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**Psychological Morbidity and Expressed Motivation
In Patients Requesting Rhinoplasties**

and Research Portfolio

Submitted in partial fulfillment of the degree of Doctor of
Clinical Psychology within the Faculty of Medicine,
University of Glasgow

Craig A. Macneil
August 1997

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28

TABLE OF CONTENTS

	Pages
Introduction and Acknowledgments	I - III
1. Literature Review	1 - 20
Psychopathology and Expressed Motivation in Patients Requesting Cosmetic Rhinoplasty.	
2. Research Proposal	21- 33
Self Report Of Psychopathology, Personality Factors and Self-Esteem In Patients Requesting Cosmetic Rhinoplasty.	
3. Research Paper	34 - 53
Psychological Morbidity and Expressed Motivation in Patients Requesting Rhinoplasties.	
4. Service Evaluation Project	54 - 64
Evaluation of the Service Provided by the Spinal Injury Network to the Queen Elizabeth National Spinal Injuries Centre.	

	Pages
5. Clinical Case Research Study	65 - 83
Body Dysmorphic Disorder and Domestic Violence - A Single Case Study.	
6. Clinical Case Research Study	84 - 100
Assessment and Unsuccessful Intervention with Recurrent Abdominal Pain in an Asian Child - A Single Case Study.	
7. Clinical Case Research Study	101 - 117
Alcohol Dependence with Comorbid Extended Bereavement Reaction - A Single Case Study.	
8. Appendices	118 - 157

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For P.M., a brilliant psychologist.

MAJOR RESEARCH PROJECT LITERATURE REVIEW

Psychopathology and Expressed Motivation in Patients Requesting Cosmetic Rhinoplasty - A Review of the Literature

This paper is written according to the guidelines specified
by *Psychosomatic Medicine* (please see Appendix 1.1)

Craig A. Macneil

Psychopathology and Motivation in Rhinoplasty Patients
(abbreviated title)

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"One general misconception about cosmetic patients is that they are seeking enhancement of beauty to gratify perfectionistic or infantile needs for social success or "popularity" ...but their aim is rather to get rid of self-conscious preoccupations and body concerns as a way of freeing themselves of emotional barriers and blocks and to the end of better managing the fundamental problems of living."

- Edgerton, Jacobsen & Meyer (1961, p.144)

"The face is the mirror of the soul"

- Cicero (In Synott, 1989, p.614)

Abstract

This review will examine literature on psychopathology and motivational factors in patients seeking cosmetic surgery, and rhinoplasty in particular. This will be put in context of cultural history and research on body image, self-esteem and physical appearance. It will be discussed that despite strong social, cultural and historical significance being attached to physical attractiveness, and that rhinoplasty patients have been identified as significantly more disfigured than controls, this population, and males in particular, are described overwhelmingly in the literature as psychopathological. It is suggested that motivation for cosmetic surgery is not simply a rational response to social disadvantage, as a number of individuals without disfigurement seek surgery, while a number with disfigurement do not. It is concluded that due to methodological weaknesses in much of the literature further research is necessary.

Key words: Cosmetic surgery, psychopathology, motivation.

The Cultural Importance of Physical Appearance

Reviews by Synott (1989; 1990) describe the 'beauty mystique' - in which beauty is equated with goodness and ugliness with evil - as having been a pervasive and intrinsic part of western culture for thousands of years. For example Aristotle suggested that the face represents 'mental character' (in Synott, 1989 p.614), Aquinas that "the beautiful and the good are identical in reality" (ibid p.602), and Castiglione in the 15th century stated "for the most part the ugly are also evil and the beautiful good" (ibid p.682).

Synott (1990) suggests that the beauty mystique is evident in a number of areas including physiognomy, philosophy, theology, linguistics, ethnic relations, television and films, cosmetics, advertising, criminology, poetry and literature, including children's stories and works by Milton, Arthur Conan Doyle, Ian Fleming, Mary Shelley, Agatha Christie, Robert Louis Stevenson, Oscar Wilde, Roald Dahl, George Orwell and William Shakespeare (pp.55-72). He concludes, "The consensus within European cultural history has been impressive. Beauty is objective, relative to goodness and to God, and moral and physical beauty are related. (In addition) it is located primarily in the face"(Synott, 1989, p.625).

Bradbury (1994) proposes that the literature on 'stigma' (e.g. Goffman, 1963) - in which physical marks ('stigmata') would be used stereotypically to signify negative qualities in an individual - may be a useful way to conceptualise why this effect may have occurred.

Social Psychological and Socioeconomic Research on Physical Attractiveness

Although research on physical attractiveness has been conducted since the 1920s (Perrin, 1921; Thornton, 1943, 1944), it was perhaps research by Walster et al (1966), (replicated by Dion et al, 1972), who found a large degree of cultural consensus as to what constituted facial attractiveness, that began empirical study and investigation of the implications of facial appearance.

Research has found that perceived physical attractiveness is more important than personality measures, intelligence, similarity of interests or any other factor in predicting whether 'blind date' partners wished to see each other again (Walster et al, 1966; Brislin & Lewis, 1968; Tesser & Brodie, 1971). In addition, physically attractive individuals have been attributed with more desirable personalities, greater chance of career success and of finding happiness, of becoming good husbands or wives, and as being more sensitive, kind, interesting, strong, poised, sociable and outgoing than those who are less physically attractive (review in Dion et al, 1972; Kalick, 1982).

Evidence of the 'beauty mystique' has appeared in other research. For example, Efran (1974) found in a simulated jury experiment that attractive defendants were more likely to be acquitted, or if found guilty to be recommended for shorter sentences. With all else being equal, more attractive people, both male and female, have also been found experimentally to be more likely to be successful in employment applications (Dipboye et al, 1975), and in a national study of 4000 Canadians, to earn more than who were less attractive (Kaczorowski, 1989, in Synott, 1989). Finally, appearance has been found to be influential in numerous other areas including politics, advertising, teachers' expectations and parental discipline (reviewed in Bull & Rumsey, 1988), with physical unattractiveness being found to inhibit helping behaviour (Bull & Stevens, 1981, in Robin et al, 1988).

Body Image, Self Esteem and Psychological Functioning

Originating from the individual's subjective experience of their physical appearance and their interpretation of others' reactions to them (Schilder, 1964), the importance of body image has been identified both in psychological and surgical literature (Linn & Goldman, 1949; Reich, 1969; Thomson et al, 1978; Belfer et al, 1970; Baumeister, 1993).

Edgerton et al (1961) highlighted the importance of body image, defining it as the "basic foundation of personality function" (p.138), and Belfer et al as "that aspect of the self-concept ...around which other aspects of the self-concept are elaborated" (in Robin et al, 1988, p.541). Support for a high correlation between body image and self concept measures has been identified empirically in the general population (Secord & Jourard, 1953; Rosen & Ross, 1968) with Clifford et al (1984) finding that for females undergoing reconstructive surgery, the concepts of 'face', 'figure' and 'body' were closest to that of 'me'.

The research literature has identified body image as particularly relevant to self-esteem, with recent study finding correlations of around .7 and .8 between perceived physical appearance and global self-esteem in the general population (Baumeister, 1993, p.95). This high correlation been found to be stable across a number of groups including young and older children, adolescents and adults, and is equally high in special populations such as the intellectually gifted and learning disabled (ibid). Baumeister concluded that for the normal population, "evaluation of one's looks takes precedence over every other domain as the number one predictor of self-esteem" (p.96).

The subjective importance of body image in terms of self-esteem and personality, in addition to the cultural and social significance of physical appearance described earlier, has clear implications for individuals with physical abnormalities. For example, in research on congenital abnormality in children, Easson (1966) noted "adverse emotional reaction based on individual or cultural values resulting in marked limitation of emotional growth and stability ... so that the resulting emotional defect was more handicapping to the child's functioning than the initial physical defect" (p.458). Harris (1981) found in a population of adults with various abnormalities of appearance that "about two thirds ... described feelings of inferiority, unattractiveness, lack of confidence (and) insecurity" (p.318). Sweitzer (1989), supporting this view, stated, "abnormal appearance affects the development of body image and consequently the individual's personality and self-esteem" (p.249). This may be particularly relevant to prospective rhinoplasty patients, who in research in which raters categorised photographs, were found to be significantly more disfigured than controls (Hay, 1970; Robin et al, 1988).

However, it is important to note that there does not appear to be a direct correlation between severity of disfigurement and psychological symptomatology on various measures (Robin et al, 1988; Barsky, 1944; Hay, 1970; Olley, 1974). Prospective cosmetic surgery patients have been differentiated on psychiatric symptom scores from controls with similar appearance (Robin et al, 1980), the latter showing significantly less pathology. There is not a simple linear or inevitable relationship between physical disfigurement and psychopathology, and Bradbury (1994) described a number of intervening variables occurring in the literature on resilience, which perhaps mediate between physical appearance and psychopathology. These include "...intelligence, sense of humour, a stable childhood and a strong sense of self-esteem" (p.304).

Cosmetic Surgery and Psychology

The American Medical Association (1974) defined cosmetic surgery as "Surgery ... to review or change texture, configuration or relationship with contiguous structure, any feature which would be considered to the average prudent observer within the range of 'normal'" (in Greer, 1984, p.473).

Recognition of a relationship between cosmetic surgery and psychological issues has had a long history, with Tagliocozzi (1597) describing rudimentary facial restorations on injured soldiers as "... not so much that may delight the eye but that they may buoy up the spirit and help the mind of the afflicted" (in Kalick, 1978, .244).

More recently, this relationship has been described by Schweitzer (1989) who stated "the aims of corrective or cosmetic surgery have always been to improve the psychological well-being of patients" (p.250), and Wright & Wright (1975), who proposed that "regardless of the physical need for aesthetic improvement, individuals who seek facial plastic surgery always have underlying psychological considerations" (p.151).

Prospective Rhinoplasty Patients and Psychopathology

Rhinoplasty is perhaps the oldest and most commonly undertaken form of cosmetic surgery (Guyuron, 1995), with suggested reasons for this including the conspicuousness of the nose (Linn & Goldman, 1949, p.310), with cultural (ibid), and psychodynamic explanations (Gifford, 1972; Thomson, 1978) also having been offered.

There has been much interest in examining psychopathology in potential rhinoplasty and other cosmetic surgery patients. This may be partly due to the wish to identify why individuals undertake pain, inconvenience, risk of complication, uncertainty of result, and expense (Burk et al, 1985) in order to alter their appearance, which as noted previously is often within normal limits. With cosmetic surgery being elective, Barsky (1944) suggests that this may make these patients more vulnerable than other surgical patients, as their extreme enthusiasm to undertake the surgery may leave them open to commercial exploitation. Concern about psychological status in prospective cosmetic surgery patients has also been heightened by research on the cosmetic surgical insatiable patient (Reich, 1975; Groenman & Sauer, 1983) and patients suffering somatic delusions and Body Dysmorphic Disorder (Druss et al, 1971; Veale et al, 1996).

Research has described a high proportion of patients seeking cosmetic surgery, and rhinoplasty in particular, to be suffering from various psychopathology (Hill & Silver, 1950; Jacobsen et al, 1960; Meyer et al, 1960; Hay, 1970; Reich, 1969). Linn and Goldman (1949) stated, "With few exceptions the patients who came for rhinoplasty were clearly ill from a psychiatric point of view. This illness varied from minor neurotic reactions at one extreme to overt schizophrenic psychosis at the other" (p.308). Both Robin et al (1988) and Gipson and Connolly (1975) reported high incidence of schizophrenia and severe neurosis in rhinoplasty patients, with psychiatric diagnosis being reported in around 50-80% of this group (reviewed in Burk et al, 1985).

Slator (1993), examining National Health Service and private rhinoplasty patients, concluded "...when a patient with no history of injury does gain a referral to the N.H.S., it is probably because he/she has had a particularly high level of psychological disturbance" (p.331).

Hill and Silver (1950) expressed extreme concern regarding the psychological status of this group, suggesting that the desire for consultation with a cosmetic surgeon should itself be regarded as a symptom of neurosis (p.354). Supporting this stance, Meerloo (1956) specifically identified patients requesting surgery for minimal disfigurements, asserting that this group suffered serious psychopathology, and generally that "plastic surgery often intervenes in a complicated psychological battle" (p.42).

Concern regarding psychopathology has also examined the prevalence of personality disorder and whether there is a 'personality type' common to rhinoplasty patients. Linn and Goldman (1949), studying 58 potential rhinoplasty patients, concluded, "there emerged with great regularity ... a constellation of symptoms which we have designated as the psychiatric syndrome of the rhinoplasty patient" (p.307). These included concern that others looked down on them, shyness, seclusiveness, social anxiety, poor concentration, work disturbance, and concern that they were being observed by others (ibid).

Research has indicated personality disorder in 14-65% of cosmetic surgery patients (reviewed in Wengle, 1986a). Hay (1970) suggested 40% of cosmetic rhinoplasty patients presented with a personality disorder, adding that, "... (on) symptom measures (i.e., general hostility, personal illness and neuroticism) there were highly significant differences between the patients and the controls" (p.93), and that on personality measures, they were "... significantly more obsessed, introverted and intropunitive" than controls (ibid). It is also notable that within this group, male rhinoplasty patients have been identified as particularly pathological (Linn & Goldman, 1949; Wright & Wright, 1975; Thomson et al, 1978; Edgerton, 1985; Cash, 1986).

Contrary to the psychopathological viewpoint, a review by Groenman and Sauer (1983) stated "the personality of the cosmetic surgical patient shows as a rule no deviation or a very slight one, from normality" (p.242). This was supported by Wright & Wright (1975) who stated "...most cosmetic patients are neither deeply disturbed psychologically, nor likely to emerge as severe personality problem cases" (p.148).

Goin and Goin (1986) with some justification, commented of the literature on rhinoplasty patients, "As a rough rule, the older the date of the publication, the more disturbed the patient appears to be" (p.91). However, a number of recent papers also suggest significant psychopathology in this group. For example, Jerome (1992) reported of prospective rhinoplasty candidates, "the patients were significantly more disturbed on measures of psychiatric morbidity than the control subjects and scored higher on measures of neuroticism and social anxiety and lower on measures of extroversion" (p.577).

Perhaps one of the most helpful developments in understanding the psychological status of cosmetic surgery patients, and moving away from the polarised debate of psychologically 'ill' or 'not ill', is a model by Burk et al (1985) advocating inconsistent self-esteem. This suggests that individuals seek cosmetic surgery to reduce cognitive dissonance (Festinger, 1957) between their overall self-esteem, which is normal, and a decreased physical self-esteem which relates to the specific body part they are unhappy with. Surgery is considered by Burk et al to be a non-psychotic reaction (p.271) to reduce this inconsistency.

Expressed Motivations for Surgery

Knowledge of prospective cosmetic surgery patients' motivations has been identified as crucial to successful outcome, not least because of concerns about psychopathology

in this group, but also, as Hill and Silver (1950) note, "... motivation must necessarily affect the prognosis of the cosmetic change on the total personality adjustment" (p.354). Greer (1984) proposed "understanding the motivations, expectations and desires of a patient seeking cosmetic surgery is at least as important as manual dexterity in achieving consistently satisfactory results" (p.474).

With many papers distinguishing between internal and external motivations, the former involving the patient's subjective desire to alter their appearance and the latter involving the patient wishing to please others, internally motivated individuals are seen as being better candidates for surgery (Goin et al, 1976; Edgerton & Knorr, 1971).

In an early paper looking specifically at the motivations of cosmetic rhinoplasty patients, MacGregor and Schaffner (1950) identified eleven commonly found themes. These included the wish to alter personality by altering appearance, to alleviate feelings of inferiority, the "... extreme narcissistic need to be admired...", the wish to alter a physical feature similar to that of "...a rejecting or rejected parent", and the unconscious use of a physical defect to justify failure in life (p.289). The differentiation between 'conscious' and 'sub-conscious' motivations was also described by Reich (1969), the former including self-consciousness (also in Belfer et al, 1979), interpersonal problems, employment reasons and commencing a new chapter in their lives, and the latter often relating to the symbolic significance of the nose (p.9).

Research describing motivations for cosmetic rhinoplasty in more psychodynamic terms has included the desire to 'change sex' or improve sexual attractiveness, to increase power or passivity, regression, sadistic/masochistic fantasies, penis envy, castration concerns, homosexual conflict, sibling rivalry (Hill & Silver, 1950), and

parental identification (Meyer et al, 1960; Jacobsen et al, 1960). Although many of these hypotheses are pervasive in early papers, generally little or no empirical validation is offered.

It should be noted that due to fear that the operation may be refused, prospective cosmetic surgery patients may not express their real motivations to the surgeon. Instead it has been found that more acceptable 'functional' reasons may be given by patients (Reich, 1969). Goin et al (1976) found that in 60% of patients having face-lift operations, "pre-operative stated motivations differed from the motivations stated post-operatively" (p.273), typically expressing reasons connected with employment and "responsibility" formerly, and "vanity" and expectations of life change latterly. It was further discussed that a conscious or unconscious "hidden agenda" might exist.

Wengle (1986a), and Hill and Silver (1950) concluded that patients seeking rhinoplasty do so for multiple and unique reasons. Unfortunately this is an area that has little empirical research in recent years and conclusions should therefore be made with caution.

Conclusions and Areas Needing Further Research

There has been considerable evidence suggesting numerous socioeconomic benefits associated with physical attractiveness, and that body image plays an important part in self-esteem. It has also been found that prospective rhinoplasty patients can be discriminated from controls on the basis of increased deformity. Kalick (1978) proposed a rational motivation for this group, suggesting "cosmetic surgery, by improving patients' experience, directly enhances their social value to their peers, and thus enables them to gain greater social rewards" (p.247). Burke et al (1985) concurred, noting the 'illness' model of cosmetic surgery patients "...fails to take into

account the strong, if unspecified, and public norms of beauty prevalent in our culture as well as the social world of the patient" (pp.270-271).

However, this approach does not appear to adequately explain why individuals with minimal or no objective deformity, who are therefore not responding to social disadvantage also request cosmetic surgery, and why many individuals with severe abnormalities do not. Khoo (1982) alluded to both "circumstantial" and "constitutional" factors (p.283) but little further study appears to have been conducted clarifying these. The view expressed by Kalick (1978) and by Burk et al (1985) also fails to explain why a number of researchers have found no correlation between subjectively measured deformity and level of psychological distress. The situation is clearly more complex than physical deformity resulting in socioeconomic disadvantage leading to the rational request for cosmetic surgery.

Although a fascinating literature exists examining cosmetic rhinoplasty and psychological issues, Wengle (1986b) noted that research in this area is "...still young" (p.489). Importantly, there is an absence of recent psychological, empirical and replicable studies. Much of the research, particularly prior to 1985, is based on small sample sizes, using anecdotal, small *n* or single case reports, and has no surgical control groups. In many studies data was obtained through psychiatric interview, with little specificity as to how this was undertaken and without standardised psychometric measures (e.g., Barsky, 1944; Book, 1971; Easson, 1966; Edgerton et al, 1961; Harris, 1981; Hill & Silver, 1950; Linn & Goldman, 1949; MacGregor & Schaffner, 1950; Olley, 1974; Reich, 1969; Schweitzer, 1989; Updegraff & Meninger, 1934). In addition, research generally excludes subjects with minimum deformity (Hueston et al, 1985), and is based primarily on the North American population.

It appears that a number of issues require further clarification, including:

- 1) Whether there is significant psychopathology in prospective rhinoplasty patients on objective measures of anxiety, depression, neuroticism and self-esteem.
- 2) Whether expressed motivations and expectations of these patients reflect societal pressures.
- 3) Whether individuals within this group suffering greater deformity present with higher rates of psychopathology.
- 4) Whether male patients present with higher psychopathology on standardised measures.
- 5) Whether there are discrete personality characteristics associated with this group.

Empirical examination of these and other areas may help us better understand the motivations, expectations and psychological state of patients requesting rhinoplasty.

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MAJOR RESEARCH PROPOSAL

Self Report Of Psychopathology, Personality Factors And Self-Esteem In Patients Requesting Cosmetic Rhinoplasty

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SUMMARY

This research will examine a number of psychological concepts relating to patients on a waiting list for cosmetic rhinoplasty in a specialist hospital (Canniesburn) in the Greater Glasgow area. Specific areas which will be examined are reported self-esteem, anxious and depressive symptomatology and personality characteristics of these patients.

Subjects will be selected by specialists in the hospital on the basis of their requests for surgery being of a cosmetic rather than functional nature, and asked if they would be willing to participate in a piece of psychology research. With their agreement, subjects will be sent a letter giving details of the study and given an appointment with the researcher.

During this appointment subjects will be asked to participate in a brief semi-structured interview, which will be followed by three questionnaires: the Culture Free Self-Esteem Inventory (CFSEI-2 Form AD) (Battle, 1992), the Hospital Anxiety and Depression Scale (HADS) (Zigmond and Snaith, 1983) and the Short Scale of the Revised Eysenck Personality Questionnaire (EPQ-RS) (Eysenck, Eysenck and Barrett, 1985).

Between thirty and thirty-five subjects will participate, who will be aged between eighteen and fifty years old, with both males and females being included.

INTRODUCTION

A number of researchers have identified the importance of perceived physical attractiveness to psychological and social functioning (see Synott, 1992, for review). Harris (1981) found in a study of patients with various abnormalities of appearance

that "about two-thirds ...described feelings of inferiority, unattractiveness, lack of self-confidence (and) insecurity ..." (p.318).

Harris (ibid) described a number of other areas in which his subjects described how they believed their appearance had affected their lives including the use of 'camouflage' techniques to disguise their appearance, withdrawal from social activities, hostility to others, sexual promiscuity, self-contempt, extreme self-consciousness, and difficulties in interpersonal relationships (pp.315-320).

A number of papers have pointed to the specific importance of the nose in physical appearance. For example, Linn and Goldman (1949) described the nose as "...the most conspicuous structure in the human body. There is no way to hide it except by hiding the entire face" (p.310). They add, "the patient who develops an obsession relating to the nose is particularly plagued because of the conspicuousness of the organ" (ibid). The importance of the nose has also been described in psychodynamic terms (e.g. Hill and Silver, 1950).

Considerable controversy surrounds the area of psychopathology in patients seeking cosmetic surgery, and rhinoplasty in particular. For example, Linn and Goldman (1949) reported, "With few exceptions the patients who came for rhinoplasty were clearly ill from a psychiatric point of view. This illness varied from minor neurotic reactions at one extreme to overt schizophrenic psychoses at the other" (p.308). Meerloo (1956) suggested that patients requesting surgery for minimal disfigurements suffered serious psychopathology, and that plastic surgery "intervenes in a complicated psychological battle". Hay (1970) found rhinoplasty patients to be more "obsessoid", introverted, intrapunitive and to have higher personal illness scores than controls.

In contrast with this, Groenman and Sauer (1983) reviewed two earlier papers (Groenman, 1978; Shipley et al, 1977, 1978), concluding that "the personality of the cosmetic surgical patient shows as a rule no deviation, or only a very slight one, from

normality" (p.242). Goin and Goin (1986) somewhat pointedly noted of psychological/psychiatric literature on rhinoplasty patients, "As a rough rule, the older the date of the publication, the more disturbed the patient appears to be" (p.91).

However, in contrast to this, a recent paper by Jerome (1992) stated, "the patients (i.e. on a waiting list for cosmetic rhinoplasty) were significantly more disturbed on measures of psychiatric morbidity than the control subjects and scored higher on measures of neuroticism and social anxiety and lower on measures of extroversion" (p.577).

It is due to the controversy surrounding this group, in addition to rhinoplasty being amongst the most commonly requested forms of cosmetic surgery (Book, 1971), and attracting considerable research, that this area has been selected for study.

AIMS

This research will examine four specific psychological areas relating to patients seeking cosmetic rhinoplasty, these being:

- 1) Expressed motivations for seeking surgery in intra/interpersonal terms
- 2) Anxious and depressive symptomatology
- 3) Expressed self-esteem in personal and social terms
- 4) Significant personality traits relating to this group, particularly neuroticism and extroversion

HYPOTHESES

Hypotheses are made for both the subject group as a whole and for within-group differences based on gender and severity of disfigurement (please see SUBJECTS section).

A. Comparing all Subjects with Test Norms

- 1) Subjects' scores of anxiety and depression will be significantly higher than in the normal population.
- 2) Subjects will score higher on neuroticism and lower on extroversion than the norm, testing Jerome's (1992) assertion.
- 3) The frequency of expressed motivations for surgery for the group as a whole will be in the following order: functional reasons, self-consciousness, to improve interpersonal relationships, employment reasons, as part of a start to a 'new life', and a need to be admired (found by Reich, 1969).
- 4) Subjects' scores on all measures of self-esteem will be significantly lower than for the normal population.

B. Within Group Comparison

- 1) Subjects' scores on anxiety and depression will not correlate significantly with their independently rated 'severity of disfigurement' classification (please see SUBJECTS section). This hypothesis is based on an observation by Harris (1982).
- 2) Males will show more extreme scores than females on all measures.

METHODOLOGY

Patients referred to Canniesburn Hospital for rhinoplasties which the consultant assesses to be for cosmetic as opposed to functional reasons, will be asked by the consultant, on their initial appointment to the hospital, if they would be willing to participate in a psychology research project. With their agreement, it will be explained that they will be contacted by letter, and given more details of the study. A letter will then be sent inviting the patient to attend an appointment with the researcher, which will include a brief description of the aims of the study and of what they will be asked to do. It will be stressed that attendance of this appointment is not compulsory, and will in no way affect their treatment at the hospital.

Subjects will attend one appointment with the researcher who will again explain that involvement in the research is voluntary and that they are free to withdraw their consent at any point. During this appointment, all subjects will be administered a brief semi-structured interview by the researcher, and will be asked to complete three questionnaires.

An estimation of the length of time to complete the questionnaire and the semi-structured interview will be made from piloting this with five of the subjects, who may be included in the results.

SUBJECTS

Subjects will be selected by surgeons and consultants from adult outpatients requesting rhinoplasty at Canniesburn Hospital. It has been requested that patients are selected on the basis that their reasons for seeking surgery are for cosmetic rather than functional reasons. Therefore subjects who seek reconstructive rhinoplasties following trauma or disease will be excluded from this research.

It is intended that around 30-35 subjects will be included in the study, with ages from 18-50 years and including subjects of both sexes. However, it is recognised from the literature that there is likely to be an unequal gender distribution within the population in favour of females (Dull and West, 1991).

Subjects will be classified by two independent raters (clinical specialists at Canniesburn Hospital) for severity of disfigurement using Hay's nine-point criteria (1970). This scale ranges from 'perfect feature' at one end, to 'very marked imperfection' at the other, and should allow for meaningful comparisons between groups on all the measures.

The interview and completion of questionnaires will be undertaken in an office within Canniesburn which has been arranged with the field supervisor.

SEMI-STRUCTURED INTERVIEW

The semi-structured interview will be designed to establish:

- 1) Expressed motivation for requiring surgery using Anderson and Johnson's checklist (1978, p.91).
- 2) How subjects feel their appearance affects their life in interpersonal and intrapersonal terms.
- 3) Subjects' expectations of the effects of surgery in intra/interpersonal terms.
- 4) What prompted the subject's request for surgery now, and whether previous requests had been made to G.P.s or other referring agents which had been refused.

Data will be collected of demographic factors (gender, age and marital status), the latter two of which, with subjects' consent, could be obtained from medical records.

QUESTIONNAIRES

1) The Hospital Anxiety and Depression Scale (HADS) (Zigmond and Snaith, 1983) - a 14 item scale designed to screen for anxiety and depression in a general hospital setting, with research indicating its validity in primary care and community settings (ibid).

2) The Second Edition of the Culture Free Self Esteem Inventory, (CFSEI 2 Form AD), (Battle, 1992), comprising 40 forced-choice, yes/no questions, with four subsections: 'general self-esteem', 'social/peer related self-esteem', 'personal self-esteem' and a lie subtest. A total score can also be obtained. This measure claims to be quick to administer (suggested time of 10-15 minutes), easy to understand, has reasonable test-retest reliability (0.81), content validity, and concurrent validity (with the BDI and MMPI), and also appears to give meaningful subtest scores.

3) The Short Scale Eysenck Personality Questionnaire - Revised (EPQ-RS) (Eysenck, Eysenck and Barrett, 1985) - a 48-item yes/no questionnaire measuring the four factors of Psychoticism (P), Extroversion (E), Neuroticism (N) and Lie (L), which have been found in several studies (e.g. McKenzie, 1988) to be real, reliable and replicable across populations and sexes.

PRACTICAL APPLICATIONS

This research may be practically applicable in identifying possible key psychological features which would help professionals involved in cosmetic surgery in understanding the motives and underlying issues of their patients. This could improve the psychological/ psychiatric assessment of patients and may help focus therapy or counselling in addition, or as an alternative to surgery.

Specifically this could involve:

- 1) Improving the psychological/psychiatric assessment of patients by allowing the consultant to immediately inquire about particular areas identified by the research as relevant to this group, e.g. low self-esteem in a particular domain, specific anxious or depressed cognitions or personality traits which make this group particularly vulnerable.
- 2) A clearer understanding, in psychological terms, of the motivations of cosmetic surgery patients.
- 3) Assisting in identification of particular psychological factors which may make an individual particularly suitable for surgery, e.g. realistic appraisal of objective deformity and reasonable expectations of surgical outcome.
- 4) To identify psychological factors which may contraindicate surgery, or in which referral to a psychologist or psychiatrist may be more beneficial for both the patient and the service.
- 5) In assisting patients following surgery, described by Edgerton, Jacobsen and Meyer (1961) as "clarification of psychological issues (which) can facilitate smoother post-operative course by reducing anxiety".

DATA ANALYSIS AND ETHICAL APPROVAL

Attempts will be made to match subjects on gender, age and severity of disfigurement as far as possible given that there are likely to be unequal numbers of males and females and that little control can be exercised over patients requesting surgery in a given period. Data will be analysed using the SPSS statistical package, with calculation of many of the correlations being possible through one or two-tailed T-

tests. Analysis will be conducted both within the subject group and between the subject group and established norms, with this being undertaken for all the subscores on the three questionnaires.

The researcher is currently seeking ethical approval for this project through the Research Ethics Committee of the Glasgow Royal Infirmary University N.H.S. Trust. This will take a minimum of six weeks, and ten weeks should alterations be required. Therefore the project should commence around mid June 1996.

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MAJOR RESEARCH PROJECT PAPER

Psychological Morbidity and Expressed Motivation In Patients Requesting Rhinoplasties

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Written in accordance with guidelines for *The British Journal of Plastic Surgery*
(Appendix 2.1)

Psychological Morbidity and Expressed Motivation In Patients Requesting Rhinoplasties

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SUMMARY. Research was undertaken to assess psychological morbidity, expressed motivation and expectations of surgery in individuals (n=50) who had requested cosmetic rhinoplasties. Subjects participated in semi-structured interviews, completed three questionnaires and were categorised on their appearance by two means. Hypotheses were made for the total subject population and for differences according to gender and independently-rated severity of nasal disfigurement. Results supported some hypotheses, with subjects indicating higher anxiety and neuroticism, and lower extraversion and self-esteem than normed scores. Although less disfigured subjects appeared to show greater neuroticism and lower self-esteem, this relationship was not statistically significant ($p < .05$). Other hypotheses were not supported, as subjects did not meet clinical 'caseness' for depression, and males did not appear to be significantly more psychopathological on any measures and scored significantly lower neuroticism than females. Results should be interpreted with caution due to small subgroup sizes in the sample.

INTRODUCTION

Study of the interface between psychology and cosmetic surgery has had an extremely long history (see Tagliocozzi, 1597 in Kalick, 1978), with assertions in numerous papers that the surgeon's awareness of psychological issues is of critical importance to successful outcome (McKinney & Cunningham, 1992; Pertschuk, 1991; Reich, 1982; Schweitzer, 1989; Stewart et al, 1996; Wright & Wright, 1975; Greer, 1984).

A particularly significant aspect of this appears to be professionals' awareness of subjects' motivations and expectations, which Greer (1984) described as "...at least as important as manual dexterity in achieving consistently satisfactory results" (p.474). Several papers examine these areas (Hill & Silver, 1950; MacGregor & Schaffner, 1950; Reich, 1969; Wengle, 1986).

A number of studies have suggested that cosmetic surgery patients, and those requesting rhinoplasties in particular, exhibit higher psychological morbidity than the normal population, and a high prevalence of personality disorders, neurosis and psychosis is reported in this group (Edgerton et al, 1960, 1991; Hill & Silver, 1950; Jacobsen et al, 1960; Meyer et al, 1960; Hay, 1970; Reich, 1969). Male rhinoplasty patients have been described as particularly pathological (Linn & Goldman, 1949; Wright & Wright, 1975; Thomson et al, 1978; Edgerton, 1985; Cash, 1986). A review by Goin & Goin (1981) concluded "All evidence strongly suggests that they (rhinoplasty patients) are more psychologically disturbed than the general population" (p.125).

However it is notable, particularly in earlier research, that many used small sample sizes and very few included control groups or standardised measures, with diagnoses often appearing in the absence of empirical assessment. Due to these shortcomings further study appeared necessary.

Research Questions

The research was designed to test the following hypotheses (based on a literature review by Macneil, 1997);

- 1) Subjects will report higher depression, anxiety and neuroticism, and lower self-esteem and extraversion than normed scores.
- 2) These scores will be unrelated to severity of disfigurement.
- 3) Males will show higher depression, anxiety and neuroticism, and lower self-esteem and extraversion than females.

Through the semi-structured questionnaire, the research would also examine subjects' expressed motivations for, and expectations of, the surgery.

Method

Subjects

Letters including information about the research, a consent form and a prepaid envelope were written to all the patients ($n=112$) who were on waiting lists for rhinoplasty or septorhinoplasty operations at two Glasgow hospitals (Canniesburn Hospital (CH) and Glasgow Royal Infirmary (GRI)) between July 1996 and May 1997.

All subjects had been accepted for surgery, with waiting times varying from one day (inpatient subjects) to an unspecified period which would be within twelve months (outpatients).

A number of potential subjects failed to reply ($n=38$, or 34%), others refused to participate ($n=19$, 17%) and a small number failed to attend ($n=5$, 4%), leaving a total of 50 subjects (45%). All subjects had requested the operation themselves, were adult (aged 16-54, $x=30.5$, $sd=10$) with males ($n=14$) and females ($n=36$) being included. Both inpatients ($n=22$) and outpatients ($n=28$) participated. Subjects were unpaid but offered travel expenses.

Initially, consultants had been asked to compile lists of potential subjects whose requests for surgery were due to cosmetic concerns. Reconstructive or post-traumatic patients, who may be more likely to present with functional difficulties (i.e. breathing problems or nasal pain) would therefore be excluded. This exclusion criterion was considered due to awareness that these groups may differ on psychiatric and psychosocial characteristics (Hay, 1970; Meyer et al, 1960 in Bonne et al, 1996).

However, in practice both groups were included in the research (cosmetic $n=29$, post-trauma subjects $n=16$), with a third group, a small number of individuals with congenital deformity ($n=5$), also participating. This occurred for three main reasons:

Firstly the 'cosmetic' and post-traumatic groups proved difficult to differentiate (please see *Rating of Subjects*), with subjects occasionally expressing functional difficulties or having experienced injury when this was not evident from the referral letter, medical notes or their appearance. Potential cosmetic surgery patients have been noted to claim functional difficulties where none are present due to concerns that they may be refused the operation (Reich, 1969).

Secondly, while some subjects undoubtedly experienced functional difficulties, many of these also expressed cosmetic motivations for their operations, and on occasion continued with their request despite being informed that improvement of function may not occur, or may even deteriorate following surgery, for example if surgery involved cosmetic reduction of nasal airways.

A third consideration was that it appeared early in the research that there were distinct subgroups within subjects, both in terms of appearance and psychological presentation. It was considered important to include and empirically assess possible differences between them.

Severity of Nasal Disfigurement and Category of Presentation

Standardised photographs of 38 subjects were obtained from the Medical Illustration Departments of the hospitals. Photographs of the remaining 12 subjects were not obtainable for reasons including medical photography departments being closed at weekends when some subjects were admitted. Absence of photographs occurred as a random process. Slides of subjects, from four standard angles i.e. front, left and right profile and below, were presented to eight independent raters (three males and five females) who comprised four clinical and four non-clinical staff at one of the hospitals (CH). Raters were asked to give each subject a 'severity of nasal disfigurement' (SND) score according to a five-point criteria ranging from 'perfect/almost perfect feature' (1) to 'very marked imperfection' (5) (Appendix 2.2). This was abbreviated from Hay (1970) who found a reasonable test-retest correlation for this procedure (.72). Raters were asked to base scores on the proportion, width, hump, length, straightness

and tip of the nose (a combination of criteria used by Mendelson & Farrell, 1995, and Bonne et al, 1996).

Analysis of interrater reliability showed that while judges agreed unanimously in only two cases, six or more raters agreed within two points for 36 of the 38 cases. There were no significant differences ($p < 0.05$) between SND ratings according to the gender or professional status (i.e. clinical or non-clinical) of the rater. The median score for each subject was used in data analysis.

As mentioned previously, subjects were also differentiated according to whether their presentation could be described as cosmetic (i.e. no breakage or injury to the nose and medical notes not describing functional difficulties), post-traumatic (i.e. the nose had been broken or otherwise injured), or congenital (if congenital nasal deformity e.g. Binder's Syndrome was present). This differentiation was made through examination of referral letters and medical notes, asking subjects if they had required hospital treatment following nasal injury, or if visual examination indicated clear injury or breakage. While recognising that a small number of cases would be categorised arbitrarily by the researcher if medical information was unavailable or if subjects' reports differed from visual evidence, it was felt that this was a reasonable procedure on which to base classification.

Summaries of subject numbers for both SND and category of presentation (i.e. cosmetic, post-trauma and congenital) are in Figures 1 and 2.

Figure 1. Subject Numbers Categorised as Cosmetic, Post-Traumatic or Congenital Deformity

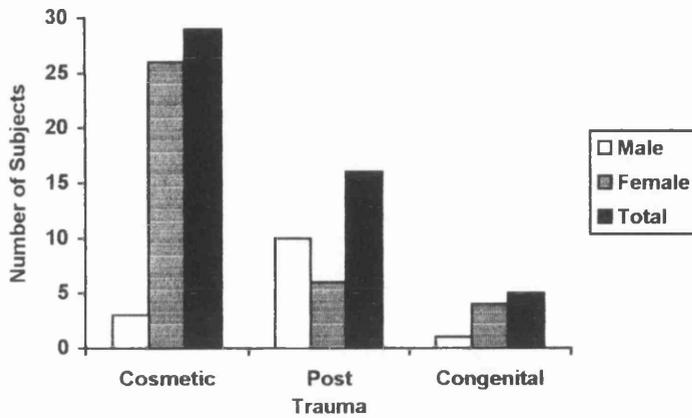
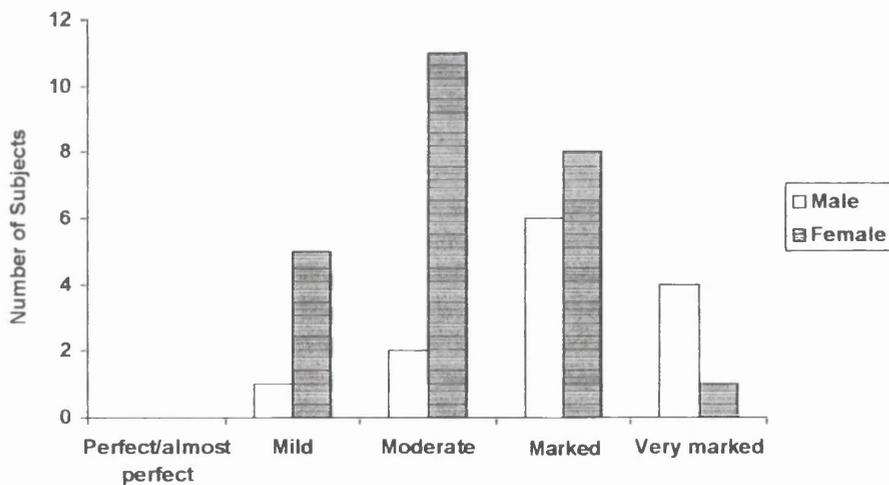


Figure 2. Severity of Nasal Disfigurement (SND) Ratings by Independent Judges



No subjects obtained a median score indicating perfect/almost perfect feature.

Materials

The following instruments were administered: 1) The Hospital Anxiety and Depression Scale (HADS) (Zigmond & Snaith, 1983), a fourteen item screening measure for Anxiety and Depression in a general hospital setting. 2) The Culture Free Self-Esteem Inventory, Second Edition (CFSEI 2 Form AD) (Battle, 1992), a forty item questionnaire with five subsections; General, Social/peer-related, Personal, Total and a Lie subtest. 3) The Revised Short Scale Eysenck Personality Questionnaire

(EPQ-RS) (Eysenck et al, 1985), a 48 item questionnaire comprising Psychoticism, Extraversion and Neuroticism and Lie subscales.

A semi-structured interview schedule (Appendix 2.3), designed by the researcher, comprising nine items was also administered. This was constructed primarily to assess motivation for requesting surgery, frequency of thoughts about their noses and appearance, the nature and extent to which subjects believed their appearance affected their lives, expectations of surgery, and reactions of significant others to their request for surgery. It was believed the semi-structured format would allow flexibility and development of issues described by subjects.

The mean interview length was 40.3 minutes (s.d.= 23.8, range 21-180). Subjects' responses to items in the semi-structured interview were recorded verbatim. In assessing expressed motivation, subjects were asked the item 1 from the interview and then to select reasons from a checklist developed by Anderson & Johnson (1978) (Appendix 2.4). They were then asked to identify and rank their three most important motivations.

Procedure

Subjects were offered a single appointment with the researcher in the hospital to which they had been referred. The objectives of the study were briefly described and subjects asked again if they consented. The semi-structured interview was then undertaken followed by the three questionnaires, with the order of these being randomised to avoid order effect.

Data was analysed using SPSS for Windows 6.0.

RESULTS

There were no significant differences ($p < .05$) on any measure according to hospital of referral, between inpatients and outpatients, or between two age groups (above and below the mean of 30.4 years). Married and unmarried subjects differed significantly on only two measures, the former indicating significantly higher EPQ-RS Lie scores ($t = -2.4$, $df = 48$, $p = .020$) and the latter higher Psychoticism scores ($t = 2.53$, $df = 48$, $p = .015$).

Subjects presented with a rate of unemployment ($n = 18$ or 36%) considerably higher than national (6.4%) or regional (7.3%) norms for this age group (Office for National Statistics, unadjusted figures, June 1997). Independent T-tests found unemployed subjects reported significantly lower scores on Total self-esteem ($t = -2.15$, $df = 48$, $p = .037$) and Extraversion ($t = -2.17$, $df = 48$, $p = .035$), and significantly higher scores on Neuroticism ($t = 2.70$, $df = 48$, $p = .009$), HADS Anxiety ($t = 3.15$, $df = 48$, $p = .003$) and HADS Depression ($t = 2.34$, $df = 48$, $p = .023$) than employed subjects.

Hypothesis 1

a) Anxiety and Depression

Scores for the HADS are in Table 1. Subjects scores indicated a 'borderline' for caseness on anxiety but not depression. A summary of scores according to whether subjects met caseness ($score > 10$) were 'borderline' (8-10) or non-cases (< 8) for both anxiety and depression are presented in Appendix 2.5. Subjects also appeared to present higher mean HADS Anxiety and Depression scores than a combined group of functional and organic dysphonia subjects (Millar et al, in submission) and healthy controls (Deary et al, in press) (a table of comparisons between groups on this measure and the EPQ-RS is in Appendix 2.6). Both these research projects were also based on adult West of Scotland populations.

Table 1. The Hospital Anxiety and Depression Scale

HADS SUBSCORE	Gender	Mean	Std. Dev.	Range	N
Anxiety	Male	8.4*	4.9	1-13	14
	Female	9.5*	3.8	4-21	36
	TOTAL	9.2*	4.1	1-21	50
Depression	Male	4.0	2.4	1-10	14
	Female	4.7	3.9	1-16	36
	TOTAL	4.5	3.6	1-16	50

* 'Borderline' for clinical caseness (Zigmond & Snaith, 1983), with the cut-off being 8-10.

b) Neuroticism and Extraversion

Analysis was undertaken by pairing each subject's score with an age and gender matched norm (Eysenck et al, 1985). A table of results on the EPQ-RS is presented in Appendix 2.7. Independent T-tests indicated subjects scored significantly higher on Neuroticism ($t=3.68$, $df = 98$, $p = .000$) and lower on Extraversion ($t=-2.13$, $df = 98$, $p = .018$) than norms for the EPQ-RS. Mean scores also appeared higher for Neuroticism and lower on extraversion than the research by Miller et al and Deary et al (Appendix 2.6).

c) Self-esteem

CFSEI scores are presented in Appendix 2.8. Subjects scored 'low' in only one category (Personal self-esteem), but their mean score was only 0.4 above the cut-off for 'low' in 'Total self-esteem'. Male and female subjects scored 'high' on Social self-esteem.

Hypothesis 1 was therefore supported in part.

Hypothesis 2

Category of Presentation and SND

Chi-square analysis indicated that although a relationship appeared to exist between category of presentation and SND, with congenital subjects showing higher SND scores ($x=4.40$, $sd=.55$) than post-traumatic ($x=3.64$, $sd=.93$) and cosmetic subjects ($x=3.11$, $sd=.81$), this did not reach statistical significance ($X^2=11.73$, $df=6$, $p=.068$).

Mean scores for EPQ-RS Neuroticism were as follows: cosmetic subjects ($x=8.14$, $sd=2.72$) post trauma ($x=7.19$, $sd=2.72$), and congenital ($x=4.20$, $sd=3.21$). One-way ANOVA did not show a statistically significant difference ($p<.05$) on this measure between the groups. However, post-hoc Student-Newman-Keuls identified that cosmetic subjects reported higher neuroticism than congenital subjects. There were no statistically significant differences ($p<.05$) between cosmetic and post-traumatic, or post-traumatic and congenital subjects on any measures.

Linear regression indicated that when employment status was controlled for, cosmetic subjects showed significantly higher Neuroticism than congenital subjects ($\beta=.62$, $t=2.91$, $p=.006$). Significant differences also emerged between congenital and cosmetic subjects on CFSEI Total scores ($\beta=.32$, $t=2.34$, $p=.02$) when controlling for employment, the former scoring higher than the latter.

A one-way ANOVA did not identify statistically significant differences ($p<.05$) between Neuroticism scores by SND. However, post-hoc Least-Significant Difference analysis found differences between groups rated '2' (mild imperfection) and '5' (very marked imperfection), the former reporting higher Neuroticism ($x=9.50$, $sd=3.02$) compared with the latter ($x=5.00$, $sd=4.30$). No other significant differences ($p<.05$) between groups on SND were evident.

Controlling for employment status using linear regression indicated no significant differences between groups on SND for Neuroticism or CFSEI Total scores ($p<.05$).

Hypothesis 2 was therefore supported in part. However conclusions from many of these analyses should be made with caution due to small numbers in some subgroups.

Hypothesis 3

Gender

Independent T-tests showed males were rated as significantly more disfigured than females ($t=2.75$, $df = 36$, $p=.009$). Statistically significant gender differences occurred for EPQ-RS Neuroticism ($t=1.77$, $df=48$, $p =.042$), and Psychoticism ($t=2.87$, $df=48$, $p=.003$) with females scoring higher on the former and males on the latter. Gender differences did not reach statistical significance ($p<.05$) on any other measure.

Hypothesis 3 was not supported.

Expressed Motivations And Expectations

A summary of data on expressed motivations is in Appendix 2.9. ‘To eliminate self-consciousness about my appearance’ was the most commonly reported reason for requesting surgery ($n=36$). Weighting of scores (described in Appendix 2.9) also showed this to be rated as the most important reason.

The greatest number ($n=30$) described an expectation that surgery would result in either increased social confidence or reduction of social discomfort. The second most commonly expressed expectations were reduction of criticism or teasing by others ($n=5$), and functional improvement ($n=5$).

Extent and Ways in Which Subjects Felt Their Lives Were Affected by Their Appearance

The extent to which subjects reported their lives were affected by their appearance is presented in Figure 3. The largest group of subjects reported that they felt their lives were “very much” affected by their appearance ($n=14$). 18 subjects (the largest group) reported they thought about their noses or appearance “almost all the time” (Figure 4).

Figure 3. Reported Effect on Subjects' Lives from Semi-Structured Interview (item 5)

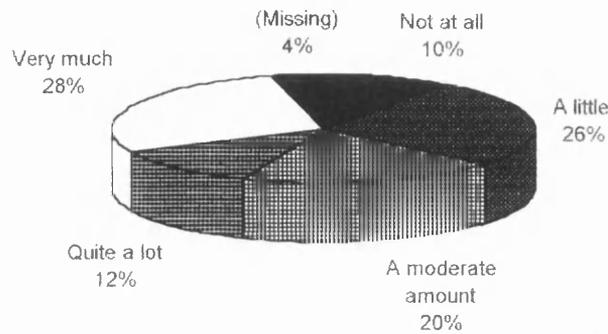
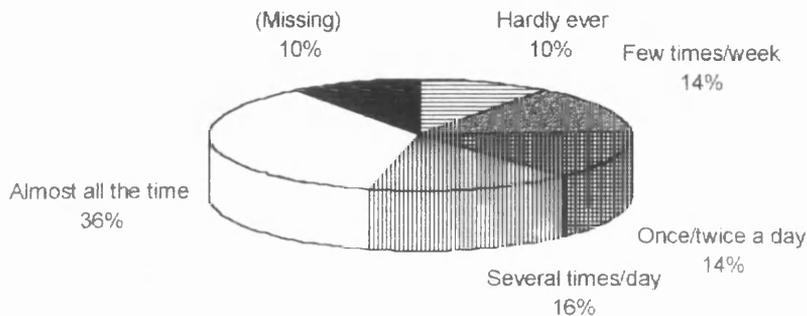


Figure 4. Frequency of Subjects' Thoughts About their Noses/Appearance (Semi-Structured Interview item 4)



Many subjects ($n=35$) described feeling social discomfort or low self-confidence as a result of their appearance. Of these, a number ($n=18$) described social avoidance to varying degrees. Subjects also stated various means of 'disguising' their appearance including wearing particular hairstyles ($n=9$) or make-up ($n=5$), turning their faces, particularly to avoid being observed in profile ($n=7$), covering their faces with their hands ($n=6$) or wearing glasses when this was unnecessary ($n=5$).

Perceived Reactions of Significant Others to Subjects' Requests for Surgery

This was assessed through subjects' comments to item 8 of the semi-structured questionnaire (Appendix 2.3). Subjects reported that reactions included 'being supportive' ($n=21$), not being taken seriously or being told there was "nothing wrong" with them ($n=24$), being "unsupportive", "shocked" or "worried" ($n=11$), or had said

little or nothing about this (n=7). A number of subjects indicated they had not informed any of their family or friends (n=7).

DISCUSSION

This research examined a number of psychological aspects of patients on waiting lists for cosmetic rhinoplasties. Results indicated that subjects showed higher psychopathology in terms of meeting borderline criteria for HADS Anxiety, and reporting higher Neuroticism, lower Extraversion and lower Personal self-esteem than norms. The latter is defined by Battle (1992) as "...the aspect of self-esteem that refers to an individuals' most intimate perceptions of self-worth" (p.4).

When controlling for employment status, a notable consideration in this group, significant differences emerged on two measures, with cosmetic subjects showing higher Neuroticism and lower Total self-esteem than congenital subjects.

Contrary to much of the literature, males were not found to be more psychopathological on any measures, and indicated significantly lower Neuroticism than females. Three factors may help clarify this finding. Firstly, males were rated as significantly more disfigured than females. Secondly, males' requests for surgery were more likely to be post-traumatic. Thirdly, 57% of males expressed functional difficulties as a motivation for surgery compared to 28% of females. It therefore seems possible that males' requests for surgery were more likely to be in response to physical discomfort and more severe disfigurement with accompanying socioeconomic implications (see Bull & Rumsey, 1988 for review), than to affective distress. McKinney & Livingston (1991) describe some individual's requests for surgery as "...rooted in a very realistic assessment of one's appearance and not based on psychodynamic derangement" (p.10).

Subjects reported 'high' Social self-esteem, defined by Battle (1992) as "...the aspect of self-esteem that refers to the individuals' perceptions of the quality of their

relationships with peers” (p.3). This appears contradictory to previous research, and to subjects describing interpersonal concerns as significant factors for requesting surgery. It appears possible that this finding may be due to cultural differences, with norms for this test being developed on a North American population. It is also notable that this subtest comprises only eight items and has the lowest correlation between other CFSEI subtests both in this research (0.57 to 0.65) and in Battle’s (1992) development of the measure (0.40 to 0.57). It therefore appears unwise to draw any firm conclusions from this result.

Employment status appeared a significant variable on a number of measures. Although this may at first appear to be a confounding variable, it seems possible that high unemployment in this population, rather than being coincidental was an artifact of the psychological distress experienced by some subjects. This hypothesis is made due to the abnormally high prevalence of unemployment in this group, that subjects described notable social avoidance, and that motivations and expectations often related to a desire to reduce interpersonal discomfort. Clearly, many working environments would be difficult for some of these subjects.

50% of subjects were rated as either having ‘mild’ or ‘moderate’ imperfections in their appearance, a finding similar to Bonne et al (1996) who described that this population are often not severely disfigured. However, subjects were sufficiently concerned about their appearance to request surgical alteration. It is also notable that severity of disfigurement appeared unrelated to measures of psychopathology, with some indication (Least Significant Difference analysis) that subjects rated as less disfigured presented with significantly higher neuroticism. As noted earlier, however, this did not reach statistical significance. It is suggested that this further may further emphasise that body image is an almost solely internal concept and associated distress may be largely unrelated to objective measures.

It should be noted that there were high correlations between some measures, (.963 between CFSEI General and Total scores). There was also a high negative correlation

between CFSEI Total score and EPQ-RS Neuroticism (-.719). The latter measure correlated at .587 and .441 with HADS Anxiety and Depression scores respectively.

It is recognised that this research did not have a formal control group. This occurred for two reasons. Firstly, it was felt that due to having three groups described in previous literature as psychologically different would allow each to be compared and correlated with the other. Secondly, age-matched norms were available on all standardised measures, and contemporary data for a West of Scotland adult population of similar gender distribution was available for the EPQ-RS and HADS.

Inclusion of photographs of a control group not requesting rhinoplasties may have allowed a useful comparison. Further study may also wish to include subjects' own ratings of their appearance in comparison to that of raters, the former having been found to rate themselves as more significantly disfigured (Bonne et al, 1996). It would be hypothesised that subjects showing greatest discrepancy between their own and others' ratings may present with the greatest psychological distress.

Another area of interest for future research may be studying individuals with nasal deformity who do not seek surgery, thereby further examining resilience issues discussed by Bradbury (1994).

A final area outwith the remit of this study, due to the small number of subjects who had undergone their surgery at its conclusion, was postoperative follow-up with these subjects. It would appear of great interest to identify whether subjects' distress had been reduced and their expectations realised.

Acknowledgments

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SERVICE EVALUATION PROJECT

Evaluation of the Service Provided by the Spinal Injury Network

To the Queen Elizabeth National Spinal Injuries Centre

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Target journal: *Clinical Psychology Forum*, published by the Division of Clinical Psychology of the British Psychological Society. Full details of guidelines are in Appendix 3.1.

Introduction

As Kennedy (1991) notes, “Few physical injuries have such sudden and devastating consequences as a spinal cord injury (SCI)” (p.129). In addition to the resulting physical, behavioural and social restrictions, psychological impacts including anxiety, depression, cognitive impairment, chronic pain, sexual dysfunction, and institutional dependency are perhaps the most prevalent and adverse effects reported following SCI (Crewe & Krause, 1987; Brucker, 1983; Trieschmann, 1980; Siller 1969).

A review by Trieschmann (1980) describes the significant social implications of SCI, perhaps most notably that the individual may begin to perceive him/herself as “different”. This is often confirmed by others’ reactions to people with SCI, which includes “...pity, sadness, confusion, guilt and curiosity” (ibid p.87). Trieschman (1980) described that due to the inhibited behaviour people may present as a result of this, the SCI person may feel it is their responsibility to put others at their ease, despite difficulty they may experience in social interaction themselves.

It is also notable that institutionalisation following SCI, which can often be lengthy, may itself cause problems, with Trieschman (1980) noting that “...hospital may unintentionally undermine social competence since there is little opportunity to practice social skills” (p.105).

Research has indicated that for people recovering from medical interventions and physical illness in general, levels of adjustment can be related to social support (Wallson et al, 1983). Furthermore, support involving social integration and relationships which “...reassure the worth of the individual” have been found to be predictive of lower depression scores in individuals with SCI (Elliot et al, 1992 p.485). Schultz and Decker (1985) found that a lack of perceived social support was a major predictor of depression in SCI persons, and that social support had a number of mitigating effects on depressive behaviour. Conversely, it has been found that “A

significant proportion of deaths among persons with spinal cord injury have been attributed to self-neglect and suicide” (Krause & Crewe, 1987 p.205), with survivors being described as having better psychosocial adjustment and exhibiting greater social activity.

For these reasons it was deemed relevant to assess the input of a voluntary organisation providing social support and a number of activities to SCI patients in a specialist centre.

Background to Project

The Queen Elizabeth National Spinal Injuries Centre (NSIC) based in the Southern General Hospital, Glasgow, is a forty-eight bed unit opened in September 1992, designed to offer acute medical, and later physical rehabilitation for individuals who have suffered SCI. Patients are all adult, with fourteen females and thirty-two males at the time of this research.

The Spinal Injuries Network (‘Spin’) is a volunteer project established in March 1994 which describes its aim as “to offer assistance and support to people who people who are experiencing the life changes that go with spinal injury” (The Spin Project: A Brief Description, 1994). Volunteers’ involvement is described as comprising two main areas these being “firstly , they listen, discuss and provide information; secondly, by means of social events, tuition and various other strategies, they encourage independent thinking” (ibid). Spin had eight volunteers working in the NSIC at the time of this research.

Aims and Objectives

The primary objectives of this project were to evaluate the services provided by Spin to both inpatients and outpatients of the NSIC, and to make recommendations for future service delivery based on information obtained.

Research Questions

Research questions were devised by examining the aims Spin described themselves (The Spin Project: A Brief Description, 1994; The Spin Report 1994/95), and also included further issues deemed relevant to future service provision. These were;

- What was the level of awareness of Spin's work among patients in the NSIC?
- How many of the services provided by Spin were utilised?
- What information was being provided by Spin and in what form (i.e. written or verbal)?
- Whether patients perceived the services provided by Spin as beneficial.
- How patients felt the service provided by Spin could be improved.

Method

Data was collected through a sixteen item questionnaire (Appendix 3.2), which comprised both open and closed questions. Administration was through semi-structured interviews, with responses being recorded verbatim. The semi-structured format was considered the most appropriate method for three reasons;

- 1) To increase likelihood of compliance in completing the questionnaires given the potential small sample size.
- 2) To assist individuals who may have been physically unable to complete the questionnaire.

3) To enable subjects to raise issues and concerns which were most pertinent to them, to allow flexibility and encourage inclusion of specific or additional areas as appropriate.

The questionnaire was administered verbally, by one interviewer, following subjects being given a brief introduction to the purpose and format of the research (Appendix 3.3). Both the questionnaire and the introduction were assessed on a computer-based version of the Flesch Reading Ease test. Results showed that 79.3% of the population should be able to “readily understand” the material.

Interviews took between two and ninety minutes to administer, with a mean of slightly over ten minutes per interview.

Where the question involved making choices from a list (i.e. questions 2, 3, 5 and 10), and enlarged copy of items was available to assist subjects with poor eyesight.

The questionnaire was piloted on a colleague in the psychology department of the hospital and four inpatients of the NSIC, the latter of whom were included in the final report.

Subjects

Subjects were selected by three means;

- 1) Fourteen were suggested by the clinical psychologist who was working in the unit, who had a knowledge of the mental and physical health, and subsequent suitability for interview of many of the inpatients.
- 2) Two subject were suggested by Spin due to having had previous involvement with the organisation.
- 3) Four subjects were chosen at random from the NSIC and outpatients.

All the patients who were involved with Spin at the time of this research were included in the study (n=13), and while recognizing this could bias results in favour of a more positive evaluation of the organisation, clearly patients who were not involved with Spin in any way would be able to contribute little in way of evaluating their work.

Of the twenty subjects included, fourteen were inpatients and six outpatients. All had suffered SCI resulting in various degrees of disability. Ages ranged from 17 to 83 ($X=44.7$, $sd=17.9$). Fifteen male and five female subjects were included, this proportion approximately reflecting the gender ratio of the NSIC. Inpatients had been in the NSIC from between one and ten months ($X=6.4$, $sd=3.4$)

Of the total forty-six patients in the NSIC at the time of this research, two subjects refused to be interviewed, and eight potential subjects had been discharged. Other subjects were difficult to obtain due to having visitors (who were allowed at any time), daily and often lengthy medical procedures including physiotherapy, physical frailty or tiredness, and other associated problems which would have made interviewing ethically questionable.

Results

All twenty subjects had heard of Spin, with the largest number (n=10) having heard of the organisation through one of its volunteers.

Of the activities provided, 'talking to a Spin volunteer' was the most commonly reported activity (n=12 Appendix 3.4), although this may simply have reflected the fact that many of the patients who had been involved in Spin's earlier activities had since been discharged from the NSIC.

No subjects reported participating in any activities which they did not enjoy.

Of the thirteen subjects who responded to the question relating to information given by Spin, the majority (n=10) expressed that contact had been of a more social than informative nature. No respondents reported receiving written information from Spin, although this was available. Of the six respondents who stated they had been given specific information from Spin, all rated this as having been 'good' or 'very good'. The three subjects who gave details of this specific information stated that this related to specific practical issues, i.e. coping with disability (n=1), transport issues (n=1), and information on further education and contacts for business proposals (n=1).

In terms of improving quality of life (question 12), a number of comments were made which were seen to overlap with responses to the final question, which asks for further comments about Spin. Responses to these two questions were therefore considered together, and were classified as 'informative' or as 'positive' or 'negative' evaluations of Spin. These were assessed by the researcher and an independent rater, an overall concordance of 85% being obtained. It may be worth noting, however, that differences of opinion related to only two different comments which were repeated. The researcher's evaluation was used for this report due to having knowledge on the tone and context in which the comments were made.

Sixty-two comments were made in response to these questions. Forty-two could be considered a positive evaluation of Spin, seventeen informative, and three negative (Appendix 3.5). Positive comments included "they give people an interest, which is very important", "It's a tremendous organisation" and "them coming in is something to look forward to".

Six subjects noted the importance of Spin's work in particular for patients who received few visitors. This can be seen as particularly given that the NSIC is a national centre in which a number of patients had family and friends who lived far from the Glasgow area, and where visiting was difficult.

Informative comments (n=17) included; “they could have activities at the weekends because with no physiotherapy they can be boring”, and “Spin could maybe coordinate with other disabled organisations or put us in touch with other disabled people”.

The three comments which can be considered critical of Spin were nonetheless constructive. For example, two subjects stated “Spin should increase its activities”, while the third stated “Spin should get information to outpatients sooner”.

Discussion

What is the level of awareness of Spin's work?

It was clear that there was a high level of awareness of Spin's presence in the NSIC with all subjects having heard of them. However, it also appeared that a number of subjects (n=7) were unclear about Spin's role, making comments such as “I'm not really sure what they do”.

How many of the services provided by Spin were utilised?

Of the twenty subjects, thirteen had utilised one or more of Spin's services, either by talking to one of its volunteers or attending one of its activities. However, as mentioned in the *Subjects* section, it is recognised a somewhat biased sample was used.

What information is being provided by Spin and in what form?

Three subjects gave details of specific information they had been given by Spin. All of this was in verbal form. Spin's work was described more in terms of general discussion and support. It appeared that subjects did not see the role of Spin as giving direct information, with one subject stating “I wasn't given any specific information but if I wanted to know anything they would be able and willing”

Do patients perceive the services provided by Spin as beneficial?

The majority of subjects (n=13) were positive, and in some cases extremely so, about Spin's work, with the other seven making no comment about them. The group who made no comment explained that this was largely due to a lack of awareness of the services Spin provided.

How do patients feel the service provided by Spin could be improved?

A number of suggestions were made relating to improving the service, including interest in more theatre/musical activities (n=8) and more outings, particularly to parks or cultural events such as art galleries or museums (n=3). Film shows, quizzes and discussions were also suggested, as was coordination with other disabled groups (n=3)

Conclusion and Recommendations

This research project clearly had a fairly small sample size. This was dictated largely by a small number of patients in the NSIC, and within this group, of difficulty recruiting subjects who were physically and mentally able to participate, and who had enough knowledge of Spin's work to be able to contribute meaningfully. However results do appear to be representative of a cross-section of patients in the NSIC who were able to participate in the activities which Spin offered.

Results showed that Spin was considered, by the majority of subjects with whom they had been involved, to be a positive and supportive organisation whose contribution to the NSIC was valued.

In terms of additional recommendations to Spin for future service delivery, it is significant that of the thirteen subjects who had been involved in one or more of Spin's activities, ten had heard of them through one of its members, as opposed to from the notice-board or other means. Equally significant was that of the seven subjects who had not been involved in any of Spin's activities, only one had been

approached by a Spin volunteer. This would suggest that the most effective way of involving patients in Spin's activities is for its volunteers to physically approach patients, as information on notice-boards and newsletters appeared to be largely ignored. However, it is recognised this would need to be undertaken appropriately and sensitively.

Spin may also wish to consider the large number of miscellaneous comments made by subjects relating to service provision and suggestions of additional activities. Details of these, with a full report of the research were made available to the Spin coordinator.

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CLINICAL CASE RESEARCH STUDY

Body Dysmorphic Disorder and Domestic Violence - A Single Case Study

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Written in accordance with guidelines for *Behavioural and Cognitive Psychotherapy*
(Appendix 4.1).

Body Dysmorphic Disorder and Domestic Violence: A Single Case Treatment Study

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Body Dysmorphic Disorder (BDD) has been described in various forms in the medical and psychological literature for over 100 years. It is defined as obsessive preoccupation with an imagined physical flaw in someone whose appearance is within normal limits. It remains a poorly understood disorder, with empirical work consisting largely of single or small *n* case reports. The following case study describes a sixteen session intervention with a woman (Mrs. L) meeting criteria for BDD relating to her facial complexion, who was also the victim of an abusive marital relationship. A broadly cognitive-behavioural approach was utilised, in which depressed thinking was identified and challenged, and perception and implications of physical attractiveness examined. Self-esteem and problem-solving components were also included. Finally, exposure and response-prevention strategies specific to her BDD were undertaken. Flexibility was important as was assessment and discussion of how Mrs. L's life experiences may have influenced or exacerbated her condition. Various outcome measures were utilised and a significant decrease in symptomatology appeared evident at conclusion of treatment.

Introduction

The importance of body image to depression, self esteem and general psychopathology has been recognised by a number of researchers (Baumeister, 1993; Clifford et al 1984; Edgerton et al, 1961; Harris, 1981; Hay, 1970; Rosen & Ross, 1968; Schweitzer, 1989; Secord & Jourard, 1953). Having been defined as "...the way in which the body appears to ourselves" (Schilder, in Phillips, 1996, p.199), body image has been noted to comprise not simply our perception of our bodies but "...the emotional significance we attach to certain physical parts" (Goin & Goin, 1981 p.62). Described as "...a core aspect of our identity" (Phillips, 1996, p.199) it is, however, a complex concept, and is recognised to be "...dynamic, fluctuating (and) evolving" (Goin & Goin, 1981 p.62).

Body Dysmorphic Disorder (BDD) is a distressing and disabling body image disorder which has been described in various forms in the medical literature for over 100 years (Morselli, 1886 in Rosen & Reiter, 1996). Described in the DSM IV (American Psychiatric Association, 1994) and the ICD 10 (World Health Organisation, 1992), it is defined by Brady et al (1990) as "...a nondelusional preoccupation with an imagined defect in appearance, in a normal-appearing person" (p.538).

This preoccupation can relate to almost any body part, including facial complexion (scars, wrinkles, acne, paleness, redness), hair, eyes, mouth, teeth, ears, breasts, hands, feet, thighs and buttocks (reviewed in Phillips 1991). Concern may be expressed in specific or general terms, and may focus on one or many body parts.

BDD can be an extremely serious disorder in a number of ways, leading to increased social avoidance and isolation, diminished functioning, extremely low self-esteem and can cause significant distress in family members (Hay, 1970; Neziroglu & Yaryura-Tobias, 1993a; Phillips, 1991; Phillips, 1996). Other effects can include excessive amounts of time spent covering or concealing the effected body part (Hay 1970),

seeking or obtaining unnecessary cosmetic treatments or surgery (Andreason & Bardach, 1977) and risk of suicide. Phillips (1996) suggested 86% of this population have suicidal ideation, and Veale et al (1996a) found that 24% of their BDD population had previously attempted suicide. Psychiatric hospitalisation in BDD sufferers is also relatively common (Phillips 1991) .

Research has identified high comorbidity of BDD with other disorders including mood disorders, psychosis, substance abuse and personality disorders, including paranoid, avoidant and obsessive-compulsive types (Andreason & Bardach, 1977; Braddock, 1982; Hay 1970; Veale et al 1996a; Phillips, 1996). Prevalence of personality disorder in sufferers of BDD has been estimated to be as high as 72% (Hay, 1970).

The treatment literature on BDD has included antipsychotic medication, antidepressants, ECT, benzodiazepines, plastic surgery, modified leukotomy and psychological treatments (Hollander et al, in Phillips, 1991) including eye movement desensitisation (Brown et al, 1997). Phillips (ibid) concluded “No clear consensus emerges regarding the treatment of choice for body dysmorphic disorder...” (p.1144). However single case and small *n* cohort studies (Marks & Mishan, 1988; Newell & Shrubbs, 1994; Neziroglu et al, 1996; Neziroglu & Yaryura-Tobias, 1993a; Neziroglu & Yaryura-Tobias, 1993b; Phillips et al 1995; Phillips, 1996; Raich et al 1995; Rosen et al 1995; Schmidt & Harrington 1995; Veale et al 1996b) have shown that elements of cognitive-behaviour therapy, including modifying intrusive thoughts and exposure and response-prevention, used either solely, or in addition to pharmacotherapy, can be effective in treatment of BDD.

Method

Subject

Mrs. L was a 31 year old married woman with two sons, referred by her General Practitioner due to "...a depressive problem". This was described as "quite obsessive, regarding looking in mirrors and spending excessive time examining all parts of her face and commenting regarding any minute scar". Physiological causes for visual discrepancies had been assessed by her G.P., and nothing was identified.

Mrs. L presented with a number of anxious and depressive symptoms including low mood, hot flushes, palpitations, dry throat, lethargy, disturbed sleep, poor concentration, somatic tension and poor appetite. She met the DSM IV criteria for a major depressive episode, and reported previous suicidal ideation, but had neither made any suicide attempts nor self-injured.

Low self esteem was also evident, with Mrs. L making comments such as "I don't say or do the right things or look right" (sic) and "I feel I'm nothing". She added "I've lost my confidence", which she attributed largely to a feeling of physical unattractiveness. This related specifically to her facial complexion, which she described as being "covered with red blotches", "small scars" and "small holes". She was of normal appearance. Her presentation was consistent with the DSM IV (American Psychiatric Association, 1994) criteria for Body Dysmorphic Disorder, and also met all relevant additional criteria described by Phillips (1996).

Case History

Mrs. L described that her father had been physically abusive towards her mother, which resulted in divorce when Mrs. L was aged nine. After living with her father for a brief period she moved to live with her mother and step-father. She described herself as hating her natural father.

It became clear that Mrs. L during her 14 year marriage had been a victim of extreme domestic violence. She was able to recall 18 occasions in which her husband had physically assaulted her and many more in which he had been verbally and emotionally abusive.

Describing herself as always having been a “nervous person”, Mrs. L stated she had first been aware of feeling self-conscious and depressed about her complexion following the birth of her second son, around seven years prior to seeking treatment. This birth appears to have involved a number of complications, including retention of the placenta for around eleven weeks post-partum, and of post-natal depression (confirmed by psychiatric assessment around three years after the birth). Stating she felt extremely self-conscious at the time, Mrs. L undertook electrolysis for facial thread veins at a private clinic but felt this had left her facially scarred. Following this, she had attended two different clinics for cosmetic treatment and planned further treatment. Shortly after this she attended an appointment with a psychiatrist, who made a diagnosis of “...unspecified affective psychosis”. She failed to attend any follow-up appointments.

Mrs. L’s described frequent intrusive rumination regarding her facial complexion stating “I think about it all the time”. She also showed a number of related behavioural compulsions which included spending up to three hours looking at herself in the mirror, invariably observing her reflection in shop windows and feeling unable to leave the house without applying make-up. Other behavioural effects included social avoidance, extreme discomfort when meeting new people, having given up jobs, and being extremely aware of lighting. She described feeling “paranoid and self-conscious”. Comparison of her appearance to others and reassurance seeking were also evident. These behaviours, rather than lifting her mood, would often increase her distress. It would also make her late for a number of engagements.

Compliments on her appearance, which she received regularly, would often be regarded cynically or angrily dismissed, frustrating her that she could see significant flaws in her complexion while others, including her family and friends, could not. She explained that she had, on a number of previous occasions, wanted to deliberately scar her face in order to be “taken seriously”.

Measures of Assessment

- 1) The Beck Depression Inventory (BDI) (Beck et al, 1961).
- 2) The Dysfunctional Attitude Scale (DAS) (Weissman & Beck, 1978).
- 3) Daily diaries of cognition and emotion.
- 4) Subjective scale of 1-100% of unhappiness with facial appearance.
- 5) A record of average time spent daily in front of the mirror.
- 6) Self portrait of her face, on which Mrs. L was asked to indicate perceived defects.

Details of these measures and initial results are in Appendix 4.2.

Formulation

Although considerable debate exists as to the aetiology of BDD (Phillips, 1991; Phillips 1996), with neurobiological and sociocultural theories having been offered, among psychological theories, criticism and victimisation have been recognised as influential (Phillips, 1996). It appeared conceivable that being in a marital relationship for fourteen years which involved both physical and mental abuse, in which Mrs. L was regularly criticised and demeaned both privately and in company, could have maintained or exacerbated feelings of worthlessness and unattractiveness.

Hoff (1990), finding that nearly 80% of women who had been in an abusive relationship with a partner described their self-image as 'poor' or 'very poor' (page 38), concluded "...battering exacts an enormous toll on the woman's acceptance of herself" (ibid).

Marshall (1994a, 1994b) noted the use of subtle techniques by abusive partners such as inducing guilt and encouraging dependence to be undermining to the victims confidence (in Vitanza et al, 1995). Romero (1985) noted similarities between strategies used on prisoners of war and on abused partners, including psychological abuse in the context of violence, intermittent reinforcement and isolation of victim's support systems, proposing that this results in destruction of the individual's self-identity. It is also notable that unlike a discrete traumatic event which can challenge basic beliefs about safety and security, emotional abuse by a partner has been described as "...gradually eroding (the victim's) assumptions about herself and the world" (p.25). This has been found to result in confusion about self-concept (Pelham, 1981), relationships (Berger, 1988), behaviour (Weinstein, 1989) and cognitive processes (Chaiken et al 1989) (in Vitanza et al, 1995).

Phillips (1996) described a process of possible aetiology of BDD in which an individual 'displaces' "...emotional conflict, or feelings of inferiority, guilt or poor self image..." into a more manageable dislike of their physical appearance (p.177). Although there is little empirical validation of this theory, it appeared to have some relevance to Mrs. L, with evidence for this present in statements made by her such as "My face is holding me back from getting on with my life", and "If I didn't have my face like this, I would be happy".

Treatment

Intervention consisted of two assessment and 14 treatment sessions. All sessions lasted around sixty minutes. At the onset of treatment a contract was negotiated of weekly to fortnightly sessions which would be reviewed every six sessions. The proposed treatment rationale was discussed following the second session. This was to include intervention with depressive symptoms, intervention with BDD including an information component, and self-esteem and problem-solving work related to her experience of domestic violence (Cascardi & O'Leary, 1992).

Building rapport was considered to be extremely important during initial intervention, due to her previous victimisation by males, and also as individuals with BDD, due to shame or fears of not being taken seriously are often extremely reluctant to engage in treatment (Phillips, 1996).

Intervention included explaining the cognitive model of depression and giving a handout on this (*Coping with Depression* by Beck and Greenberg, 1974). Eliciting negative automatic thoughts and reframing incidents involving depressogenic schema, both general, and specific to her appearance was also included. Further cognitive restructuring was based on items on the Dysfunctional Attitude Scale to which Mrs. L had given extreme responses. Examining Mrs. L's perception of the importance of physical attractiveness was also deemed relevant.

Generating alternative explanations for people "staring" at her, as well as examining evidence for and against particular dysfunctional assumptions was undertaken. On certain cognitions, the 'downward arrow' technique (Burns 1980 in Hawton et al, 1989) was utilised, in which underlying assumptions can be identified (Blackburn & Davidson, 1995) and general inferences drawn from specific situations (Hawton et al,

1989). Due to somatic tension reported by Mrs. L, relaxation and breathing exercises (Jacobsen, 1938 in Hawton et al, 1989) were taught, with handouts given on these.

During the fifth session, Mrs. L explained that she had decided to leave her husband following a particularly violent physical attack. This situation demanded a flexibility of treatment, and led to session agendas being altered accordingly. Transitional issues resulting from this event (described by Hoff, 1990), concern about continued harassment, in addition to a number of practical problems had emerged. It was considered that inclusion of problem-solving strategies based on those described by Hawton & Kirk (1989) would be useful (in Hawton et al 1989). Information was also offered on a local Women's Support Project, but Mrs. L did not utilise this resource.

Guilt and confusion relating to staying in an abusive relationship were expressed a number of times during treatment. Mrs. L described distress and disbelief that after witnessing her mother being physically abused by her father, she should find herself in similar circumstances with her own husband. Hoff (1990) reviewed a number of theories as to why "battered women" stay in abusive relationships, and relevant aspects were discussed with Mrs. L.

From session eight onwards, the focus of treatment altered slightly in favour of a somewhat more behavioural approach; identifying triggers through an ABC model (Ellis, 1977) and including graded exposure and response-prevention. It was agreed that attempts were to be made to limit time spent in front of mirrors to a maximum of half an hour in order to apply make-up. It was also suggested that hypothesis testing was to be undertaken, in which Mrs. L would attempt to leave her home for short periods without make-up. This was to demonstrate that while acquaintances may notice a difference in her appearance, they would neither be horrified nor think any less of her. Contingencies were discussed and prepared for, with discussion about

increasing this length of time according to a graded exposure model. Attempts had been made to begin behavioural work earlier but Mrs. L was clearly extremely distressed by, and resistant to this. Therapeutically, it was felt that too much pressure to comply with this earlier would have resulted in her defaulting from treatment.

Results

Scores on the BDI reduced from 40 (session 2) to 25 in session 16 (discharge) (Appendix 4.3). This was considered a significant reduction, but still left Mrs. L in the “moderately depressed” category (Beck et al, 1961). On the DAS, Mrs. L’s scores reduced from 201 (session 2) to 166 (discharge), with reductions in both ‘perfectionism’ and ‘social approval’ subscales (Appendix 4.4).

There was a notable reduction in time spent in front of the mirror, from an average of around 120 minutes at initial assessment to around 30 at discharge. Recording of this data was unfortunately not regularly undertaken by Mrs. L.

Subjectively, Mrs. L described being “able to think more clearly”, and was beginning to make a number of plans regarding relationships, employment and housing. She also reported having gone out socially with work colleagues, something she had previously avoided. She was not, however, able to go out without make-up and reported that her unhappiness with her appearance although reduced, was still about 85% at discharge.

Discussion

This study appears to show that an intervention including exposure and response-prevention, cognitive restructuring, problem solving and flexibility of approach can be effective in reducing some symptomatology in BDD. It is notable that pharmacological (Prothiaden 150mg) and psychiatric input had been previously

unsuccessful with Mrs. L, and that BDD has itself been noted as difficult to treat (Phillips, 1991).

Although Mrs. L attended every session, compliance during certain aspects of treatment, particularly behavioural intervention and recording of cognitions, proved difficult. It appeared that a tolerant and flexible approach was needed in response to this, as it was arguably more important to develop trust and rapport with Mrs. L particularly given her previous abusive relationships with males and her default from treatment six years previously. In therapeutic terms this approach seems to have been successful, with Mrs. L engaging well in treatment, and indicating feeling "safe" discussing and disclosing a number of previously covert and distressing self-critical cognitions.

Mrs. L's continued desire to undertake cosmetic surgery was considered to require a particularly sensitive approach. Although it was recognised that this may have interfered with her engagement in psychological treatment, Mrs. L's consideration of surgery as an option appeared to serve an important function. It was felt that simply challenging or undermining this would have been of little help therapeutically and would most likely have caused further distress.

In assessment terms, to the author's knowledge when Mrs. L attended treatment no normed BDD questionnaires were available, but have since been developed (e.g. Phillips, 1996; Rosen & Reiter, 1996). It was decided that a standardised obsessive-compulsive questionnaire would not be useful, as although both obsessive and compulsive elements appeared to be present, these did not appear to generalise outwith concern regarding her complexion.

In conclusion, BDD appears to be a rare disorder (Newell & Shrubbs 1994), but estimates of prevalence vary significantly (Phillips, 1991) perhaps due to a lack of standardised assessment measures. A number of researchers (Bloch & Glue, 1988; Neziroglu & Yaryura-Tobias 1993b; Schmidt & Harrington, 1995; Phillips 1991; Phillips, 1996) have noted that BDD is not particularly well understood in terms of aetiology, course or treatment. Phillips (1996) notes of treatment specifically, "Our knowledge of its effectiveness is still preliminary, with little published data and no placebo-controlled studies" (p.263). Although a growing literature is now emerging, clearly more study is required to help us understand this complex and distressing disorder.

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CLINICAL CASE RESEARCH STUDY

Recurrent Abdominal Pain in Childhood - A Single Case Study

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Written in accordance with guidelines for the *Journal of Child psychology
and Psychiatry* (Appendix 5.1)

RECURRENT ABDOMINAL PAIN IN CHILDHOOD: A SINGLE CASE STUDY

Abstract. Psychological factors have long been recognised in pain mediation, with the importance of cognition in pain perception being illustrated by Beecher's (1959) study of reported pain following military and civilian injury (in Wall & Melzack, 1984, p.167). Although somatoform disorders - in which physical symptoms are reported in the absence of clear organic aetiology - have attracted a number of psychological studies, the literature on children with this condition is relatively recent, sparse and uncontrolled. The following case study describes an unsuccessful eight session intervention with a ten year old Asian girl referred due to suspected psychosomatic abdominal pain. It is suggested that engagement with a psychological model, parental involvement and assistance, and awareness of cultural factors in such cases are of critical importance in terms of effective outcome.

Key Words: Recurrent Abdominal Pain, Assessment, Intervention.

INTRODUCTION

Abdominal pain has been identified as the most commonly reported recurrent pain in childhood (Friedman, 1975; Schechter in Levine, 1984), occurring in 10-25% of school age children and adolescents (Campo & Fritsch 1994). However, research has suggested that an "identifiable organic etiology" is identified in as few as 7% of these cases (Levine 1984).

While children reporting recurrent abdominal pain (RAP) have traditionally been divided into "organic" or "psychogenic" groups, recent models have recognised somatic predisposition, lifestyle, habit, environment, critical events, temperament and

learned response patterns (Levine, 1984) in addition to cultural factors (Abu-Saad, 1984a ; Abu-Saad, 1984b; Zborowski, 1952) in its mediation.

Significant differences have been found between ethnic groups in behaviour, beliefs and attitudes to pain (reviewed in Lipton & Marbach, 1984). As Larkins (1977) noted, “The experience of pain defies explanation in purely physiologic or biologic terms: the sociocultural aspect of pain must also be taken into account”. Zola (1983) added “...everyone has a cultural heritage which is part and parcel of an individual’s health practices” (in Lipton & Marbach, 1984 p.1280).

Of particular relevance to clinical psychology are the somatoform disorders, in which somatic symptoms occur in the absence of clear organic aetiology. Tending to peak in late childhood and early adolescence (Campo & Fritsch, 1994), a number of studies have found somatisation to be fairly common (review in *ibid*).

Somatoform disorders have been conceptualised in a number of ways including as a product of emotional arousal and distress (Garralda, 1996), as a cognitive phenomenon, as a psychological defence against unpleasant affect (Goldberg & Bridges, 1988) and as a result of social learning or modelling and operant and classical conditioning (Campo & Fritsch, 1994). Health beliefs in other family members have also been implicated in aetiology, and it appears significant that somatisation is also often found in parents of children with RAP (Campo & Fritsch, 1994). However, debate continues as to whether this is genetically or environmentally mediated.

The importance of family characteristics in the onset and maintenance of somatic disorders has been identified by a number of researchers (Minuchin et al 1975; Mullins & Olsen, 1990 in Ammerman & Hersen, 1995). Minuchin et al (1975) identified four ‘transactional characteristics’; enmeshment, overprotectiveness, rigidity and lack of conflict resolution as “...typical of families with psychosomatically ill children” (p.1033).

Further research describes somatisation as a means of communication, either within a family in which this is poor (review in Ammerman & Hersen, Eds., 1995; Campo & Fritsch, 1994), or in individuals who have 'alexithymia', or difficulty expressing emotions (Ammerman & Hersen, 1995; Loeff, 1970; Lloyd, 1986).

Campo and Fritsch (1994) suggested that factors which may be indicative of a somatising disorder as opposed to physical disease, include the presence of stressful life events; previous somatisation or other psychiatric disorder; apparent interpersonal, familial or social benefits in displaying pain behaviours; if it appears to be a communicative act; if symptoms violate known physiological patterns; or if the pain fluctuates in response to sleep, interpersonal or familial factors. Also of relevance is indifference to the symptom which has been identified in numerous studies (*ibid*). However it is recognised that all these symptoms may also be present in individuals with organic disease.

Controlled literature on psychological intervention with RAP in children is scarce. However, coping skills training (Linton, 1986), behavioural work (Finney et al, 1989), family intervention (Minuchin et al, 1975), progressive muscular relaxation with breathing exercises (James in Tyrer, 1992), light exercise (Holzman & Turk, 1986; Wall & Melzack, 1984) and cognitive distraction (Holzman & Turk, 1986) have been found to be effective in pain management programmes. In one of the few controlled studies on RAP, self-recording of pain, cognitive distraction, relaxation and encouragement of social activity was found to be effective (Sanders et al, 1989). It appears important that some form of structured intervention occurs with children suffering RAP as Lansdown & Sokel (1993) noted, "left to themselves, children rarely seem to develop coping strategies" (p.106).

Finally, Ammerman & Hersen (1995) discuss the importance of collaboration between mental health professionals and general practitioners in order to allow for physical

cause. They note Caplan's (1970) study in which 40% of children diagnosed as having somatoform disorders were later found to have a physical disease which explained their symptoms.

Method

Subject

Miss H was a ten-year-old Muslim girl of Pakistani origin, who was the eldest in a sibship of three. She was referred by her GP due to reporting "non-specific abdominal pain" which had been "thoroughly investigated" by urologists and surgeons (medical notes). No evidence for an organic cause had been identified.

She had suffered a urinary tract infection when aged three and underwent tests including renal ultrasound, DMSA and X-ray. No abnormality was found. When aged nine, Miss. H attended an accident and emergency department, with medical notes stating "...feel this is nonspecific abdominal pain but will admit overnight". Resulting tests found "nil of note" and she was discharged the following day with no follow-up requested.

Miss H described that for around 12 months she had experienced a "sharp" pain in her abdomen that was "like a stone". It appeared to occur daily, most commonly in the evenings, with an onset of around 10-20 seconds, and an average duration of 10-15 minutes but on occasion lasting up to two hours.

She presented as a smiling, shy girl who reported that she had no current concerns. She described herself as liking school and her teacher, and that she had many friends, her father adding "she is friends with her whole class". No incident of victimisation or other distress, either at home or school was described. Miss H. had not begun her menstrual periods.

ASSESSMENT MEASURES AND RESULTS OF INITIAL TESTING

Due to the often complex nature of abdominal pain in children, detailed assessment was undertaken incorporating self-report of pain frequency, intensity, duration and other associated factors, cognition and behaviour, medical history, emotional state, significant life events and possible secondary gain. Collateral information was obtained from Miss H's family and teacher.

Formal testing materials included:

- 1) The McGill Pain Questionnaire (Melzack, 1975) (Appendices 5.2-5.4).
- 2) The Children's Depression Inventory (CDI) (Kovacs, 1982) (Appendix 5.5).
- 3) The State-Trait Anxiety Inventory for Children: Forms C1 and C2 (STAI-C) (Spielberger et al, 1970) (Appendix 5.5).

A daily pain diary designed by the interviewer, comprising ten items including a visual analogue scale of pain severity (Appendix 5.6) was administered. Miss H was also asked to draw herself and how she pictured the inside of her stomach when suffering abdominal pain.

Due to sexual abuse (Livingston et al, 1988) and death of relatives (Apley, 1975) having been identified in some research on RAP in children, inquiries were delicately made to Miss H regarding these. She reported that neither these, nor other significant life events had occurred.

On the McGill Pain Questionnaire, Miss H indicated the location of her pain as slightly above the umbilicus but occasionally in the middle of her back (Appendix 5.4). Both the closeness of the pain reported to the centre of the abdomen and the variance in reported location have been identified in the literature as implying non-organic aetiology (Schechter, 1984).

Miss H's results on the CDI, in addition to both state and trait scores on the STAI-C were all in the normal range, with no extremes on any subdomain (Appendix 5.5). Her drawings were unremarkable, giving little insight to her condition. Her two week baseline is described in Appendix 5.7.

Pain Behaviour

Miss H reported rarely requesting medication, seeking support from family or friends, or using distraction, physical activity or any other measures to reduce her pain. On most occasions described in her baseline diary, she appeared to simply continue her activity despite the level of pain on occasion being described as a '10'. She reported she did not ever cry, and had on a number of occasions made no attempt to alert peers, her family or teacher to her distress. Miss H impassively stated her reason for this being as, "they're not going to do anything or give me any medicine" and that she "couldn't be bothered" to tell people. She herself had not wished to take any medication. Her aunt confirmed Miss H "doesn't like to make a big issue of it".

Although the hypothesis of secondary gain through parental attention had been considered, it appeared that while her mother would occasionally rub her stomach when she reported pain, her father tended to ask her to simply sit down until the pain subsided.

Report from Class Teacher

After obtaining consent from Miss H and her parents, an appointment was arranged with her class teacher. Her teacher, who had taught Miss H for around ten months described her as a "strange little girl" who was "very quiet and shy". Her academic performance was described as "average". Her teacher reported that Miss H appeared to have one very close friend, but they tended not to interact with any other pupils. This was a markedly differing account to that of Miss H and her father.

Attention was drawn to physical education classes which her teacher believed to be of major concern to Miss H. She explained that Miss H appeared "very, very self-conscious" and reluctant to change her clothing in front of others, adding "she can't cope with her developing body". Again this differed greatly from Miss H's assertion that while not particularly keen on physical education, that "it doesn't worry me".

Miss H had been absent for a total of 23 days in a ten month period which had led to a request from the school to see Miss H's parents.

Formulation

Miss H would meet all but one of the criteria for Undifferentiated Somatoform Disorder 300.81 in the DSM IV (American Psychiatric Association, 1994), with "clinically significant distress or impairment in social, occupational or other important areas of functioning", being doubtful (p 452). It is noted that establishing a clear psychiatric or psychological diagnosis in suspected somatising patients can be extremely difficult (Ammerman & Hersen, 1995), and that children rarely display enough symptoms to meet standard diagnostic criteria (McGrath, 1995).

A number of complicated aspects emerged from this case. Most notably was the marked discrepancy between Miss H's calm reporting of an extremely high level of pain (Appendix 5.2-5.4) and that this did not appear to be reflected in any other aspect of her functioning including cognition, affect or behaviour. Janet (1907) popularised the concept that "hysterical" patients often presented with "la belle indifference", showing inappropriately little concern about their symptoms (in Gould et al 1986). It may be significant that Srinath et al (1993) identified hysteria to be significantly more common in Asian than Western children.

Additional confusing elements were that Miss H's anxiety and depression scores were not significant even as a result of the extreme pain described, the contradictory reports given by Miss H and her class teacher, and the absence of any clear secondary gain which would be expected should a more "psychosomatic" aetiology be present.

Much of this confused presentation was considered to be associated with an unwillingness or inability by Miss H to express negative affect, reporting no concerns while collateral reports suggested otherwise. Miss H described that she was never in trouble either at home or school, and if she became annoyed her mother would tell her "not to be angry" and to "control" herself. She stated that neither of her parents ever lost their temper, with her GP stating that Miss H's family were "almost too good to be true". It is interesting to note that Minuchin et al's (1975) "poor conflict resolution and/or conflict avoidance" present in the psychosomatic family includes strong religious or ethical codes which can lead to difficulties being left unresolved (p.1031).

Treatment Procedures

It was decided that although a clear "psychological" aetiology was somewhat tentative, Miss H would be offered pain management techniques. These would include cognitive, affective and behavioural components, and that should relevant aetiological issues emerge they would be examined during treatment.

It was also believed that intervention should involve other family members, particularly her parents whose collaboration was felt to be of significant importance. Discussion with Miss H's parents regarding the rationale of a psychological approach, modelling of pain behaviour and future management were to be discussed. In addition it would be suggested that acknowledgment of her pain without encouraging it would be undertaken. This was suggested by McGrath & Feldman (1986, p.56) to avoid the child reporting more extreme pain to 'convince' the observer.

Unfortunately, after the initial assessment, Miss H's parents failed to attend any further appointments despite being invited on numerous occasions. Miss H and her parents had failed to attend numerous appointments at the hospital, with their GP, and in the psychology department. It also emerged from discussion with her aunt that Miss H's mother was somewhat hostile to her daughter receiving psychological intervention.

While recognising these difficulties, intervention continued with Miss H. This included progressive muscular relaxation and breathing exercises (Holzman & Turk, 1986) giving Miss H a handout of these techniques and setting a homework task. A light exercise routine was discussed and implemented. Cognitive distraction techniques were also introduced, with Miss H being asked to describe and draw her "favourite place". She was then encouraged to imagine this in great detail using all her senses when she felt the onset of pain. In a meta-analysis of 51 studies with adults (Fernandez & Turk, 1989), this approach was found to be the most effective of a number of psychological techniques in enhancing pain tolerance and threshold, and reducing reported pain.

Finally, it was discussed with Miss H that her "progress" would be plotted on a graph and her diary reviewed at the start of each session. This was to encourage self-monitoring and assist in identifying potential 'patterns' or 'triggers'. All these techniques were deemed potentially useful as aids to reconceptualising pain as actively manageable as opposed to a passive phenomenon.

During all the sessions it was recognised that a large degree of sensitivity and caution was necessary, particularly when discussing psychological components in the aetiology or maintenance of pain. As Campo (1995) notes, "somatising patients and their families are often extremely negative about psychiatric assessment..." (in Ammerman & Hersen, 1995, p.436). Therefore, great care was taken in stressing to Miss H and her parents at the start of the intervention that her pain was considered

genuine, and that attendance at a psychology department did not mean it was deemed to be "all in her head".

Attempts to examine discrepancies between the reported intensity of Miss H's pain and her somewhat surprising cognitive, behavioural and affective responses were to yield little, with Miss H appearing unable to offer any explanation for this. Discussion of how emotion was expressed in her family and concerns she may have had about school and physical education also failed to achieve any positive outcome, with Miss H denying any concerns.

Close collaboration with both Miss H's GP and a paediatrician was undertaken in the management of this case, while recognising that unnecessary medical investigations could encourage conviction of physical illness (Campo & Fritsch, 1994).

RESULTS

It appeared that Miss H obtained little if any benefit from intervention in terms of symptom reduction. She continued to report significant pain at discharge, but maintained her confusingly calm and apathetic presentation. However, systematic assessment of outcome proved difficult as her pain diary data was too erratic from which to draw any firm conclusions. Although she kept records over the two week initial baseline, there was no complete data for any of the following weeks.

DISCUSSION

There were considered to be a number of significant obstacles to effective intervention in this case. These included the initial adherence of Miss H's and her parents to a physiological model; failure to attend appointments, undertake homework or keep adequate records; apparent hostility to a psychological approach by her mother and

lack of controlled treatment research in this area on which to base intervention (Larsson, 1992).

Another factor which may have been significant to the lack of a satisfactory outcome was the researcher's limited knowledge of how ethnic and religious factors may have contributed to this case. Although there have been over 200 articles published since 1960 discussing pain and ethnicity (Ng et al, 1996), to the researcher's knowledge (PsychLit 1974-1997 and Medline 1966-1997 databases) there are no published studies looking specifically at pain in children of Pakistani origin and little on pain and the Islamic faith. Lipton & Marbach (1984) reviewed 120 papers which included 29 ethnic groupings. None of these appeared to include Pakistani subjects.

A final point of note are criticisms of the concept of somatisation itself. Merskey & Chandarana (in Tyrer, 1992) among others have criticised its validity, suggesting it allows psychological diagnosis to be made simply where there is insufficient organic evidence. Campo & Fritsch (1994) also advise caution when working with this disorder suggesting that children with somatisation "...represent a heterogeneous group, with a variety of different patterns of presentation and a multiplicity of interrelated causes" p.1232).

In conclusion, childhood somatoform disorders appear extremely complex phenomena in which controlled empirical data is lacking. It is also significant that research on pain in children is of recent origin (McGrath, 1995), and that the prognosis described in the RAP research is generally not encouraging (review in Larsson, 1992). In this case, intervention was complicated by a number of other factors, particularly by an apparent failure to achieve a collaborative approach.

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CLINICAL CASE RESEARCH STUDY

Alcohol Dependence with Comorbid Extended Bereavement Reaction - A Single Case Study

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Written in accordance with guidelines for *Behavioural and Cognitive Psychotherapy*
(Appendix 6.1)

Alcohol Dependence with Comorbid Extended Bereavement Reaction: A Single Case Treatment Study

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The following case study describes assessment and treatment of a thirty-seven year old woman (Mrs. W), referred due to an ‘unresolved grief’ reaction following the death of her mother four years previously. It also emerged that Mrs. W had been subjected to physical and emotional abuse by her husband, from whom she had separated, and was drinking an excessive amount of alcohol. Assessment of drinking antecedents, behaviour and consequences was linked to self-monitoring and development of alternative coping strategies. Included in this was an awareness of the ‘cycle of change’ model and utilisation of brief motivational interviewing. Treatment involved a broadly cognitive behavioural programme designed to reduce Mrs. W’s alcohol intake, maintain this reduction and avoid relapse. Following a reduction in her alcohol use, grief therapy involving elements described by Worden (1991) was undertaken. A general problem-solving component was also included. There was a significant reduction of symptomatology on almost all measures, with this being maintained at six-week follow up.

Keywords: Alcohol, bereavement, assessment, treatment

Introduction

Alcohol:

Excessive alcohol consumption has been linked to numerous physiological (Medical Council on Alcoholism, 1986), social (Anderson et al, 1988) and psychological problems (Orford 1992) including liver damage, cancer, unemployment, criminal activity, depression and significantly increased suicide risk (Hawton, 1987). Both the World Health Organisation (1984) and the Royal College of Psychiatrists (1986) have

expressed significant concern about alcohol abuse, the latter describing it as “...the major public health issue of our time”.

Hodgson (1994), reviewing a number of treatment approaches to alcohol abuse concluded that those directed towards improving social relationships, encouraging self-control and involving stress management and brief motivational counselling were the most effective. A relapse prevention component has been identified as important in working with alcohol problems (review in Annis & Davis, 1989), with estimations of between 45% and 50% returning to pre-treatment levels of morbidity (Armor et al, 1978).

Bereavement:

Grief has been shown in a number of prospective and retrospective studies to exacerbate both physical and psychiatric morbidity (Reviewed in Worden, 1991).

Birtchnell (1975) found that parental bereavement can leave some individuals more prone to psychiatric breakdown and identified a highly significant relationship between psychiatric breakdown and the death of a parent in adult life.

Worden (1991) suggested that normal grieving consists of four ‘tasks’ (pp.10-18) but that in some individuals these are not successfully completed. This, he suggests can lead to pathological or complicated bereavement, including chronic, delayed, exaggerated and masked grief reactions (ibid).

The literature identifies a number of factors which have been associated with complicated grief (Reviewed in Sanders, 1989). These include, firstly, excessive attachment to the deceased. Secondly is the situation of the death, with sudden or traumatic death being associated with greater shock and somatisation problems (Lendrum & Syme, 1992). Thirdly is premorbid personality, with early childhood losses, excessive neuroticism and dependency disorders being significant. Fourthly is

minimal or absent social support. Finally are concurrent crises, which may include coincidental deaths (Lendrum & Syme, 1992).

A number of treatment components have been associated with successful outcome in complicated grief. These include problem-focused work, specifically aimed at behaviours and cognitions that hinder the grieving process (Schut et al, 1997), intervention with ruminations, social withdrawal and extension of coping repertoire (ibid p.70), and examining anger, guilt and helplessness (Lendrum & Syme, 1992). Problem solving and 'skill building' have also been recognised as important, particularly if the individual had a highly dependent relationship with the deceased (Worden, 1991 p.71).

Method

Subject

Mrs. W was a thirty-seven year old mother of two, referred to clinical psychology by her G.P. who considered she was suffering "unresolved grief". She appeared significantly depressed, describing a number of anxious and depressive symptoms including persistent low mood, tearfulness, poor sleep (onset and maintenance), anergia/ fatigue, poor concentration, inability to make decisions, anhedonia, guilt, somatic tension and a degree of social avoidance. Mrs. W met DSM IV (American Psychiatric Association, 1994) criteria for a major depressive episode.

It also became clear that Mrs. W had been using alcohol to a significant extent. She described drinking around 55 units of alcohol per week over a period of around three to four years since her mother's death, during which she had not been longer than two days without drinking. The Scottish Council on Alcohol (1993) recommended a safe limit of 14 units per week for women, defining over 35 units per week as "very heavy drinking".

Onset and Relevant History

Mrs. W described that she had experienced a “difficult” marriage, during which her husband, in addition to abusing alcohol and illicit drugs, had threatened and carried out mental and physical abuse. This had culminated in an assault on Mrs. W during which her husband had thrown a number of objects at her, broken her nose, and had threatened to shoot both her and their daughters (aged eight and four at the time). Following this Mrs. W had left her husband, moved back with her mother, and began divorce proceedings.

Within one month of Mrs. W and her daughters moving, and four years previous to seeking treatment, her mother died of a coronary artery atheroma (CVA). Mrs. W had been present at the time of death. This appeared a particularly distressing event, with Mrs. W becoming extremely tearful when speaking about it. She described feeling extremely lonely in the time since her mother’s death, and that she became upset whenever she thought of, or talked about her mother.

Notable denial was also evident, with Mrs. W stating, “I never thought of my mum dying”, and “I’ve never come to terms with it”. It appeared that she had an extremely close and perhaps overdependent relationship with her mother, stating “she was always there” and “she was my best friend” .

When asked how she had dealt with her mother’s death, Mrs. W responded, “I’ve coped by drinking”. She added that while this made her feel “ashamed”, and that she did not feel “in control”, it also gave her “a bit of confidence”.

Measures of Assessment

Measures of mood included;

- 1) The Beck Depression Inventory (BDI) (Beck et al, 1961).
- 2) The Beck Anxiety Inventory (BAI) (Beck et al 1988).
- 3) A weekly activity schedule.

Assessment of alcohol use included quantity, quality, pattern and related problems. It appeared that Mrs. W met the criteria for alcohol dependence syndrome (WHO, 1977 in Galanter, 1983) reporting subjective awareness of drinking, increased tolerance, narrowing of drinking repertoire and salience of drink-seeking behaviour. She added that she would “panic if there’s not much left”. Before her mother’s death she described herself as a “social drinker” where “drinking wouldn’t cross my mind”. She noted, “now it crosses my mind every night”. It also appeared that while still able maintain part time work, parts of many evenings were “blank” with Mrs. W being unable to recall events.

Standardised measures of alcohol use were;

- 4) The Situational Confidence Questionnaire (SCQ-100) (Annis 1987).
- 5) The 20 item Severity of Alcohol Dependence Checklist (SADC) (Stockwell et al 1983).
- 6) The 42-Item Inventory of Drinking Situations (IDS-42) (Isenhart, 1991, a shortened version of the IDS, Annis, 1982) (Isenhart, 1993).
- 7) A drinking diary, measuring number of units consumed daily, and associated circumstances and affect.

Further description of these measures are in Appendix 6.2.

Assessment Results and Formulation

Mrs. W presented with depressive symptoms characteristic of chronic grief reaction (Worden, 1991), with comorbid alcohol dependency. Psychometric results indicated severe depression, moderate anxiety and alcohol dependence.

It appeared that due to extremely close relationship with her mother, combined with the absence of a supportive partner, Mrs. W felt unable to cope on her own. As a result she described abusing alcohol to help her forget, which led to guilt and low mood, precipitating further use.

Mrs. W appeared to fit four of Sander's (1989) five 'risk factors' for developing complicated grief. These were having had a particularly close relationship with her mother, witnessing an extremely distressing death and having little social support with no partner or close family. She had also experienced two significant 'concurrent crises', namely the death of her father less than a year previous to her mother's, and an extremely distressing relationship with and separation from her husband.

Treatment

Intervention consisted of two assessment sessions followed by fifteen 60-minute treatment sessions. A contract was negotiated and reviews were to occur every six sessions. A six week follow-up session was also included. Approaching alcohol use first was undertaken for a number of reasons. Firstly, alcohol itself is a significant chemical depressant (Royal College of Psychiatrists, 1979). Secondly, while the influence of alcohol on bereavement outcome is not well documented, "...alcohol can be an aggravating influence in bereavement as well as an increased suicide risk..." (Sanders, 1989 p.127). Finally, guilt, a significant component of Mrs. W's grief, seemed related to feeling she had "let down" her mother, particularly with her heavy

drinking. It was hypothesised therefore that a decrease in alcohol consumption would lead to diminished guilt and lift her mood.

Intervention with Alcohol Dependence

Initially, a gentle motivational interviewing approach (Miller, 1983; Miller & Rollnick, 1991) was utilised in which questions were asked of Mrs. W designed to elicit her own concerns about her drinking and to encourage cognitive dissonance (Festinger, 1957 in Miller & Rollnick, 1991) between her drinking behaviour and awareness of its consequences. This approach also encourages individual responsibility and internal attribution of change. The ‘decisional balance’ was discussed and evaluated early in treatment with Miller (1983) noting that “every individual coming to an alcohol treatment facility... feels two ways about their drinking” (p.153). Miller (ibid) suggests a significant task of the professional is of “...tipping the balance in the right direction” (p.154).

Identifying environmental supports in addition to cognitive, affective and behavioural coping strategies was undertaken, with utilisation of a wide range of coping strategies being encouraged, an approach supported by the literature. (Litman et al 1979, 1983). Cognitive and affective input included assessment of automatic thoughts and mood prior to, during and following drinking, and eliciting positive self-statements.

The behavioural component included distraction, planning alternative routes to avoid off licenses, taking limited amounts of money when going out, and awareness of behavioural ‘triggers’, which included that drinking occurred almost solely in the kitchen. The IDS-42 was particularly useful for identify behavioural, cognitive and affective risk situations, with Mrs. W’s scores across the eight categories being presented in Appendix 6.3.

Anticipating problem situations and rehearsing alternative coping strategies also proved an important aspect of treatment. For example, Mrs. W appeared very concerned about the response of her ex-husband to her request for child support. She anticipated that if he refused, she would be likely to drink. She described, however, wanting to avoid thinking about such a refusal, often using such cognitive and behavioural avoidance, and stating “I’m hoping for the best”. She was encouraged to confront this possibility and generate plans of how she would cope. Her husband did refuse, but having prepared for this it did not lead Mrs. W to a drinking episode. A number of similar situations were discussed and contingencies planned for.

Due to the guilt experienced by Mrs. W and its effect in increasing likelihood of further drinking, the ‘abstinence violation effect’ was discussed, with Mrs. W being encouraged to view episodes of drinking as ‘slips’ rather than ‘failures’ (Marlatt & Gordon 1985 in Velleman, 1992).

Intervention with Bereavement

Bereavement work began in the seventh session, with much of this being based on Worden’s (1991) procedures for grief therapy (pp.81-88). This comprises nine elements including establishing a therapeutic alliance, reviving memories, and assessing which of four grieving tasks is not completed.

It appeared that part of Mrs. W’ difficulty was related to the third grief task i.e. adapting to environment where the person is missing. Worden (ibid) suggests problem-solving strategies to be a major part in working with this and that the person should be helped “...to overcome his or her helplessness by trying out new skills, developing new roles and in general is encouraged to get back to living” (p.82)

Bereavement work also included identifying and reframing two cognitions which seemed critical to Mrs. W’s bereavement reaction. Firstly was that she had “panicked”

while her mother was experiencing her CVA and she should have attempted mouth to mouth resuscitation (CPR). Secondly was that Mrs. W had left the room almost immediately prior to her mother's death. Both these issues appeared to result in significant guilt, largely due to her belief that if she had acted differently her mother may have survived.

Mrs. W was asked to describe in detail the events around her mother's death, which was understandably distressing for her. However, it emerged that Mrs. W had, in fact, reacted remarkably calmly, phoning the emergency services immediately. She had also contacted a neighbour, asking her to collect and look after her daughters on their return from school so they would not enter the house. It was also discussed and recognised by Mrs. W that in a serious CVA, CPR would have been unlikely to have saved her mother's life.

The second cognition, that of Mrs. W leaving the room immediately previous to her mother having her CVA, and that she had "left her when she needed me" was examined, again being asked to describe events in detail. It emerged that her mother had in fact asked Mrs. W to leave the room minutes before her death. Discussion of this led to Mrs. W suggesting an alternative explanation that her mother, being aware she was dying, did not wish Mrs. W to see her.

This work appears to have led to important shifts in cognition, with Mrs. W stating in a later session, and at discharge "there's nothing more I could have done" and "I think she wanted me to leave".

A problem-solving component similar to that described by Hawton & Kirk (in Hawton et al, 1989) was included, being identified as an important aspect of work with both bereavement (Worden, 1991) and alcohol problems (Velleman in Dryden & Rentoul Eds., 1991). It also appeared relevant given Mrs. W's presentation of extremely low

self-confidence which appeared related to her abusive marriage. A physical relaxation component was included for her somatic tension, with a handout given on this.

Treatment Outcome

Mrs. W reported a notable improvement in mood at the conclusion of treatment, her BDI and BAI scores reducing to a subclinical level (5 and 9 respectively) (Appendix 6.4). Her alcohol consumption had also diminished considerably to a mean of 10 units per week over the final three weeks and at follow up (Appendix 6.5), with her SADQ score decreased to 15 indicating 'minimal/no dependence'. On the SCQ-39 she described increased confidence in coping across all subscales, with a mean increase of 20% (Appendix 6.6). All these measures were maintained at a six week follow up.

Worden (1991) suggested outcome in bereavement work should be evaluated through symptom relief, subjective experience, and behavioural changes. The first of these has been described. Subjectively, Mrs. W described being able to talk about her mother without becoming tearful, something she had previously been unable to do, and that she was able to think back fondly to time spent together. Behaviourally, she stated she was able to spend time in the sitting room, which had previously led to upsetting reminiscence about her mother. Finally, at the end of treatment, Mrs. W reported that as a result of her decreased alcohol use "now I think my mum would be really pleased with me".

Mrs. W's weekly activity schedule remained quite low, with her appearing quite reluctant to become involved in more activities. She stated that she preferred to stay at home and "my life revolves around the girls". While this was understandable given that she was a single parent with two fairly young daughters, it was discussed that as they became older and more independent, it would be important for Mrs. W to develop and maintain her own interests. She described a number of activities she was considering for the future, including attending nightschool.

Discussion

Clinical assessment and a number of psychometric measures indicated that an approach incorporating relapse prevention measures, a protocol for use with complicated bereavement and general problem-solving skills can be effective in treating extended grief reaction with comorbid alcohol dependence.

However, some shortcomings of this study are recognised. Firstly, because Mrs. W was divorced, both her parents were dead and none of her colleagues were aware of her level of alcohol use, it was not possible to obtain corroborative reports of alcohol consumption, which is recognised to be important. Secondly, assessment of cognitive function and physiological effects as a result of alcohol use may have been useful. However it was felt that due to Mrs. W's extremely distressed initial presentation, this may not have been helpful in therapeutic terms. Finally, use of a specific measure of grief reaction may have been useful. However, as Schut et al (1997) note, "no methodologically sound scales for coping with bereavement are as yet available...", adding that scales measuring stress reactions are inappropriate to bereavement work (p.64).

In conclusion, estimates of alcohol prevalence are consistently high both for clinical and non-clinical populations (Royce, 1981 in Ellis et al 1988). Research on alcohol comorbidity has included post-traumatic stress disorder (Stewart, 1996), anxiety (Schuckit & Hesselbrock, 1994), depression (Petty, 1992) and stressful life events (review in Allan & Cooke, 1985). However, with some notable exceptions (Blankfield, 1983; Valanis et al, 1987) there appears to be little research specifically examining assessment or intervention with alcohol and bereavement. The author suggests that this is an area which requires and merits further study.

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Appendix 2.2

Rater's Sheet for Severity of Disfigurement

Rater Name..... Gender..... Age.....

Professional Title.....

Please rate each subject according to the following criteria:

- 1 = Perfect/almost perfect feature
- 2 = Mild imperfection
- 3 = Moderate imperfection
- 4 = Marked imperfection
- 5 = Very marked imperfection

Subject Number

1	[]	21	[]	41	[]
2	[]	22	[]	42	[]
3	[]	23	[]	43	[]
4	[]	24	[]	44	[]
5	[]	25	[]	45	[]
6	[]	26	[]	46	[]
7	[]	27	[]	47	[]
8	[]	28	[]	48	[]
9	[]	29	[]	49	[]
10	[]	30	[]	50	[]
11	[]	31	[]		
12	[]	32	[]		
13	[]	33	[]		
14	[]	34	[]		
15	[]	35	[]		
16	[]	36	[]		
17	[]	37	[]		
18	[]	38	[]		
19	[]	39	[]		
20	[]	40	[]		

Thank you for your assistance

Appendix 2.3

 SEMI STRUCTURED INTERVIEW FOR PATIENTS
 REQUESTING COSMETIC RHINOPLASTY
 AT CANNIESBURN HOSPITAL/ GLASGOW ROYAL INFIRMARY

Started _____ Severity _____ Date ____/____/____
 Finished _____ Post-trauma? no [] yes [] _____
 Length of interview: _____ mins. Subject No. _____
 Name _____ Age _____ Male [] Female []
 Employed? no [] yes [] Occupation _____
 M [] S [] Sep [] D [] W [] Postcode _____
 I/P [] O/P [] Date for operation? no [] yes [] _____

1. For what reason (s) did you request surgery at Canniesburn Hospital/ GRI? (Free recall then present Anderson & Johnson checklist to rank)

2. When did you first request surgery? _____

3. Why did you request surgery when you did?

4. How often do you think about you appearance/ nose?

1 _____ 2 _____ 3 _____ 4 _____ 5 _____
 hardly a few times once/ twice several times almost all
 ever a week a day a day the time

HAD	EPQ-RS	CFSEI
	X SD	Classification
	N-	G-
D-	P-	S-
A-	E-	P-
	L-	L-
		Total-

Appendix 2.3 (cont.)

5. How much do you feel your appearance affects your life at the moment?

1	2	3	4	5
not at all	a little	a moderate amount	quite a lot	very much

6. In what ways do you feel that your appearance affects your life at the moment?

7. What changes do you expect the surgery will make to your life?

8. What do your family/ friends think about you requesting/ having the operation?

9. Is there anything you would like to add?

Check subject has been photographed by hospital/ been offered travel expenses

Appendix 2.4 Anderson & Johnson's (1978) Checklist

Check below the reasons why you want the operation:

- | | |
|--|---|
| <input type="checkbox"/> To improve my appearance | <input type="checkbox"/> To cause other people to react better to me |
| <input type="checkbox"/> To eliminate self-consciousness about my appearance | <input type="checkbox"/> To help achieve certain career goals |
| <input type="checkbox"/> Have an inferiority complex about my appearance | <input type="checkbox"/> To help solve personal problems |
| <input type="checkbox"/> It makes me look ugly | <input type="checkbox"/> To relieve my depressed feelings |
| <input type="checkbox"/> People tease me or make derogatory remarks | <input type="checkbox"/> To help me solve certain personal problems |
| <input type="checkbox"/> To improve function (e.g. breathing) | <input type="checkbox"/> Because of a family resemblance I dislike |
| <input type="checkbox"/> So I can make up better | <input type="checkbox"/> I get few compliments about my looks |
| <input type="checkbox"/> So I can use different hair styles | <input type="checkbox"/> To improve my relations with the opposite sex |
| <input type="checkbox"/> To help me get or keep a job | <input type="checkbox"/> My looks prevent achievement of certain goals |
| <input type="checkbox"/> To help me look better for my age | <input type="checkbox"/> Because of dissatisfaction with previous surgery |
| <input type="checkbox"/> To please or impress others | <input type="checkbox"/> Because I look dissipated or tired |
| <input type="checkbox"/> To give me a psychological uplift | <input type="checkbox"/> Because I feel young; I want to look younger |
| <input type="checkbox"/> To make me look more masculine or feminine | <input type="checkbox"/> To help my career |
| <input type="checkbox"/> To please a relative or friend | <input type="checkbox"/> To give perfection to my looks |
| <input type="checkbox"/> To make me beautiful or handsome | <input type="checkbox"/> Other reasons _____
_____ |
| <input type="checkbox"/> To make other things in my life better | |

Appendix 2.5HADS Anxiety and Depression Scores by Caseness

HADS ANXIETY	Males	Females	Total
Not case	7	12	19
'Borderline'	1	12	13
Case	6	12	18
Total	14	36	50

HADS DEPRESSION	Males	Females	Total
Not case	13	30	43
'Borderline'	1	2	3
Case	0	4	4
Total	14	36	50

Appendix 2.6 Comparison of Mean HADS and EPQ-RS Scores to
Dysphonic and Normal Controls

Subscale	Cosmetic Rhinoplasty (n=50) (present study) Mean Scores (sd)	Organic/Functional Dysphonia (n=204) (Millar et al)	Healthy Male Controls (n=25) (Deary et al)	Healthy Female Controls (n=26) (Deary et al)
EPQ-RS				
Neuroticism	7.4 (3.5)	6.0 (3.6)	4.5 (3.7)	5.4 (3.4)
Extraversion	6.1 (4.3)	7.8 (3.6)	4.5 (3.7)	7.2 (3.6)
Psychoticism	2.6 (1.5)	2.0 (1.6)	2.3 (1.6)	1.7 (1.7)
Lie	4.9 (2.7)	6.2 (2.6)	5.2 (2.8)	5.0 (2.7)
HADS				
Anxiety	9.2 (4.1)	7.4 (4.2)	4.8 (3.3)	4.6 (3.3)
Depression	4.5 (3.6)	4.3 (3.6)	2.4 (2.3)	2.2 (2.7)

Appendix 2.7 EPQ-RS Subscales Compared to Norms

EPQ-RS Subscale	Gender	Subject x (sd)	Subject Range	N	Test x (sd)	Significance
Neuroticism	Male	6.07 (4.40)	0-12	14	5.20 (0.18)	t=.75, df=13, p=.466 (ns)
	Female	7.97 (2.96)	3-12	36	5.77 (0.44)	t=4.38, df=35, p=.000**
	TOTAL	7.44 (3.48)	0-12	50	3.48 (0.46)	t=3.68, df=98, p=.000**
Extraversion	Male	6.43 (4.34)	0-12	14	7.16 (0.78)	t=-.66, df=13 p=.519 (ns)
	Female	5.97 (4.39)	0-12	36	7.52 (0.50)	t=-2.17, df=35 p=.037*
	TOTAL	6.10 (4.34)	0-12	50	7.42 (0.60)	t=-2.13, df=98, p=.018*
Psychoticism	Male	3.50 (1.70)	1-7	14	3.46 (0.49)	t=.09, df=13, p=.926 (ns)
	Female	2.22 (1.30)	0-5	36	2.46 (0.24)	t=-1.13, df=35, p=.267 (ns)
	TOTAL	2.58 (1.51)	0-7	50	2.74 (0.56)	t=-.72, df=98, p=.476 (ns)
Lie	Male	4.93 (3.22)	0-9	14	3.22 (0.54)	t=2.13, df=13, p=.053 (ns)
	Female	4.86 (2.46)	0-9	36	3.50 (0.50)	t=3.23, df=35, p=.003**
	Total	4.88 (2.66)	0-9	50	3.42 (0.52)	t=3.81, df=98, p=.000**

*p<.05 **p<.01

Appendix 2.8 The Culture Free Self Esteem Inventory

CFSEI Subscale	Gender	Mean	Percentile	Range	Std. Dev.	Category	N
General	Male	11.5	35	7-15	2.8	Intermediate	14
	Female	10.0	31	2-15	3.4	Intermediate	36
	TOTAL	10.4	29	2-16	3.3	Intermediate	50
Social	Male	6.6	53	3-8	1.4	High	14
	Female	6.6	50	3-8	1.3	High	36
	TOTAL	6.6	51	3-8	1.3	High	50
Personal	Male	3.7	33	0-8	3.0	Intermediate	14
	Female	3.0	34	0-8	2.2	Low*	36
	TOTAL	3.2	29	0-8	2.5	Low*	50
Lie	Male	5.4	24	1-8	1.8	-	14
	Female	5.5	24	2-8	1.7	-	36
	TOTAL	5.5	24	1-8	1.7	-	50
Total	Male	21.9	35	14-31	5.6	Intermediate	14
	Female	19.8	32	7-32	6.3	Low*	36
	TOTAL	20.4	29	7-32	6.2	Intermediate	50

There were no statistically significant differences ($p < .05$) between genders on this measure.

Appendix 2.9 Subjects' Expressed Motivations for Surgery

REASON	N	ws	REASON	N	ws
To improve my appearance	33	40	To cause others to react better to me	7	3
To eliminate self-consciousness about my appearance	36	78	To help achieve certain goals	4	2
Have an inferiority complex about my appearance	22	20	To help solve personal problems	5	5
It makes me look ugly	14	3	To relieve my depressed feelings	14	8
People tease me or make derogatory remarks	22	13	To help me solve certain personal problems	3	0
To improve function (e.g. breathing)	18	34	Because of a family resemblance I dislike	2	0
So I can make up better	4	1	I get few compliments about my looks	2	0
So I can use different hair styles	6	0	To improve my relations with the opposite sex	5	3
To help me get or keep a job	4	0	My looks prevent achievement of certain goals	3	4
To help me look better for my age	7	2	Because of dissatisfaction with previous surgery	4	3
To please or impress others	4	1	Because I look dissipated or tired	1	0
To give me a psychological uplift	28	32	Because I feel young; I want to look younger	0	0
To make me look more masculine or feminine	3	1	To help my career	4	0
To please a relative or friend	2	3	To give perfection to my looks	7	3
To make me beautiful or handsome	3	0	Other reasons	2	0
To make things in my life better	1	0			

ws = weighted score. This was calculated by reversing the rank order of the three most important reasons chosen by subjects i.e. the reason ranked number one would be given a score of 3, the second most important reason a score of 2 and the third most important reason a score of 1.

CLINICAL PSYCHOLOGY FORUM

Clinical Psychology Forum is produced by the Division of Clinical Psychology of The British Psychological Society. It is edited by Steve Baldwin, Lorraine Bell, Jonathan Calder, Lesley Cohen, Simon Gelsthorpe, Laura Golding, Craig Newnes, Mark Rapley and Arlene Vetere, and circulated to all members of the Division monthly. It is designed to serve as a discussion forum for any issues of relevance to clinical psychologists. The editorial collective welcomes brief articles, reports of events, correspondence, book reviews and announcements.

■ Notes for contributors

Articles of 1000-2000 words are welcomed. Shorter articles can be published sooner. Please check any references. Send two copies of your contribution, typed and double spaced. Contributors are asked to keep tables to a minimum; use text where possible.

News of Branches and Special Groups is especially welcome.

Language: contributors are asked to use language which is psychologically descriptive rather than medical and to avoid using devaluing terminology; i.e. avoid clustering terminology like "the elderly" or medical jargon like "schizophrenic".

Articles submitted to **Forum** will be sent to members of the Editorial Collective for refereeing. They will then communicate directly with authors.

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■ **Clinical Psychology Forum** is published monthly and is dispatched from the printers on the penultimate Thursday of the month prior to the month of publication.

Appendix 3.2Semi-Structured Interview Schedule

Note if inpatient/outpatient, age, gender, and length of time in unit.

1) Have you heard of Spin? Yes [] No [] (if no, go to question 15)

2) How did you hear about Spin?

Family []	Friends []
Other patients []	Staff []
Notice board []	Hospital Radio []
Member of Spin []	Newsletter []
Other []	(please say how)

.....

3) Which, if any, of their activities have you participated in?

(if none go to question 8)

Social Night for World Cup Final	[]
Ceilidh with the Monrovians	[]
All-day craft fair	[]
St. Valentines Hearts and Flowers Fair	[]
Easter bonnet making competition	[]
Trip to King's Theatre, Glasgow	[]
Trip to RSAMD 'Peter Pan'	[]
Evelyn Glennie Concert, Usher Hall	[]
Christmas Shopping at St. Enoch Centre	[]
Creative Writing	[]
Drawing	[]
Painting	[]
Bridge	[]
Concert given by members of RSAMD	[]
Reading Spin Newsletter	[]
Other (please say what)	[]

.....

Appendix 3.2 (continued)

11) How would you rate the level of support you have been given by Spin volunteers?

Very good [] Good [] Reasonable [] Poor [] Very poor []

12) In what way/ways, if any, do you think Spin has improved your quality of life while on the Unit?

13) Which of the skills/activities/information that you have been given by Spin would be/ have been helpful on discharge from the Unit?

14) Are there any activities you would be interested in which Spin could provide, that they don't at the moment?

.....

15) What do you think is the best way to let people know about Spin's activities?

Hospital radio [] Posters on notice boards []

Newsletters [] Other [] (please say how)

.....

16) Have you any other comments to make about Spin?

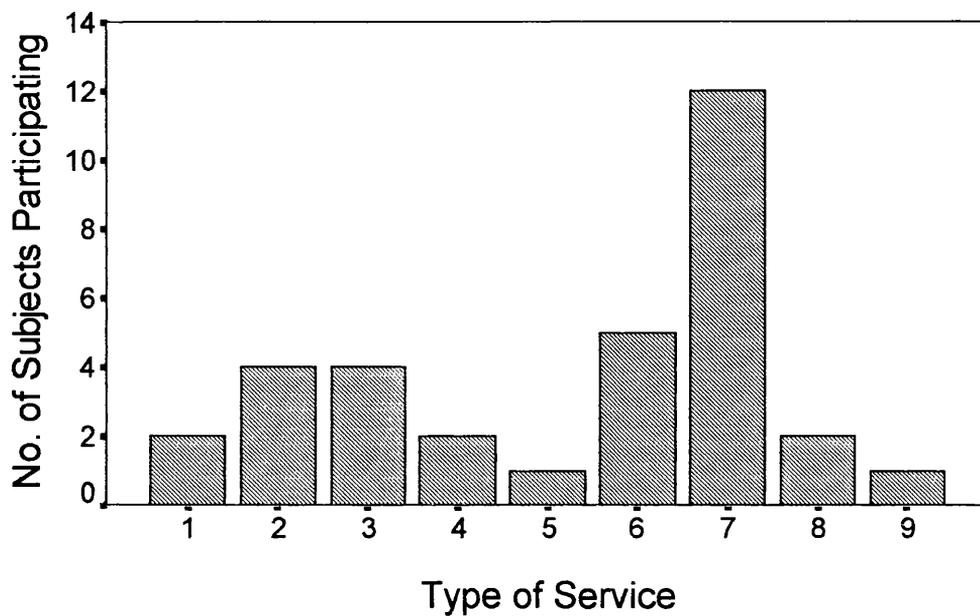
Appendix 3.3Introduction of Research to Subjects

The introduction was given as follows:

“(Introduce self) I’m looking at the work of Spin (the Spinal Injury Network) in the Unit and would like to ask you some questions about it. I do not work for Spin, but am interested to look at their input to the Unit and get an idea of how much, and which of their services are being used. I would also like to know which parts of their work have been helpful to you, and based on the results of the research, to let them know of any changes that you think could improve their service. The information you give will be treated in complete confidence, with no names being given in the report, so please feel free to be as honest as you want”

Appendix 3.4

Number Of Subjects Participating In Main Activities



1 = Ceilidh

2 = Bonnet making

3 = Concerts

4 = Painting

5 = Bridge

6 = Newsletter

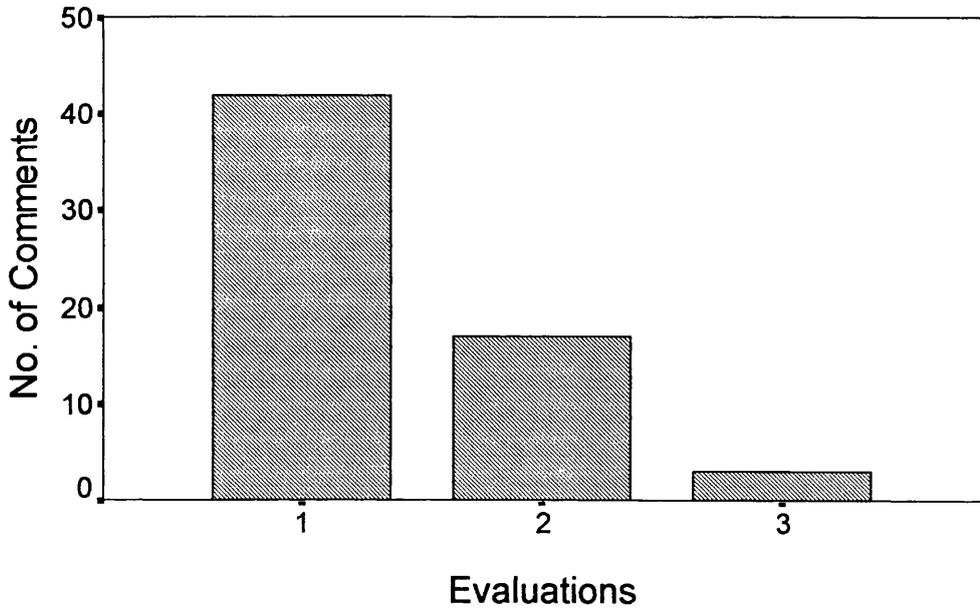
7 = Talking

8 = Lectures

9 = Poetry

Appendix 3.5

Evaluations of Work by The Spinal Injury Network



1 = Positive

2 = Informative

3 = Negative

Appendix 4.1 *Behavioural and Cognitive Psychotherapy* Instructions to Authors

Instructions to Authors

1. **Submission.** Articles written in English and not submitted for publication elsewhere, should be sent to Paul Salkovskis, Editor, *Behavioural and Cognitive Psychotherapy*, Department of Psychiatry, University of Oxford, Warneford Hospital, Oxford OX3 7JX, UK.

2. **Manuscript preparation.** Four complete copies of the manuscript must be submitted. Original figures should be supplied at the time of submission. Articles must be typed double-spaced throughout on standard sized paper (preferably A4) allowing wide margins all round. Where unpublished material, e.g. behaviour rating scales, therapy manuals, etc. is referred to in an article, copies should be submitted to facilitate review.

Manuscripts will be sent out for review exactly as submitted. Authors who want a blind review should mark two copies of their article "review copy" omitting from these copies details of authorship.

Abbreviations where used must be standard. The Système International (SI) should be used for all units; where metric units are used the SI equivalent must also be given. Probability values and power statistics should be given with statistic values and degrees of freedom [e.g. $F(1,34) = 123.07, p < .001$], but such information may be included in tables rather than the main text.

Spelling must be consistent within an article, either using British usage (*The shorter Oxford English dictionary*), or American usage (*Webster's new collegiate dictionary*). However, spelling in the list of references must be literal to each original publication.

Details of style not specified here may be determined by reference to the *Publication manual of the American Psychological Association* or the style manual of the British Psychological Society.

Articles should conform to the following scheme:

- (a) **Title page.** The title should phrase concisely the major issues. Author(s) to be given with departmental affiliations and addresses, grouped appropriately. A running head of no more than 40 characters should be indicated.
- (b) **Summary.** This should summarize the article in no more than 200 words.
- (c) **Text.** This should begin with an introduction, succinctly introducing the point of the paper to those interested in the general area of the journal. *Attention should be paid to the Editorial Statement which appears in the January and July issues at the back of the Journal.* References within the text should be given in the form Jones and Smith (1973). When there are three or up to and including five authors the first citation should include all authors; subsequent citations should be given as Williams et al. (1973). Authors with the same surname should be distinguished by their initials. The approximate positions of tables and figures should be indicated in the text. Footnotes should be avoided where possible.
- (d) **Reference note(s).** A list of all cited unpublished or limited circulation material, numbered in order of appearance in the text, giving as much information as possible about extant manuscripts.
- (e) **References.** All citations in the text should be listed in strict alphabetical order according to surnames. Multiple references to the same author(s) should be listed chronologically, using a, b, etc., for entries within the same year. Formats for journal articles, books and chapters should follow these examples:
 BECKER, M. R. and GREEN, L. W. (1975). A family approach to compliance with medical treatment: a selective review of the literature. *International Journal of Health Education* 18, 173-182.
 THORP, R. G. and WETZEL, R. J. (1969). *Behaviour modification in the natural environment*. New York: Academic Press.
 ROSKIES, E. and LAZARUS, R. S. (1980). Coping theory and the teaching of coping skills. In P. O. Davidson and S. M. Davidson (Eds). *Behavioural medicine: changing health lifestyles*. New York: Brunner/Mazel.
- (f) **Footnotes.** The first, and preferably only, footnote will appear at the foot of the first page of each article, and subsequently may acknowledge previous unpublished presentation (e.g. dissertation, meeting paper) financial support, scholarly or technical assistance, or a change in affiliation. In concluding (or only) paragraph must be the name and full mailing address of the author to whom reprint requests or other inquiries should be sent.
- (g) **Tables.** Tables should be numbered and given explanatory titles.
- (h) **Figure captions.** Numbered captions should be typed on a separate page.
- (i) **Figures.** Original drawings or prints must be submitted for each line or half-tone illustration. Figures should be clearly labelled and be camera-ready wherever possible.

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Appendix 4.2Description of Measures and Initial Scores for Mrs. L

1) The Beck Depression Inventory (BDI) (Beck et al, 1961), perhaps the most commonly used self-report scale measuring depression (Wilson et al, 1989) was administered in sessions two, eleven and sixteen (discharge). Mrs. L scored 40 during initial assessment, a score of 31 and above indicating “severe” depression (Beck et al, 1961)

2) The Dysfunctional Attitude Scale - Form A (DAS) (Weissman & Beck, 1978). This is a 40 item test in which each item is scored by the subject on a 1-7 scale. Possible scores are therefore 40-280. It is designed to assess maladaptive thinking patterns or schema, which according to Beck’s cognitive theory are believed to be relatively stable and can predispose individuals to depression (in Peselow et al, 1990). Factor analysis of the DAS (Blatt et al, 1995) has identified two primary factors; ‘perfectionism’ and ‘social approval’. Subscores for these are available. The DAS has been reported to have good internal consistency, reliability and correlates highly with depression inventories (Hamilton & Abramson, 1983; Gotlib, 1992; Oliver & Baumgart, 1985 in Peselow et al 1990). Peselow et al (1990) found means of 151.41 (sd 35.3) for a depressed group (n=112) and 96.05 (sd 22.5) for non-depressed controls (n=22), while Robins et al (1990) found scores of 142.7 (sd 39.7) and 166.7 (sd 38.1) for groups of endogenous and nonendogenous depressed subjects. Clearly, Mrs. L with an initial total score of 201 is notably higher than subjects of both these studies. This measure was administered in sessions two, five, eight eleven, fourteen and at discharge.

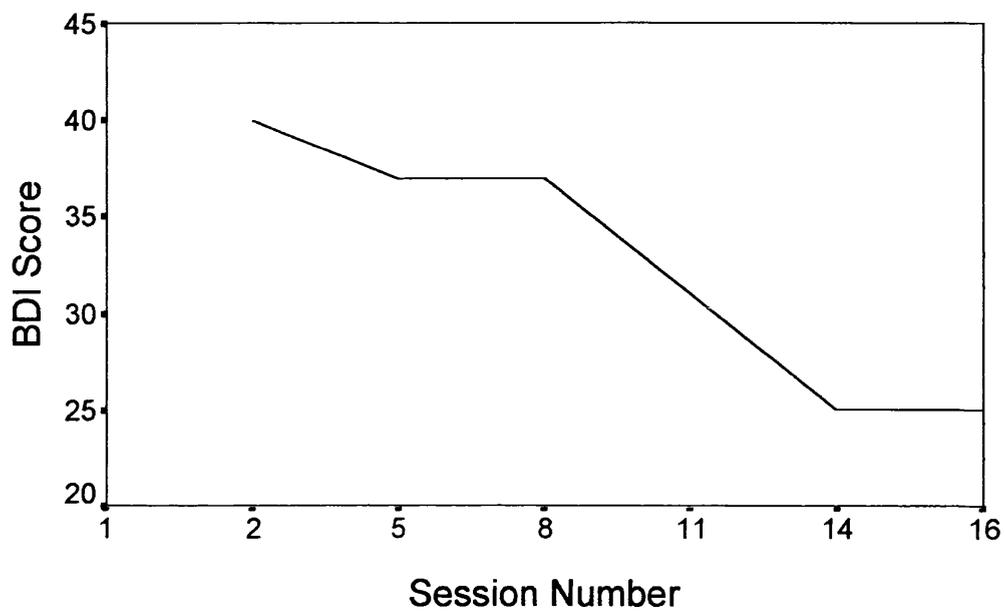
3) Daily diaries of cognition and emotion were undertaken from session eight.

Appendix 4.2 (Cont.)

4) Subjective scale of 1-100% of unhappiness with facial appearance was administered in sessions two, eleven and at discharge. During initial assessment she described feeling 100% unhappy with her appearance.

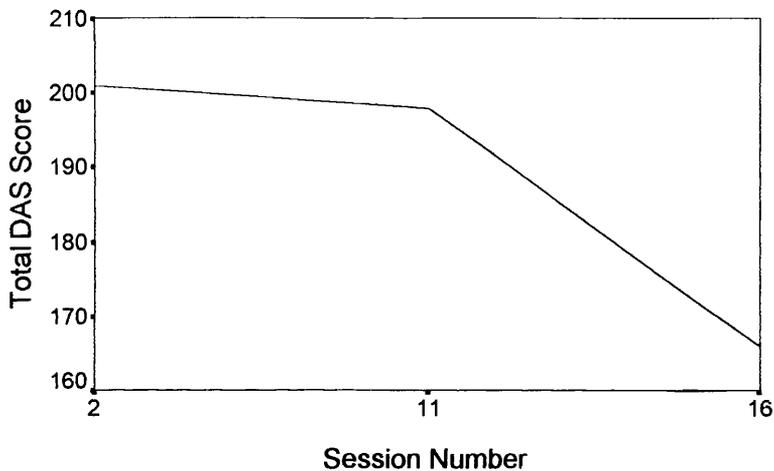
5) A record of average time spent daily in front of the mirror. Mrs. L did not keep an accurate record of this.

6) Self portrait of face, on which Mrs. L was asked to indicate her perceived defects. This was used as a tool for initial assessment. It is notable that Mrs. L's mother did not recognise her from this picture due to the severity of facial disfigurement she had indicated.

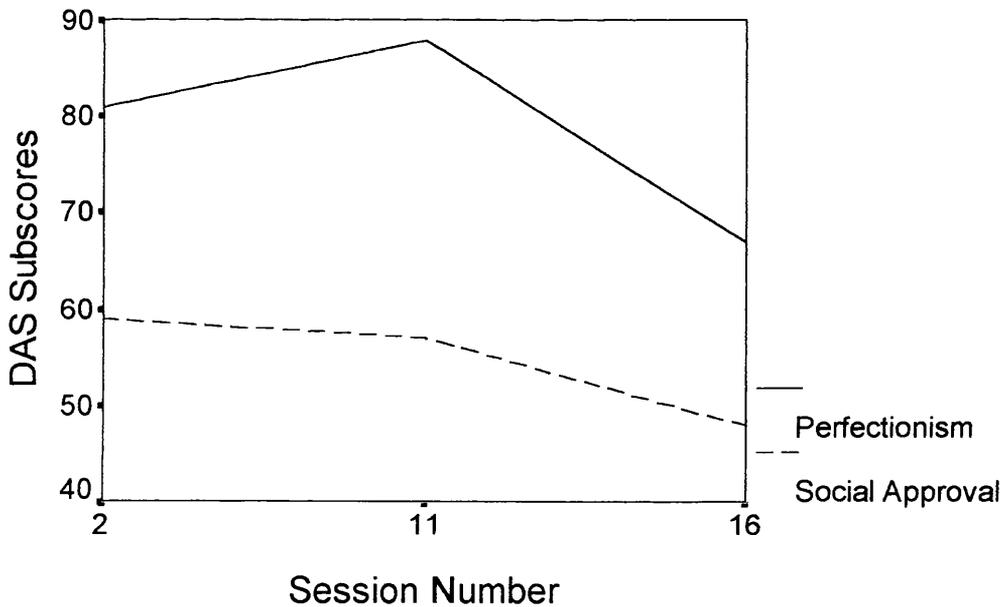
Appendix 4.3**Beck Depression Inventory (BDI) Scores for Mrs. L by Session**

Appendix 4.4

Dysfunctional Attitude Scale (DAS) Total Score for Mrs. L
by Session



Perfectionism and Social Approval DAS Subscales
for Mrs. L by Session



Appendix 5.1 *Journal of Child Psychology and Psychiatry* Instructions to Authors

JOURNAL OF CHILD PSYCHOLOGY AND PSYCHIATRY

AIMS AND SCOPE

1. This Journal aims to enhance theory, research and clinical practice in child and adolescent psychology and psychiatry and the allied disciplines through the publication of papers concerned with child and adolescent development, especially developmental psychopathology and the developmental disorders. An important function of the Journal is to bring together empirical research, clinical studies and reviews of high quality, arising from different points of view. Contributions from any discipline that further knowledge of the mental life and behaviour of children are welcomed. Papers are published in English, but submissions are welcomed from any country. Contributions should be of a standard which merits presentation before an international readership.
2. Papers may assume any of the following forms.
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These should make an original contribution to empirical knowledge, to the theoretical understanding of the subject, or to the development of clinical research practice.
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These will survey an important area of interest within the general field and may be offered or commissioned. All papers in the Annual Research Review, Annotations and Practitioner Reviews are usually commissioned.
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The Journal will publicize details of forthcoming international meetings and conferences only. Send copy to the Journal Secretary (address below) to arrive at least 6 months prior to the meeting deadline to ensure inclusion in an appropriate issue. Details of UK meetings may be advertised in the *Child Psychology and Psychiatry Review* and/or *ACPP Newsletter* of the Association for Child Psychology and Psychiatry, which appear quarterly. Copy should be sent to the *Review & Newsletter* Editors at the JCPP/ACPP Office.
5. The Journal is published in February, March, May, July, September, October and November, with an extra issue, the Annual Research Review, appearing as the first issue of each year, making a total of 8 issues per annum. The Journal is published on behalf of the Association for Child Psychology and Psychiatry by Elsevier Science.

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3. Papers should be submitted to any Editor whose name appears on the inside front cover of the Journal. Papers for the Joint Editors should be submitted care of:

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Journals & Publication Office
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London SE1 1SD.
Telephone: 0171 403 7458
Faxline: 0171 403 7081
E-Mail: sgjt400@sgghms.ac.uk

 Papers may be submitted directly to any of the Corresponding Editors whose addresses are shown on the inside front cover.

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2. Authors whose papers have been given final acceptance are encouraged to submit a computer disk (5.25" or 3.5" HD/DD disk) containing the final version of the papers along with two printed copies to the editorial office: do not send disk with initial submission of paper. Please observe the following criteria:
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 - (b) Specify what computer was used (either IBM compatible PC or Apple Macintosh).
 - (c) Include the text file and separate table and illustration files, if available.
 - (d) The file should follow the general instructions on style/arrangement and, in particular, the reference style of this journal as given in the Notes for Contributors.
 - (e) The file should be single-spaced and should use the wrap-around end-of-line feature (i.e. no returns at the end of each line). All textual elements should begin flush left, no paragraph indents. Place two returns after every element such as title, headings, paragraphs, figure and table callouts, etc.
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Appendix 5.1 (Continued)

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The abstract should not exceed one hundred words and should be typed double spaced. (In addition, a longer summary may, if desired, be included at the end of the main article.)

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8. Acknowledgements

These should appear on a separate sheet, double spaced, at the end of the body of the paper, before the References.

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The Journal follows the text referencing style and reference list style detailed in the Publication Manual of the American Psychological Association.

(a) References in text.

References in running text should be quoted as follows: Smith and Brown (1990), or (Smith 1990), or (Smith, 1980, 1981a,b), or (Smith & Brown, 1982), or (Smith, 1982; Brown & Green, 1983).

For up to five authors, all surnames should be cited the first time the reference occurs, e.g. Smith, Brown and Jones (1981) or (Smith, Brown & Jones, 1981). Subsequent citations should use "et al." (not underlined and with no period after the "et"). e.g. Smith et al. (1981) or (Smith et al. 1981).

For six or more authors, cite only the surname of the first author followed by "et al." and the year for the first and subsequent citation. Note, however, that all authors are listed in the Reference List.

Join the names in a multiple author citation in running text by the word "and". In parenthetical material, in tables, and in the References List, join the names by an ampersand (&).

References to unpublished material should be avoided.

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Full references should be given at the end of the article in alphabetical order, and not in footnotes. Double spacing must be used.

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References to books should include the authors' surnames and initials, the full title of the book, the place of publication, the publisher's name and the year of publication.

References to articles, chapters and symposia contributions should be cited as per the examples below:
Kiernan, C. (1981). Sign language in autistic children. *Journal of Child Psychology and Psychiatry*, 22, 215-220.

Jacob, G. (1983a). Development of coordination in children. *Developmental Studies*, 6, 219-230.

Jacob, G. (1983b). Disorders of communication. *Journal of Clinical Studies*, 20, 60-65.

Thompson, A. (1981). *Early experience: the new evidence*. Oxford: Pergamon Press.

Jones, C. C. & Brown, A. (1981). Disorders of perception. In K. Thompson (Ed.), *Problems in early childhood* (pp. 23-84). Oxford: Pergamon Press.

Use Ed.(s) for Editor(s); edn for edition; p.(pp.) for page(s); Vol. 2 for Volume 2.

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These should be constructed so as to be intelligible without reference to the text. Tables should be double spaced. The approximate location of figures and tables should be clearly indicated in the text.

Figures will be reproduced by photo-offset means directly from the author's original drawing and photographs, so it essential that figures are of a professional standard. Line drawings, good photo prints and sharp copy from laser printers are acceptable. Graphic work printed on a dot matrix printer is not acceptable. Illustrations for reproduction should normally be about twice the final size required. Half-tones should be included only when they are essential and they should be glossy prints, mounted on separate sheets. All photographs, charts and diagrams should be referred to as "Figures" and numbered consecutively in the order in which they are first referred to in the text.

Figure legends should be typed on a separate page.

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No rigid rules are observed, but each paper should be consistent within itself as to nomenclature, symbols and units. When referring to drugs, give generic names, not trade names. Greek characters should be clearly indicated.

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The Journal has a policy of anonymous peer review and the initial refereeing process seldom requires more than three months. Authors may request that their identity be withheld from referees but it is their responsibility to ensure that any identifying material is removed from the manuscript. Most manuscripts accepted for publication require some revision, details of which are sent to authors.

Rejected manuscripts will not be returned to authors, unless a request for the return of one copy is made to the Journal Secretary within 1 month of receiving notice of rejection.

When a paper is accepted for publication, the authors will receive proofs for correction when the manuscript is first set. Authors should correct printers' errors but not introduce new or different material at this stage.

The original manuscript and figures will be discarded 1 month after publication unless the Publisher is requested (on submission of the manuscript) to return original material to the author.

Fifty free reprints will be supplied to the senior author. Reprints can be obtained at a reasonable cost if ordered at the time when the first proofs are obtained. A reprint order will be sent with the proofs and reprints are normally despatched within 6 weeks of publication.

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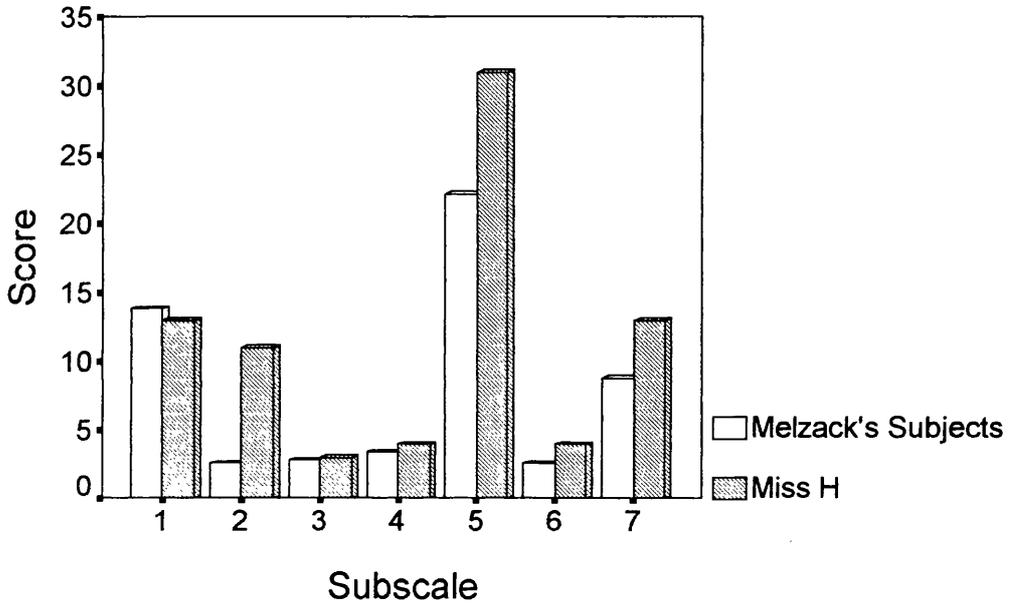
Appendix 5.2 Description of the McGill Pain Questionnaire and Comparison of Miss H's Results With Those of Melzack (1975)

The McGill Pain Questionnaire (Melzack, 1975) is a 20-item self-report scale comprising a list of pain descriptors. It has been found to have strong content and construct validity, allowing for "finely-grained assessment of the quality of pain experiences" (Craig, in Wall & Melzack, 1984, p158). It also provides a body outline diagram for the patient to identify the exact location of their pain. Melzack et al (1985) described a scoring system to derive a Pain Rating Index (PRI) based on weighting the scores of four subscales (in Weinman et al, 1995). Although no normative data are available, Melzack (1975) obtained mean scores for 7 different groups of pain patients (menstrual, arthritis, cancer, dental, back pain, phantom limb and post-herpetic) (in Weinman et al, 1995). Scores for Number of Words Chosen (NWC) ranging from 0 to 78 and Present Pain Intensity (PPI) ranging from 0-5 with 1 being 'no pain' and 5 'excruciating' were obtained. A total score is also derived.

<u>Subscale</u>	<u>Miss H Score</u>	<u>Mean for Melzack's Subjects</u>	<u>Sd</u>
Sensory	13	13.9	2.6
Affective	11	2.6	0.6
Evaluative	3	2.8	0.8
Miscellaneous	4	3.4	1.5
Total	31	22.2	3.7
PPI	4	2.6	0.4
NWC Score	13	8.8	1.4

Appendix 5.3

**Graph of Scores on The McGill Pain Questionnaire:
A Comparison of Miss H and Mean Scores of Melzack's Subjects**



1 = Sensory

2 = Affective

3 = Evaluative

4 = Miscellaneous

5 = Total

6 = PPI

7 = NWC

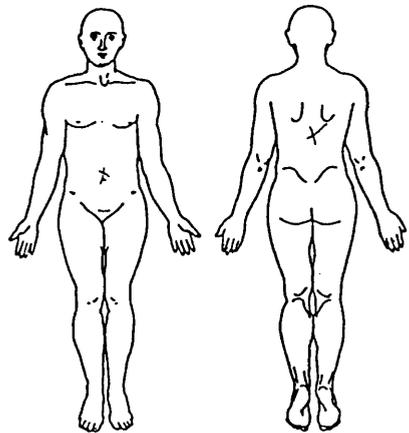
McGill Pain Questionnaire

Patient's Name H Date 11/7/96 Time 3:30 am/pm

PRI: S _____ A _____ E _____ M _____ PRI(T) _____ PPI _____
 (1-10) (11-15) (16) (17-20) (1-20)

1 FLICKERING QUIVERING PULSING THROBBING BEATING ✓ POUNING	11 TIRING EXHAUSTING ✓
2 JUMPING FLASHING SHOOTING	12 SICKENING ✓ SUFFOCATING
3 PRICKING ✓ BORING DRILLING STABBING LANCINATING	13 FEARFUL FRIGHTFUL TERRIFYING ✓
4 SHARP ✓ CUTTING LACERATING	14 PUNISHING GRUELLING CRUEL VICIOUS KILLING ✓
5 PINCHING ✓ PRESSING GNAWING CRAMPING CRUSHING	15 WRETCHED BLINDING
6 TUGGING PULLING ✓ WRENCHING	16 ANNOYING TROUBLESOME MISERABLE ✓ INTENSE UNBEARABLE
7 HOT BURNING SCALDING SEARING	17 SPREADING RADIATING PENETRATING PIERCING
8 TINGLING ITCHY SMARTING STINGING	18 TIGHT NUMB DRAWING SQUEEZING TEARING
9 DULL SORE HURTING ✓ ACHING HEAVY	19 COOL COLD FREEZING
10 TENDER TAUT RASPING SPLITTING	20 NAGGING NAUSEATING AGONIZING DREADFUL ✓ TORTURING
	PPI 0 NO PAIN 1 MILD 2 DISCOMFORTING 3 DISTRESSING 4 HORRIBLE ✓ 5 EXCRUCIATING

BRIEF _____ MOMENTARY _____ TRANSIENT _____	RHYTHMIC _____ PERIODIC _____ INTERMITTENT _____	CONTINUOUS _____ STEADY _____ CONSTANT _____
---	--	--



E = EXTERNAL
I = INTERNAL

COMMENTS:

Appendix 5.5Assessment of Anxiety and Depression in Miss H

Measuring anxiety and depression was considered important, being recognised both in the aetiology (Merskey & Chandarana in Tyrer, 1992, p.45), and as a result of pain (ibid, p.36).

1) The Children's Depression Inventory (CDI) (Kovacs, 1982), a 27 item self-report questionnaire comprises five subsections (negative mood, interpersonal problems, ineffectiveness, anhedonia and negative self-esteem) and gives a total depression score. This measure has been found to have strong reliability and test-retest scores (Smucker et al, 1986).

Children's Depression Inventory

Scale A Total (Negative Mood) -	0
Scale B Total (Interpersonal Problems) -	0
Scale C Total (Ineffectiveness) -	0
Scale D Total (Anhedonia) -	2
Scale E Total (Negative Self Esteem) -	0
Total CDI Score -	2

2) The State-Trait Anxiety Inventory for Children: Forms C1 and C2 (STAI-C) (Spielberger et al, 1970), consists of two, twenty-item self-report scales. These tests have shown evidence of internal consistency and test-retest reliability (in Quay & Werry, 1986). Strong evidence has also supported the state-trait distinction for anxiety in children (Hedl & Papay, 1982).

Miss H obtained raw scores of 25 and 23 on forms C1 and C2 which were respectively 14 and 6.7 points below the norms. This showed Miss H to be less anxious than age matched norms.

Appendix 5.6MISS H's PAIN DIARY

- 1) Day
- 2) Time
- 3) What I was doing when it happened.
- 4) When and what I had eaten.
- 5) Where exactly was the pain?
- 6) Who was there at the time?
- 7) Type of pain (e.g., "sharp", "dull", "thudding", "burning").
- 8) How soon it went away.
- 9) How I dealt with it (e.g., spoke to someone, thought about something else, took medicine, etc.).
- 10) How severe was it (put "X")?

I-----I

no pain as bad as possible

This was evaluated for reading difficulty on a computer-based version of the Flesch-Kincaid Reading Ease Test and found to be equivalent to grade 1.7, i.e., that it could be readily understood by a child aged 5-6 years old and older.

Appendix 5.7

MISS H's TWO WEEK BASELINE

WEEK 1:

Time	Activity	Eaten	Where	Others	Type	Duration	Activity	Severity
19.45	toilet	curry	middle	no-one	dull	10 mins	spoke to mum	2
11.30	school	toast	sides	teacher	sharp	30 mins	just sat	6
07.30	in bed	nothing	sides	sister	sharp	30 mins	none	9
14.00	school	"lunch"	middle	friends	sharp	60 mins	just sat	9
19.00	eating	pizza	sides	parents	sharp	40 mins	just sat	4
19.30	TV	curry	sides	no-one	sharp	60 mins	-	10
12.30	lunch	toast	middle	school	sharp	60 mins	binned lunch	10

WEEK 2

Time	Activity	Eaten	Where	Others	Type	Duration	Activity	Severity
19.30	dinner	-	sides	parents	sharp	30 mins	just sat	10
16.00	TV	toast	sides	no-one	sharp	120 mins	just sat	10
19.00	eating	curry	sides	parents		60 mins	just sat	8
14.00	school	sand-wich	sides	teacher	sharp	60 mins	kept working	10
16.00	dressing	lunch	middle	family	sharp	120 mins	-	-
19.30	eating	fish/chips	sides	parents	sharp	20 mins	stopped eating	8
18.30	TV	curry	whole tummy	no-one	sharp	10 mins	watched TV	5

Few consistent triggers or patterns emerged, with food consumed, prior activity, and individuals present all appearing to vary with each episode. The location of the pain was reported as mostly "in the sides" but also occurs in her "middle" and whole stomach.

Appendix 6.1 *Behavioural and Cognitive Psychotherapy Instructions to Authors*

Instructions to Authors

1. **Submission.** Articles written in English and not submitted for publication elsewhere, should be sent to Paul Salkovskis, Editor, *Behavioural and Cognitive Psychotherapy*, Department of Psychiatry, University of Oxford, Warneford Hospital, Oxford OX3 7JX, UK.

2. **Manuscript preparation.** Four complete copies of the manuscript must be submitted. Original figures should be supplied at the time of submission. Articles must be typed double-spaced throughout on standard sized paper (preferably A4) allowing wide margins all round. Where unpublished material, e.g. behaviour rating scales, therapy manuals, etc. is referred to in an article, copies should be submitted to facilitate review.

Manuscripts will be sent out for review exactly as submitted. Authors who want a blind review should mark two copies of their article "review copy" omitting from these copies details of authorship.

Abbreviations where used must be standard. The Système International (SI) should be used for all units; where metric units are used the SI equivalent must also be given. Probability values and power statistics should be given with statistic values and degrees of freedom [e.g. $F(1,34) = 123.07, p < .001$], but such information may be included in tables rather than the main text.

Spelling must be consistent within an article, either using British usage (*The shorter Oxford English dictionary*), or American usage (*Webster's new collegiate dictionary*). However, spelling in the list of references must be literal to each original publication.

Details of style not specified here may be determined by reference to the *Publication manual of the American Psychological Association* or the style manual of the British Psychological Society.

Articles should conform to the following scheme:

(a) **Title page.** The title should phrase concisely the major issues. Author(s) to be given with departmental affiliations and addresses, grouped appropriately. A running head of no more than 40 characters should be indicated.

(b) **Summary.** This should summarize the article in no more than 200 words.

(c) **Text.** This should begin with an introduction, succinctly introducing the point of the paper to those interested in the general area of the journal. *Attention should be paid to the Editorial Statement which appears in the January and July issues at the back of the Journal.* References within the text should be given in the form Jones and Smith (1973). When there are three or up to and including five authors the first citation should include all authors; subsequent citations should be given as Williams et al. (1973). Authors with the same surname should be distinguished by their initials. The approximate positions of tables and figures should be indicated in the text. Footnotes should be avoided where possible.

(d) **Reference note(s).** A list of all cited unpublished or limited circulation material, numbered in order of appearance in the text, giving as much information as possible about extant manuscripts.

(e) **References.** All citations in the text should be listed in strict alphabetical order according to surnames. Multiple references to the same author(s) should be listed chronologically, using a, b, etc., for entries within the same year. Formats for journal articles, books and chapters should follow these examples:

BECKER, M. R. and GREEN, L. W. (1975). A family approach to compliance with medical treatment: a selective review of the literature. *International Journal of Health Education* 18, 173-182.

THORP, R. G. and WETZEL, R. J. (1969). *Behaviour modification in the natural environment*. New York: Academic Press.

ROSKIES, E. and LAZARUS, R. S. (1980). Coping theory and the teaching of coping skills. In P. O. Davidson and S. M. Davidson (Eds). *Behavioural medicine: changing health lifestyles*. New York: Brunner/Mazel.

(f) **Footnotes.** The first, and preferably only, footnote will appear at the foot of the first page of each article, and subsequently may acknowledge previous unpublished presentation (e.g. dissertation, meeting paper) financial support, scholarly or technical assistance, or a change in affiliation. In concluding (or only) paragraph must be the name and full mailing address of the author to whom reprint requests or other inquiries should be sent.

(g) **Tables.** Tables should be numbered and given explanatory titles.

(h) **Figure captions.** Numbered captions should be typed on a separate page.

(i) **Figures.** Original drawings or prints must be submitted for each line or half-tone illustration. Figures should be clearly labelled and be camera-ready wherever possible.

3. **Proofs, Reprints and Copyright.** Proofs of accepted articles will be sent to authors for the correction of printers' errors; author's alterations may be charged. Authors submitting a manuscript do so on the understanding that if it is accepted for publication exclusive copyright of the paper shall be assigned to the Association. In consideration of the assignment of copyright, 25 copies of each paper will be supplied. Further reprints may be ordered at extra cost; the reprint order form will be sent with the proofs. The publishers will not put any limitation on the personal freedom of the author to use material contained in the paper in other works.

1) The Beck Depression Inventory (BDI) (Beck et al, 1961), a 21 item self-report which is one of the most frequently used measure of depressive symptomatology (Gotlib & Hammen, 1992). Mrs. W initially scored 27, which has been defined as defined as 'severe' (Beck in Wilson et al, 1989)

2) The Beck Anxiety Inventory (BAI) (Beck et al 1988), a 21 item self report scale used to measure the severity of anxious symptoms (Beck et al, 1993). A total score of 0-63 is obtained. Mrs. W initially scored 16. This is defined as 'moderate' (Beck et al, 1988) and is significantly higher than the mean scores of 6.6 (sd = 8.4) and 12.5 (sd = 9.4) developed by Gillis et al (1995) and Creamer et al (1995) respectively on non-clinical samples.

3) The weekly activity schedule indicated Mrs. W participated in around 4 activities per week which she described obtaining 'mastery' or 'pleasure' from.

4) The Situational Confidence Questionnaire (SCQ-100) (Annis 1987). This self-report scale measures perceived likelihood of coping in a number of situations across 8 main subcategories. Initially Mrs. W indicated a mean of 57% likelihood of coping (range 40%- 70%).

5) The 20 item Severity of Alcohol Dependence Checklist (SADC) (Stockwell et al 1983). Mrs. W obtained a score of 24 which put her in the 'mild/moderate' range. However, this may have underestimated her level of dependence as she described being unable to imagine a situation where she had been "...completely off drink for a few weeks" (questions 17-20).

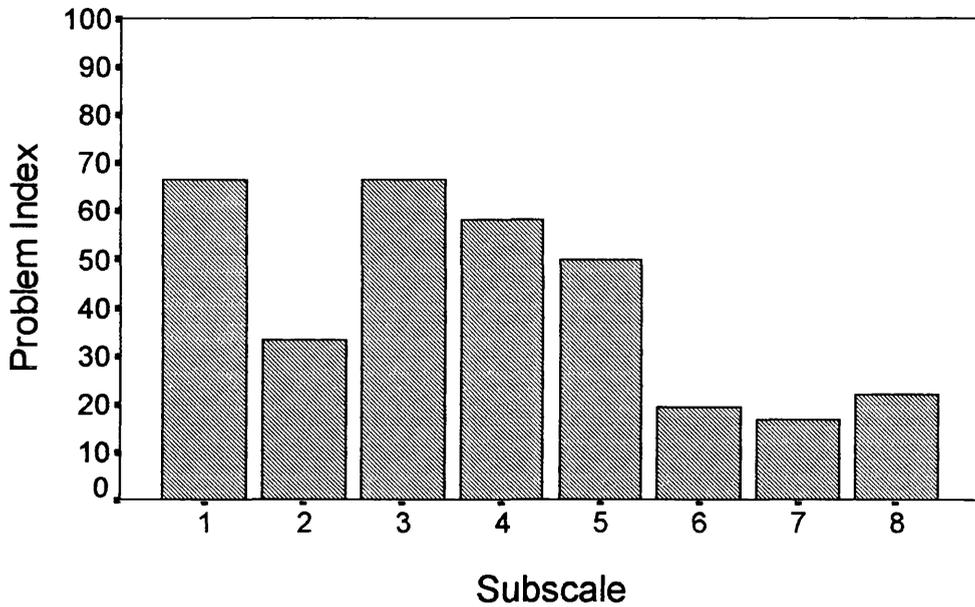
Appendix 6.2 (Continued)

6) The 42-Item Inventory of Drinking Situations (IDS-42) (Isenhart, 1991, a shortened version of the IDS, Annis, 1982), designed to assess likelihood of relapse in 8 types of risk situations (Isenhart, 1993). Initial assessment (session 3) showed that while Mrs. W's profile could be considered a largely 'generalised' one (Appendix 6.3), which tends to be associated with poorer outcome (Annis & Davis 1989), that 'pleasant emotion', 'testing personal control', 'urges and temptations' and 'unpleasant emotion' appeared the most likely to precede an episode of drinking.

7) A drinking diary, measuring number of units consumed daily, and associated circumstances and affect. This showed Mrs. W. consumed an average of 39 units for the first two sessions. This was almost solely while alone, in the evening (when her daughters were asleep), in the kitchen of her house, and was associated with negative affect including anger, annoyance and loneliness.

Appendix 6.3

Inventory of Drinking Situations (IDS-42)
for Mrs. W at Initial Assessment



1 = Unpleasant Emotions/ Frustrations

5 = Urges and Temptations

2 = Physical Discomfort

6 = Conflict with Others

3 = Pleasant Emotions

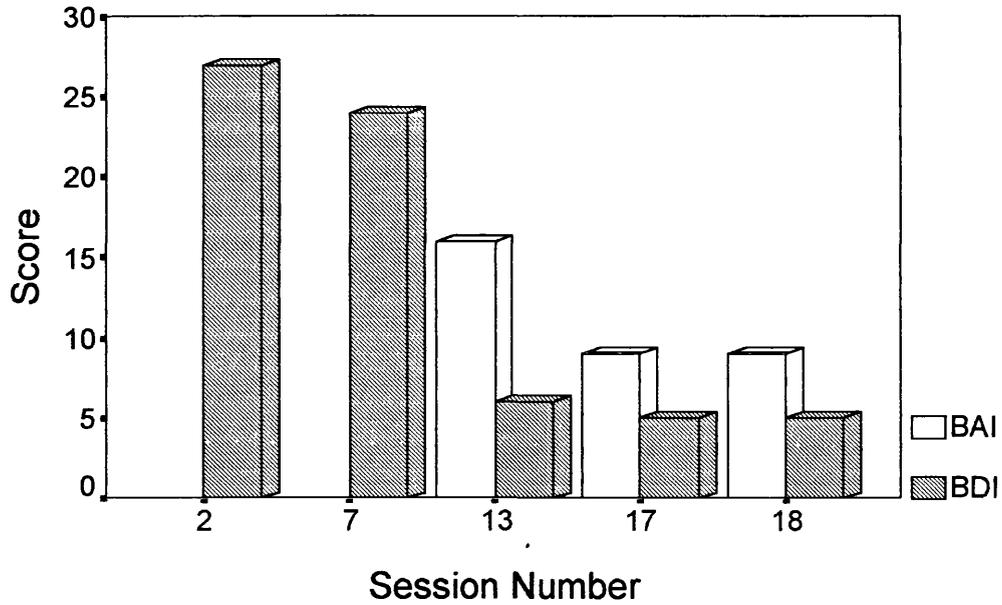
7 = Social Pressure to Drink

4 = Testing Personal Control

8 = Pleasant times with others

Appendix 6.4

Beck Anxiety Inventory (BAI) and Beck Depression Inventory (BDI)
Scores for Mrs. W by Session



Session 18 = 6 week follow up

Note

BDI score at session 2 = 27 ('Severe')

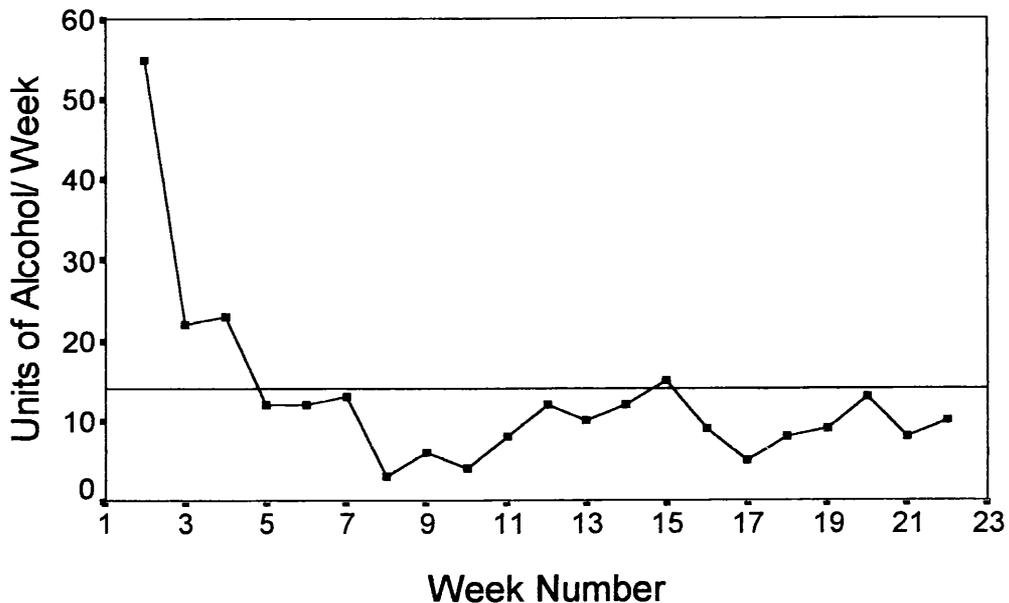
BDI scores at sessions 17 and follow-up = 5 ('Not depressed')

BAI score at session 13 = 16 ('moderate' anxiety)

BAI scores at sessions 17 and follow-up = 9 ('mild' anxiety)

Appendix 6.5

Reported Weekly Units of Alcohol Consumed by Mrs. W

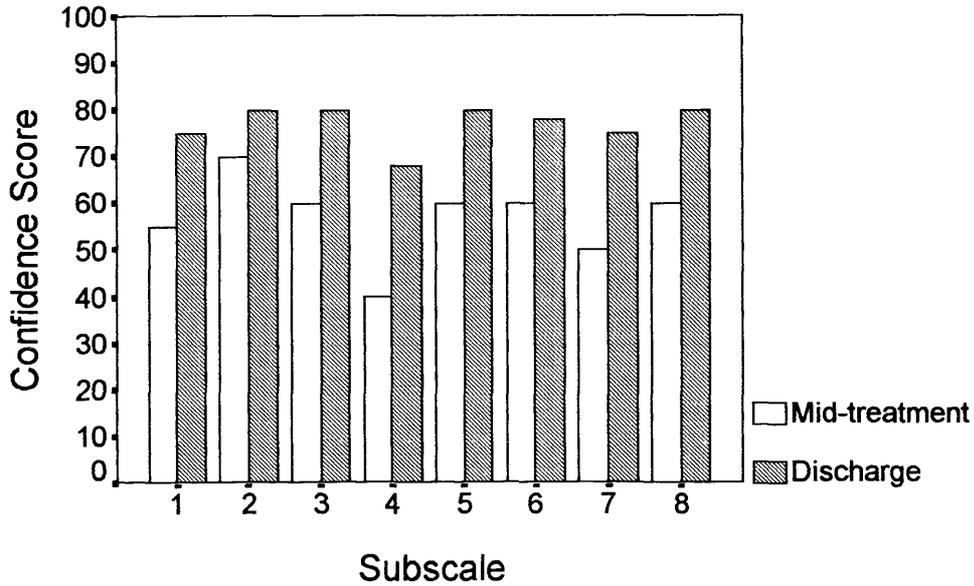


Reference line at 14 units = recommended weekly total for women (Scottish Council on Alcohol, 1993)

Abstinence had initially been suggested by Mrs. W as an objective for therapy. However, by mid-treatment, it was agreed that this would not be essential and that reduction of alcohol use to within a reasonable limit would be acceptable. Research has indicated that for individuals in employment with a relatively short history of alcohol abuse, controlled drinking may lead to better outcome (Heather & Robertson, 1983; Ward, 1988, both in Velleman, 1992). Further considerations were that Mrs. W appeared capable of restricted drinking and that the AVE appeared to be particularly detrimental to her progress. Therefore, 'allowing' reduced consumption seemed appropriate.

Appendix 6.6

Situational Confidence Questionnaire (SCQ-39)
for Mrs. W at Mid-Treatment and Discharge



1 = Unpleasant Emotions/ Frustrations

5 = Pleasant Emotions

2 = Physical Discomfort

6 = Positive Social Situations

3 = Social Problems at Work

7 = Urges and Temptations

4 = Social Tension

8 = Testing Personal Control