two shorter meetings instead.

The meeting will be in four parts:

1. I will ask you questions about yourself. These will be questions about your age and where you live.
2. I will ask you some questions about how you feel about yourself.
3. I will show you some pictures that make up a story. I will ask you to imagine you are in these situations.



The person in these situations will say something to you. Some situations will include nice things and sometimes negative things. I will ask you questions about these situations.

4. I will ask you to do some puzzles with pictures and words.



The meeting will be recorded with a tape recorder.

### **What if I change my mind and do not want to take part during the study?**



You can change your mind about taking part, or stop, at any time. You do not have to give a reason.

If you change your mind this will not affect the care and support you receive.

### **Will anything bad happen to me if I take part?**



You have to give up about an hour of your time. It is unlikely that anything bad will happen because of taking part.

### **Are there any benefits to taking part?**



You are unlikely to feel any benefit from talking to me. People who have taken part in other studies have found it interesting. I will send you a copy of the results when I have them. In the future, it is hoped the study will allow psychologists to help people who have been treated badly by others.

### **Will other people find out about what I say?**



Anything you say is kept private. The information will be kept very safely on a computer.

I may write about things you have said in a report. Your name will not be used in this report. No one will know that you have spoken to me unless you tell them.

The only time I might have to talk to someone else, is if I think you need extra help. This will only happen if I am very worried about you or someone else.

### **What will happen to what I say?**

When the study is finished, I will write about what you and the other people have said.



Other psychologists will be able to read it. A copy is also kept at the library at the hospital so other people can read it too.

### **How can I take part?**

You can let your college tutor know and they will pass your name onto me. I will then arrange to meet you in college.



You can also fill in the reply sheet. You can give it to me or post it in the stamped addressed envelope. You can ask someone to help you with this.

**Thank you for reading this.**



**You can ask me questions about the study.**

**You can phone, email or write to me.**



Lynn Ackland  
Section of Psychological Medicine,  
Gartnavel Royal Hospital  
1055 Great Western Road  
Glasgow  
G12 0XH

Tel: 0141 211 3920

Email: [9803684a@student.gla.ac.uk](mailto:9803684a@student.gla.ac.uk)

**Someone else you can ask questions, and find out what taking part in a study is about:**

**My supervisor**

Professor Andrew Jahoda  
Consultant Clinical Psychologist  
Section of Psychological Medicine  
Gartnavel Royal Hospital  
1055 Great Western Road  
G12 0XH  
Tel: 0141 211 3920

## Reply sheet

If you want to take part in my study, please fill in this sheet. You can give it to me or post it using the stamped addressed envelope provided.

Name .....

Address .....

.....

.....

Telephone Number .....

College.....

Lynn Ackland  
Section of Psychological Medicine  
University of Glasgow  
Gartnavel Royal Hospital  
1055 Great Western Road  
GLASGOW  
G12 0XH

## CONSENT FORM

Coping with criticism and praise.

A research study

	<b>Please circle</b>	
	<b>Yes</b>	<b>No</b>
I have read and understood the information sheet	✓	✗
I have asked all the questions I want to	✓	✗
My questions have been answered	✓	✗
I know it is OK to say 'No' to taking part. I don't have to say why.	✓	✗
I know I can change my mind and say 'No' later on.	✓	✗
I know that a report will be written about the things I have said. I know the report will not include my name.	✓	✗
I agree to the meeting being recorded	✓	✗
<b>I agree to take part in the research study</b>	✓	✗

\_\_\_\_\_  
**Name of participant**                      **Date**                      **Signature**

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

\_\_\_\_\_  
**Researcher**                      **Date**                      **Signature**

**Researcher**  
Lynn Ackland  
Trainee Clinical Psychologist  
Section of Psychological Medicine  
Gartnavel Royal Hospital  
Administration Building  
1055 Great Western Road  
G12 0XH

**Supervisor**  
Professor Andrew Jahoda  
Consultant Clinical Psychologist  
Section of Psychological Medicine  
Gartnavel Royal Hospital  
Administration Building  
1055 Great Western Road  
G12 0XH

Tel: 0141 211 3920

Email: 9803684a@student.gla.ac.uk

Thank you for agreeing to take part in the study



## **PARTICIPANT INFORMATION SHEET**

### **Coping with criticism and praise; the emotional wellbeing of people with intellectual disabilities.**

#### **A research study**

You are being invited to take part in a research study. This study is being conducted as part of my university course at the University of Glasgow. Before you decide it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Ask us if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part.

Thank you for reading this.

#### **What is the purpose of the study?**

This study will investigate how people cope with different situations. I am interesting in situations where people are given criticism or praise by another person. I am hoping to investigate if there are differences between people who have a learning disability and those who don't, in the way they cope with these situations. This is important as being given criticism or treated negatively by other people can have an impact on our mental health. Therefore, this study would improve our understanding of how people cope with negative situations. In the future this may help psychologists consider how to help people who have been treated in this way.

The study runs from October 2010 to August 2011.

#### **Why have I been chosen?**

You have been chosen as you are an adult between 18 and 65 years old who attends college. I hope to speak to 42 people throughout the research study.

#### **Do I have to take part?**

It is up to you to decide whether or not to take part. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form. If you decide to take part you are still free to change your mind at any time and without giving a reason.

The decision not to take part will have no effect on your college course or grades.

**What if I change my mind and do not want to take part during the study?**

You can change your mind about taking part, or stop, at any time. You do not have to give a reason.

**What will happen to me if I take part?**

I will visit the college to give you information about the study. If you agree to take part, you will meet with the researcher on one occasion. We will meet at your college at a time that suits you. This meeting will last about an hour.

The meeting will be in four parts:

1. Completion information sheet about yourself (age, living situation, involvement with mental health services)
2. Completion of 2 questionnaires. These include questions about how you feel about yourself.
3. Praise and criticism task. You will be asked to imagine yourself in some scenarios. In these scenarios you will either be told something positive or negative about yourself. You will then be asked questions based on these scenarios.
4. Test of cognitive ability. This includes some puzzles and tests that give an estimate of cognitive ability (IQ).

The meeting will be recorded using a sound recorder.

**What do I have to do?**

Taking part in the study will involve one meeting (as described above) with the researcher. You are not required to make any changes or restrictions to your lifestyle.

**What are the possible disadvantages and risks of taking part?**

We do not think that there are any risks of taking part in the study. In the unlikely event that you find taking part in the study upsetting, I will stop the study and give you time to discuss how you feel. It is your decision whether you continue with the study. I can also inform your family or doctor how you are feeling, if you wish.

**What are the possible benefits of taking part?**

It is unlikely that there will any direct benefit from taking part in the study. Previous studies, with similar tasks, have been interesting to the people who have taken part.

The information collected from the study will be used to develop a better understanding of how being treated negatively by others affects people. This may help us consider how to help people who have been treated poorly.

**Will my taking part in this study be kept confidential?**

All information collected about you during the course of the research will be kept strictly confidential. Any information about you will have your name and address removed so that you cannot be recognised from it. The data will be stored on an encrypted laptop and backed up on a secure NHS drive. The study will comply with the Data Protection Act (2000).

**What will happen to the results of the research study?**

The study will be written up in my thesis as part of my doctorate course. This will be completed in September 2011. This thesis will be available in the university library.. The study may also be published in professional journals. You can request a copy of the results if you wish. You will not be able to be identified from the results that you took part in the study. All results are anonymised.

**Who is organising and funding the research?**

This study is being completed as part of my Doctorate of Clinical Psychology course at the University of Glasgow. The course is funded by NHS Education Scotland, who provides the funding for this study.

**Who has reviewed the study?**

The University of Glasgow has reviewed and approved this study. The faculty of Medicine ethics committee has reviewed and provided ethical approval for the study.

**How do I take part?**

If you want to take part in the study, fill in the reply sheet. You can give it to me or post it in the stamped addressed envelope.

**Contact for Further Information**

**Researcher**

Lynn Ackland  
Trainee Clinical Psychologist  
Section of Psychological Medicine  
Gartnavel Royal Hospital  
Administration Building  
1055 Great Western Road  
G12 0XH

**Supervisor**

Professor Andrew Jahoda  
Consultant Clinical Psychologist  
Section of Psychological Medicine  
Gartnavel Royal Hospital  
Administration Building  
1055 Great Western Road  
G12 0XH

Tel: 0141 211 3920

Email: 9803684a@student.gla.ac.uk

Thank you for reading this information sheet

**Reply sheet**

If you want to take part in my study, please fill in this sheet. You can give it to me or post it using the stamped addressed envelope provided.

Name .....

Address .....

.....

.....

Telephone Number .....

Lynn Ackland  
Section of Psychological Medicine  
University of Glasgow  
Gartnavel Royal Hospital  
1055 Great Western Road  
GLASGOW  
G12 0XH



### CONSENT FORM

**Title of Project:** Coping with criticism and praise; the emotional wellbeing of people with intellectual disabilities.

**Name of Researcher:** Lynn Ackland

**Please initial box**

- 1. I confirm that I have read and understand the information sheet dated.....  
(version..... ) for the above study and  
have had the opportunity to ask questions.
- 2. I understand that my participation is voluntary and that I am free to  
withdraw at any time, without giving any reason, without my legal rights  
being affected.
- 3. I agree to take part in the above study.

Name of subject	Date	Signature
-----------------	------	-----------

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

Researcher	Date	Signature
------------	------	-----------

1 for subject; 1 for researcher

## **CHAPTER THREE**

### **Advanced Clinical Practice 1: Reflective Account**

#### **Reflections on the professional and emotional transition of a final year trainee**

**Lynn Ackland**

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**Submitted in part fulfilment of the requirements for the Degree of Doctor of  
Clinical Psychology**

## **Abstract**

This reflective account has provided me with the opportunity to use my current career stage and transition to qualification as a source of reflection and learning. I have used my initial broad reflections as a foundation to an in-depth reflection based on a specific experience of working as a Trainee Clinical Psychologist within a multi-disciplinary team. I have used Gibbs' model of reflection, which is a six stage structured model, to focus my thoughts and reflections surrounding this experience in order to gain self-awareness and learning. This reflective account has allowed me to consider issues such as formulating complex difficulties, integrating psychological knowledge into multi-disciplinary care and communicating formulations with team members and families. Throughout I have made reference to specific guidelines and research to ensure that this reflection is embedded within a framework of competency and skills development.

## **CHAPTER FOUR**

### **Advanced Clinical Practice 2: Reflective Account**

#### **Training other professionals in psychological principles and ways of working**

**Lynn Ackland**

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**Submitted in part fulfilment of the requirements for the Degree of Doctor of  
Clinical Psychology**

## **Abstract**

This reflective account focuses on the Clinical Psychologist in a training role and utilises Rolfe's model as a broad framework for the reflection. My initial reflections focus on my personal experience of working within a specialist trauma team, and the development of my skills during this time. Within a training role, I have reflected on my experience of training support staff who work with people who are homeless, and the skills that I believe I can bring to a training environment. I have focused on three aspects of my own practice; the therapeutic relationship, personal well-being and reflective practice. I have discussed how these skills can be applied to a training environment and my plan to develop them further.

