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# Psychological Distress Following Surgical Management of Early Pregnancy Loss Detected at Initial Ultrasound Scanning: A Trauma Perspective

**and**

**Research Portfolio**

**Tracy M. Walker (BA Hons.)**

**Submitted in partial fulfillment for the degree of Doctorate in Clinical Psychology, Faculty of Medicine, University of Glasgow, 1997.**

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## Chapter 1: Major Research Project Literature Review

# EARLY MISCARRIAGE EXPERIENCED AS A TRAUMATIC EVENT: A LITERATURE REVIEW

Tracy Walker

Trainee Clinical Psychologist

Department of Psychological Medicine

Gartnavel Royal Hospital.

This paper was written according to guidelines of The British Journal of Medical Psychology. A copy of authors' notes can be found in Appendix 1.

# EARLY MISCARRIAGE EXPERIENCED AS A TRAUMATIC EVENT: A LITERATURE REVIEW.

**Summary:** This paper reviews research which has addressed the psychological impact of the experience of early miscarriage. The main focus rests on the conceptualisation of this life event as a traumatic experience. Existing research is cited and recommendations for future work are highlighted. These include the incorporation of larger sample sizes into future studies and the need to address other types of Early Pregnancy Loss (EPL), for example, missed abortion and blighted ovum (rather than only spontaneous losses). In an attempt to find out more about the exact nature and course of anxiety in the post miscarriage period, it is also suggested that the extent to which women who experience EPL meet criteria for the new DSM-IV category of Acute Stress Disorder (ASD) be assessed. Following on from findings in the animal literature, it is anticipated that the predictability of the event (i.e. EPL) will be an important factor in terms of any resulting psychological impact. Further work in this area is clearly warranted; one practical reason for this is that no professional follow-up after a first early miscarriage is currently provided as a matter of routine.

Miscarriage is a common phenomenon, occurring in as many as 1 in 5 recognised pregnancies (Smith, 1988). A miscarriage can be defined, in general terms, as the loss of a pregnancy within the first 24 weeks. In medical terminology, this is referred to as a "spontaneous abortion", i.e. the expulsion of the fetus from the womb. Other types of miscarriage include "missed abortion", where there is early fetal death in utero or "blighted ovum" which is diagnosed when the gestation sac develops without any evidence of embryonic development; these might be detected at initial ultrasound scanning and result in surgical management to ensure that all the tissue from the pregnancy is removed.

Research interest into the subject of early miscarriage or Early Pregnancy Loss (EPL) has only developed in the last decade or so. In general, studies have focused on the psychological consequences that may ensue in women who have experienced EPL. More specifically, early investigations concentrated on the concept of loss and therefore explored such an event in the context of the process of bereavement. Consequently, at a theoretical level, more is known about depressive symptomatology following miscarriage. However, recent research has utilised a range of psychological assessment measures, which has broadened the picture in relation to the psychological sequelae of EPL.

In this literature review, research advances into psychological distress following EPL will be described. The concept of miscarriage as a traumatic event will then be addressed in the context of recent research findings. An exploration of the theoretical framework of stressful life events will follow on from this. Finally, it will be proposed that EPL can, in certain circumstances, result in the development of acute stress symptomatology, which undoubtedly has implications for follow-up care.

As already mentioned, initial research into the emotional sequelae of EPL concentrated on the detection of depressive symptomatology. In one of the earliest investigations to utilise standardised assessment measures, including the Present State Examination (Wing et al., 1978) and the Beck Depression Inventory (BDI; Beck, 1967), Friedman and Gath (1989)

found that 48% of their sample met psychiatric "caseness" showing depressive symptoms 4 weeks after their miscarriage; this was found to be four times higher than figures derived from community samples. Furthermore, they identified several predisposing factors for depressive features including single status, previous psychiatric history, previous miscarriage and having no existing children.

An American study by Neugebauer et al., (1992) involved a large sample of women who participated in a telephone interview; this was a matched-pairs design, the independent variable being whether a woman was pregnant or not. The Centre for Epidemiologic Studies Depression Scale (CES-D) was utilised. Results indicated that two weeks after miscarriage, women were four times more likely to exhibit significant depressive symptoms in comparison to the controls. Furthermore, levels of depressive symptomatology remained three times higher than the control group for those who were first interviewed six weeks and six months after they had miscarried. Several longitudinal studies have established a pattern to these depressive symptoms (e.g. Robinson et al., 1994); they tend to be high both initially and at 3 month follow-up. Thereafter, they usually subside but may increase again at 1 year post miscarriage, which evidently fits in with the normal bereavement process, whereby the first anniversary of a particular loss may exacerbate symptoms for a time.

Much of the more recent research into women who miscarry has focused on the occurrence of anxiety symptoms. Consistent with current cognitive theories of anxiety (e.g. Beck et al., 1985), a miscarriage could be construed as a threat, i.e. to the ability to procreate. In evolutionary terms, the passing on of genes through our children could be described as a basic need. Any threat to this could result in a fear that this might not be possible. This would be particularly true if a miscarriage occurred during a first pregnancy. Such a perception could maintain anxiety and furthermore, lead to concurrent depressive symptomatology.

Prettyman et al., (1993) carried out a 3 month follow-up of psychological morbidity after early miscarriage, through administration of the Hospital Anxiety and Depression Scale (HADS), (Zigmond and Snaith 1983). This longitudinal study was one of the first to highlight clinically important levels of anxiety in the post miscarriage period; in this particular study almost one third of women were experiencing high levels of anxiety at 3 months post miscarriage. This level of anxiety was considerably higher than that of women in a general population sample.

One practical reason for attempting to identify the nature and course of psychological distress following EPL is that currently it is not medical practice to provide professional follow-up as a matter of routine. If it is in fact the case that psychological distress following EPL is common, as research has indicated, then it may be that this policy requires to be reviewed. In one Glasgow study, Hamilton (1989) found that 74% of women who agreed to participate actually attended for a follow-up appointment six weeks post miscarriage; this clearly illustrated a need for such a service provision.

It is also equally important to assess factors which might influence emotional adjustment in this instance. A good review of potential predictors was carried out by Slade (1994). These included previous psychiatric contact or life experience of bereavement, aspects of reproductive history, planned vs. unplanned pregnancy and aspects of the process of miscarriage, e.g. whether it was perceived as a highly stressful life event and characteristics of care provided.

From the literature addressed, Slade was unable to determine any concrete predictors of emotional adjustment to the experience of miscarriage, apart from previous significant psychological distress. She concluded that one possible reason for this was the fact that the meaning of the event for the individual was not considered and consequently highlighted the need to investigate the potential relevance of cognitive factors in relation to emotional adjustment. In addition, it was suggested that the experience of miscarriage

could be an extremely stressful one. For example, associated factors may include considerable pain, blood loss and an operation. It could therefore have more relevance to conceptualise it as a traumatic life event; This might shed more light on the nature of anxiety consequent to miscarriage and also broaden the type of emotional assessment measures employed in future research..

A few recent studies have approached their investigations from the perspective of a trauma model. In one small sample study, Tunaley et al., (1993) utilised The Impact of Events Scale (IES), (Horowitz et al.,1979), as well as other measures of anxiety and depression, in an attempt to determine cognitive processes involved in the psychological adaptation to a first miscarriage. The IES is a self-report measure of current subjective distress related to a specific event. It consists of two separate subscales which measure levels of intrusion and avoidance pertaining to this event. This study examined cognitive processes in relation to adapting to a negative event, based on an earlier model which was developed from the reactions of women suffering from breast cancer (Taylor, 1983).

They established that lower levels of intrusive thoughts were associated with having an explanation for the miscarriage. Furthermore, belief in a medical cause was associated with lower anxiety. Lower scores on the intrusion subscale were also associated with the experience of miscarriage having resulted in a general reappraisal of life values. Finally, perceptions of personal control over the outcome of future pregnancies was found to be associated with higher levels of anxiety, i.e. the greater the belief in self-control, the higher the level of anxiety. Tunaley et al.(1993) therefore concluded that cognitive mediators as well as emotional consequences should be taken into account in future investigations into the psychological impact of miscarriage.

In another very recent study which was also based on the conceptualisation of early miscarriage as a traumatic event, Lee et al. (1996) utilised a controlled interventional design, which examined the influence of psychological debriefing on emotional adaptation

in women following early miscarriage. The standardised emotional assessments used were the HADS and the IES; some quantitative data regarding reactions to miscarriage and perceptions of care was also collected. These assessments were completed at one week and four-month post miscarriage. Psychological debriefing was carried out with half of the women at approximately two weeks post miscarriage. Significantly high levels of anxiety were found in 36% of the sample at one-week post miscarriage; this was comparable to the Prettyman et al.(1993) study. At four-month follow-up, mean scores of anxiety and depression had decreased significantly; however, it is important to note that anxiety scores were still significantly higher than general population scores. Lee et al. (1996) also established evidence to support a trauma model of the process of EPL; at the first assessment phase, i.e. one week post miscarriage, mean intrusion and avoidance scores were similar to those found in the Horowitz et al. (1979) study but they had significantly decreased at four-month follow-up. The sample in the latter study comprised of people who had requested psychotherapy after experiencing a traumatic life event and consequently developed stress response syndromes.

Surprisingly, psychological debriefing did not influence emotional adaptation, although it was perceived to be helpful. Possible explanations for this as noted in the study included a small sample size (n=39), i.e. it was too small to detect any significant differences, unintended beneficial effects of the assessment process (both groups completed the measures employed) and individual coping strategies. On the basis of their findings the researchers suggested that, in terms of routine follow-up care, early assessment would be important in order to determine which women should be offered subsequent intervention.

To date, investigations which have focused on a trauma model of EPL have been largely preliminary on account of small sample sizes. However, they have suggested post traumatic stress symptoms to be the most prominent in the period immediately after the EPL (e.g. Lee et al. (1996) found mean intrusion and avoidance scores to be highest one week post miscarriage.) More research in the context of larger sample sizes is warranted

in an attempt to reach firmer conclusions as to the validity of perceiving psychological distress from the perspective of a trauma model.

Some research has indicated that certain aspects of an event could play a role in determining the extent to which it is perceived as stressful. For example, in one study derived from the animal literature, Foa et al.(1992) suggested that the degree to which a stressful life event was regarded as unpredictable and uncontrollable was related to the probability of developing Post Traumatic Stress Disorder (PTSD). That is, the more predictable the event, the less stressful it would be experienced. Other research concerning perceived controllability and the development of PTSD has also found that such symptoms tend to be more severe if negative events are perceived as uncontrollable (Kushner et al., 1992). Activation and confirmation of existing schematic models, as well as a shattering of assumptions e.g. of invulnerability, were suggested by the researchers as possible explanations for this finding.

Clinical experience has suggested that it would be of interest to explore this concept in the context of two specific types of EPL, namely those which are detected at initial ultrasound examination. This procedure usually takes place at approximately the 12th week of pregnancy. For a significant number of women this establishes an early pregnancy complication. This may indicate missed abortion or blighted ovum.

Some of these women will have had some prior indication that perhaps their pregnancy is not progressing according to plan, e.g. they might have experienced a little bleeding or pains during the early weeks of pregnancy. Others will have had no such indication that they have a non-continuing pregnancy. In the light of the studies conducted by Foa et al.(1992) and Kushner et al.,(1992), it would be of both clinical and practical importance to compare these two scenarios in order to establish whether prior indication of a non-continuing pregnancy serves to minimise the degree of resulting psychological distress. This would further existing research in two ways; firstly, it would involve assessing

psychological distress following two specific types of EPL (existing work has tended to focus on spontaneous losses.) Secondly, it would build on animal research in the context of PTSD and set about applying hypotheses derived from animal studies to human participants.

The current author plans to conduct one such study; it is envisaged that it will be based on larger numbers than in previous studies. The participants will consist of women who have experienced an EPL detected at initial ultrasound examination. It is hypothesised that those women who have no prior warning of any pregnancy complication will be more emotionally distressed at 3 week follow-up, compared to women who have some prior warning; i.e. the less predictable the EPL, the greater the consequent psychological distress. It is also hypothesised that any emotional distress detected will have greatly decreased at 3 month follow-up. Consistent with existing research, the nature of emotional distress will be conceptualised in terms of EPL being viewed as a traumatic life event. The main emphasis of this study will be on the extent to which participants meet diagnostic criteria for the new DSM-IV category of Acute Stress Disorder (ASD).

ASD is diagnosed when high levels of dissociative symptoms, anxiety and other responses occur within one month of experiencing or witnessing physical trauma and last for a minimum of two days to a maximum of one month, causing distress and dysfunction. Individuals must have responded to the trauma with intense fear, helplessness or horror (this is identical to criteria for PTSD). They must have three of a total of five dissociative symptoms:- depersonalisation, derealisation, amnesia, numbing or stupor. Additionally, individuals require to have one symptom from each of the three classic PTSD categories, namely intrusion of traumatic memories, including flashbacks or nightmares; avoidance and anxiety or hyperarousal.

ASD has been implicated in the development of PTSD, particularly if symptoms remain untreated. This is extremely pertinent in the context of a first early miscarriage because it

is the norm that no professional follow-up care is routinely provided. In fact, in addition to building on existing research in this area, another important reason for the study taking place is to determine whether routine follow-up care should be implemented. At the very least, early assessment could detect those women most at risk of ASD or general emotional distress and subsequently establish appropriate intervention.

In conclusion, investigation into psychological distress following early miscarriage has, in recent years, progressed from being solely viewed from the perspective of loss, with an emphasis on the process of grief and depressive symptomatology. The utilisation of more varied emotional assessment measures such as the HADS and the IES has established the potential for EPL to be experienced as highly stressful. Cognitive mediators such as the meaning of an EPL to each individual have been highlighted as important in determining subsequent psychological distress. Recent studies have made theoretical advances regarding the development of PTSD. They have emphasised perceptions of predictability and controllability to be pertinent factors in its occurrence. Further research is clearly required. As well as replicating existing studies with larger sample sizes, future investigations should attempt to shed more light on the exact nature and course of anxiety, with particular emphasis on signs of acute stress or post traumatic stress in the post miscarriage period. Any findings would be of use in decisions concerning professional follow-up, which may be required as a matter of routine.

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## Chapter 2: Major Research Project Proposal

# Psychological Distress following Surgical Management of Early Pregnancy Loss (EPL) detected at Initial Ultrasound Scanning.

## 2.0 APPLICANT

Tracy Walker, Trainee Clinical Psychologist, Department of Psychological Medicine, University of Glasgow, Academic Centre, Gartnavel Royal Hospital, 1055, Great Western Road, Glasgow G11 0XH.

## FIELD SUPERVISORS

Dr. Alan Cameron, Consultant in Obstetrics and Gynaecology, Queen Mother's Hospital (QMH).

Dr. Margaret McNay, Consultant in Obstetric Ultrasound, QMH.

Sister Anne Byrne, midwife, QMH.

## ACADEMIC SUPERVISOR

Dr. Kate Davidson, Research Tutor, Department of Psychological Medicine, University of Glasgow, Academic Centre, Gartnavel Royal Hospital, 1055, Great Western Road, Glasgow G11 0XH.

## 2.1 SUMMARY

Pregnant women attending the ante-natal clinic at the QMH are routinely offered ultrasound examination when booking at approximately the twelfth week of pregnancy. For a significant number of women, this establishes that there is an early pregnancy complication. This may include missed abortion or blighted ovum. Missed abortion is the

condition where there is early fetal death in utero; blighted ovum is diagnosed when the gestation sac develops without any evidence of embryonic development.

While some of these women will have had some prior indication that perhaps their pregnancy is not progressing according to plan, for example, they might have experienced a little bleeding or pains during the early weeks of pregnancy, others will have had no idea at all that there is any problem present with the pregnancy. Once such a complication has been recognised the patient requires counselling about further treatment. Options are to await spontaneous onset of miscarriage which may require an Evacuation of the Uterus (ERPC) or the patient may be offered an elective admission for an ERPC. The purpose of an ERPC is to remove the tissue from the pregnancy.

Clinical experience suggests that there will be a difference in the two above-mentioned groups of women, i.e. those with some prior warning of a non-continuing pregnancy and those with no prior warning, in relation to their subsequent psychological distress. The main focus will be the extent to which participants meet diagnostic criteria for the new DSM-IV category of Acute Stress Disorder (ASD). Evidence of more general emotional distress will also be investigated. This study would take place at the QMH. Those women who had experienced an EPL would be asked to attend a follow-up appointment, so that their psychological state could be assessed. At present a return appointment is only offered after two EPLs.

Findings in the predicted direction could have a range of practical implications:

1. Our understanding of the emotional experience of EPL could be developed further.

2. In the event of ASD or acute stress symptoms being found, the stressful nature of EPL would need to be acknowledged and indeed, addressed; continuation of such

symptoms may impair quality of life, disrupt social and other functioning and potentially lead to Posttraumatic Stress Disorder (PTSD).

3. If significant levels of emotional distress are found, the provision of services for the aftercare of EPL would need to be re-assessed. For example, follow-up appointments could be made a matter of routine after one EPL..

## 2.2 INTRODUCTION

The experience of miscarriage is common; it has been reported to occur in as many as 20% of recognised pregnancies (Smith, 1988.) Studies throughout the last decade have tried to establish the possible consequences that this could have on a woman's psychological well-being.

Early studies focused on the element of loss in women who have experienced a miscarriage; this has resulted in an emphasis on the occurrence of depressive symptomatology and consequently, more is known about the pattern of depressive rather than anxiety symptoms, if they become apparent in the postmiscarriage period (e.g. Neugebauer et al., 1992.)

Some research has, however, focused on anxiety symptoms; it seems likely that women who miscarry experience significant anxiety symptoms, although the exact nature of such a presentation has not yet been fully investigated. Previous studies have shed some light on possible factors which may influence emotional adjustment (see Slade, 1994 for a review.) These include :- planned/unplanned pregnancy, children/no children, previous psychiatric contact, first operation/not (i.e. ERPC), one previous miscarriage/no previous miscarriages, marital status (issues of social support), age and religion.

However, although the above factors may be pertinent here, the majority of studies attempting to address these issues have been criticised for their poor methodology. In addition, as Slade (1994) points out, this emphasis does not consider the meaning of the event for the individual and consequently highlights the need to consider the potential relevance of cognitive factors in terms of emotional adjustment in the postmiscarriage period. Furthermore, there is a need to broaden the type of emotional assessment measures used, in an effort to find out more about specific aspects of emotional adjustment and also specific anxiety states. It is important to find out more about psychological distress and potential influencing factors, in order that the degree of subjective distress be kept to a minimum. For example, those participants who meet diagnostic criteria for ASD in the postmiscarriage period could receive appropriate intervention in an effort to minimise any detrimental effects on quality of life and general functioning.

A miscarriage is, in itself, a potentially highly stressful experience. However, research conducted by Foa et al., (1992) suggests that the predictability of a traumatic event may lead to it being experienced as less stressful; it would therefore be useful to explore this suggestion in the context of EPL. If this phenomenon was supported, it could have implications for follow-up care following EPL without prior warning.

It is anticipated that it will be of interest to look at this experience in the context of the new DSM-IV category of ASD and also the more general framework of post traumatic stress symptomatology. From this, measures of intrusion and avoidance could be established and perhaps provide more insight into the role of cognitive factors in relation to emotional adjustment.

## 2.3 AIMS / HYPOTHESES

1. Women who experience EPL with no warning of any pregnancy complication, will be more emotionally distressed at 3 week follow-up, compared with women who had prior warning.

2. For those women who are found to be emotionally distressed at 3 weeks after detection of EPL, these symptoms will have subsided greatly at 3 month follow-up.

## 2.4 PLAN OF INVESTIGATION

**2.4.1 Participants:** Following diagnosis of EPL, patients will be counselled and given the opportunity to discuss their choice of management. At this point, Sister Byrne and/or Dr. McNay will ask if the patient is willing to participate in this study. If in agreement they will be requested to attend a follow-up appointment at the QMH 3 weeks after diagnosis of their EPL.

In the event of clinical levels of emotional distress, the researcher will ask the participant's permission to inform clinical staff at the QMH of current psychological state.

**2.4.2 Inclusion Criteria:** Women who have experienced an EPL detected at initial Ultrasound scanning and consequently undergone an ERPC at the QMH during June, July or August 1996.

**2.4.3 Exclusion Criteria:** those women who have experienced recurrent miscarriage i.e. three or more.

**2.4.4 Measures:** The following measures will be used to assess psychological state:

**1. Prior to discharge after ERPC**

Evaluation Questionnaire: re. participants' perceptions of medical care received e. g. how well treated; manner told (see Appendix 2.)

**2. At 3 week follow-up appointment**

**The Impact of Event Scale** (IES: Horowitz et al., 1979):- a 15 item, self-report measure of current subjective distress related to a specific event. These items comprise two separate subscales which measure levels of intrusion and avoidance pertaining to the event. It can be used for repeated measurement over time.

**The Structured Clinical Interview for Dissociative Disorders,** (SCID-D)
- the diagnostic interview schedule which incorporates ASD, according to DSM-IV classification.

**Semi-structured interview** (see Appendix 2) designed to investigate possible within group differences. This will be administered by the researcher.

**The Hospital Anxiety and Depression Scale** (HADS; Zigmond and Snaith, 1983) :- a 14 item self-report measure of severity of anxiety and depression. It can be used for repeated measurement over time.

(The duration of this appointment will be approximately 45 minutes to 1 hour.)

**3. At 3 month follow-up by means of postal questionnaires**

The IES and the HADS (see above). This would be important e.g. if some participants met the criteria for ASD, in order to establish whether it has been alleviated by then (as might be expected) or, in fact, still present.

## 2.5 DESIGN AND PROCEDURE

Two groups will be involved in the study. Initial power calculations indicate that a total of sixty-four participants would be required for a medium effect.

**Group 1**

Women who experience EPL without any warning of a pregnancy complication. The approximate group size will be 32.

**Group 2**

Women who experience EPL with prior warning of a pregnancy complication. The approximate group size will be 32.

## 2.6 DATA ANALYSIS

This will primarily be a comparison study. The following factors will be compared:

1. Groups 1 and 2 in relation to levels of distress.
2. Immediate (i.e. 2-3 days after detection of EPL) versus later surgery (i.e. ERPC).
3. Planned vs. unplanned pregnancy.
4. Living children vs. no living children.
5. Previous psychiatric/psychological contact vs. no such previous contact.
6. First operation vs. previous operation(s).
7. Previous losses vs. no previous losses.
8. One previous miscarriage vs. no previous miscarriages.

Data will be collected by means of questionnaires and diagnostic interview. Group differences will be analysed using The Statistical Package for the Social Sciences ( SPSS). Once data collection has commenced, it will then be appropriate to establish which particular statistical tests to perform in order to analyse it. That is, if the data meets the assumptions for a parametric test, e.g. each variable under test is normally distributed in both populations etc., then it will be appropriate to use independent t-tests to assess whether there is a real difference between groups at the time of administration.

Repeated measures across two time points ( at 3 week and 3 month follow-up) will be analysed differently; if the assumptions of a parametric test are met, then it will be appropriate to use a Multivariate Analysis of Variance (MANOVA). This is a relatively robust test, especially when groups are of approximately equal size.

## 2.7 TIMESCALE

It is anticipated that initial data collection will take place from June - September 1996 at the QMH. Subsequent follow-up postal questionnaires would be sent to participants at the appropriate time.

## 2.8 FINANCIAL IMPLICATIONS

There are none and there are no conflicts of interest.

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# Chapter 3: Major Research Project Paper

# Psychological Distress Following Surgical Management of Early Pregnancy Loss Detected at Initial Ultrasound Scanning: A Trauma Perspective.

Tracy Margaret Walker

Trainee Clinical Psychologist

Department of Psychological Medicine

Gartnavel Royal Hospital.

This paper was written according to guidelines of The British Journal of Medical Psychology. A copy of authors' notes and further relevant information can be found in Appendix 3.

# Psychological Distress Following Surgical Management of Early Pregnancy Loss Detected at Initial Ultrasound Scanning: A Trauma Perspective.

**3.0 Summary:** The last decade has seen increasing research interest into psychological distress following Early Pregnancy Loss (EPL). In theoretical terms, EPL was initially viewed as a loss experience, which led on to depressive symptomatology. More recent research has focused on the occurrence of anxiety symptoms postmiscarriage and has suggested that EPL should be conceptualised from the perspective of a traumatic experience for many women. This study assessed the prevalence of Acute Stress Disorder (ASD), more general post traumatic stress symptoms, anxiety and depression, soon after experiencing an EPL. Follow-up data was also collected on all the above measures except for ASD. It was hypothesised that warning signs of an EPL would result in less psychological distress three weeks after its detection. Any resulting psychopathology was expected to decrease over time. The presence of warning signs was not found to determine levels of psychological distress. It transpired that the actual experience of EPL was stressful for many women, regardless of warning signs of a pregnancy complication. Psychopathology subsided over time with the exception of anxiety which remained clinically signficant. Evidence of acute stress and persistent anxiety supported recent research and highlighted a need for routine follow-up care.

## 3.1 INTRODUCTION

Miscarriage is a common phenomenon, occuring in as many as 1 in 5 recognised pregnancies (Smith, 1988). In general terms, a miscarriage can be defined as a pregnancy loss within the first 24 weeks of gestation. In medical terminology this is referred to as a "spontaneous abortion", that is, the expulsion of the fetus from the womb. Other types of early miscarriage or Early Pregnancy Loss (EPL) include "missed abortion", where there is early fetal death in utero or "blighted ovum" which is diagnosed when the gestation sac develops without any evidence of embryonic development; these may be detected at initial ultrasound scanning at approximately 12 weeks and result in surgical management to ensure that all the tissue from the pregnancy is removed.

Research interest into the subject of psychological distress following EPL has only occurred in the last decade or so. This will be briefly described here; for a detailed review of the relevant literature please refer to Walker (same vol.). Early investigations focused on the concept of loss and consequently explored EPL in the context of bereavement and ensuing depressive symptomatology, (e.g. Friedmann and Gath, 1989). More recent research has investigated the occurrence of anxiety following EPL, (e.g. Prettyman et al. 1993). Consistent with current cognitive theories of anxiety (e.g. Beck et al. 1985), a miscarriage could be construed as a threat, i.e. to the ability to procreate and result in a fear that this might not be possible (especially in first pregnancies). This perception could maintain anxiety and lead to concurrent depressive symptomatology.

Attempts have also been made to assess factors which might influence emotional adjustment to the experience of an EPL, e.g. previous psychiatric contact, planned vs. unplanned pregnancy and other "loss" experiences, etc. In one good review, Slade (1994) could only determine previous significant psychological distress to be a predictor of emotional adjustment to EPL and suggested one reason for this might be that the meaning of the event for the individual was not considered. Slade (1994) also highlighted the

appropriateness of conceptualising EPL as a traumatic life event, given the considerable pain, blood loss and operations that may be involved. In response to this, a small number of very recent studies have addressed psychological distress from the perspective of a trauma model, (e.g. Lee et al. 1996), although they must be regarded as preliminary on account of small sample sizes. In brief, Lee et al. (1996) found significantly high levels of anxiety in 36% of their sample and evidence to support the conceptualisation of EPL as a traumatic event at one-week post miscarriage. Evidence of trauma had significantly decreased at 4 month follow-up.

Other more general research concerning the development of Post Traumatic Stress Disorder (PTSD) has suggested that the degree to which a stressful life event was perceived as unpredictable and uncontrollable was related to the probability of developing PTSD, (e.g. Foa et al.1992), i.e. the more predictable the event, the less stressful it would be experienced.

To advance findings regarding the exact nature and course of anxiety, the current study focused specifically on the extent to which participants met diagnostic criteria for Acute Stress Disorder (ASD), according to DSM-IV classification. ASD has been implicated in the development of PTSD, particularly if symptoms remain untreated. This is extremely pertinent to a first EPL since no professional follow-up is routinely provided.

Clinical experience has suggested that it would be of interest to explore this concept in the context of two specific types of EPL mentioned above, namely missed abortion and blighted ovum. More precisely, some of these women had some warning signs, e.g. bleeding or pains, in the weeks prior to ultrasound scanning, while others had no such indication that they have a non-continuing pregnancy. These two groups were compared to find out whether "predictability" of problems in the pregnancy minimised the degree of resulting psychological distress once an EPL is detected.

## 3.2 Hypotheses

1. Women with no prior warning signs of any pregnancy complication will be more emotionally distressed at 3 weeks after detection of an EPL than women who had perceived warning signs.

2. For those women found to be emotionally distressed at 3 week follow-up, these symptoms will have decreased greatly at 3 month follow-up.

## 3.3 PLAN OF INVESTIGATION

### 3.3.1 Participants

The majority of participants were recruited to the study by a midwife or consultant attached to the Ultrasound department of a local maternity hospital, where they had their initial scan. A small percentage were also recruited from the gynaecology department at a local general hospital, once data collection was well under way. Following detection of an EPL, each woman was counselled by the appropriate medical professional and given the opportunity to discuss her choice of management. Each individual was asked to participate in the study at this point. If they agreed to take part they were given a Participant Information Sheet and signed a consent form (see Appendix 3.) A letter was also sent to the participant's GP regarding the study (see Appendix 3.) Each participant was requested to attend a follow-up appointment at the maternity hospital approximately 3 weeks after this. Participants were also given the opportunity to be interviewed at home.

A total of 40 participants who had experienced an EPL participated in the study. They were divided into two specific groups, according to self-report of perceived or no perceived warning signs of EPL:-

**Group1 -** women had no perceived warning signs, (NWS; N=17) e.g. bleeding or pains, of a pregnancy complication before their scan.

**Group 2 -** women who had perceived warning signs (WS; N=23) of a pregnancy complication before their scan.

### 3.3.2 Inclusion Criteria

Women who had experienced no more than 2 EPLs detected at initial Ultrasound scanning and consequently undergone surgical management, i.e.an evacuation of the uterus (ERPC) during June 1996 - March 1997.

### 3.3.3 Exclusion Criteria

Women who had experienced recurrent miscarriage, i.e. 3 or more.

## 3.4 Measures and Design

### Service Evaluation Questionnaire

Participants were asked to complete this after their ERPC and prior to being discharged. The main focus was on perceptions of care received, e.g. how well treated, manner told etc. These findings are reported elsewhere.

## 3 WEEK FOLLOW-UP APPOINTMENT

The following baseline measures were administered by the researcher. This interview lasted for approximately 45-60 minutes.

### 1. Semi-structured interview

Designed to assess demographic and general life history variables. The extent to which certain aspects of these variables could affect emotional adjustment to the EPL was an important focus here and was consistent with existing literature (e.g. Slade, 1994).

### 2. The Structured Clinical Interview for Dissociative Disorders (SCID-D); modified version

A diagnostic interview schedule which incorporates ASD (only section administered), according to DSM-IV classification.

### 3. The Impact of Event Scale (IES); (Horowitz et al., 1979) - cognitive measure

A 15-item self-report measure of current subjective distress related to a specific event. Items comprise two separate subscales which measure levels of intrusion and avoidance pertaining to the event. It can be used for repeated measurement over time.

### 4. The Hospital Anxiety and Depression Scale (HADS); (Zigmond and Snaith, 1983) - affective measure

A 14-item self-report measure of severity of anxiety and depression. It can be used for repeated measurement over time.

**3 MONTH POSTAL FOLLOW-UP**

The IES and the HADS were sent to each participant approximately 3 months after being interviewed by the researcher. They were instructed to complete the questionnaires and return them in the s.a.e .provided. If possible, a "reminder" phonecall was made to each participant by the researcher, shortly after the questionnaires were sent out. This part of the study was incorporated to test hypothesis 2.

The overall design for the investigation involved between subjects (groups 1 and 2) and within subjects (across time) factors.

## 3.5 Data Handling

The main emphasis of the current investigation was to compare groups 1 (NWS) and 2 (WS) in relation to levels of psychological distress at the two above-mentioned time points. General comparisons according to demographic and general life history variables were made for the sample as a whole. Specific baseline group comparisons were made in relation to prevalence of ASD, cognitive measures of distress (IES) and affective measures (HADS). 3 month follow-up data (IES and HADS) was compared with baseline scores on these measures.

Data was collated, stored and analysed through The Statistical Package for the Social Sciences (SPSS).

## 3.6 Sample Characteristics

The total number of women who participated in the study was forty. The mean age was 31.3 years ( SD = 4.6; range = 21-43). Twenty-six (65%) of the sample were married;

ten (25%) women were living with their partners; one (2.5%) woman was divorced and three (7.5%) were single. Seventeen (42.5%) of the sample had children.

Mean gestation at the time of EPL was 11.1 weeks (SD = 2.1; range = 6-16). Thirty-one (77.5%) women reported their pregnancies to have been planned, whereas nine (22.5%) pregnancies were reported as unplanned. Three women reported a previous pregnancy loss. In terms of general losses, only three women had not experienced any other life events which they perceived as losses. Bereavement was, by far, the most common type of loss experience. Mean time of interview after detection of EPL was 3.1 weeks (SD = 1.0; range = 2-7).

## 3.7 RESULTS

### 3.7.1 Baseline Measures

#### 1. Demographic and General Life History Variables

No significant differences were found between the two groups; one exception to this was a significant association between group and educational history (chi square = 7.0; $p<0.05$). Women in group 1 (NWS; N=17) were more likely to have obtained a university degree, whereas women in group 2 (WS; N=23) were more likely to have completed secondary school or college courses.

#### 2. Diagnosis of Acute Stress Disorder (ASD)

Six (15%) of the total sample met the criteria for a diagnosis of ASD, according to DSM-IV (1994) Classification. Five (12.5%) were in group 2 and only one (2.5%) was in group 1. However, this difference between groups was not significant. Interestingly, 35% of the entire sample met 6 out of 7 criteria required for diagnosis. For both groups, 87.5% met 4 or more criteria. Mean number of criteria met was 5 (SD = 1.7; range = 0 - 7).

On inspection of separate criteria, 92.5% of the total sample reported re-experiencing their EPL, e.g. flashback episodes, dreams, recurrent images etc.; 72.5% noted feelings of fear, helplessness or horror; 70% experienced poor concentration, feeling on guard or restlessness and equally, 70% reported feeling anxious, difficulty sleeping or irritability. This latter figure was found to be significantly associated with group (chi-square = 4.7; $p<0.05$). Significantly more women in group 1 (NWS; N=17) experienced feeling anxious, difficulty sleeping or irritability, compared to group 2 (WS; N=23).

### 3. Cognitive and Affective Measures

i) No significant group differences were found on IES and HADS measures at initial follow-up interview. However, mean intrusion scores (particularly for group 1; 19.7; SD=7.4) were not much lower than comparable stress clinic patient scores reported in the study by Horowitz et al., (1979; mean intrusion score = 21.4; SD=9.6; mean avoidance score = 18.2; SD=10.8; mean total IES score = 39.5; SD=17.2). The median avoidance score was 11.

**Table 1: Mean Scores (M), Standard Deviations (SD) and Test Significance for The Impact of Event Scale (IES) and The HADS for Groups 1 (no warning signs) and 2 (warning signs).**

| Cognitive Measures | Group 1 (N=17) | | Group 2 (N=23) | | Significance Test | DF | p (two-tailed) |
|---|---|---|---|---|---|---|---|
| | M | SD | M | SD | | | |
| IESTOT | 34.6 | 13.7 | 31.2 | 15.1 | t = 0.75 | 38 | n.s. |
| TOTINTRU | 19.7 | 7.4 | 17.3 | 8.0 | t = 0.95 | 38 | n.s. |
| TOTAVOID | 14.9 | 9.9 | 13.8 | 9.3 | U = 191.5 | | n.s. |
| **Affective Measures** | | | | | | | |
| TOTANX | 7.7 | 3.7 | 8.6 | 4.4 | t = -1.02 | 38 | n.s. |
| TOTDEPR | 5.4 | 4.1 | 4.4 | 3.0 | t = 0.91 | 38 | n.s. |

IESTOT = total score on the IES.

TOTINTRU = total score on the intrusion subscale of the IES.

TOTAVOID = total score on the avoidance subscale of the IES.

TOTANX = total anxiety score on the HAD Scale.

TOTDEPR = total depression score on the HAD Scale

**ii) Table 2: Mean (M) Scores and Standard Deviations (SD) on the IES and the HADS for Selected Life History Variables for Entire Sample,(N=40)**

| Variable | N | IESTOT | | TOTINTRU | | TOTAVOID | | TOTANX | | TOTDEPR | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | M | SD | M | SD | M | SD | M | SD | M | SD |
| planpreg | 31 | 30.9 | 14.6 | 17.9 | 7.7 | 12.9 | 9.6 | 7.9 | 4.1 | 5.0 | 3.7 |
| unplan | 9 | 38.8 | 12.5 | 19.8 | 8.1 | 19.0 | 8.0 | 8.2 | 4.1 | 4.3 | 2.9 |
| child | 17 | 32.8 | 16.5 | 16.5 | 8.3 | 16.3 | 10.8 | 7.8 | 4.2 | 3.8 | 3.0 |
| nochild | 23 | 32.5 | 13.0 | 19.7 | 7.2 | 12.8 | 8.3 | 8.2 | 4.1 | 5.6 | 3.8 |
| therapy | 3 | 32.6 | 3.5 | 21.7 | 5.5 | 24.3 | 2.1 | 14.7 | 3.2 | 7.7 | 2.5 |
| notherapy | 37 | 31.6 | 14.5 | 18.1 | 7.9 | 13.5 | 9.4 | 7.5 | 3.7 | 4.6 | 3.5 |
| firstop | 10 | 36.2 | 13.6 | 19.6 | 7.0 | 16.6 | 9.5 | 7.7 | 3.2 | 4.6 | 2.5 |
| notfirstop | 27 | 30.7 | 15.1 | 17.4 | 8.2 | 13.3 | 9.8 | 7.8 | 4.3 | 5.0 | 3.9 |
| anyloss | 37 | 33.5 | 14.3 | 18.9 | 7.7 | 14.7 | 9.6 | 8.0 | 4.1 | 5.0 | 3.5 |
| noloss | 3 | 21.7 | 13.9 | 12.0 | 5.2 | 9.7 | 9.0 | 8.0 | 4.6 | 3.0 | 3.6 |

planpreg =planned pregnancy

unplan =unplanned pregnancy

child =living children

nochild =no living children

therapy =previous psychological/psychiatric contact

notherapy =no previous psychological/psychiatric contact

firstop =ERPC was first operation

notfirstop =ERPC was not first operation

anyloss =previous life events regarded as losses

noloss =no previous life events regarded as losses

Some significant differences for the whole sample were found on the IES and the HADS for selected life history variables. Previous psychological or psychiatric contact was found to be significantly associated with higher levels of anxiety compared to no such contact, ($U= 8.0$, $p<0.01$). Those who had unplanned pregnancies were significantly more likely to have post traumatic stress symptoms, as measured by total scores on the IES, ($U= 78.5$, $p<0.05$) compared to those whose pregnancies were planned. Some of the other measures of psychological distress approached significance:- those who had unplanned pregnancies were more likely to experience cognitive avoidance regarding their EPL ($U= 80.5$, $p<0.06$). Finally, those who had previous psychological/psychiatric contact were more likely to have post traumatic stress symptoms and experience cognitive avoidance ($U= 18.0$,$p<0.06$; $U= 18.0$, $p<0.06$). All other mean score differences (tabulated above) were not significant.

### 3.7.2 Follow-up Data

**Table 3: Comparison of Total Sample Mean Scores (M), Standard Deviations (SD) and Test Significance for the Impact of Event Scale (IES) and the HADS at Baseline (three weeks) and Follow-up (three months).**

| Cognitive Measures | baseline | | follow-up | | Significance Test | DF | p (two-tailed) |
|---|---|---|---|---|---|---|---|
| | M | SD | M | SD | | | |
| IESTOT | 32.4 | 14.3 | 26.8 | 14.7 | t = 2.36 | 32 | <0.05 |
| TOTINTRU | 18.6 | 7.8 | 14.2 | 7.5 | t = 3.25 | 32 | <0.01 |
| TOTAVOID | 14.3 | 9.5 | 12.6 | 9.2 | Z=-0.80 | | n.s. |
| **Affective Measures** | | | | | | | |
| TOTANX | 7.6 | 4.0 | 7.6 | 4.6 | t = 0.00 | 32 | n.s. |
| TOTDEPR | 4.9 | 3.7 | 3.3 | 3.0 | t = 3.97 | 32 | <0.001 |

Thirty-three participants, that is, 82.5% of the total sample (N=40), completed and returned the questionnaires. As predicted, psychological distress decreased over time. Post traumatic stress symptoms decreased significantly over time, ($t= 2.36$, $DF=32$, $p<0.05$). Intrusive thoughts decreased significantly, ($t= 3.25$, $DF= 32$, $p<0.01$), as did symptoms of depression, ($t= 3.97$, $DF= 32$, $p<0.001$). However, this was not true for anxiety levels, which remained clinically significant for the total sample, ($t= 0.00$, $DF= 32$, n.s.) or avoidance subscale scores ( median score = 12; $Z=-0.8$, n.s.), which only decreased slightly.

## 3.8 DISCUSSION

### 3.8.1 Psychological Distress at Initial (3 weeks) Follow-Up

A few recent studies, (e.g. Lee et al., 1996) have suggested that EPL can be experienced as a traumatic event by many women. The present study supported this finding. It investigated whether warning signs of an EPL resulted in less psychological distress several weeks after the loss. This was not found to be the case. No significant differences were found between the two groups in relation to actual diagnosis of ASD, or on the other two standard measures of emotional distress, namely the IES and the HADS. It is also important to note that psychological distress did not increase over the following three months; in fact it subsided. However, this was not true of anxiety levels which remained clinically significant at three month follow-up. In addition, it would have been helpful to have investigated whether ASD psychopathology was maintained at three month follow-up. This seems unlikely, however, because scores on the IES had decreased greatly.

Although no significant group differences were found, it was evident that many women in the sample as a whole experienced traumatic symptoms. Indeed, intrusion subscale scores (for group 1 in particular, i.e. NWS) were almost as high as for female stress clinic patient scores reported by Horowitz et al., (1979) at three week follow-up. Despite finding that the majority of women involved in the study did not meet criteria for ASD, evidence of acute stress symptoms was great, for the sample as a whole. For example, 70% reported feeling anxious, difficulty sleeping or irritability; indeed significantly more women in group 1 experienced these symptoms compared to group 2. This particular finding suggested limited support for the absence of warning signs resulting in greater psychological distress.

The majority of women (72.5%) reported feelings of fear, helplessness or horror Anecdotal reports regarding the precise nature of these particular feelings focused overwhelmingly on a perceived threat to the ability to procreate. This is entirely

consistent with current cognitive theories of anxiety (e.g. Beck, 1985). Interestingly, 92.5% noted re-experiencing their EPL, e.g. flashback episodes, dreams, recurrent images etc. The content of these intrusive memories seemed mainly to relate to seeing the image of their baby at Ultrasound scanning.

In the present study, levels of depression were not clinically significant for either group. Lee et al., (1996) found that only 8% of their sample had clinically significant depression scores. Interestingly, other researchers have found higher rates of depression, (e.g. Neugebauer et al., 1992). Apparent discrepancies in this respect may relate to the types of assessment used and their administration at varying time points post-miscarriage.

Some significant differences were found for the whole sample on measures of psychological distress for selected life history variables, (see results section). Small sample sizes might have precluded actual significant differences for those variables which approached significance. Slade (1994) only identified previous significant psychological distress as predictive of emotional adjustment in her review of the literature.

### 3.8.2 Psychological Distress at Three-Month Follow-Up

Interestingly, anxiety symptoms were maintained at three month follow-up. This contrasts with Lee et al., (1996); they found anxiety levels had decreased at four month follow-up. However, they still remained clinically significant. One explanation for persistent anxiety (consistent with Prettyman et al.,1993) may be continuing fears concerning a successful future pregnancy. Anecdotal reports from women who participated in the current investigation appeared to support this view. In addition to supportive counselling by the researcher at initial follow-up interview, there was an opportunity to arrange a subsequent appointment with a medical professional (a midwife) with the aim of receiving a medical explanation for the EPL. Many women opted for this. Recent studies have suggested that receiving a medical explanation could decrease anxiety (e.g. Tunaley et al., 1993). While

this may be true, it is often difficult to provide such an explanation on account of pregnancy loss occuring at this early stage.

Unintended therapeutic effects of the initial follow-up interview (and contact with a midwife) may have had a role in decreasing psychological distress over time. It is entirely possible that anxiety scores could have increased to a greater extent without these interventions.

### 3.8.3 Absence of Group Differences

There are several possible reasons for the absence of significant group differences. The results suggest that it is the actual experience of an EPL that is stressful, rather than whether it is predictable or not; this aspect does not seem to make a difference to resulting psychological distress. However, it is important to note that small sample sizes may also have precluded detection of significant diffferences.

Additionally, at initial scanning many women were told that there might be a pregnancy complication and were asked to return for a second scan to confirm or refute this one week later. This period of uncertainty was described by the majority of women as extremely stressful and may have contributed considerably to the appearance of post traumatic stress symptoms for many women postmiscarriage. The general consensus seemed to be that they would have preferred to have been told if they had a non-continuing pregnancy immediately after the first scan.

### 3.8.4 Critical Review

One of the main strengths of this investigation was its endeavour to advance research into the nature and course of anxiety (through assessment of ASD criteria) following EPL. It has also contributed to the validity of conceptualising EPL from a trauma perspective.

Additionally, it was innovative in its focus on two specific types of EPL. At a more practical level, it has highlighted a need for routine follow-up, on account of evidence of acute stress and long-term anxiety symptoms in the postmiscarriage period.

The small sample size could be described as one weakness of the study. Initial power calculations indicated that a total of sixty-four participants would be required for a medium effect; since this figure was not reached, the study may have been "underpowered." The absence of a control group, e.g. to control for unintended therapeutic effects of the initial follow-up interview represented another limitation. It would also have been useful to record any new pregnancies at three-month follow-up (or preferably later on) to assess whether the removal of this threat to the ability to procreate did, in fact, decrease anxiety.

Future research needs to address the above limitations; larger sample sizes require to be incorporated into future studies. The implementation of routine follow-up would require evaluation. It may also be beneficial to intoduce a preventative framework designed to minimise high levels of distress identified immediately after detection of an EPL.

## 3.9 Conclusion

The present study supported the conceptualisation of EPL as a traumatic experience. The actual experience of EPL was found to be extremely stressful for many women, rather than whether there was any perceived predictability (as indicated by warning signs) about it. No significant differences between groups on all measures of psychological distress were found. On the whole, psychopathology decreased over time. However, anxiety levels remained clinically significant. Evidence of acute stress and persistent anxiety prompted a recommendation for routine follow-up care.

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# Chapter 4: Single Clinical Case Research Study (1)

## TOWARDS OUTCOME MEASUREMENTS: monitoring effectiveness of anger management and assertiveness training in a group setting.

This paper has been submitted to the British Journal of Learning Disabilities. A copy of authors' notes and further relevant information can be found in Appendix 4.

**Ms Tracy Walker**
**Trainee Clinical Psychologist**
**Department of Psychological Medicine**
**Gartnavel Royal Hospital**
**Glasgow**

**and**

***Dr Sally Cheseldine**
**Consultant Clinical Psychologist**
**Department of Clinical Psychology**
**Kirklands Hospital**
**Fallside Road**
**Bothwell G71 8BB**

* **Address for correspondence**

**TOWARDS OUTCOME MEASUREMENTS: monitoring effectiveness of anger management and assertiveness training in a group setting.**

## 4.0 SUMMARY

It is becoming increasingly important for clinicians to justify the treatment approaches they use. This study illustrates one way of measuring therapeutic effectiveness in a small group of learning disabled individuals who frequently demonstrated aggressive or intimidating behaviours. The use of a self-report measure, the Provocation Inventory to monitor change, can be easily implemented in everyday clinical practice. The P.I. allowed for responses to be categorised and consequently pre- and post intervention responses could be compared. Changes recorded using the P.I. were ambiguous in terms of "improvement", although staff reports indicated group work to have been effective to some extent. The use of formal outcome measurements represents good clinical practice. Despite some limitations in the P.I., some useful recommendations for its future use are documented.

## 4.1 **INTRODUCTION**

A significant number of people with learning disabilities are referred to specialist services because of "difficult" behaviours, with aggressive type behaviours making up a substantial proportion of such referrals. In one American survey which examined the reason for referral, Benson (1985) ascertained that 30% of these people had been referred because of self-control problems.

Displays of difficult behaviours, for example aggressive or intimidating behaviours, can have a number of implications for the individual expressing them; these include issues relating to personal safety and being perceived as unsuitable for discharge or inclusion in other activities, such as work placements etc. It is frequently the case that these types of behaviour deny people access to the above-mentioned resources which would, perhaps, have been enjoyable and beneficial to them. Such behaviours also present an immense challenge to those caring for and working with these individuals; concerns involving personal risk and the safety of others in the person's environment are paramount.

Recent years have witnessed a growing interest in the treatment of anger and aggressive behaviour in a variety of clinical populations. Unfortunately, such advances have not, as yet, been replicated to nearly the same extent in the learning disability field. However, a small number of studies have been carried out. Of particular interest for the purposes of the current paper are several investigations which utilised measures to assess the effects of intervention. In one such study which addressed the effects of anger management training in a group therapy format, Benson et al.(1986), included a self-report anger inventory as one of their measures, and found decreases in aggressive responding across time. Furthermore, while acknowledging the difficulties that learning disabled individuals may have in the acquisition of anger control skills, they concluded that anger management training with this client group may be effective.

In a more recent single case study, Black and Novaco (1993) included self-report measures which were adapted from the Novaco Provocation Inventory (Novaco, 1975, 1988) as a means of measuring treatment effectiveness. Taken in conjunction with other measures, including clinical staff ratings, the researchers concluded that their client had been successful in achieving more self-control of anger and aggressive behaviour. Furthermore he was able to leave hospital and move to shared accommodation in a housing association.

The study reported here focused on the treatment effectiveness of a group therapy approach aimed primarily at reducing the aggressive or intimidating behaviours exhibited frequently by four young men with learning disabilities. The actual content of group sessions was not solely related to anger management training but also incorporated discussion of emotions and assertion skills training. In the current NHS economic climate which advocates more cost-effective treatments (e.g. group therapies) for Clinical Psychology Departments nationwide, it was of interest to make an attempt to monitor the effectiveness of this type of intervention.

### 4.1.1 GROUP STRUCTURE

The group was called "Speaking Up for Yourself" and took place at a resource centre. It ran for one and a half hours on a weekly basis for a total of eight weeks during May and June 1996. Seven out of the eight sessions were taken by the first researcher and one by the second researcher. The group consisted of four clients; clients 1 and 2 had been referred to the Clinical Psychology Department because of difficult behaviours some time previously including aggression to others and inappropriate sexual behaviour. Client 1 had also been seen individually by the second author prior to the start of the group and client 2 continued infrequent individual sessions for the duration of the group. Clients 3 and 4 had been chosen for the group by resource centre staff. They anticipated that this participation would be of benefit to them, mainly because they also exhibited aggressive or

intimidating behaviours at times. While these behaviours might occur less than once a month, the impact could be devastating. Expressive verbal abilities varied, ranging from 2 - 3 word sentences to more complex grammatical structures. This minimal level of verbal ability was felt to be necessary to allow effective participation in the proposed activities. While no formal assessment was carried out, staff were made aware of this requirement when nominating group members.

The group had three main aims:-

1. For its members to become aware of peer group feelings regarding their behaviour.

2. To increase clients' self-respect, self-value and self-confidence.

3. To decrease aggressive or intimidating behaviours towards others. This was seen as particularly important in relation to the two clients who had been referred to Clinical Psychology.

## 4.2 OUTCOME MEASURE

In order to measure change as a function of the group, clients were asked to complete a Provocation Inventory (P.I.) before and after participating in the group. This inventory had already been modified for use with learning disabled clients by Black and Novaco (1993) from Novaco's Provocation Inventory (1975), for use within institutional settings. In a further modification, the current researchers adapted this inventory to relate to community situations rather than institutional ones. Items on the inventory were concerned with the clients' responses to potentially provocative situations. All responses were verbal, and were categorised, e.g. as to whether they were physically or verbally aggressive, constructive coping etc., and used for pre- and post-intervention comparison.

Figure 1

about here (see Appendix 4.)

## 4.3 OVERVIEW OF SESSION CONTENT

Clients were firstly made aware of the confidentiality of the group and the reasons for it taking place. Initial sessions centred on the development of listening, social interactional and assertiveness skills, which, it was anticipated, would provide a good basis for working through the main group aims in subsequent sessions. Various tasks were devised to facilitate clients getting to know each other better, as well as to aid a relaxed perception of the group situation.

The emphasis initially focused on quite general aspects, e.g. clients' favourite things, likes/dislikes etc. This soon progressed to more specific work which concentrated on identifying emotions both in relation to the self and others. Pictorial material was utilised to this end. Discussion about different situations which might cause people to become upset followed. Items from the P.I. were utilised to facilitate this.

The concept of anger as a normal emotion was emphasised; it was explained to the clients that it is people's actions when they are angry which can be problematic, i.e. they might get into trouble or feel bad as a result. Various anger management strategies were addressed; they included attempts to reduce intimidating behaviours, e.g. hand gestures, facial expressions and verbal aggression, relaxation exercises and self-talk. The latter was initiated in order to address the cognitive labelling process which occurs in the initial stages of becoming angry, during the actual situation and also afterwards. Self-talk concentrated on the introduction of coping statements; the purpose of this was to equip clients with an effective way of limiting aggressive behaviour by increasing their repertoire of skills to cope with potentially provocative situations. "Just pretend" exercises were employed to familiarise clients to this approach.

## 4.4 RESULTS: PRE- AND POST TREATMENT RESPONSES ON THE P.I.

As already mentioned, responses on the P.I. were categorised for the purposes of comparative data; in this way any change that occurred during the course of the group could be measured. The categories used were as follows:- don't know, verbal aggression, physical aggression, damage to property, damage to self, withdrawal, constructive coping and other. No responses were coded as either damage to property or to self.
Percentage inter-rater reliability agreements were calculated using the formula:

$$\frac{\text{Agreements}}{\text{Agreements and Disagreements}} \times 100$$

The more stringent method where disagreements counted as double the value of agreements (because they consisted of two ratings) was used. There was 67% agreement, most disagreements falling between "withdraw" and "constructive coping". As the "withdraw" statements tended to be of the type "walk away" from a situation, these could readily be reassigned to the "constructive coping" category. On this basis, inter-rater agreement reached 82%, which was considered satisfactory.

Comparison of pre- and post treatment scores revealed the following:-

1. Client 1 conveyed an increase in responses which were coded as verbal aggression and physical aggression.

2. Clients 2 and 3 showed a decrease in their verbal aggression scores. Physical aggression scores remained the same; in fact none of client 3's responses could be categorised as such.

3. Clients 2 and 3 also showed an increase in their constructive coping responses.

4. Client 4's verbal aggression score stayed the same. No physical aggression scores were recorded. Withdrawal responses increased and constructive coping scores decreased.

## 4.5 DISCUSSION

Interestingly, comparative data on the P.I. did not reveal major changes in the anticipated direction. It is perhaps important here to list some examples of actual responses to items on the P.I. before making some suggestions as to why the above-mentioned results were obtained.

One client said that if "Someone at the Centre who you do not like punches you" he would "Hit them back." Others noted that they would either ignore this or tell one of the day centre staff. Other physical aggression responses included "push him out the way" and "throw them off the seat". Examples of verbal aggression responses included "tell them to get lost", "scream at them" and "shout in their ear".

Constructive coping responses included "say something to person with me" or "look the other way" (if someone was staring at you), "go to back of queue" or "stand and wait my turn" (if another customer said you had jumped the queue), and "tell keyworker" (if you had something important to tell staff but they said they were too busy and to come back later.)

One possible reason for the absence of major changes as measured by the P.I. is that individuals were initially quite defensive in relation to feelings of anger and aggressive reactions in particular situations. It might have been perceived that such admissions

would result in punishment of some kind. This inference could have arisen from previous consequences of behaviour in these types of scenarios. As already highlighted, one client's physical aggression responses actually increased. This supports previous research by Black (1994); over a much longer period (6 months) clients seemed to get "worse" in reporting what made them angry. This finding would fit in with being defensive initially. Indeed, for all the clients, resource centre staff reports did not match self-reports in terms of anger and aggressive behaviours, in that the former regarded these issues to be much more prevalent.

In future work of this kind, it would be important to spend time with clients before asking them to complete the P.I., in an attempt to build up a relationship with them, which would perhaps encourage more "truthful" responses at this early stage. Liaison with resource centre staff might also be beneficial in this respect, i.e. staff could reassure clients that admissions of angry feelings or aggressive behaviour would not result in them getting into trouble or being punished in some way. Formal assessment of expressive and receptive language ability would inform group leaders who could adapt material further, to ensure greater understanding by group members, but is not a necessity where staff know their clients well. Groups with mixed linguistic abilities may be beneficial.

Liaison with staff who know clients well could also be useful in designing future self-report measures. In this way self-report items could be tailored to the actual behaviours characteristic of the particular clients in question. Additionally, in vivo observations could be included as another means of measuring change. However, this is not always a realistic option given current time constraints for the majority of professionals.

It is important to note the time-limited nature of the group. Although it's aims were not solely related to anger management issues, other relevant studies have lasted for much longer time periods. To take an example, Benson et al. (1986) included twelve sessions, each lasting 90 minutes. However, there were several reasons for this time restriction;

two of the clients involved had already received some individual psychological input and participation in the group consolidated this to an extent. Furthermore, resource centre staff received feedback about the group and also recommendations for future work. In this way strategies which were perceived to be successful in the group format could continue to be implemented by staff in an effort to maintain change and perhaps increase it.

This group approach may have the disadvantage of not directly altering the nature or frequency of either provocations or staff management of aggressive responses, but it is felt that it is useful in removing some of the "blame" that is often attached to aggressors, by dealing with conflicts and resolutions in a safer setting.

There were some more general conclusions worthy of note consequent to the "Speaking Up For Yourself" group. On the whole the group aims were realised. Anecdotal information from resource centre staff indicated that some changes were evident in relation to aggressive behaviour. In particular, some of the clients appeared to be more aware of the possible consequences of such behaviour and seemed to be more able to "think things through". One client in particular was also reported by staff to be interacting much more with his peers since the group was held, as well as being generally more assertive and more self-confident. Consequently, it is envisaged that it will be possible for him to embark on a work placement in the near future.

While these reports from staff may seem incongruent with the P.I. results, it is felt that the apparent discrepancies may lie in the reasons already stated above, namely participant defensiveness, anxiety about repercussions and the brevity of intervention. Future research could explore these issues, and would ideally also provide a more reliable method for quantifying staff observations of change.

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# Chapter 5: Single Clinical Case Research Study (2)

## Cognitive-Behavioural Treatment of Adolescent Post Traumatic Stress

Tracy Margaret Walker

Trainee Clinical Psychologist

Department of Psychological Medicine

Gartnavel Royal Hospital

This paper was written according to guidelines for The Journal of Traumatic Stress. A copy of authors' notes can be found in Appendix 5.

# COGNITIVE-BEHAVIOURAL TREATMENT OF ADOLESCENT POST TRAUMATIC STRESS

**5.0 Abstract:** This case study reports cognitive-behavioural treatment of a fourteen year-old adolescent girl, who was experiencing post traumatic stress, with concurrent anxiety and depressive symptoms, following an unprovoked, serious physical assault. Assessment and ongoing treatment principles are described and discussed within the context of existing research, mainly involving adult PTSD reactions. Pre-existing personality characteristics, e.g. anxiety, are believed to have intensified psychopathology consequent to the traumatic experience. In general, Cognitive-Behavioural Therapy (CBT) appeared to be a useful treatment approach for an adolescent post traumatic stress reaction.

**Key words: adolescence, trauma, cognitive-behavioural.**

## 5.1 INTRODUCTION

Current theories and treatments of Post Traumatic Stress Disorder (PTSD) have largely developed from adult reactions to acute and major stress. However, there is widespread agreement within the literature that children and adolescents can also suffer PTSD as a consequence of a traumatic experience. Much of the existing knowledge base has developed from studies which have focused on child and adolescent survivors of disasters, e.g. the capsize of the Herald of Free Enterprise Car Ferry, (Yule and Williams, 1990) and the sinking of the Jupiter cruise ship, (Yule et al., 1990; Yule, 1992). In general, it appeared to be the case that survivors presented with similar groups of symptoms to their adult counterparts, i.e. distressing recurring recollections of the traumatic experience; avoidance of stimuli associated with the traumatic event and various signs of heightened physiological arousal. Common reactions in adolescents included significantly high rates of depression, sleep disturbance, suicidal thoughts, anxiety, panic attacks, which were often delayed, disengagement and aggressive behaviour.

Wide-ranging assessment, which incorporates measures of anxiety and depression has been recommended in recent literature. Various measures have now been indicated to assess post traumatic stress reactions in children and adolescents. Horowitz's Impact of Event Scale (IES; Horowtiz et al., 1979) has been found to be suitable for children aged eight years and over, (Yule and Udwin, 1991).

Treatment outcome studies concerning PTSD in children and adolescents are currently in their infancy. Cognitive-behavioural approaches regarded as promising. To date, however, little is known about the extent to which these require to be adapted to address child and adolescent developmental levels. The main focus of individual Cognitive-behavioural Therapy (CBT) has been to facilitate children or adolescents in making sense of what happened to them and to overcome anxiety and feelings of helplessness, (Yule, 1994). Exposure work in a supportive enviroment has been found to be useful in gaining

control of intrusive thoughts and for behavioural avoidance. Drawing the traumatic experience can aid recall of the event and associated feelings, (e.g. Pynoos and Eth, 1986).

## 5.2 SUBJECT

The present paper describes the case of C, a fourteen year old girl, who was referred, by Victim Support, to a specialist service for victims of crime. C was seriously assaulted by a group of girls in her local area and had been crying a lot and experiencing panic attacks since then.

### 5.2.1 Presenting Problems

C, her parents and younger sister, V attended for initial assessment interview. Thereafter, C was seen on an individual basis. C presented as a pleasant, quiet girl. She reported post traumatic stress symptoms, dating back to her assault. These included daily intrusive thoughts pertaining to the assault, which made her feel scared and upset, cognitive avoidance and heightened physiological arousal, e.g. irritability, sensitivity to noise. C experienced flashbacks to this traumatic experience approximately once per week. It was evident that the whole family were very distressed by what had happened to C. While C's parents were clearly extremely concerned about the change in her, they did not appear to have become overprotective of their daughters as a result.

In addition to PTSD symptoms, C also presented with general anxiety; she noted panic attacks approximately once a fortnight, headaches and breathing difficulties, which appeared to be triggered by memories of her assault. C had also developed agoraphobic-type tendencies. She would not go out with her friends, e.g. into the city centre, as she used to on a weekly basis. C would only go out in the company if an adult. She reported feeling very frightened if she had to pass a group of people of her own age, for example.

Again, this reminded her of what had happened. She was absent from school for the last week of term, but was able to return after the Easter holidays.

C also described a range of depressive symptoms. They were low mood, decreased appetite, poor concentration, tearfulness, social withdrawal, initial insomnia and early morning wakening. Other difficulties related to school. She commented that her grades at school had deteriorated quite markedly since her assault and that she had shouted at some of her teachers and friends on a few occasions.

### 5.2.2 Nature of Assault

C was initially seen approximately 2.5 months after she was seriously assaulted one evening in a street a few minutes from home. C and three of her friends were involved in an entirely unprovoked assault, committed by another group of girls similar in age but not known to them. One of these girls threw a bottle after them and began to follow them. They were verbally abusive and suddenly attacked C and her friends from behind. C was pushed to the ground and kicked repeatedly on her back and head. The incident lasted for about five minutes. A woman from a nearby house came out to investigate and the girls ran into her garden. However, the perpetrators also attacked this person before finally running off. Subsequent police investigations were unable to trace them. C sustained a cracked rib and a great deal of bruising.

### 5.2.3 Information from Guidance Teacher

Permission was obtained from C to contact her school guidance teacher, Mrs N. Apparently, her teachers had noticed that since her assault, C's concentration had diminished greatly; they were quite concerned about this. Mrs. N was unaware that C's grades had been affected, but she had not recently spoken with her teachers to investigate this. Her grades were typically among the highest. She provided some useful information

about C's premorbid history. She described C as quite overanxious and lacking in confidence. In her opinion, C was the "worst person the attack could have happened to."

## 5.3 FORMULATION

Initial impressions indicated that C was experiencing wide-ranging and quite severe psychological difficulties at the time of assessment. These appeared to be mainly consequent to experiencing a serious assault a few months before. Specifically, she presented with acute post traumatic stress symptomatology, with associated depressive and anxious symptoms. It seemed to be the case that C was prone to anxiety before this happened; she noted always having been a "worrier", e.g. regarding family and friends. C's family appeared to be very caring and supportive. Her assault had evidently been extremely distressing for them too.

## 5.4 METHODS

### 5.4.1 Measures of Assessment

The following pre- and intermediate treatment measures provided formal assessment of presenting psychological difficulties:-

1. **The Impact of Event Scale (IES; Horowitz et al., 1979)**

A 15-item self-report measure of current subjective distress related to a specific event. Items comprise two separate subscales which measure levels of intrusion and avoidance pertaining to the event.

**2. The Hospital Anxiety and Depression Scale (HADS; Zigmond and Snaith, 1983)**

A 14-item self-report measure of severity of anxiety and depression.

**3. The Children's Depression Inventory (CDI; Kovacs and Beck, 1977)**

A 27-item self-report measure which focuses on the affective, cognitive and behavioural signs of depression. It is a derivative of the Beck Depression Inventory (BDI; Beck 1978). The applicable age range is 7-17 years. Normative data exists for same age and gender peers.

The Scott Trauma Belief Inventory (TBI; Scott, 1992) was also administered early in treatment. It incorporates a set of dysfunctional trauma beliefs and provides a provisional framework of an individual's pertinent dysfunctional beliefs; however, it requires validation. Trauma beliefs held to be "absolutely" or "mostly" true were:-

I've lost a part of myself

Other people can never understand how I feel

I see this world as a bad place to live in

I don't think that justice exists in this world.

### 5.4.2 Treatment Principles

C's anxious symptoms were the initial treatment focus. Relaxed (controlled) breathing strategies and general relaxation techniques were introduced. The treatment rationale for a CBT treatment approach was explained and elaborated on through handouts. Early in treatment, C travelled alone by train into the city centre to go shopping with a relative. She admitted being extremely anxious but made good use of rehearsed coping strategies. For example, one of C's main fears was having to walk past a group of teenagers. CBT

was used to prepare her for this probable occurrence. Although C coped very well on this outing and utilised therapy principles well in vivo, she remained reluctant to go into the city centre again. A "thought diary" was introduced to identify antecedents of anxiety between sessions. It was also suggested that she invest in a personal alarm; this proved to increase her confidence when out.

CBT principles were also used to treat depressive symptoms. Behavioural measures were employed initially, e.g. daily activities, which involved spending time with friends and family, were planned during sessions and C kept a record of these.

Early introduction of anxiety management strategies facilitated treatment of specific PTSD symptoms. Containment of intrusive memories was the initial focus in this respect. C described in increasingly more detail the traumatic event she experienced within each session. She was given the task of allocating 10-15 minutes each day to draw or write about what happened. This was to desensitise her to the event and associated thoughts and feelings.

## 5.5 RESULTS

Table 1: A Comparison of Pre- and Intermediate Scores on the IES, HADS and CDI (T Scores).

| Measure | Pre-treatment Score | Intermediate treatment Score |
|---|---|---|
| **IES** | | |
| intrusion | 27 | 21 |
| avoidance | 26 | 24 |
| **HADS** | | |
| anxiety | 14 | 16 |
| depression | 13 | 11 |
| **CDI (T Scores)** | | |
| total | 81 | 78 |
| negative mood | 70 | 75 |
| interpersonal probs. | 94 | 84 |
| ineffectiveness | 74 | 74 |
| anhedonia | 71 | 63 |
| negative self-esteem | 64 | 64 |

## 5.6 DISCUSSION

The above results indicate only slight changes in presenting symptoms between pre- and intermediate treatment phases. Most noticeably, C reported fewer intrusive thoughts. Anecdotally, she appeared to have gained a great deal of control over intrusive thoughts, through thought-stopping techniques. However, the latter score (21) remained as high as Horowitz's (1979) sample of stress clinic patients (mean intrusion score = 21.4). Focusing on intrusive memories provided some useful information as to the meaning of the assault experience for C. Consistent with adult PTSD reactions, the internal, subjective experience of the trauma is one important factor, in relation to later psychological morbidity and is an important aspect in treatment. During the assault C thought that she was going to die. This belief has been found to be associated with greater PTSD symptomatology, (e.g. Williams et al., 1993; Yule et al., 1992).

It also transpired that she was only focusing on the events before the assault and avoided thinking about the actual assault. The supportive therapeutic enviroment facilitated this progression. C was able to accept that it was an unprovoked, unpredictable assault, which she could have done nothing to prevent.

Acts of deliberate violence, in particular child physical and sexual abuse are perceived to lead to greater psychopathology than other kinds of traumatic experiences, (e.g. Hodgkinson and Stewart, 1991). This perhaps helps to explain why C's psychological difficulties are persisting. Premorbid factors are another important focus in this respect. Pre-existing personality or emotional disorder, (in addition to high levels of stress or exposure and family history of psychiatric disorder) have been described as vulnerability factors in the development of PTSD, (Scott and Stradling, 1992). C reported a tendency to worry about family and friends and furthermore, teacher reports described her as "overanxious". Interestingly, she stated that no one had noticed any major emotional changes in the other girls who were involved.

Levels of anxiety increased slightly. There could be many reasons for this. Frequently focusing on intrusive thoughts may have exacerbated anxiety. Additionally, C reported some family problems, which were evidently a source of worry for her (and the rest of the family) at the intermediate treatment phase. While the HADS is not typically used to assess children's anxiety, it seemed to be an appropriate clinical tool for use with an adolescent. CDI scores indicated some reductions in depressive symptoms. Anecdotally, she noted increased motivation, fewer sleep problems and increased interest in spending time with family and friends.

### 5.6.1 Future Treatment Directions

Planned treatment strategies include continuing with imaginal exposure and the introduction of more structured behavioural exposure work to decrease anxiety. C remains frightened of future assault; cognitive restucturing will be implemented to help re-assess this degree of threat. Cognitive therapy techniques will also be used address negative perceptions and dysfunctional beliefs as identified on the TBI. Terr (1991) noted that trauma experienced in childhood or adolescence can shatter basic trust and autonomy, which can lead to long-term changed attitudes about people, life and the future that are difficult to alter. Finally, C was evidently extremely sensitive to parental distress and appeared to minimise her feelings etc. so as not to upset her mother in particular. It might be useful to give C's parents the opportunity to discuss the impact of her experience on them, so that they can become desensitised to the trauma and support C emotionally to aid her recovery.

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# Chapter 6: Single Clinical Case Research Study (3)

## TREATMENT OF COMPLICATED GRIEF IN A MALE ADOLESCENT

Tracy Margaret Walker

Trainee Clinical Psychologist

Department of Psychological Medicine

Gartnavel Royal Hospital.

This paper was written according to guidelines for Clinical Child Psychology and Psychiatry. A copy of authors' notes and further relevant information can be found in Appendix 6.

# TREATMENT OF COMPLICATED GRIEF IN A MALE ADOLESCENT

**6.0 Abstract:** The present case study describes the treatment of an extended, intensive grief reaction, complicated by a major depressive episode in an adolescent boy. The treatment principles employed were largely in accordance with Worden's (1993) tasks of mourning. Cognitive-Behavioural Therapy (CBT) techniques were utilised to treat depressive symptoms. One standard treatment outcome measure of child and adolescent depression was used to record data at three points in therapy. A behavioural measure (nightmare frequency) was also used during grief therapy work. Forced mourning techniques and CBT for depression were found to be effective treatment approaches in this instance. Findings are discussed in the context of existing literature.

**Keywords: complicated grief, adolescent, depression.**

## 6.1 INTRODUCTION

For adults, the death of a close friend or relative can be an extremely stressful life event. To date, few studies have researched the effects of bereavement on children and adolescents. The majority of such investigations have focused on reactions to the death of a parent; much less is known about reactions to other attachment figures, e.g. grandparents, friends, siblings etc.

Van Eerdewegh et al., (1982) carried out a widely-quoted, prospective, controlled study of 105, 2-17 year old children who had experienced the death of a parent. Results indicated a significant, but transient increase in dysphoria, the persistence of mild depression and a significant degree of impairment in school performance in older children. Several risk factors for a grief reaction and later depression were identified; these included mental illness in the surviving parent (see also Harris et al., 1986) and the loss of the same sex parent, particularly for boys.

Treatment outcome studies in cases of child or adolescent complicated grief reactions are equally sparse. In adult cases of bereavement and concurrent depressive symptoms, forced or operational mourning techniques have proved effective (e.g. Mawson et al., 1981). Although not yet evaluated, it seems sensible to assume that these techniques would be equally effective with children and more particularly perhaps with adolescents, as their grief reactions tend to be comparable to adult reactions.

As indicated above, depressive symptoms are common in bereaved children and can potentially have an extremely negative impact on functioning. Several studies have also demonstrated that depression in childhood has a tendency to recur in adult life, (e.g. Harrington et al., 1990). Cognitive-Behavioural Therapy (CBT) has emerged as a very effective mode of intervention in this area, which is consistent with adult depression. Beck's (1979) cognitive model of depression has been shown to be applicable to children,

(e.g. Rehm and Carter, 1990). Stark et al.,(1991) found that CBT resulted in greater improvements in depression and a decrease in depressive cognitions when compared to traditional counselling techniques.

## 6.2 SUBJECT

The current case study reports an extended and intensive grief reaction, complicated by a major depressive episode, in a male adolescent, D, aged 15. He was referred to a Child and Family Clinic by his GP because of difficulties coping and recent aggressive behaviour. D's grandfather had died of TB, secondary to long-term ill-health some 7 months before his attendance. D had lived on his own with him from the age of 4. Treatment approach and outcome will be discussed in the context of existing research into adolescent bereavement and depression.

### 6.2.1 Presenting Problems

Initial assessment involved the whole family, namely D, his parents and younger sister. D presented as an extremely sad, angry young man. He was reluctant to talk at length during the family sessions and found it difficult to allow himself to become upset. He described a general inability to cope as well as various depressive symptoms; these included low mood, loss of motivation and feelings of worthlessness. He had some suicidal thoughts but no intention of acting on them. Additionally, he reported difficulty sleeping (on average he slept for a maximum of 3 hours each night) and frequent nightmares. More recently, he had been dreaming about his grandfather.

It appeared to be the case that D had never allowed himself to openly grieve for his grandfather; he noted feeling closer to him than to his father. He had taken on much of the responsibility of caring for his grandfather during the last few years of his life.

Other difficulties for D related to school; he had not attended school for several months and was receiving home tuition. D's grandfather had died on the day of his first standard grade exam and consequently, this affected his performance on the exams that he sat. D had been seeing an Educational Psychologist on a weekly basis at his school over the last three months. Apparently, D had perceived himself to be under stress at school for several years; he noted several teachers "picking on" him throughout secondary school.

### 6.2.2 Background

Mrs M, D's mother had been seriously depressed for approximately 8-10 years. The main antecedent appeared to have been the sudden death of her mother. Current depressive symptomatology included feeling down for much of the time and sleep difficulties. D said that his mother had "gone to pieces" since her father died. He was clearly very concerned about her and seemed to have taken on much of the responsibility of caring for her. In fact, this was another reason for his non-attendance at school; he did not want to leave her at home alone.

## 6.3 FORMULATION

D appeared to be experiencing an extended and intensive grief reaction relating to the death of his grandfather, complicated by a major depressive episode. He had been unable to really begin the process of working through painful bereavement issues. This profound sense of loss was undoubtedly contributing to D's depressed state and very probably impacting negatively on his ability to cope with life in general.

It seemed important to remember that D was experiencing anxious and depressive symptoms before this loss. These may have been consequent to concerns about i) his grandfather's deteriorating physical health, ii) his mother's mental health and feeling responsible for her from an early age and iii) perceived stress at school.

## 6.4 METHODS

### 6.4.1 Measures of Assessment

1. The Children's Depression Inventory (CDI; Kovacs and Beck, 1977)

A 27-item self-report measure which focuses on the affective, cognitive and behavioural signs of depression. It is a derivative of the Beck Depression Inventory (BDI; Beck 1978). The applicable age range is 7-17 years. Normative data exists for same age and gender peers.

2. Behavioural measure

Frequency of nightmares was recorded on a weekly basis throughout client contact. Nightmares or dreams are common consequent to a bereavement.

### 6.4.2 Treatment Procedures

D was seen on a mainly weekly basis over a three-month period. The main aspects of treatment were as follows:-

i) Grief Work

The initial focus was on enabling D to confront his grief. The therapeutic principles employed were largely in accordance with Worden's (1993) tasks of mourning. D was provided with a jotter in which to write down his thoughts and feelings regarding his grandfather's death. Through expression of his painful thoughts and feelings, D began to work through them. Feelings of anger and guilt were addressed through letter writing to the individuals (not sent) to whom this anger was directed and through re-enacting saying good-bye to his grandfather, which he had been unable to do.

ii) Treatment of Depression

In the initial treatment stages it was also important to focus on D's depressive symptoms (although focusing on bereavement issues was undoubtedly addressing these too). D's activity levels were increased substantially. Sleep management strategies were introduced; he was also given a relaxation tape. D's thought processing was consistent with Beck's (1979) cognitive model of depression. His self-image was particularly negative. CBT principles were used to challenge these perceptions. Cognitive restructuring was also employed in relation to negative beliefs (e.g. "I am a failure") and feelings of guilt and anger.

## 6.5 RESULTS

D progressed well. Once he began to work through his grief, his mood and general presentation became much brighter. A referral to adult clinical psychology services was made on behalf of D's mother. It was envisaged that this would be beneficial for D ( it would relieve him of the age-inappropriate responsibility of caring for her). The prospect of his mother receiving psychological help almost certainly contributed to his more cheerful presentation. He was able to return to school (part-time) three months into treatment. He found this extremely difficult, but continued to attend and gradually physiological symptoms of anxiety decreased through the application of anxiety management techniques.

Figure 2 (see appendix 6) shows T Scores on the CDI recorded at three time points: pre-treatment, intermediate and follow-up (the latter scores were recorded after four months of treatment with another clinical psychologist at the same clinic). All scores decreased over time, except on the Interpersonal Problems Subscale, which remained the same across time.

Figure 2

about here

Figure 3 (see appendix 6) conveys nightmare frequency. They persisted for the duration of therapeutic contact. However, they became less frequent and less distressing for him.

Figure 3

about here

## 6.6 DISCUSSION

The present paper describes the reaction of an adolescent to the death of his grandfather and in this respect alone, it has contributed to existing literature, which tends to focus on parental loss. It is important to remember however, that D's grandfather was a father-figure for him. Consistent with the literature, a number of risk factors made it more likely that D would develop an extended grief reaction and later depression; he experienced several concurrent losses, e.g. the loss of a close, confiding relationship, (i.e. his grandfather), the loss of his home, (he had to move to his family's home) and the loss of his role in caring for his grandfather. D also experienced obstacles to the grieving process , namely feelings of anger and guilt (Worden, 1993), which meant that he had been unable to move on. Once these feelings were acknowledged and D had the opportunity to address the things which were making him angry and guilty, he progressed.

Another relevant risk factor is mental illness in a surviving parent. Van Eerdewegh et al., (1985) found that, irrespective of gender, the highest scores on various measures of psychological distress, e.g. dysphoria and depressive syndromes following bereavement, were associated with having a mentally ill (most usually depressed) mother. It could also

be argued that D had learned in early childhood not to cope with bereavement , given that this was identified as the antecedent for his mother's depression.

It seems probable that D possessed limited coping skills, on account of a premorbid history of mental health difficulties, which would have contributed to the likelihood of him developing an abnormal grief reaction. Weller et al., (1989) ascertained that depression and other psychiatric problems in children following bereavement were predicted by pre-existing psychiatric difficulties in the child or a family history of these or psychiatric problems, usually depression, in the surviving parent.

It would have been interesting to have assessed the extent to which D met a diagnosis of Post Traumatic Stress Disorder (PTSD). PTSD, according to DSM-IV classification (American Psychiatric Association, 1994), incorporates loss-induced stress, which would clearly fit with the experience of bereavement, particularly if there was high dependence on the dead person, as was evident in D's case. Furthermore, D experienced persistent nightmares for the duration of contact. Some of these involved re-experiencing the death of his grandfather and associated issues and would fit with the conceptualisation of a traumatic experience.

CBT seemed to be a very useful and effective approach in treating adolescent extended grief, complicated by depression. D was mature for his age and related well to the principles of treatment, e.g. cognitive restructuring. Family work was also extremely important; it facilitated openness as to Mrs. M's severe depression, which was an important focus during therapy. The content of the current case report describes the first four months of intervention. Thereafter, D continued therapy with a colleague to address some long-term issues, e.g. coping with a depressed parent. At the time of writing, this contact has been ongoing albeit on a less frequent basis, for a further four months (it was at this point that follow-up data on the CDI was recorded).

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# Chapter 7: Small Scale Service Evaluation Project

## ASSERTION GROUP THERAPY FROM CLIENT AND THERAPIST PERSPECTIVES

Tracy Margaret Walker

Trainee Clinical Psychologist

Department of Psychological Medicine

Gartnavel Royal Hospital.

This paper was written according to guidelines of Clinical Psychology Forum. A copy of authors' notes and further relevant information can be found in Appendix 7.

## 7.0 INTRODUCTION

Interest in research associated with assertiveness has increased in recent years. Problems in displaying assertive behaviour have been found to overlap with a variety of mental health difficulties, including depression, anxiety, social anxiety, agoraphobia and obsessive-compulsive disorder (e.g. Emmelkamp 1982; Emmelkamp, van de Hout and de Vries 1983; Arrindell, Sanderman, Hageman, Pickersgill, Kwee, Van der Molen and Lingsman 1990). Although assertiveness can be difficult to define, in general, assertiveness training methods are designed with a view to clients achieving a balanced style of self-expressiveness that lies somewhere between humiliating passivity and intimidating aggression.

There has been much research into the efficacy of group therapy in general. Terri and Lewinsohn (1986) found no evidence of behavioural group therapy being inferior to individual therapy, for example. LaPointe and Rimm (1980) looked at cognitive, assertive and insight-oriented group therapies in the treatment of reactive depression in women. Results revealed significant improvements for all groups in depression, rationality and assertiveness. At follow-up, however, members of the assertiveness groups were the only ones who did not seek further treatment. Similarly, Sanchez et al., (1980) found assertion training to be more effective than traditional psychotherapy in self-reports of increased assertiveness and in alleviating depression.

The small-scale investigation reported here focused on an evaluation of a group therapy format for the enhancement of assertive behaviour in nine clients who were referred to the group by their individual therapists. In the current economic climate in the NHS, where more cost-effective treatments, waiting list initiatives and the like are paramount in Clinical Psychology Departments nationwide, it was of interest to establish both client and therapist satisfaction, as well as effectiveness of treatment, in relation to this type of service provision. This area of client satisfaction can be described as the ultimate aim of

any service. Client opinion is also of importance in terms of the use of services and furthermore, satisfaction in this respect would result in continuing treatment, which means a greater likelihood of treatment effectiveness.

Three main questions posed by this study were as follows:

1. What was the level of client satisfaction with Assertion Group Therapy?
2. What was the level of therapist satisfaction with Assertion Group Therapy?
3. How effective was this treatment approach?

## 7.1 METHODOLOGY

### 7.1.1 Course Structure

The Assertion Group Therapy (AGT) Course was run over a total of six sessions with one additional follow-up session one month after the last treatment session, by two Clinical Psychologists and one Assistant Psychologist. The venue was a local community centre.

Each weekly session lasted two hours and followed a structured format with a tea/coffee break approximately half way through. The chosen format was as follows:

Week 1 Rights and Responsibilities; Listening skills.

2 Interference from Emotions e.g. Anger, Anxiety, Embarrassment.

3 Practical Skills (a) e.g. Nonverbal Behaviour, Broken Record.

4. Practical Skills (b) e.g. Positive Thinking, Rebukes, Requests.

5. Dealing with Anger; Giving Criticism; Dealing with Criticism.

6. Step by Step Process for Increasing Assertiveness.

### 7.1.2 Participants

a) Clients: A recently-run AGT Course which involved a total of nine participants was the main focus in the study. Six participants continued their individual therapy for the duration of the group. Some data from a second group of seven clients run by two Clinical Psychologists two years previously, was also available and is reported below.

b) Therapists: Four Clinical Psychologists who continued to see the clients they referred to the recent group for its duration and thereafter, were also involved in the study.

## 7.1.3 Methods of Data Collection Used

### 1. Client satisfaction with AGT:

Six participants (and the seven clients from the previous group) completed an Assertion Group Follow-Up Questionnaire (see Appendix 7). Appropriate Likert-style scales and open-ended questioning were used to collect the information required.

**Interview Schedule (See Appendix 7)**

Six participants were also interviewed by the researcher after the follow-up session. They were informed that this would be anonymous and in confidence. Interviews lasted approximately 15-20 minutes and focused on participant opinion of AGT.

### 2. Therapist satisfaction with AGT:

A "Therapist Questionnaire" (see Appendix 7) was devised by the researcher to ascertain therapist opinion of the recently-run AGT Course. Four Clinical Psychologists completed these questionnaires for a total of six clients.

### 3. Effectiveness of Treatment

Two treatment outcome measures were administered:

a) The Assertion Inventory (A1), Gambrill and Richey, 1975).

b) The General Health Questionnaire (GHQ-28; Goldberg 1972).

## 7.2 RESULTS

### 7.2.1 Client Satisfaction with AGT:

#### i) Assertion Group Follow-Up Questionnaire:

The following key elements were revealed:

Content of Sessions:

The majority of participants rated the content of the sessions as very helpful (4/5 rating). Some participants were less happy with particular aspects , for example, some of the practical skills taught, namely "Broken Record" and "Positive Thinking" (neutral rating of 3). Five out of the thirteen clients were less happy with the "practising a set situation" part of the course and also gave this a neutral rating.

Perception of Improvement/Change:

Seven of the participants felt that their self-respect to be much improved and that their confidence in dealing with others was much better.

Group Structure:

All participants rated being a member of a group and meeting people with similar problems as very useful (4/5 rating).

Opinion of Therapists:

The participants unanimously felt that the therapists explained things very well. More than half of the participants felt it was important to see their individual therapists during the time of the group.

Suggestions for Improvements:

Qualitative data revealed the following:-

i) fewer role plays
ii) name tags for participants
iii) use of short video to exemplify assertive behaviour in specific situations
iv) future meetings to revise skills acquired.

**ii) Interview Schedule:**

Qualitative data for six participants of the recently-run course revealed the following key elements.

1. 4 out of 6 liked being a member of a group and meeting people with similar problems to their own.

2. 5 out of 6 would have liked fewer role-plays.

3. 5 out of 6 felt the therapists were expert in what they did.

4. 5 out of 6 noted that "encouraging" and "helpful" best described the therapists; the former was seen as being the most important.

5. 6 out of 6 thought that the therapists either gave practical advice or suggested solutions.

### 7.2.2 Therapist satisfaction with AGT:

1. The four therapists had noticed improvements in four of their clients, including increased motivation, more self-confidence and reduction in low mood.

2. The therapists felt that 3 out of the 6 clients would have spent longer in individual therapy, had they not attended the course.

3. All therapists thought that AGT reflects good use of therapists' time.

4. Suggestions for improving the course included "opportunity for self-help to be facilitated" and "therapists working on improving their delivery".

5. Suggestions for other more cost-effective interventions included one-day workshops, one qualified and one trainee or assistant clinical psychologist to run the course and large scale didactic format similar to "Stress Control" (White, Keenan and Brooks, 1992).

### 7.2.3 Effectiveness of Treatment:

The treatment outcome measures used are reported in the table below. Four complete (pre- and post) data sets for The Assertion Inventory (A1) and five for The General Health Questionnaire (GHQ-28) were available.

**Table 1: Pre and Post Treatment Measures for the Assertion Inventory (A1) and The General Health Questionnaire (GHQ-28).**

| | A1 | A1 | A1 | A1 | GHQ-28 | GHQ-28 |
|---|---|---|---|---|---|---|
| | degree of discomfort | degree of discomfort | response probability | response probability | pre | post |
| | pre | post | pre | post | | |
| Participant 1 | 95 | 123 | 135 | 137 | 2 | 0 |
| Participant 2 | 148 | 144 | 129 | 118 | 27 | 20 |
| Participant 3 | 127 | 96 | 132 | 124 | 11 | 1 |
| Participant 4 | | | | | 0 | 0 |
| Participant 5 | 125 | 121 | 133 | 107 | 22 | 7 |

## 7.3 DISCUSSION

### 7.3.1 Client satisfaction with AGT:

On the whole, the participants in the study seemed to be reasonably satisfied with the AGT Course. Indeed, this was perhaps reflected in the excellent attendance of the group; apart from one participant missing several sessions on account of illness, there were no actual "drop-outs".

Similar findings were established for both open and closed types of data collection. The "same boat" phenomenon is clearly in line with previous research such as that carried out by Upper and Ross (1977) who reported some advantages of a group format to therapy, namely social reinforcement and vicarious learning. In addition to being cost-effective AGT was well-received by the participants.

There was some dissatisfaction with the role plays; although it is understandable that people who have difficulties being assertive are not particularly keen on role play situations (indeed who is), they are nonetheless useful therapeutic tools in this instance. Perhaps future courses could make the initial role play situations slightly easier, by making them extremely structured, for example and then clients could progress to role-playing more difficult situations, with a less structured format. This would give clients the opportunity to get to know the other group members a little beforehand and also to increase their confidence. One participant suggested using a short video to exemplify assertive behaviour in specific situations; this might be a good starting point.

Very few participants gave ratings of less than 3 on any part of the questionnaire. This is to be expected; one of the difficulties with this type of data collection is the whole issue of social desirability. Perhaps the participants were anxious to please and wanted to avoid disappointing their therapists. Another difficulty is response acquiescence, where people

tend to agree with whatever is being suggested in a questionnaire. Although participants were generally satisfied with AGT, they still perceived concurrent individual therapy as important. For some, assertion skills were clearly only part of their difficulties and therefore, time to focus on other issues was still seen as important.

### 7.3.2. Therapist satisfaction with AGT:

AGT was evidently well-received by the therapists involved in the study. Although they did not unanimously feel that their clients would have spent longer in individual therapy had they not attended the course, the reason for this was predominately the nature of the clients' other difficulties, as opposed to any dissatisfaction with AGT. In terms of therapist and client perceptions of improvements or change, no major areas of disagreement were found. The issue was mainly one of varying degrees; for example, one therapist felt that a client probably had not benefitted from AGT because she did not attend several sessions but the client noted that she was avoiding others to a lesser extent.

Therapists' suggestions for improvements that might be made to the AGT Course included facilitating self-help after the course had taken place formally; therapists could encourage participants to meet informally.

Some participants clearly felt that future sessions would be useful. This would be with a view to maintaining the positive effects of peer group support (e.g. Powell, 1987). Therapists could also have occasional input in relation to this. Furthermore, it may also be cost-effective for Clinical Psychologists to facilitate self-help AGT Courses in the absence of any such formal courses being run; perhaps previous attenders of formal courses run by a Clinical Psychology Department could have leadership roles in these.

In terms of more cost-effective options, one suggestion was to adopt a large-scale, didactic format similar to "Stress Control" (White, Keenan and Brooks 1992), in order to

enhance assertiveness skills. This would undoubtedly be much more cost-effective and would probably involve fewer group exercises such as role-plays, which would appeal to clients. If assertion training was combined with general anxiety management principles in this format, then a number of clients would probably not require individual therapy at all, as is indicated by the above-mentioned study.

### 7.3.3 Effectiveness of Treatment:

There was insufficient information to comment on possible effectiveness of treatment to any great extent. In addition to this difficulty, it is also important to highlight that most of the participants involved in the study were concurrently being exposed to two types of therapy. Since there was no control group involved in this study it is not possible to be at all certain of any treatment effects attributable to either group or individual therapy. It was felt, however, that it would still be useful to include these results. One participant showed a slight increase in his pre- and post scoring on The A1. This finding is, of course, not necessarily anything to do with the AGT Course, but could be attributable to a number of things, for instance, personal difficulties. The other three sets of data did convey slight decreases in scores across pre- and post A1 measures.

All five complete sets of data for the GHQ-28 showed reductions in scoring on this assessment measure or in one participant's case no change (pre- and post score = 0). Although these findings must be treated with caution, they do look promising, especially as the participants were already involved in individual therapy at the pre-assessment stage.

Outcome data was incomplete because data was collected outwith the treatment sessions. Future work would need to ensure this was done within the treatment sessions, especially in the light of the excellent attendance.

## 7.4 SUMMARY AND CONCLUSIONS

NHS Services are coming under increasing pressure in the current economic climate; group therapy formats represent cost-effective approaches to treatment. This small scale study conveyed that AGT Courses were well-received by clients and therapists. Suggestions for even more cost-effective treatment options included large scale, didactic AGT Courses. Perhaps AGT should be designed on a longer time-scale, if indeed peer support has beneficial effects in treatment. Furthermore, if similar self-help courses were to go ahead, it would be important for Clinical Psychologists to develop a supervisory role in these and have infrequent contact with them.

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## APPENDIX 1: Major Research Project Literature Review

## NOTES FOR CONTRIBUTORS

1. The *British Journal of Medical Psychology* is an international journal with a traditional orientation towards psychodynamic issues. Whilst maintaining a broad theoretical base and insisting upon sound and sensible methodology its objective is to avoid the more simplistic approaches to psychological science.

The Journal aims to bring together the medical and psychological disciplines and this is reflected in the composition of the Editorial Team. Collaborative studies between psychiatrists and psychologists are especially encouraged.

Original theoretical and research contributions are invited from the fields of psychodynamic and interpersonal psychology, particularly as they have a bearing upon vulnerability to, adjustment to and recovery from both medical and psychological disorders.

The Journal aims to promote theoretical and research developments in the fields of subjective psychological states and dispositions, interpersonal attitudes, behaviour and relationships and psychotherapy. Clinical or case studies will be considered only if they illustrate unusual forms of psychopathology or innovative forms of therapy which carry important theoretical implications. In all studies concise and clear presentation is essential and it is strongly recommended that the patient's permission to publish is sought.

2. The circulation of the Journal is world-wide. There is no restriction to British authors; papers are invited and encouraged from authors throughout the world.

3. The readers are medical psychologists, in particular those concerned with psychotherapy, from the disciplines of psychology, sociology and medicine. Thus they include clinical psychologists, psychiatrists and social workers.

4. Papers should be as short as is consistent with clear presentation of the subject matter; in general they should not exceed 5000 words. The title should indicate as briefly as possible the subject of the article. A 200 word summary should be provided but, with experimental papers, should specify hypotheses, methods, results and conclusions.

5. Brief Reports limited to 1000 words may include research studies and theoretical, critical or review comments whose essential contribution can be made briefly. They also include research studies whose importance or breadth of interest are insufficient to warrant publication as a full article or case reports making a distinctive contribution to theory or technique. A summary of not more than 50 words should be provided.

6. The Editors will reject papers which evidence discriminatory, unethical or unprofessional practices.

7. Publication is speeded by care in preparation.

*(a)* Contributions should be typed in double spacing with wide margins and only one side of each sheet. Sheets should be numbered. The top copy and at least three good duplicates should be submitted and a copy should be retained by the author.

*(b)* This journal operates a policy of blind peer review. Papers will normally be scrutinized and commented on by at least two independent expert referees as well as by the editors or an associate editor. The referees will not be made aware of the identity of the author. All information about authorship including personal acknowledgements and institutional affiliations should be confined to a removable front page and the text should be free of such clues as identifiable self-citations ('In our earlier work...'). The paper's title should be repeated on the first page of the text.

*(c)* Tables should be typed in double spacing on separate sheets. Each should have a self-explanatory title and should be comprehensible without reference to the text. They should be referred to in the text by arabic numerals. Data given should be checked for accuracy and must agree with mentions in the text.

*(d)* Figures, i.e. diagrams, graphs or other illustrations, should be on separate sheets, numbered sequentially 'Fig. 1' etc., and each identified on the back with the author's name and the title of the paper. They should be carefully drawn, larger than their intended size, suitable for photographic reproduction and clear when reduced in size.

*(e)* Bibliographical references in the text should quote the author's name and the date of publication thus: Jones (1994). They should be listed alphabetically by the author at the end of the article according to the following format:

Herbert, M. (1993). *Working with Children and the Children Act*, pp. 76–106. Leicester: The British Psychological Society.

Neeleman, J. & Persaud, R. (1995). Why do psychiatrists neglect religion? *British Journal of Medical Psychology*, **68** 169–178.

Particular care should be taken to ensure that references are accurate and complete. Where books are available in both hardback and paperback please give references to both editions and publishers. Give all journal titles in full.

*(f)* SI units must be used for all measurements, rounded off to practical values if appropriate, with the Imperial equivalent in parentheses. A guide to SI Units is given in the BPS *Style Guide*, available at £3.50 per copy from The British Psychological Society, St Andrews House, 48 Princess Road East, Leicester LE1 7DR, UK.

*(g)* Authors are required to avoid the use of sexist language.

*(h)* Supplementary data too extensive for publication may be deposited with the British Library Document Supply Centre. Such material includes numerical data, computer programs, fuller details of case studies and experimental techniques. The material should be submitted to the editors together with the article, for simultaneous refereeing.

8. Proofs are sent to authors for correcting of print, but not for introduction of new or different material. Fifty complimentary copies of each paper are supplied to the senior author; further copies may be ordered on a form supplied with the proofs.

9. Submission of a paper implies that it has not been published elsewhere and is not currently under submission for publication elsewhere. Authors are responsible for getting written permission to publish lengthy quotations, illustrations, etc., of which they do not own the copyright.

10. Work published in full or in substantial part elsewhere is not acceptable. Where the work is substantially similar to work published, accepted or submitted elsewhere by the author or author's research group, this should be clearly stated in the manuscript and a copy of this work should be sent to the editor.

11. To protect the interest of authors and journals against unauthorized reproduction the BPS requires copyright to be assigned to the Society (by signing a form), on the express condition that authors may use their own material elsewhere at any time without permission.

## APPENDIX 2: Major Research Project Proposal

Participant study no._____

## SATISFACTION WITH HOSPITAL CARE

We are interested in your feelings about the care you received at The Queen Mother's Hospital when you had your ultrasound scan and the medical care that you received afterwards. In order for us to monitor our services, it would be appreciated if you could complete this questionnaire. Thank you for your help.

| | Not at all | | | | Very |
|---|---|---|---|---|---|
| 1. How satisfied were you with the way you were told at ultrasound scanning that there was something wrong with your pregnancy? | 1 | 2 | 3 | 4 | 5 |
| 2. How convinced were you that the correct diagnosis had been made? | 1 | 2 | 3 | 4 | 5 |
| 3. Were the various treatment options for this well-explained to you? | 1 | 2 | 3 | 4 | 5 |

3. Which of the following options did you choose:

   a. elective admission for a D&C? ____

   b. await natural onset of miscarriage? ____

| | | | | | |
|---|---|---|---|---|---|
| 4. Were you satisfied with the way you were treated by the hospital staff: | | | | | |
| a. at ultrasound? | 1 | 2 | 3 | 4 | 5 |
| b. at admissions? | 1 | 2 | 3 | 4 | 5 |
| c. on the ward? | 1 | 2 | 3 | 4 | 5 |
| d. in theatre/recovery? | 1 | 2 | 3 | 4 | 5 |
| 5. Did you feel that you were given enough information and advice about experiencing an early pregnancy loss? | 1 | 2 | 3 | 4 | 5 |
| 7. How useful do you think it would be for you to have the opportunity to talk through your feelings about your miscarriage with a professional in the near future? | 1 | 2 | 3 | 4 | 5 |

**Participant study no.** _____

## SEMI-STRUCTURED INTERVIEW SCHEDULE

Did you have any indication before the scan that all might not be well with your pregnancy, e.g. any bleeding or pains?

Were you aware of the incidence of miscarriage?

Any previous pregnancy losses prior to this one?

If yes, at what stage in the pregnancy did this occur?

Have you experienced any other events in your life which may be regarded as losses, e.g. bereavement?

Was this pregnancy a planned one?

Was the D&C your first operation?

If no, what other ones have you had?

## APPENDIX 3: Major Research Project Paper

## NOTES FOR CONTRIBUTORS

1. The *British Journal of Medical Psychology* is an international journal with a traditional orientation towards psychodynamic issues. Whilst maintaining a broad theoretical base and insisting upon sound and sensible methodology its objective is to avoid the more simplistic approaches to psychological science.

The Journal aims to bring together the medical and psychological disciplines and this is reflected in the composition of the Editorial Team. Collaborative studies between psychiatrists and psychologists are especially encouraged.

Original theoretical and research contributions are invited from the fields of psychodynamic and interpersonal psychology, particularly as they have a bearing upon vulnerability to, adjustment to and recovery from both medical and psychological disorders.

The Journal aims to promote theoretical and research developments in the fields of subjective psychological states and dispositions, interpersonal attitudes, behaviour and relationships and psychotherapy. Clinical or case studies will be considered only if they illustrate unusual forms of psychopathology or innovative forms of therapy which carry important theoretical implications. In all studies concise and clear presentation is essential and it is strongly recommended that the patient's permission to publish is sought.

2. The circulation of the Journal is world-wide. There is no restriction to British authors; papers are invited and encouraged from authors throughout the world.

3. The readers are medical psychologists, in particular those concerned with psychotherapy, from the disciplines of psychology, sociology and medicine. Thus they include clinical psychologists, psychiatrists and social workers.

4. Papers should be as short as is consistent with clear presentation of the subject matter; in general they should not exceed 5000 words. The title should indicate as briefly as possible the subject of the article. A 200 word summary should be provided but, with experimental papers, should specify hypotheses, methods, results and conclusions.

5. Brief Reports limited to 1000 words may include research studies and theoretical, critical or review comments whose essential contribution can be made briefly. They also include research studies whose importance or breadth of interest are insufficient to warrant publication as a full article or case reports making a distinctive contribution to theory or technique. A summary of not more than 50 words should be provided.

6. The Editors will reject papers which evidence discriminatory, unethical or unprofessional practices.

7. Publication is speeded by care in preparation.

*(a)* Contributions should be typed in double spacing with wide margins and only one side of each sheet. Sheets should be numbered. The top copy and at least three good duplicates should be submitted and a copy should be retained by the author.

*(b)* This journal operates a policy of blind peer review. Papers will normally be scrutinized and commented on by at least two independent expert referees as well as by the editors or an associate editor. The referees will not be made aware of the identity of the author. All information about authorship including personal acknowledgements and institutional affiliations should be confined to a removable front page and the text should be free of such clues as identifiable self-citations ('In our earlier work...'). The paper's title should be repeated on the first page of the text.

*(c)* Tables should be typed in double spacing on separate sheets. Each should have a self-explanatory title and should be comprehensible without reference to the text. They should be referred to in the text by arabic numerals. Data given should be checked for accuracy and must agree with mentions in the text.

*(d)* Figures, i.e. diagrams, graphs or other illustrations, should be on separate sheets, numbered sequentially 'Fig. 1' etc., and each identified on the back with the author's name and the title of the paper. They should be carefully drawn, larger than their intended size, suitable for photographic reproduction and clear when reduced in size.

*(e)* Bibliographical references in the text should quote the author's name and the date of publication thus: Jones (1994). They should be listed alphabetically by the author at the end of the article according to the following format:

Herbert, M. (1993). *Working with Children and the Children Act*, pp. 76–106. Leicester: The British Psychological Society.

Neeleman, J. & Persaud, R. (1995). Why do psychiatrists neglect religion? *British Journal of Medical Psychology*, **68**, 169–178.

Particular care should be taken to ensure that references are accurate and complete. Where books are available in both hardback and paperback please give references to both editions and publishers. Give all journal titles in full.

*(f)* SI units must be used for all measurements, rounded off to practical values if appropriate, with the Imperial equivalent in parentheses. A guide to SI Units is given in the BPS *Style Guide*, available at £3.50 per copy from The British Psychological Society, St Andrews House, 48 Princess Road East, Leicester LE1 7DR, UK.

*(g)* Authors are required to avoid the use of sexist language.

*(h)* Supplementary data too extensive for publication may be deposited with the British Library Document Supply Centre. Such material includes numerical data, computer programs, fuller details of case studies and experimental techniques. The material should be submitted to the editors together with the article, for simultaneous refereeing.

8. Proofs are sent to authors for correcting of print, but not for introduction of new or different material. Fifty complimentary copies of each paper are supplied to the senior author; further copies may be ordered on a form supplied with the proofs.

9. Submission of a paper implies that it has not been published elsewhere and is not currently under submission for publication elsewhere. Authors are responsible for getting written permission to publish lengthy quotations, illustrations, etc., of which they do not own the copyright.

10. Work published in full or in substantial part elsewhere is not acceptable. Where the work is substantially similar to work published, accepted or submitted elsewhere by the author or author's research group, this should be clearly stated in the manuscript and a copy of this work should be sent to the editor.

11. To protect the interest of authors and journals against unauthorized reproduction the BPS requires copyright to be assigned to the Society (by signing a form), on the express condition that authors may use their own material elsewhere at any time without permission.

Participant study no._____

## PARTICIPANT INFORMATION SHEET

### PRIVATE AND CONFIDENTIAL

**Study of Emotional Distress following Early Pregnancy Loss detected at initial Ultrasound Scanning.**

You are invited to participate in the above-named study. The aim of this study is to find out how women feel in the weeks just after they have experienced an early pregnancy loss and whether this changes after a few months. The results of this study will help to inform us about the needs of women who find themselves in this situation. We will also examine the current service that is provided and make any changes that we feel would be beneficial for women who have similar experiences in the future.

If you agree to take part, you will initially be asked to attend for an appointment at The Queen Mother's Hospital approximately three weeks after your early pregnancy loss was diagnosed; this will be to complete some questionnaires, to ask you some specific questions about how you have been feeling since then and also to record some more general information about you. Next, you will be sent two further short questionnaires three months after this, which, will, once again, question how you have been feeling. This follow-up part of the study will help to find out if your feelings surrounding your early pregnancy loss have changed since you were last seen.

A short letter will be sent to your GP to inform him/her of your participation in this study, if you agree to do so. However, I would like to stress that the information given on the questionnaires that I will ask you to complete and your answers to both the specific and more general questions that I will ask you will be treated in the strictest confidence.

If you have any queries or questions about the study please contact me:

Tracy Walker
Department of Psychological Medicine
University of Glasgow
Academic Centre
Gartnavel Royal Hospital
1055, Great Western Road
Glasgow
G11 0XH.

## CONSENT FORM

## PRIVATE AND CONFIDENTIAL

**Study of Emotional Distress following Early Pregnancy Loss detected at Initial Ultrasound Scanning.**

I have read the participant information sheet and agree to take part in this study which has been explained to me by _____.

Signature of participant ---------- Date:----------

Signature of doctor ---------- Date:----------

Signature of witness ---------- Date:----------

Participant Study No._____

Dear Dr._____

Re:----------
---

The above-named patient has agreed to participate in the following study:-

**Study of Emotional Distress following Early Pregnancy Loss detected at Initial Ultrasound Scanning.**

Pregnant women attending the gynaecology department at The Western Infirmary are routinely offered ultrasound examination, in order to investigate signs of an early pregnancy complication. For a significant number of women, this establishes that there is an early pregnancy complication. These women, who have had some prior indication that perhaps their pregnancy is not progressing according to plan, will be compared with another group of women (data collected elsewhere), who have had no idea at all that there was any problem present with the pregnancy. Clinical experience suggests that there will be a difference in the two above-mentioned groups of women in relation to their subsequent psychological distress.

Data will be collected by means of questionnaires, diagnostic interview and semi-structured interview.

Please contact us if you have any queries about this study.

Yours sincerely

## APPENDIX 4: Single Clinical Case Research Study (1)

BILD Publications, Frankfurt Lodge, Clevedon Hall, Victoria Road,
Clevedon, Avon BS21 7SJ
Tel: 01275 876519 Fax: 01275 343096



# British Journal of Learning Disabilities

NOTES ON THE SUBMISSION OF MANUSCRIPTS

## EDITORIAL POLICY AND GUIDELINES FOR AUTHORS

These guidelines are provided to assist authors in the preparation of manuscripts which conform to the BILD Publications house style. Failure to conform with these guidelines will inevitably delay the process of review and involve authors in additional work. We would, therefore, urge you to read through these notes carefully before submitting materials to ***The British Journal of Learning Disabilities.***

### AIMS OF THE JOURNAL

BJLD is a multi-disciplinary professional journal publishing articles which will draw the attention of those who are working in the field of learning disabilities to innovations in professional practice, to new ideas emerging from research, and to evaluations and reviews of on-going work which has general, professional relevance. Material submitted to BJLD should be original and any opinions expressed should be either supported by data or by well-reasoned arguments.

Reports on practice and research papers should be supported by descriptions of methodology and evidence which permits readers to evaluate the conclusions drawn. Reviews (commissioned or otherwise) should be supported by argument, data from relevant references and should place the review topic within the context of other developments in the field.

Submissions which are divided into two or more linked papers will only be accepted in exceptional circumstances and when the subject matter clearly justifies this approach.

### LAYOUT

Articles should be typed, double-spaced, on one side only of A4 paper, with a 1.5" margin on each side. Pages should be numbered consecutively in the top right-hand corner, commencing with the title page.

### TEXT

The text should be written in the third person, in 'plain English', with an international, multi-disciplinary readership in mind. Descriptions should be clear and concise and terminology specific to a particular profession should be explained for the benefit of people in other professions.

Care should be taken to use non-sexist language and, when referring to disabilities etc., to emphasise the person rather than the disability, so descriptions such as *people with learning disabilities* should be used rather than *the learning disabled.* Clumsy expressions such as *he/she, he or she* or *s/he* should be avoided, for example, by using the plural verb. Use the term 'participants' to describe those involved in research rather than 'subjects'.

Full references to the sources of all statistical measures used must be supplied.

If any technical terms specific to a particular profession are unavoidable, they must be explained briefly in the text immediately following. Statistical information should be translated into simple statements of significance, but the source of the measures used **must** be fully referenced and the full statistical data should be available from the main corresponding author.

## COPIES

**Four** copies should be submitted, one of which should be the original typescript. One copy should be retained by the author.

## LENGTH

Articles should not exceed 2,000 words (approximately eight pages of a double-spaced A4 typescript).

## ORDER OF CONTENTS

### Title Page

The title page should contain a short main title to indicate content and a sub-title if it is necessary to clarify this further

### Authors

**On a separate page** include the first name and surname of each author, with details of their respective professional occupations and addresses. Where there is more than one author, indicate who should receive correspondence.

### Summary

A concise 150 word summary should precede the main text. It should indicate the content and findings of the article.

### Main Text

The main text should be presented in a logical sequence and be divided by appropriate sub-headings.

### Acknowledgements

The author(s) should acknowledge individuals and agencies who have assisted in the work and **must** acknowledge those from whom reprint or photographic reproduction permissions have been obtained. **It is the responsibility of the author(s)** to obtain all necessary permissions and to confirm in writing that such permissions have been granted.

### Tables and Figures

Each Table and Figure should be presented on a separate sheet at the end of the work. Each one should be numbered in Arabic numerals and given an appropriate heading. The preferred position in the text should be indicated in the left-hand margin and the text should refer to each Table or Figure in turn.

### Photographs

Glossy, sharply defined, black and white photographs are preferred. Each one should be lightly numbered in pencil on the reverse. A list of the photograph numbers and their respective relevant captions should be typed on a separate sheet. **The author(s) must seek** all relevant rights and permissions for using the photographs and must enclose a letter stating that these have been obtained.

### References

The author(s) are responsible for the accuracy of references and for their correct presentation. References should be listed on a separate sheet, in alphabetical order, following the Harvard system, as follows:

**Journal articles** Gardner, D. and Rose, J. (1994)
Stress in a social services day centre
British Journal of Learning Disability 22 (4), 130-33.

**Books** Jones, R.S.P. and Eayrs, C. B. (eds) (1993)
Challenging Behaviour and Intellectual Disability. Clevedon: BILD Publications

**Book chapters** Oliver, C. (1993) Self-injurious behaviour: from response to strategy. In C. Kiernan. (ed)
Research to Practice? Implications of Research on the Challenging Behaviour of People with Learning Disability. Clevedon: BILD Publications

All references listed must be cited appropriately within the text using one or other of the following styles:

"Kerins, Hickey & Haydock (1985) stated that ..."
or
"In an article about providing modern apartments for adults (Kerins, Hickey & Haydock, 1985) it was stated that ..."

Journal titles should **not** be abbreviated. The letters a, b, c, should be added after the date if more than one paper by the same author(s), published in the same year, is quoted.

Reference lists which are not of an acceptable standard will be returned to the author(s) for correction.

### Letters

Letters which either provide or seek information on any aspect of research into learning disability and its associated conditions are welcome, as well as those which discuss the content of previous ***British Journal of Learning Disabilities*** articles. The first name, surname, professional occupation, and address of the correspondent(s) should be given at the end of the letter. Any references quoted should be listed on a separate sheet and prepared in accordance with the guidance given above for *Article References*

## LENGTH

Letters should be restricted to no more than 500 words (approximately three pages of A4 double-spaced typescript). Two copies should be submitted.

## REVIEWS

Reviews of books detailing research findings and advances in the field will usually be specifically requested by the Editor, but uncommissioned reviews will also be considered. Two copies should be submitted. Reviews should not exceed 500 words.

## ASSESSMENT PROCEDURE

All articles submitted to ***The British Journal of Learning Disabilities*** are assessed by at least two anonymous assessors who are chosen because of their expertise in the specific topic covered. As well as the originality and importance of the content, assessors will be looking for work that is presented in a logical, clear and concise form.

## EDITING

The Editor reserves the right to edit any contribution to ensure that it conforms with the requirements of ***The British Journal of Learning Disabilities***. A copy of the edited contribution will not normally be sent to the author(s) for approval prior to publication. However, where extensive editorial changes are made, papers will be returned to the authors with a request that the paper is retyped with the amendments incorporated. All authors of articles (but not those of letters or book reviews) will be sent a set of proofs for checking.

## COPYRIGHT

Copyright in any article accepted for publication in ***The British Journal of Learning Disabilities*** is assigned to the publishers **BILD (Publications)** by the author(s) at the time of acceptance. The author(s) must confirm at the time of submission that it has not and will not be submitted for consideration elsewhere and that copyright will be so assigned if the article is accepted. (If the article is not accepted, copyright reverts to the author(s)). Once published, the article cannot subsequently be published elsewhere, in full or in part, or be reproduced or transmitted in any form including photocopying and recording without prior permission from the publishers. All reasonable requests to reproduce contributions will be considered.

No fees are payable to authors but five free copies of the issue of the ***British Journal of Learning Disabilities*** in which the contribution is published are provided at the time of publication.

C:\WORDSTAR\USER7\PUBS\GLB\LDN3 December 1995

# FIGURE 1 - PROVOCATION INVENTORY

| | | Don't know | Verbal aggression | Physical aggression | Damage to property | Damage to self | Withdrawal | Constructive coping | Other | 1.<br>2.<br>3. |
|---|---|---|---|---|---|---|---|---|---|---|
| 1. | You are trying to tell the staff at the Centre something important - but you think they are not listening to you. | | | | | | | | | |
| 2. | You are walking along the street and a couple of teenagers start calling you names. | | | | | | | | | |
| 3. | You tell the truth about something but the staff will not believe you - they think you are lying. | | | | | | | | | |
| 4. | You are sitting quietly eating your lunch in a cafe and someone keeps staring at you. | | | | | | | | | |
| 5. | You are watching your favourite TV programme ( ) and someone stands in front of the TV and you cannot see. | | | | | | | | | |
| 6. | You want to buy a pint of milk in a local shop but the shop assistant says that you do not have enough money. | | | | | | | | | |
| 7. | You want to ask the staff at the Centre something important but they say they are busy and tell you to come back later. | | | | | | | | | |
| 8. | You get up from your seat for a little while and come back to find someone has sat in it. | | | | | | | | | |
| 9. | You and some people in the Centre are having a row but it is only you who gets the blame for it. | | | | | | | | | |
| 10. | You are waiting to pay for some shopping and another customer says that you have jumped the queue. | | | | | | | | | |
| 11. | You are trying to watch the TV and people will not be quiet, so you cannot hear. | | | | | | | | | |
| 12. | You are asked to get up when you do not want to or you are not feeling very well. | | | | | | | | | |
| 13. | Someone at the Centre who you do not like punches you. | | | | | | | | | |
| 14. | Someone tells you off in front of everyone else. | | | | | | | | | |

## APPENDIX 5: Single Clinical Case Research Study (2)

## Instructions to Contributors

1. Manuscripts, in quadruplicate and in English, should be submitted to the Editor-Elect:

*Regular mail*
Dr. Dean G. Kilpatrick
Medical University of South Carolina
National Crime Victims Research and Treatment Center
Department of Psychiatry and Behavioral Sciences
171 Ashley Avenue
Charleston, South Carolina 29425-0742

*Overnight mail*
Dr. Dean G. Kilpatrick
Medical University of South Carolina
National Crime Victims Research and Treatment Center
165 Cannon Street
Third floor, Room OC310
Charleston, South Carolina 29403-5713

Authors must submit manuscripts in a form appropriate to blind review (i.e., identifying information should appear *only* on the title page). Manuscripts should use nonsexist language. Three paper formats are accepted. *Regular articles* (usually no longer than 7,500 words, *including* references and tables) are theoretical articles, full research studies, and occasionally reviews. Purely descriptive articles are rarely accepted. *Brief reports* (2,500 words, *including* references and tables) are for case studies that cover a new area, preliminary data on a new problem or population, condensed findings from a study that does not merit a full article, or methodologically oriented papers that replicate findings in new populations or report preliminary data on new instruments. *Commentaries* (1,000 words or less) cover responses to previously published articles or, occasionally, essays on a professional or scientific topic of general interest. Response commentaries, submitted no later than 8 weeks after the original article is published (12 weeks if outside the U.S.), must be content-directed and use tactful language. The original author is given the opportunity to respond to accepted commentaries. *Book/media reviews* are solicited by the Book Review Editor.

2. Submission is a representation that the manuscript has not been published previously and is not currently under consideration for publication elsewhere. A statement transferring copyright from the authors (or their employers, if they hold the copyright) to the International Society for Traumatic Stress Studies will be required before the manuscript can be accepted for publication. The Editor will supply the necessary forms for this transfer. Such a written transfer of copyright, which previously was assumed to be implicit in the act of submitting a manuscript, is necessary under the U.S. Copyright Law in order for the publisher to carry through the dissemination of research results and reviews as widely and effectively as possible.

3. Type double-spaced on one side of $8\frac{1}{2} \times 11$ inch or A4 white paper using generous margins on all sides and a font no smaller than 10-point, and submit the original and three copies (including copies of all illustrations and tables).

4. A title page is to be provided and should include the title of the article, author's name (no degrees), author's affiliation, acknowledgments, and suggested running head. The affiliation should comprise the department, institution (usually university or company), city, and state (or nation) and should be typed as a footnote to the author's name. The suggested running head should be less than 80 characters (including spaces) and should comprise the article title or an abbreviated version thereof. Also include the *word count*, the complete mailing address and telephone number for the corresponding author during the review process, and, if different, a name and address to appear in the article footnotes for correspondence after publication.

5. An abstract is to be provided, no longer than 120 words.

6. A list of 4–5 key words is to be provided directly below the abstract. Key words should express the precise content of the manuscript, as they are used for indexing purposes.

7. Illustrations (photographs, drawings, diagrams, and charts) are to be numbered in one consecutive series of Arabic numerals. The captions for illustrations should be typed on a separate sheet of paper. Photographs should be large, glossy prints, showing high contrast. Drawings should be prepared with india ink. Either the original drawings or good-quality photographic prints are acceptable. Identify figures on the back with author's name and number of the illustration.

8. Tables should be numbered (with Arabic numerals) and referred to by number in the text. Each table should be typed on a separate sheet of paper. Center the title above the table, and type explanatory footnotes (indicated by superscript lowercase letters) below the table.

9. List references alphabetically at the end of the paper and refer to them in the text by name and year in parentheses. In the text, all authors' names must be given for the first citation (unless six or more authors), while the first author's name, followed by et al., can be used in subsequent citations. References should include (in this order): last names and initials of *all* authors, year published, title of article, name of publication, volume number, and inclusive pages. The style and punctuation of the references should conform to strict APA style—illustrated by the following examples (however, use indentation below):

*Journal Article*
Friedrich, W. N., Urquiza, A. J., & Beilke, R. L. (1986). Behavior problems in sexually abused young children. *Journal of Pediatric Psychology, 11*, 47–57.

*Book*
Kelly, J. A. (1983). *Treating child-abusive families: Intervention based on skills-training principles*. New York: Plenum Press.

*Contribution to a Book*
Feindler, E. L., & Fremouw, W. J. (1983). Stress inoculation training for adolescent anger problems. In D. Meichenbaum & M. E. Jaremko (Eds.), *Stress reduction and prevention* (pp. 451-485). New York: Plenum Press.

10. Footnotes should be avoided. When their use is absolutely necessary, footnotes should be numbered consecutively using Arabic numerals and should be typed at the bottom of the page to which they refer. Place a line above the footnote, so that it is set off from the text. Use the appropriate superscript numeral for citation in the text.

11. **The journal follows the recommendations of the 1994 *Publication Manual* of the American Psychological Association (Fourth Edition)**, and it is suggested that contributors refer to this publication.

12. After a manuscript has been accepted for publication and after all revisions have been incorporated, manuscripts may be submitted to the Editor's Office on **personal-computer disks.** Label the disk with identifying information—kind of computer used, kind of software and version number, disk format and file name of article, as well as abbreviated journal name, authors' last names, and (if room) paper title. Package the disk in a disk mailer or protective cardboard. **The disk *must* be the one from which the accompanying manuscript (finalized version) was printed out.** The Editor's Office cannot accept a disk without its accompanying, matching hard-copy manuscript. Disks will be used on a case-by-case basis—where efficient and feasible.

13. **The journal makes no page charges.** Reprints are available to authors, and order forms with the current price schedule are sent with proofs.

## APPENDIX 6: Single Clinical Case Research Study (3)

# CLINICAL CHILD PSYCHOLOGY AND PSYCHIATRY

## AIMS AND SCOPE

*Clinical Child Psychology and Psychiatry* brings together clinically oriented work of the highest distinction from an international and multidisciplinary perspective, offering comprehensive coverage of clinical and treatment issues across the range of treatment modalities.

*Clinical Child Psychology and Psychiatry* is interested in advancing theory, practice and clinical research in the realm of child and adolescent psychology and psychiatry and related disciplines. The journal directs its attention to matters of clinical practice, including related topics such as the ethics of treatment and the integration of research into practice.

Multidisciplinary in approach, the journal includes work by, and is of interest to, child psychologists, psychiatrists and psychotherapists, nurses, social workers and all other professionals in the fields of child and adolescent psychology and psychiatry.

## INSTRUCTION TO AUTHORS

The Editor apologizes for the apparent pedantry of these instructions, but emphasizes that adherence to them will ensure rapid and efficient processing of your contributions, and will enhance the article itself.

*Peer review process.* The Editor will screen manuscripts for their overall fit with the aims and scope of the journal. Those that fit will be further reviewed by two or more independent reviewers. Papers will be evaluated by the Editorial Board and refereed in terms of merit, readability and interest. Unsolicited manuscripts will not be returned to the author.

*Submission of MSS.* Four copies of each manuscript, **typed in double spacing throughout**, and on one side only of white A4 or US standard size paper, should be sent to the Editor at the address given below.

*Format of MSS.* Each manuscript should contain the following, in the correct order.

(a) Title page to include the title of the paper, full name of each author, current professional position and work context, and indicators of which author will be responsible for correspondence. A word count should also be included.

(b) Abstract page: the abstract itself not to exceed 200 words (150 for preference), and up to 5 key words to be listed on the same page. This page should carry the title of the paper but not the author name(s).

(c) Main text: not usually to exceed 7500 words and to be clearly organized, with a clear hierarchy of headings and subheadings (3 weights of heading maximum).

(d) References: Citation of references follows APA (American Psychological Association) style. References cited in the text should read thus: Brown (1955: 63–64); (Brown, 1995, pp. 63–64; Green & Brown, 1992, p. 102, table 3). The letters a, b, c, etc., should distinguish citations of different works by the same author in the same year (Black, 1989a, 1989b). All references cited in the text should appear in an alphabetical list, after the Notes section.

(e) Figure, tables, etc.: should be numbered consecutively, carry descriptive captions and be clearly cited in the text. Keep them separate from the text itself, but indicate an approximate location on the relevant text page.

(f) Author biographies: On a separate sheet provide a one-paragraph bio-bibliographical note for each author – up to 100 words for a single author, but none to exceed 65 words in a multi-authored paper.

*Style.* Use a clear and readable style, avoiding jargon. If technical terms must be included, define them when first used. Use plurals rather than he/she, (s)he, his or hers: 'If a child is unhappy, he or she...' is much better expressed as 'When children are unhappy, they...'.

*Spelling.* British or American spellings may be used (the 'z' versions of British spellings are preferred to the 's' versions, as given in the Oxford English Dictionary).

*Punctuation.* Use single quotation marks, with double inside single. Present dates in the form 9 May 1996. Do not use points in abbreviations, contractions or acronyms (e.g. DC, USA, DR, UNESCO).

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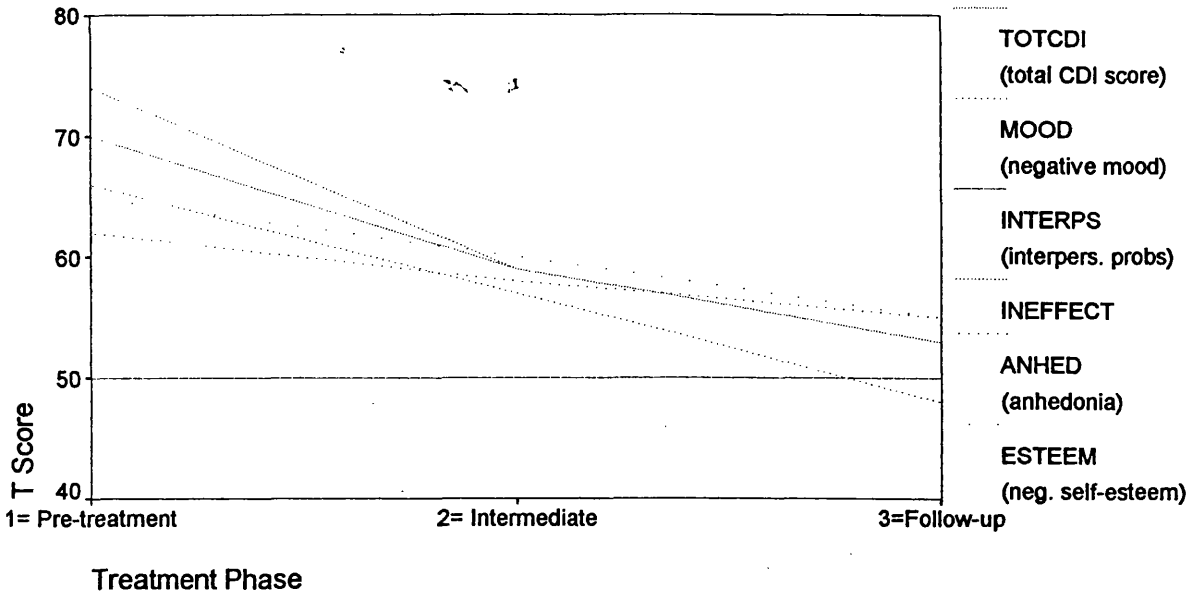
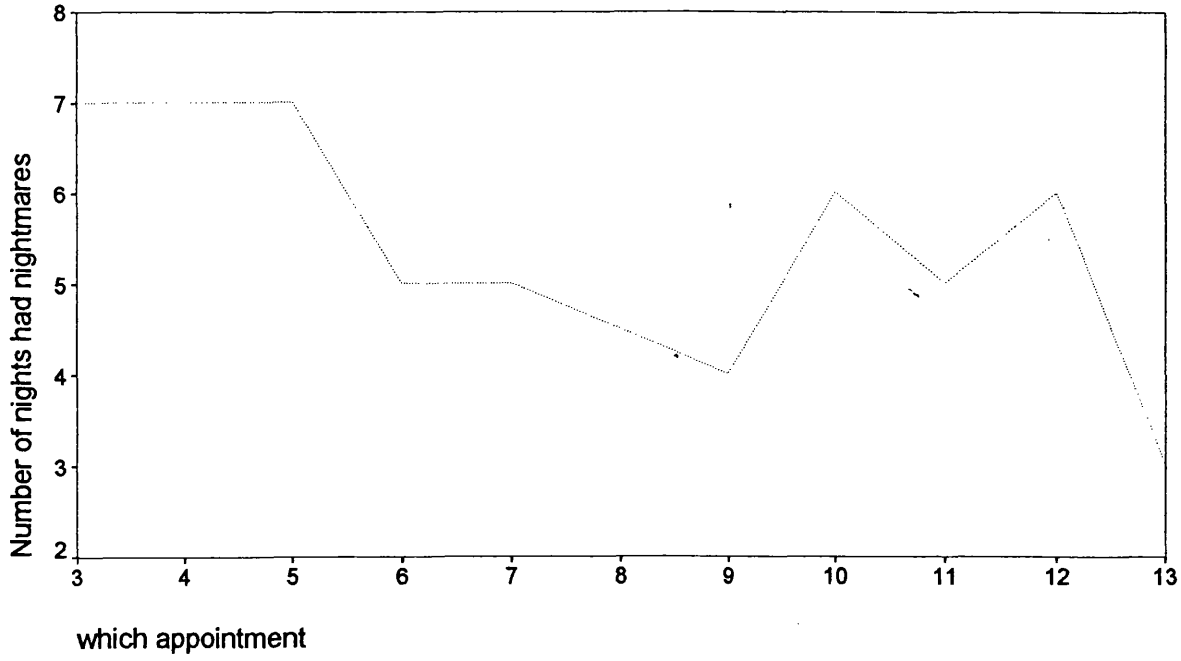
## Figure 2: T Scores On The CDI:




## Figure 3: Frequency of Nightmares



## APPENDIX 7: Small Scale Service Evaluation Project

# 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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**Craig Newnes**
Psychology Consultancy Service
Chaddeslode House
Abbey Foregate
Shrewsbury SY2 6AX

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Department of Clinical Psychology
Queen's Park Hospital
Haslingden Road
Blackburn
Lancashire BB2 3HH

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## ASSERTION GROUP FOLLOW-UP QUESTIONNAIRE

Please help by giving your views on the group, by circling the figure which indicated how useful you found different parts of the programme.

| | Not at all helpful | | | | Very helpful |
|---|---|---|---|---|---|
| **Week 1** | | | | | |
| Rights and Responsibilities | 1 | 2 | 3 | 4 | 5 |
| Listening Skills | 1 | 2 | 3 | 4 | 5 |
| **Week 2** | | | | | |
| Interference from emotions, e.g. anger, anxiety, embarrassment | 1 | 2 | 3 | 4 | 5 |
| **Week 3** | | | | | |
| Practical skills (a) e.g. nonverbal behaviour, broken record | 1 | 2 | 3 | 4 | 5 |
| **Week 4** | | | | | |
| Practical skills (b) e.g. positive thinking, rebukes, requests | 1 | 2 | 3 | 4 | 5 |
| **Week 5** | | | | | |
| Dealing with anger | 1 | 2 | 3 | 4 | 5 |
| Giving criticism | 1 | 2 | 3 | 4 | 5 |
| Dealing with criticism | 1 | 2 | 3 | 4 | 5 |
| **Week 6** | | | | | |
| Step by step process for increasing assertiveness | 1 | 2 | 3 | 4 | 5 |

**Feedback about you: Have you changed?**

Compare the way you are now with how you were before the start of the group.

| | Much worse | | No change | | Much better |
|---|---|---|---|---|---|
| Self-respect | 1 | 2 | 3 | 4 | 5 |
| Confidence in dealing with others | 1 | 2 | 3 | 4 | 5 |
| Avoidance of other people | 1 | 2 | 3 | 4 | 5 |
| Problems of anxiety, panic or tension | 1 | 2 | 3 | 4 | 5 |
| Depression | 1 | 2 | 3 | 4 | 5 |
| Standing up for your rights | 1 | 2 | 3 | 4 | 5 |

During the group programme we used different methods to help you to become more assertive and to meet the goals which you had set for yourself. Please indicate how useful each of these were for you:-

| | Not at all | | | | Very useful |
|---|---|---|---|---|---|
| Being a member of a group | 1 | 2 | 3 | 4 | 5 |
| Meeting people with similar problems | 1 | 2 | 3 | 4 | 5 |
| Realising that you had rights | 1 | 2 | 3 | 4 | 5 |
| Learning how to analyse the problem | 1 | 2 | 3 | 4 | 5 |
| Learning new patterns of behaviour | 1 | 2 | 3 | 4 | 5 |
| Learning new ways of thinking | 1 | 2 | 3 | 4 | 5 |
| Discussing real problems | 1 | 2 | 3 | 4 | 5 |
| Practising set situation | 1 | 2 | 3 | 4 | 5 |
| Practising outside of the group | 1 | 2 | 3 | 4 | 5 |

**Feedback about us: What should we change?**

Now tell us what you thought of us!

| | Not at all | | | | Very |
|---|---|---|---|---|---|
| How well did we explain things? | 1 | 2 | 3 | 4 | 5 |
| How interesting did we make it? | 1 | 2 | 3 | 4 | 5 |
| How good was our time management? | 1 | 2 | 3 | 4 | 5 |
| How safe did we make it? | 1 | 2 | 3 | 4 | 5 |
| How important was it to see your individual therapist during the time of the group? | 1 | 2 | 3 | 4 | 5 |

**How could we improve the group?**

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TRACY WALKER
PSYCHOLOGIST
DEPARTMENT OF PSYCHOLOGY
BELLSDYKE HOSPITAL.

IN CONFIDENCE

INTERVIEW SCHEDULE

ABOUT INDIVIDUAL THERAPY :

WHAT DID YOU LIKE?

WHAT DID YOU DISLIKE?

WHAT WAS THE MOST HELPFUL THING?

WHAT WAS THE LEAST HELPFUL THING?

WHAT WERE THE BEST THINGS?

WHAT WERE THE WORST THINGS?

WHAT WOULD YOU HAVE LIKED MORE OF?

WHAT WOULD YOU HAVE LIKED LESS OF?

WHAT WAS THE MOST DIFFICULT THING FOR YOU?

WHAT WERE YOUR EXPECTATIONS OF THE GROUP? WERE THEY MET?

DID THE THERAPISTS SEEM EXPERT IN WHAT THEY WERE DOING?

WAS THIS IMPORTANT?

WHICH OF THE FOLLOWING QUALITIES BEST DESCRIBES THE THERAPISTS:-

HELPFUL
KIND
ENCOURAGING
GIVES PRACTICAL ADVICE/SUGGESTS SOLUTIONS

WHICH OF THESE QUALITIES WAS THE MOST IMPORTANT FOR YOU?

TRACY WALKER
PSYCHOLOGIST
DEPARTMENT OF PSYCHOLOGY
BELLSDYKE HOSPITAL.

IN CONFIDENCE

INTERVIEW SCHEDULE

ABOUT THE GROUP :

WHAT DID YOU LIKE?

WHAT DID YOU DISLIKE?

WHAT WAS THE MOST HELPFUL THING?

WHAT WAS THE LEAST HELPFUL THING?

WHAT WERE THE BEST THINGS?

WHAT WERE THE WORST THINGS?

WHAT WOULD YOU HAVE LIKED MORE OF?

WHAT WOULD YOU HAVE LIKED LESS OF?

WHAT WAS THE MOST DIFFICULT THING FOR YOU?

WHAT WERE YOUR EXPECTATIONS OF THE GROUP? WERE THEY MET?

DID THE THERAPISTS SEEM EXPERT IN WHAT THEY WERE DOING?

WAS THIS IMPORTANT?

WHICH OF THE FOLLOWING QUALITIES BEST DESCRIBES THE THERAPISTS:-

HELPFUL
KIND
ENCOURAGING
GIVES PRACTICAL ADVICE/SUGGESTS SOLUTIONS

WHICH OF THESE QUALITIES WAS THE MOST IMPORTANT FOR YOU?

## THERAPIST QUESTIONNAIRE

Have you noticed any improvements in your client since he/she attended Assertion Group Therapy? YES NO DK

If yes, what have you noticed?

Have you noticed any other changes in your client since he/she attended Assertion Group Therapy? YES NO DK

If yes, what have you noticed?

Do you think your client would have spent longer in individual therapy if he/she had not participated in the group? YES NO DK

Comments?

Do you think Assertion Group Therapy is a good use of therapist time? YES NO DK

Comments?

Can you suggest anything that might improve this type of intervention?

Can you suggest other types of intervention which might be more cost-effective?

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