

**PSYCHOLOGICAL ASPECTS OF CHILDREN AND  
ADOLESCENTS WITH DUCHENNE MUSCULAR  
DYSTROPHY (DMD) AND RESEARCH PORTFOLIO.**

**This portfolio is submitted in partial fulfilment of the Degree of Doctor of  
Clinical Psychology within the Faculty of Medicine, University of Glasgow.**

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**MAJOR RESEARCH PROJECT LITERATURE  
REVIEW**

# **PSYCHOLOGICAL ASPECTS OF DUCHENNE MUSCULAR DYSTROPHY (DMD) IN CHILDHOOD AND ADOLESCENCE : A REVIEW**

**Selected Journal: Clinical Child Psychology and Psychiatry (Appendix 1)**

## **ABSTRACT**

This paper reviews the extant literature on the psychological aspects of Duchenne Muscular Dystrophy (DMD) and discusses the clinical implications of its impact on children and their families. DMD is the commonest form of muscular dystrophy and the most severe, following a progressive and fatal course of muscular weakness and deterioration. Research on psychological aspects of DMD is rather old and restricted to a small number of studies of varying methodological quality. However, the clinical presentation of DMD, the developmental stage of the child, social/environmental restrictions and family interactions have all been implicated in psychological difficulties within this group. Seminal work and directly relevant research from other areas is discussed and suggestions are made to guide both research and service provision.

**Key words:** Duchenne Muscular Dystrophy, psychological aspects, developmental stage, social restrictions, family interactions.

## INTRODUCTION

Some 10-15% of children under 16 years of age are affected by chronic long-term conditions (Cadman and Boyle 1991, Rutter, Tizard and Whitmore 1970, Weiland, Pless and Roghman 1992). Population based studies have consistently identified maladjustment in chronically sick children both in relation to siblings (Eiser 1991) and healthy peers (Perrin 1993). Those children with central nervous system involvement appear to be more at risk of psychological problems than rather chronically ill children (Siedel, Chadwick and Rutter 1970, Breslau and Marshall 1985, Sinemma 1992).

Muscular Dystrophies illustrate many of the difficulties associated with central nervous system involvement. Duchenne Muscular Dystrophy (DMD) is the commonest form of muscular dystrophy and the most severe. DMD follows a progressive degenerative course which leads to death in the late teens or early twenties (Emery 1993). Normally, healthy children gradually achieve physical and emotional independence with age, but these tasks are restricted by DMD. (Hallum and Krumboltz 1993).

While previous empirical work has addressed the chronic stress experienced by families with a DMD child (Buchanan 1979, Firth 1983 Renwick 1992), there has been a paucity of research concerned with psychological and emotional aspects in DMD boys themselves. Evidence which is available is rather old and based on a small number of studies on varying quality. This paper will review the seminal work on psychological aspects of DMD and draw upon recent findings from other directly relevant areas as appropriate.



## **CLINICAL PRESENTATION**

DMD is characterised by a sex-linked recessive pattern of inheritance that is carried by an asymptomatic female and transmitted to 50% of her sons (Gilgoff and Dietrich 1985) and affects 1 in 25,000 live male births per year (Emery 1990). Impaired motor developments can be observed in boys as young as 3 years of age and progressive loss of motor function continues until a wheelchair becomes necessary typically, at 10-12 years of age (Noshiro and Matsuda 1993). The disease progresses through the upper body until death occurs, usually secondary to respiratory or cardiac failure. There is only a 25% estimated chance that a boy with DMD will live to the age of 20, and typically the family must assume total care for the boy 6 - 8 years before his death (Holroyd and Guthrie 1986).

## **DMD AND FAMILY LIFE**

### **Marital**

The potential negative effects of a chronic illness on families with chronically ill children have been widely recognised (Turk and Kerns 1985). Although previous research has suggested that marital disruption, divorce and disharmony between both parents are associated with having a DMD child (Buchanan 1979, Witte 1985), the evidence is not conclusive (Hallem and Krumboltz 1993, Firth 1993, Renwick 1992).

### **Psychological**

Chronic emotional stress is considered to be one of the most significant problems identified by parents (Firth 1983, Pullen 1984, Holroyd and Guthrie 1986). This is largely due to the unrelenting physical, emotional and medical care required by the progressing disease. DMD parents in particular report more stress within a wider spectrum of problem areas than parents of children with other diseases (Thompson 1992, Renwick 1992).

Numerous cases narratives have suggested high levels of parental anxiety, over protection and excessive feelings of responsibility and guilt associated with the hereditary nature of DMD (Taft 1973, Pullen 1984, Madorsky 1983). Empirical work has found evidence that mothers in particular self-report poor psychological adjustment with feelings of hoplessness and depression (Thompson 1992). Sibling resentment has also been documented (Pullen 1984), while other researchers suggest that older sisters may adopt a maternal or protective role, yet at the same time harbour concerns about the possibility of their having an affected son (Emery 1993)

### Social

The intensive parental caring role may mean that the focus for the family becomes DMD itself and as a result many parents find it difficult to participate or benefit from external activities or supports. This is of concern as a family's psychological adjustment to chronic illness has been found to be closely related to the medical, social and community support they received (Varni and Wallander 1989).

While it appears that there is a complex system of disease and situational factors which affect family stress, there is evidence that family interactions may play an important role in coping with chronic illness in general (Minuchin 1974) and DMD in particular (Thompson 1992) and additionally that better adjusted children seem to come from more cohesive families (Pless 1993, Eiser 1992a). Clinically, this suggests that any assesment or treatment approach should involve the whole family.

## CHILDREN AND DMD

Very little research has been carried out into the ways in which children cope with chronic diseases (Perrin 1983) and the available DMD literature consists of personal observations or case studies (Green 1952, Morrow and Cohen 1954, Blumberg 1959, Taft 1973), and in the cases of Pope-Gratten (1976) and Kornfield and Siegel (1980) on interpretation of figure drawings. Recent empirical research in this area is particularly scarce.

### Parent/Teacher Reports

In a unique study, Leibowitz and Dubowitz (1981) compared parental and teacher reports of 53 DMD boys of school age. On the Rutter Scales, it was found that teachers reported a preponderance of anti-social disturbance in these boys (34%), whereas parents reported a preponderance of neurotic disturbance (37%). DMD children had a higher incidence of deviant scores on both scales than normal children and also a higher rate than has been found among physically handicapped children without central nervous system involvement (Breslau and Marshall 1985, Blum 1992). Although it is usual for handicapped boys who are emotionally disturbed to show more antisocial than neurotic behaviour (Pless and Roghman 1992) the teacher and parental reports contradicted each other in this particular study. This suggests that future research needs to identify problem areas which are pertinent to DMD.

### Scholastic

An intellectual impairment in around 20-25% of DMD children has been identified (Karagan 1979) and estimates vary from slightly below average to approximately one standard deviation below the mean (Dubowitz 1979, Marsh and Munsatt 1974). Detailed examination of cognitive and reading skills reveals a typical pattern of deficient phonological processing and reading skills (Lebowitz and Dubowitz 1981). A relationship between low scores on cognitive

tests and high scores on Rutter teacher questionnaires has been well documented in the literature (Dorman 1988). These findings can be interpreted in a number of ways e.g. the cognitive disability may make school stressful, or the child's emotional disturbance may interfere with learning. Alternatively, both emotional problems and the learning difficulties might derive from some third factor, such as neurological disorder (Breslau and Marshall 1985). It is also difficult to isolate specific cognitive deficit from emotional disturbance and emotional behavioural disturbance from the consequences of interrupted education due to the illness itself (Charlton 1991). From a practical point of view, it is important for all concerned with DMD children to be aware of these risks. However, not all children are affected in these ways and each case must be assessed independently (Emery 1993).

#### Parental Stress and Child Adjustment

Parent's, (primarily mother's), report poor psychological adjustment to their child's DMD and also report high rates of internalising behaviour problems in their children (Thompson 1992), such behavioural problems are consistent with findings of other children with chronic illness, and central nervous system involvement (Breslau 1985). It is important to note however, that parental distress and depression in particular is influential in parental perceptions of their child's behaviour. Many depressed parents tend to over-report problem or difficult behaviours (Compas 1992, Canning 1993, 1994, Hamlet 1992).

### Socio-Emotional

While the reactions of a child to his disease vary from individual to individual, symptoms rather than the notion of disease per se have a profound effect on a child's emotional development (Fischman 1979). Usually DMD boys are not initially aware of any differences between themselves and other boys, but as they become older they begin to note their own deficits and that peers are physically and sometimes intellectually their superiors (Pullen 1984, Witte 1988). As DMD progresses, so does the boy's physical dependency (Buchanan 1979), this handicap is associated with increasing social and environmental restrictions (Hallen and Krumboltz 1993). DMD boy's social life and interests often became home-based and/or family orientated by both physical and environmental necessity. (Firth 1983). With fewer opportunities to try out socialising skills, some authors report that DMD boys may have more difficulty in moving out of a narcissistic stage of development (Mearig 1973, Kornfield and Siegel 1980). This may result in poor interpersonal skills, self consciousness, low frustration tolerance and limited social perspective taking (Bayrakal 1975, Fischman 1979). A proportion of boys may feel their physical deterioration makes them unattractive, and expressions of shame, embarrassment and self-blame have been identified (Emery 1993). In view of these difficulties it is not surprising, therefore that the majority of studies report increased withdrawal, loneliness and depression with increased age and progression of the disease.

### Psychiatric Disturbance

The only comprehensive psychiatric research to date has been carried out by Fitzpatrick (1986). This study investigated psychiatric disorder in 25 DMD boys in comparison with an age matched control group. In psychiatric interviews, the DMD parents identified a significant proportion of their sons as having both psychological problems and poor peer relationships.

They were also significantly more likely than control parents to describe their sons as “anxious” or “worrying”. DMD boys themselves said that they were “sad and had few friends or social life. The author noted that DMD boys behaved differently during these psychiatric interviews, and showed more anxiety, low mood and engagement difficulties. A clinical diagnosis of psychiatric disorder was made for 52% of the DMD boys compared to 10% for control boys with Dysthmic Disorder and Major Depressive Disorder being the most prevalent diagnoses. Interestingly, no psychiatric diagnosis was made for any DMD boy below the age of 9 years. The author considers that as the DMD boys become older, they generally become more withdrawn, socially isolated and depressed, similar to adolescents with cystic fibrosis e.g. (Boyle 1976). It is concluded that “depression may be an expected response to a disabling, progressive and life threatening disorder” (Fitzpatrick 1986)

These findings must be viewed tentatively for a number of reasons. The diagnosis of depressive disorder in chronically ill children is a controversial area (Kashani 1985, Canning 1994). For example, somatic symptoms such as weight changes, sleep disturbance, psychomotor retardation and poor energy are all diagnostic criteria for depression (DSMIV 1994, Kovacs 1981), but these are also features of DMD itself and can occur in patients who do not have a depressive disorder. Also, older boys with DMD tend to have limitation of facial expression, gesture and animation which is secondary to widespread muscular weakness (Noshiro and Matsuda 1993). These features combined in some cases with low intelligence, may make boys appear to be depressed even when they are not.

Clearly, the presence or absence of psychiatric disorder represents a somewhat limited assessment of the psychological or emotional aspects of DMD. Future research should aim to

incorporate self-report as well as parent/teacher measures and cover wider psychosocial areas. This would provide a more representative picture of an individual's psychological status.

## **ADOLESCENCE AND DMD**

DMD individuals typically experience the most severe physical effects of DMD during their teenage years. These impinge significantly as they simultaneously address the complex developmental tasks which are associated with this stage of life (Erikson 1968, Ettinger 1993). The extant research suggests that this is the time when psychological problems become most evident (Taft 1973, Buchanan 1979, Firth 1983, Witte 1985, Emery 1993).

### **Independence**

Increasing dependence at a time when he should be gaining independence precludes an easy transition through adolescence (Fischman 1979) and a particular hurdle for the DMD adolescent is having to give up walking and become wheelchair bound. It is usually some time before the "wheelchair is seen as a symbol of mobility rather than invalidity". (Nicholls 1971). The DMD boys dependence on his parents for self-care, practical help and transport increases with his decreased mobility. These features in particular are juxtaposed against the increased social and environmental independence enjoyed by his peers.

### **Peer Relations/Social Isolation**

Recreational, social and educational clubs and activities provide opportunities to meet people and form acquaintances. This is particularly so in adolescence (Blum 1992). However, as DMD progresses, adolescence becomes a time of social isolation when hobbies and social life become restricted to the home and family, largely through physical and environmental necessity (Firth 1983). DMD boys often find it difficult to develop close friendships and lack

opportunities to practice social skills through daily social contact with peers (Renwick 1992). Other authors report major concerns for DMD boys are the reactions of some of their peers to their physical appearance (Sinemma 1992), this may make social interactions even more difficult.

### Body Image and Self Esteem

Self esteem is a major factor in both psychological well being and social integration (Sinemma 1992). During adolescence the physical self becomes a central concern, and aspects of the physical self influence both body image and feelings of self-esteem (Blum 1992). The progressiveness of DMD has a profound impact on body image and boys tend to report feelings of shame about their increasingly deformed body, and also feelings of helplessness to do anything about it. Many judge themselves as being inferior to their peers, and as a consequence develop feelings of low self-worth (Arnold and Chapman 1992, Thompson 1992). These issues are of concern as they are viewed as contributing to the development of depressive feelings (Milvac 1985).

### Sexuality

Sexuality issues are intertwined with peer relations, body image and the mastery of independence (Blum 1992). These factors along with modesty and personal privacy are compromised by DMD as the adolescent becomes increasingly dependent on another person, usually his mother for basic self-care skills. This physical closeness and personal restrictions make normal adolescent concerns about emerging sexuality difficult areas to address. In addition typical adolescent experimentation with sex is practically impossible when the DMD patient may be too weak to masturbate and/or is socially isolated (Morgan 1975).



Sexuality in DMD is an area which has been infrequently addressed in literature and yet it is of major importance during this developmental stage of life (Smith 1991).

Professionals and parents should be aware that DMD adolescents need to develop high levels of social skills competency to overcome the social effects of disability and to enable mastery of the adult demands of independence and sexuality.

### Psychological Problems

A subsequent proportion of boys develop emotional and behavioural problems which are considered to be a reaction to their illness. There is evidence that these problems are most common in boys who do not have information about their disease, or who have been told half-truths (Buchanan 1979, Firth 1983, Emery 1993). In addition, other researchers have found that the declining adolescent often turns in on himself becoming depressed, isolated uncommunicative and withdrawn (Taft 1973, Pullen 1984). The literature suggests it is these isolated adolescents who experience the most intense fears related to their illness, core features of which are being alone while ill and experiencing the dying process (Madorsky 1981, Bach 1991).

## **DISEASE COMMUNICATION AND THE DMD FAMILY**

### **Parents**

One of the most commonly identified areas within parental distress are the issues of what to tell the boys about their illness, (Thompson 1992, Buchanan 1979). Most parents handle this aspect of care alone and as a result very little is known about the factors which are involved in deciding how such information is communicated (Madorsky 1983). The small number of studies which are available suggest that very little open communication takes place within the family (Firth 1983, Fitzpatrick 1986) and that many families adopt a “protective” approach with their children (Share 1972, Bluebond-Langer 1978). This approach advocates that children are shielded from full knowledge of their condition as such information is to increase a child’s anxieties and fears. Lack of meaningful communication occurs not only as a result of shielding the child. Some parents do not communicate as they have a profound sense of guilt relating to the heredity nature of the condition (Pullen 1984). Also some families may feel incapable of answering a child’s questions as they find it difficult to cope with their own anxieties concerning the illness (Madorsky 1983).

### **DMD Boys**

Research from the oncology field suggests that children of all ages are often frequently aware of the seriousness of their condition but that they also realise that parents and staff do not wish them to discuss the matter openly. As a result children can experience anxiety, loneliness and depression (Golding 1990, Claflin 1991). The literature suggests that DMD children who have emotional or behavioural problems often have not been told anything about their disease or have been told partial truths (Buchanan 1979, Firth 1983). Other researchers have suggested that DMD children develop an awareness of their prognosis which does not appear to be age dependent but rather is the outcome of the progressive and cumulative effects of the

disease (Bach 1991). The major question remains whether such children actually understand the concepts of finality and life cessation as associated with the impending progressiveness of their condition or whether they are reacting to circumstances with the diminished capacities and resources they possess.

### Open Communication?

This approach has many strong proponents (Claflin 1991, Chesler 1986, Goldman 1990, Eiser 1992, Pullen 1984). It proposes that children benefit from frank discussions related to their illness, and illness related questions are encouraged. Support for this view has been through recent oncology research (Goldsmith and Christie 1993) and also from some innovative older research which used projective techniques to elicit children's concerns about present and future body integrity (Waechter 1968, 1971, Spinetta 1973, 1981). It was found that the children with fatal illnesses expressed more illness related concerns and made more death related references than other ill children. One of the most significant findings was that the children whose families gave them the opportunity to discuss their illness expressed less illness concerns and death related imagery than did other fatally ill children who had not had such an opportunity.

### When and How to Communicate?

It would be logical to assume that as the patient ages both he and the family would become increasingly interested in receiving assistance and information on both disease progression and disease communication. Madorsky (1983) found no support for this hypothesis and stated that whether a patient and family want to deal with life, illness or death issues are a highly individual matters. However, this can be problematic if there is a conflict in wishes within the family. In a study of 20 adolescents DMD boys it was found that the majority of boys raised

issues of their illness surprisingly often with their parents, but that these parents had marked difficulties in engaging with their sons (Witte 1985). This is a commonly reported family injunction, and the avoidance of acknowledgement with each other of issues about the disease means that each family member remains existentially alone in facing death (Bach 1991, Madorsky 1983). Further research is needed to elucidate how a family communicate their illness concerns and what factors are the most influential. The understanding of coping with death related issues is crucial to understand and to help the DMD family cope with life issues.

## CONCLUSION

Firm conclusions cannot be drawn but some tentative themes emerge from this review. Firstly there is some evidence for an increased risk of psychological and social problems in children and adolescents with DMD compared with non-affected children. Secondly, this increased risk is more apparent in DMD adolescents who are reported to have more problems than other age groups. Thirdly, issues of disease communication are of concern to both parents and boys and difficulties in this area may have a negative effect on individual and familial functioning.

Previous research has been limited by small sample sizes and studies of varying methodological quality. Future research needs to address the above issues in a methodologically sound manner, with specific hypotheses and appropriate tools of measurement. This approach would provide an increased understanding of problems and how both individuals and the family cope with DMD. Clinical and research perceptions could then become more integrated and facilitate the development of effective service provision.

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# MAJOR RESEARCH PROJECT PROPOSAL

**PSYCHOLOGICAL ASPECTS OF DUCHENNE  
MUSCULAR DYSTROPHY (DMD) IN  
CHILDREN AND ADOLESCENTS**

## **APPLICANTS**

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**Medical Consultant:** Professor J B Stephenson, Consultant in Paediatric Neurology, Fraser of Allander Unit, Yorkhill NHS Trust, Yorkhill G3 8SJ.

## **TITLE**

“Psychological Aspects of Children and Adolescents with Duchenne Muscular Dystrophy”.

## **SUMMARY**

Some 10 - 15% of children under 16 years of age are affected by chronic long-term conditions. While emotional sequelae are more frequent for all chronically ill children as compared with normal, those with central nervous system involvement appear to be more at risk. Duchenne Muscular Dystrophy (DMD) is the commonest form of muscular dystrophy and illustrates many of the problems associated with central nervous system involvement. DMD is a progressively fatal disorder characterised by muscle wasting and weakness. Research findings concerning the psychological aspects of DMD are based on a relatively small number of studies, the majority of which have relied on parent or teacher reports of behaviours and have

not included control groups. Additionally, empirical evidence of anxieties about both disease and disease communication within families is lacking. This study will aim to address these issues.

All DMD subjects will be recruited from the Neuromuscular clinic at Yorkhill NHS Trust.

The findings of this study will provide knowledge to facilitate effective service provision.

## **INTRODUCTION**

Some 10 - 15% of children under 16 years of age are affected by chronic long term conditions (Cadman and Boyle 1991, Rutter, Tizard and Whitmore 1970, Pless 1993). Population based studies have consistently identified maladjustment in chronically sick children, both in relation to siblings (Eiser 1991) and healthy peers (Compas 1992). Children with central nervous system involvement appear to be more at risk than other chronically ill children of maladjustment (Siedel, Chadwick and Rutter 1970, Breslau and Marshall 1988, Sinemma 1992).

Muscular dystrophies illustrate many of the problems associated with central nervous system involvement. Duchenne Muscular Dystrophy (DMD) is the most common form of muscular dystrophy and the most severe (Emery 1993). DMD has a sex-linked recessive pattern of inheritance, carried by an asymptomatic female and transmitted to 50% of her sons (Gilgoff and Dietrich 1985). Children with DMD usually demonstrate impaired motor development before age 3, with wheelchair confinement and upper body involvement by the age of 10 - 12. Gradually the muscles that control respiration and heartbeat fail, leading to death, usually in the late teens (Holroyd and Guthrie 1986).

The DMD clients of the Neurology Clinic at Yorkhill NHS Trust are identified as a group about whom staff have expressed concern regarding their psychological and emotional needs.

There has been surprisingly little empirical work on the psychological and emotional status of DMD boys themselves. The majority of studies are rather old of varying methodological quality concentrating either on associated intellectual impairment in 20-25% of cases

(Karagan 1979, Dubowitz 1979) or on case reports or observations (Blumberg 1959, Bayrakal 1975). More recent studies have relied heavily on parental or teacher reports. DMD boys are reported as presenting significantly more behaviour problems than their peers or other physically handicapped children (Leibowitz and Dubowitz 1981). Parental reports in particular identify high rates of internalising problems (Thompson 1992). Psychiatric disturbance, primarily depressive disorders have been found and these are said to increase with age (Fitzpatrick 1986). Parental concerns about what to tell their sons about their disease have been well documented (Pullen 1984, Madorsky 1983). Recent research in chronic illness generally has revealed an association between good adjustment of children to their disease and good communication within the family about the disease (Boyle 1976, Goldman and Christie 1993) and it is of note that boys with emotional and/or behaviour problems have been identified as lacking in information about their disease or as having partial truths (Buchanan 1979, Firth 1983, Witte 1985).

Clearly, what emerges is that psychological problems are associated with DMD and also that family communication may be implicated in a child's adjustment to his disease. However, no empirical work on these factors has been carried out using self-report standardised psychological measures and neither has a matched control group been included. In addition investigation of boys concerns about their illness and the type of illness communication within families is lacking. Clarification of these issues would help facilitate effective service provision for the needs of this group.

## **AIMS AND HYPOTHESES**

It is hypothesised that there are differences between DMD boys and a healthy matched control group on self-report psychological measures and also that DMD boys express more illness related concerns. It is further suggested that there is an association between these concerns and type of family communication about illness.

Questions to which answers will be sought are as follows:-

1. Is there a significant difference between the DMD and control group on the psychological measures?
2. Are there relationships between the different variables?
3. Is there a significant difference between the groups on a projective test pertaining to illness concerns?
4. Is there a relationship between DMD family type of illness communication and the boys illness concern scores?

## **PLAN OF INVESTIGATION**

### **Subjects**

#### **DMD Group**

This study will survey the total population of clients registered at Yorkhill NHS Trust Glasgow who meet the following inclusion criteria: prior or current registration at the Neuromuscular Clinic; condition diagnosed as DMD; age between 7 - 17 years; intelligence within the normal range (IQ above 80 as determined by previous standardised psychometric assessments). It is estimated that 35 clients will meet this inclusion criteria.



## Control Group

A control group of healthy able bodied children will be recruited through the register of two local schools. They will be matched on the basis of age and year in school and must meet the following inclusion criteria; current attendance at the school, no chronic physical condition, age between 7 and 17, intelligence within the normal range (as determined by teacher reports and age appropriate scholastic attainments). It is estimated that 190 children will meet the inclusion criteria.

## MEASURES

### Childrens Depression Inventory (CDI) Kovacs 1980/81)

The CDI is a downward extension of the Beck Depression Inventory for adults (Beck, et al 1961). It is a self-report instrument with 27 items which are scored on a 3 point scale. Each item represents a depressive symptom and is scored 0 for absence of the symptom and 2 for the most severe form of the symptom. Total scores range from 0 - 54. Mild depression is indicated by scores of approximately 9 and above, and moderate depression by scores of 16 or above. Studies of the psychometric properties of the CDI indicate good internal consistency, reliability and validity (Saylor, Finch, Spirito and Bennett 1984).

### The State-Trait Anxiety Inventory for Children (STAIC), (Spielberger 1973).

The STAIC is comprised of separate, self-report scales for measuring two distinct anxiety concepts: state anxiety and trait anxiety. Each scale consists of 20 items that are rated on a 3 point scale and are summed to obtain a total score. Total scores on either the scale range from a minimum of 20 to a maximum of 60. Normative data and evidence supporting the instruments reliability and validity is provided in the manual (Spielberger 1973)

(Coopersmith Self-Esteem Inventory School Form),(Coopersmith 1982)

This is a 58 item self-report questionnaire. All items are short statements and are answered “like me” or “unlike me”. The number of items answered are summed and the total raw score is multiplied by two. The maximum possible score is 100, while the mean score is in the range of 70 to 80 with a standard deviation of 11 - 13. The manual provides information on standardisation and reliability (Coopersmith 1982).

Previous research has found these three widely used measures to be sensitive to psychological difficulties in children and adolescents (Cohen et al 1987; Swearingen and Cohen 1985)

**PROJECTIVE TEST**

Waechters Adapted Pictures Test (Waechter (1968, 1971)

This test consists of four pictures from the Thematic Apperception Test (Murray 1943) and four pictures designed by Waechter (1968). Each picture is considered to elicit illness related anxiety or themes. The pictures are shown individually and the child is requested to tell a story about each picture. The stories will be analysed according to the author's scoring criteria. No range of scores for this instrument have been established, neither has standardisation or reliability data. Content validity has been established by using the same set of pictures with different groups of ill children (Spinetta 1981).

Family Communication Type

The DMD family care officer will be asked to estimate the type of communication about the illness used by the following range of responses are available:-

Open Conversation, Acknowledged, Prevented, Not Discussed, Ignorance, Unknown.

These categories are taken from a pilot staff questionnaire devised by Goldman and Christie (1993). This measure is qualitative and no standardisation or validity data is available.

## **DESIGN AND PROCEDURE**

A different matched subject design is selected to compare two groups who differ in medical status. The independent variable in the study is DMD while the dependent variables are psychological status.

### **DMD Group**

All eligible DMD subjects and their parents will be contacted by telephone by the Family Care Officer who will explain the purpose of the study. A consent form and letter of explanation will then be sent to interested clients. Subjects who consent to participate will attend either an individually scheduled 90 minute scheduled session at Yorkhill NHS Trust to complete the measures or complete them with the author at home. Home visits may be necessary due to the limited mobility, transportation difficulties and physical needs of the subjects.

### **Control Group**

All eligible control subjects and their parents will be contacted by letter via the headteacher to explain the purpose of the study. A consent form will be enclosed. Subjects who consent to participate will then be matched with DMD boys on the basis of age and year in school. These subjects will attend a 90 minute scheduled session during the school day to complete the measures.

## **DATA ANALYSIS**

All data will be collated, stored and analysed using the SPSS/PC Statistical Package.

In addition to descriptive statistics, two tailed independent t-tests will be used to compare group means. Pearson product moment correlation co-efficients will be used to assess relationships between the different variables and medical status. A one-way analysis of variance (ANOVA) will be used to compare different types of family communication and projective test scores. Probability levels below 5% will be considered significant.

## **PURPOSE**

The purpose of this study is to determine the nature of psychological problems and levels of illness concerns as rated by DMD boys themselves. This study will help to improve awareness of any problems experienced by those boys. The results will guide health care professionals, parents and teachers in establishing effective service provision as appropriate.

## **TIMESCALE**

This study will start in March 1994 and is anticipated to be of 10 months duration.

## **ETHICAL APPROVAL**

Ethical approval is necessary and will be requested from Yorkhill Ethical Committee

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# **MAJOR RESEARCH PROJECT PAPER**

**PSYCHOLOGICAL ASPECTS OF CHILDREN AND  
ADOLESCENTS WITH DUCHENNE MUSCULAR  
DYSTROPHY**

**Selected Journal:- Clinical Child Psychology and Psychiatry (Appendix 2.1)**

## **ABSTRACT**

This study investigated the hypothesis that there were significant differences between boys with Duchenne Muscular Dystrophy (DMD) and a healthy matched control group on a variety of psychological variables and illness concerns. The relationship between illness concerns and family communication type in DMD families was also investigated. 20 DMD boys and 58 control group boys (aged between 7 - 17 years) participated in the study. Significant differences were found between the groups on depression and self-esteem scores. No relationship between illness concerns and type of family communication was identified. Possible aetiological factors and approaches to management are discussed.

**Key words:-** Duchenne Muscular Dystrophy, psychological variables, communication, aetiology, management.

## INTRODUCTION

Some 10-15% of children under 16 years of age are affected by chronic long-term conditions (Cadman and Boyle 1991, Rutter, Tizard and Whitmore 1970, Pless 1993). Population based studies have consistently identified maladjustment in chronically sick children both in relation to siblings (Eiser 1991) and healthy peers (Compas 1992). Children with central nervous system involvement appear to be more at risk than other chronically ill children (Siedel, Chadwick and Rutter 1970, Breslau and Marshall 1985, Sinemma 1992).

Muscular dystrophies illustrate many of the problems associated with central nervous system involvement. Duchenne Muscular Dystrophy (DMD) is the commonest form of muscular dystrophy and the most severe. It is characterised by progressive muscle wasting and weakness which becomes clinically evident around age of 3-5 years and leads to an inability to walk by the age of 12 and death in the late teens or early twenties (Emery 1993). It is inherited as an X-linked recessive trait and affects only boys.

Most studies of the psychological and emotional aspects of DMD have concentrated on either the intellectual impairment in 20 to 25 per cent of cases (Dubowitz 1979) or on the high levels of chronic emotional stress experienced by families (Buchanan 1979, Firth 1983). Early reports in the literature consist of case studies and personal observations of emotional disorders (Blumberg 1959, Bayrakal 1975). Later work relies primarily on parent or teacher reports of behaviour (Lubowitz and Dubowitz 1981, Thompson 1992). A full review of the literature on psychological aspects of DMD may be found in Urquhart (1995).

No empirical work has involved a comprehensive assessment of these boys, using standardised self-report psychological measures, and none has involved a matched control group. In

addition no previous work has investigated boys' illness concerns, nor the types of illness communication within DMD families. This study then was concerned with these issues.

The particular hypothesis under investigation was that there are differences between DMD boys and a healthy matched control group on psychological variables and also that DMD boys express more illness related concerns. It is further suggested there is an association between these concerns and the type of family communication about illness. Answers to the following questions were sought:-

1. Is there a significant difference between the DMD and control group on the psychological measures?
2. Are there relationships between the different variables?
3. Is there a significant difference between the groups on a projective test pertaining to illness concerns?
4. Is there a relationship between DMD family types of illness communication and the boys illness concern scores?

## **METHOD**

### **Design**

A different subject design was selected to compare two groups who differed in medical status. The independent variable in the study was DMD while the dependent variables were psychological status.

### **Subjects**

#### **DMD Group**

This study identified the total population of DMD clients registered at an NHS Trust Hospital for sick children. The inclusion criteria was as follows: prior current registration at the hospital's Neuromuscular Clinic; condition diagnosed as DMD; age between 7-17 years; intelligence within the normal range (IQ above 80 as determined by previous standardised psychometric assessments), 32 clients met this criteria.

#### **Control Group**

A control group of healthy able-bodied children was recruited through the register of two local schools. The inclusion criteria was as follows: current attendance at the school, no chronic physical condition; age between 7-17 years; intelligence within the normal range (as determined by teacher reports and age-appropriate scholastic attainments), 180 pupils met this criteria.

## **MEASURES**

### **Children's Depression Inventory (CDI) Kovacs (1980/81) (Appendix 2.2)**

The CDI is a downward extension of the Beck Depression Inventory for adults (Beck et al 1961). It is a self-report instrument of 27 items which are scored on a 3 point scale. Each item represents a depressive symptom and is scored 0 for absence of the symptom and 2 for the most severe form of the symptom. Total scores range from 0 to 54. Mild depression is indicated by scores of approximately 9 or above, and moderate depression by scores of 16 or above. The CDI has been found to have good internal consistency and satisfactory reliability and validity properties (Saylor 1984).

### **The State Trait Anxiety Inventory for Children (STAIC), Spielberger (1973) (Appendix 2.3)**

The STAIC is comprised of separate, self-report scales which measure two distinct anxiety concepts: State anxiety and Trait anxiety. Each scale consists of 20 items that are rated on a 3 point scale and are summed to obtain a total score. Total scores on either scale range from a minimum of 20 to a maximum of 60. Normative data and evidence supporting the instruments' reliability and validity is provided in the manual (Spielberger 1973).

### **Coopersmith Self-Esteem Inventory - School Form (Coopersmith 1982) (Appendix 2.4)**

This is a 58 item self-report questionnaire. All items are short statements and are answered "like me" or "unlike me". The number of items answered are summed and the total raw score is multiplied by two. The maximum possible score is 100, while the mean score is in the range of 70 to 80 with a standard deviation of 11-13. The manual provides information on standardisation and reliability (Coopersmith 1982).

Previous research has found these three widely used measures to be sensitive to psychological difficulties in children and adolescents (Cohen 1987, Swearingen and Cohen 1985).

### **Projective Test**

#### **Projective Test (Waechters Adapted Picture Test (Waechter 1968, 1971) (Appendix 2.5)**

This test consists of four pictures from the Thematic Apperception Test (Murray 1943) and four pictures designed by Waechter (1968). Each picture is considered to elicit different illness related anxiety or themes. The pictures are presented individually and the child is requested to tell a story about each picture. The scores are analysed according to the authors scoring criteria. No range of scores have been established for this test, neither has standardisation or reliability data. Content validity has been established by the use of the test with different groups of ill children (Spinetta 1981).

#### **Family Communication Type (Appendix 2.6)**

The DMD Family Care Officer was asked to estimate the type of communication about the illness used by the family. The following categories were available: Open Conversation, Acknowledge, Prevented, Not Discussed, Ignorance, Unknown. These categories were taken from a pilot questionnaire devised by Goldman and Christie (1993). This measure is qualitative and no standardisation or validity data is available.



## **PROCEDURE**

### **DMD Group**

All eligible subjects and their parents were contacted by telephone by the Family Care Officer who explained the purpose of the study. A consent form and letter of explanation were then sent to interested clients. 20 out of a possible 34 subjects agreed to participate. These subjects attended either a 90 minute scheduled session at the hospital to complete the measures or completed them with the author during a home visit. Home visits were necessary in some cases due to limited mobility, transportation difficulties and the physical needs of the subjects.

### **Control Group**

All eligible subjects and their parents were contacted by letter via the headteacher to explain the purpose of the study. A consent form was enclosed. 58 out of a possible 180 subjects agreed to participate. These subjects were then matched with DMD boys on the basis of age and year in school. These subjects attended a 90 minute scheduled session during the school day to complete the measures.

**Data Analysis** - All data was collated, stored and analysed using the SPSS/PC Statistical Package.

**RESULTS**

The age characteristics for both groups were normally distributed, for the DMD Group (N = 20) (M 11.70 S.D. 3.23) and for the Control Group (N = 58) (M 11.84 S.D. 3.18).

All data was examined by the use of histograms for normality and met the assumptions required for parametric tests. A t-test for unrelated samples was selected to assess the differences between group means on the different psychological variables.

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INSERT TABLE 1  
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Table 1 indicates that there were significant differences between group means. Depression was highly significant at the  $p<0.001$  level ( $t = -3.67$ , d.f. 76, two-tailed). Self esteem was also highly significant at the  $p<0.001$  level ( $t = 4.21$ , d.f. 76, two-tailed). These results support the hypothesis that there are differences between the two groups and indicate that the DMD group have higher depression and lower self-esteem scores. There was not enough evidence to suggest a difference for the other 2 variables and these results remain inconclusive. This may be due to the small sample size.

A scatter plot matrix was generated for all variables in both groups and linear relationships for psychological variables were revealed in the DMD group. These variables are continuous and therefore a parametric measure of association was selected to measure the associations between each group and the variables (Pearson Product Moment Correlation Co-efficient).

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INSERT TABLE 2  
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Table 2 indicates that in the DMD group depression and trait anxiety were positively correlated, ( $r = .424$ ,  $p < 0.031$  one-tailed) as were state anxiety and Trait anxiety ( $r = .636$ ,  $p < 0.001$ , one-tailed). Negative correlations were found between depression and self-esteem, ( $r = -.589$ ;  $p < 0.003$ ; one-tailed) and self-esteem and state anxiety ( $r = -.674$ ;  $p < 0.001$ ; one-tailed). This suggests an association between depression and both anxiety types and that low self-esteem is associated with high levels of depression and anxiety.

These statistically significant associations do not in themselves provide direct evidence of a causal relationship between the variables concerned.

In the control group positive correlations were found between self-esteem and age ( $r = .408$ ;  $p < .001$ ; one-tailed), depression and state anxiety ( $r = .323$ ;  $p < 0.007$  one-tailed), depression and trait anxiety ( $r = .363$ ;  $p < 0.003$  one-tailed), trait anxiety and age ( $r = .031$ ;  $p < 0.406$  one-tailed). Negative correlations were identified between depression and age ( $r = -.467$ ;  $p < 0.001$  one-tailed) and depression and self-esteem ( $r = -.686$ ;  $p < 0.001$  one-tailed). These results indicate a consistent association between variables in this group. Depression scores appear lower with age while self-esteem rises with age. It is of note that the linear association between age and psychological variables was not found within the DMD Group.

Projective Test

The data was examined by the use of histograms for normality and met the assumptions required for parametric tests. A t-test for unrelated samples was selected to assess differences between group means.

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INSERT TABLE 3  
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Table 3 indicates that there were significant differences between group means. The results were highly significant at the  $p<0.001$  level ( $t = -5.27$ , d.f. 76; two-tailed). This supports the hypothesis that there is a difference between the two group scores and that the DMD group score higher on illness related anxieties. A scatterplot revealed a linear relationship between total score and age, using the Pearson Product Moment Correlation Coefficient, a positive correlation was identified between age and total score ( $r = .304$ ;  $p<0.01$ ; one-tailed). This suggests an association between these two variables and provides support for the hypothesis.

Family Communication

A one-way analysis of variance (ANOVA) was used to compare the 5 separate types of family communication and the projective test scores. The communication style of the family was not significant ( $F = 1.116$ ;  $p>0.237$ ; two-tailed). However, results may be affected by the large number in the group catergorised as using "Ignorant" type of communication ( $n = 13$ ) as compared to the group using "Closed" type of communication ( $n = 1$ ). Hence, there is insufficient evidence to suggest that there is a difference between the groups.

**Table 1 Means, Standard Deviations, T-test Values, Degrees of Freedom and P-Values for all Psychological measures in the DMD and the Control Group**

Measure	DMD (N=20)		Control (N=58)		T-test Value	D.F.	P Value
CDI	M	S.D.	M	S.D.			
Total Score	12.60	5.87	6.93	6.20	-3.67*	76	.001
S.E.	62.80	10.90	75.20	12.63	4.21*	76	.001
Total Score	30.95	4.03	29.00	3.15	-1.97 ns	76	.060
T.A.	33.35	4.29	31.24	4.88	-1.83 ns	76	.076
Total Score							

Key: CDI: Childrens Depression Inventory, S.E.: Coopersmith Self-Esteem Inventory, S.A.: State Anxiety, T.A.: Trait Anxiety

\* Significant at p< .001

ns not significant

Table 2            Correlations (Pearsons r) among variables in DMD Group

Variable	<u>Age</u>	<u>CDI</u>	<u>S.A.</u>	<u>T.A.</u>	<u>S.E.</u>
<u>Age</u>	1.000				
<u>CDI</u>	-.053	1.000			
<u>S.A.</u>	-.280	.347	1.000		
<u>T.A.</u>	-.159	.424*	.636**	1.000	
<u>S.E.</u>	-.040	-.589***	-.674**	-.541	1.000

Key: CDI: Children's Depression Inventory; S.E.: Coopersmith Self-Esteem Inventory; S.A.: State Anxiety; T.A.: Trait Anxiety.

- \*    p   at   <0.031
- \*\*       <0.001
- \*\*\*     <0.003

Table 3

T-Test for Independent Samples for Projective Test Scores for the DMD

Group and the Control Group

DMD		Control				
(N = 20)		(n = 58)				
M	SD	M	SD	T-test Value	DF	P. Value
19.00	3.33	9.68	7.65	-5.27*	76	0.001

Key:- \* denotes significant at p<.001

## DISCUSSION

Although psychological aspects of DMD children and adolescents have been described, little quantitative data exists to document their problems in comparison with properly matched controls. This study provides an empirical data base from which to guide theory and clinical intervention.

The data supports the hypothesis that children with DMD differ from a control group on self-report psychological measures and also that they express more illness related concerns. These findings add to the literature which has documented greater risks of such problems in children with neurologically based conditions (Breslau 1985, Howe 1993). The psychological difficulties most prominent were depression (mild range), <sup>certain measures of</sup> anxiety and low self-esteem. This accords with other research in DMD child adjustment (Fitzpatrick 1986, Witte 1985). Relationships were identified between variables within the DMD group. These results are similar to those found in both chronically ill and disabled children and adolescents (Boyle 1976, Arnold and Chapman 1992). Previous research has suggested associations between age and psychological status within the DMD group (Buchanan 1979, Taft 1973), however, no empirical support was identified in this study. The data suggests that as a group, the DMD <sup>certain measures of</sup> children have a homogenous presentation of anxiety, depression and low self-esteem.

It is reasonable to assume that relative to their peers, DMD children share a variety of additional stressors relating to DMD, i.e. progressive physical weakness, treatment regimes and interrupted schooling (Clafin 1991), and this may explain the anxiety levels which are present in the group. The literature concerning physically handicapped children has indicated social adjustment is related to both anxiety and self-esteem (Sinemma 1992). Social adjustment measures are derived from involvement in organised clubs, activities, hobbies, peer



interactions, school performance and feelings of self-worth (Varni and Wallander 1991). Several of these components are compromised by the physical disability imposed by DMD, furthermore, special efforts from the family are needed to maintain these (e.g. transportation, increased time). It is of note that the disruptions implicated in the lack of socialisation, lack of autonomy and perceived negative body image are involved in the development of low self-esteem (Coopersmith 1982). Further, the literature suggests that low self-esteem is a associated factor in the generation of depressive feelings (Milvac 1985). These factors then can be viewed largely as a result of the DMD boys disability on his social and environmental milieu.

The finding that the DMD group scored higher on the projective test accords with both Waecher (1968, 1971) and Spinetta (1981) who found that fatally ill children express more illness related anxieties than healthy children. In addition, a relationship was found between age and scores on this test. This accords with Chesler (1986) who found associations between age and illness concerns in fatally ill children. However, it may be that the DMD child scores are not age related per se, but reflect the progressive as well as the cumulative effects of the disease.

There was not enough evidence to relate family communication type with the projective test score in this study. This may be due to the small numbers of families who discussed (5 %) or acknowledged (10 %) their child's illness with him. These findings are similar to Madorsky (1983) and Fitzpatrick (1986) and may be typical for DMD families. However, it is of note that the majority of children with high illness anxiety scores were those children who were from families with "Ignorant" or "Prevented" communication types, (75%). This suggests that this type of communication may not be entirely effective in preventing illness anxieties.

The results are representative of a volunteer sample, as not all DMD or healthy children who met the inclusion criteria consented to participate. As such then, the data set may be subject to bias. The study was limited in a number of other respects, i.e. the study was of cross-sectional design and as such is insensitive to changes over time that can occur for a child and family. The concurrently observed relationships therefore cannot be interpreted to suggest causal directions. Longitudinal studies should now follow to investigate both causation among the variables and to examine their developmental implications. Another limitation was that the small sample size (<30) subsequently restricted the power of analysis.

The study was based on a singular perspective, that of the children and no independent verification was sought and as such the findings may be subject to bias. In addition, the measures used included some items which may have different meanings for DMD children e.g. somatic concerns which are often part of DMD and so some scores may be artificially inflated.

The use of projective tests is always controversial, and while the story telling methods yielded data on anxieties or threat the scoring was largely subjective and whether they specifically relate to DMD remains speculative. There is a need for sharper operational definitions of the components of illness anxieties and their relationships.

However, even with these limitations the present study has a valuable contribution to make to clinical management and research implications in DMD children and adolescents.

The presence of anxiety, depression and low self-esteem in the DMD group makes these salient targets for clinical intervention to remedy these and the social isolation which appears a

key feature of the disease. DMD children may benefit from social activity programmes to reduce this isolation while providing opportunities to learn and practice interpersonal skills within a supportive environment. In addition resources and coping abilities should be strengthened via the use of cognitive behavioural approaches in specific and preventative training to improve and maintain the social competence of children and adolescents with DMD.

Clinical management within the family should begin by the encouragement of discussion regarding disease perceptions and illness expectations. Ongoing contact with the entire family may be required to facilitate communication and assess family functioning.

While the results of this study suggest that DMD is a "risk factor", only a proportion of these children experience severe psychological problems. It is now necessary to try to identify which specific features of DMD expose a child to greater risk and if indeed, some features operate to modify the adverse effects. Additionally, it may be fruitful to study how family factors interact with other factors to influence child adjustment. In communication issues particularly, it is necessary to identify which specific factors affect how parents decide upon the type used and which of these factors affect family and child adjustment.

Such advancement in knowledge would enable clinical and research work to become more integrated and would facilitate the development of effective service provision.

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**SINGLE CLINICAL CASE RESEARCH STUDY**

# **THE COGNITIVE-BEHAVIOURAL TREATMENT OF EXHIBITIONIST BEHAVIOUR : A CASE STUDY**

**Selected Journal : Journal of Forensic Psychiatry (Appendix 3.1)**

## ABSTRACT

This paper presents a single case study of the treatment of exhibitionism in a 32 year old man. The subject was treated using behavioural and cognitive techniques, and progress was evaluated using a single subject design. The findings revealed that the intervention succeeded in reducing the urges to offend and that <sup>no</sup> actual offence behaviour was reported during treatment. Follow-up interviews were defaulted so no information was available to demonstrate that these improvements persisted. The results suggested that the cognitive-behavioural treatment package could provide a useful method for the treatment of exhibitionism. Recommendations for future research are made.

## INTRODUCTION

The American Psychiatric Association Diagnostic and Statistical Manual (DSMIV) (American Association 1994) distinguishes sexual deviation as a separate category of mental illness, and the subclassifications of specific paraphilia include exhibitionism. In a review of the paraphilia literature, Snaith (1981) identified the wide varieties of phenomena and background features which exist among exhibitionists. Other researchers (Thornton 1993) have concluded that exhibitionism is not a unitary disorder with an unvarying aetiology and stereotyped behaviour pattern.

Treatment procedures used have included Aversion therapy (Rooth and Marks 1974) and Shame therapy (Serber 1970), and the results are inconclusive. This may be due to the varying methodological quality.

The most extensive and successful treatment research with exhibitionists to date has been carried out by Maletzky (1977) using a procedure termed Assisted Covert Sensitisation. Although behavioural approaches have been the most prominent in the treatment of exhibitionists they do not consider individual variability, environmental or cognitive factors.

The development and interest in the cognitive therapies over the past decade have as yet made little impact on the literature on the treatment of exhibitionism. This is surprising as general research in the treatment of sex offenders has broadened from behavioural approaches to include cognitive issues and evidence suggests that cognitive - behavioural sex offender treatment programmes are effective (Maletzky 1991, Marshall and Barbaree 1990, Perkins 1987). The assessment of motivation (Briggs 1994) cognitive distortions of denial and

minimisation (Salter 1988) and relapse prevention concepts (Pithers 1990) are becoming a central part of new treatment programmes (e.g. Directorate of Inmate programmes 1991). These programmes are usually employed in group work with varied typologies of sexual offenders within institutional settings.

To date, no empirical work nor case study has described treatment with individual exhibitionists using a cognitive-behavioural approach. This is surprising given the recommendations for individualised multifaceted therapy recommended by Snaith (1981).

This shorter research report presents an individualised intervention package comprised of cognitive-behavioural approaches in the treatment of an exhibitionist offender.

## **METHOD**

### **Subject and Case History**

W was a 32 year old man, married with a young son aged 3. He had been convicted of shameless indecency and was incarcerated for 6 weeks. On his liberation, he was referred by his G.P. "to address his offending behaviour".

W described a 15 year history of exposing himself while masturbating in front of post-pubescent females. This usually took place in his car. This behaviour began at age 17 in front of female peers. He said he became a habitual exhibitionist at this age by his own estimation exposing himself once a week. At the time of the present offence he claimed to have been free of such incidents since his previous charges in 1992. He denied having preplanned any of his offences.

He reported having had a happy stable family life and said that he related well to all female family members. No difficulties were identified with friends of either sex. His description of psychosexual development provided little of significance.

He described his marriage as “normal and happy” and his accounts of masturbation fantasies and marital sexual practices were unremarkable. Mr W had seen two different psychiatrists since 1989 and claimed to have had little treatment offered. It is of note that his referrals were on the advice of his solicitor.

He stated that his present wish to address his behaviour resulted from his wife's threat to divorce him should he offend again. He described feeling "ashamed" of his behaviour but his demeanour displayed a limited degree of seriousness.

### **COGNITIVE - BEHAVIOURAL INTERVENTION**

The cognitive-behavioural intervention package carried out by the author consisted of 14 weekly sessions of 1 - 1½ hours. On the basis of clinical interview a number of goals were set as follows:- Monitoring of urges to offend and instances where he had done so, establishing motivational grounds for treatment, identifying and confronting cognitive distortions, aversive counter-conditioning to offence behaviour and relapse prevention for maintenance of any change.



## **METHOD**

### **Self - Monitoring**

W was asked to keep a weekly diary to record urges to offend and instances where he had done so. (Appendix 3.2)

### **Motivational Interviewing**

To establish sufficient motivational grounds for treatment, a non-confrontational approach was adopted to clarify the commitment to change (Briggs 1994). The main components used were negation and the creation of cognitive dissonance. (Appendix 3.3)

### **Cognitive Distortions**

The cognitive distortions of denial and minimisation of offence behaviour can prevent further progress in treatment. These factors were accessed through Mr W's accounts of his exhibitionist behaviour. These were then challenged through rational argument and socratic questioning.

### **Assisted Covert Sensitisation**

This procedure aimed to reduce the arousal potential of particular images or thoughts. W was asked to describe scenes relevant to his urge to offend, and note when he was becoming aroused. Immediately following this he was instructed to imagine unpleasant consequences. His experiences in prison were particularly emotive and were thus selected. Emphasis was placed on the use of negative imagined consequences for arousal and positive consequences for imagined alternatives to arousal and offence behaviour.

### **Relapse Prevention**

In order to consolidate any treatment gains relapse prevention in the form of a cognitive-behavioural model for maintenance of change was introduced.

### **PROCEDURE**

The treatment was conducted according to an AB design, where A represents the baseline phase and B the intervention phase.

#### **Phase 1: Baseline**

After the initial interview, Mr W was asked to record urges to offend and instances where he had done so for a period of four weeks.

#### **Phase 2: Cognitive Behavioural Intervention**

This second phase consisted of 10 sessions of the intervention package as described. On the 10th session Mr W was asked to attend for a 3 month follow-up appointment to provide ongoing information about treatment effects.

**RESULTS**

The results were analysed for each targeted problem area.

**Urges to Offend/Offence Behaviour**

(figure 1) During the first phase, W reported an urge to offend 3 - 4 times per week. The change began after the first week of the intervention and continued throughout treatment, stabilising between 0 and 1. No actual offence behaviours were recorded.

-----  
INSERT FIGURE 1  
-----

**Motivation**

Mr W's replies to similar questions used in the initial interview were compared. He said that he now wished to progress in treatment since he now saw more clearly the options available to him without.

**Cognitive Distortions**

From minimising, he admitted the extent of his urges to offend but denied their seriousness. He then began to accept the importance of his urges to his offence behaviour but denied responsibility. Finally he admitted having conscious control over his behaviour rather than claiming it occurred "out of the blue".

**Relapse Prevention**

Mr W defaulted all follow-up appointments offered therefore no information is available about the ongoing effects of tretment.

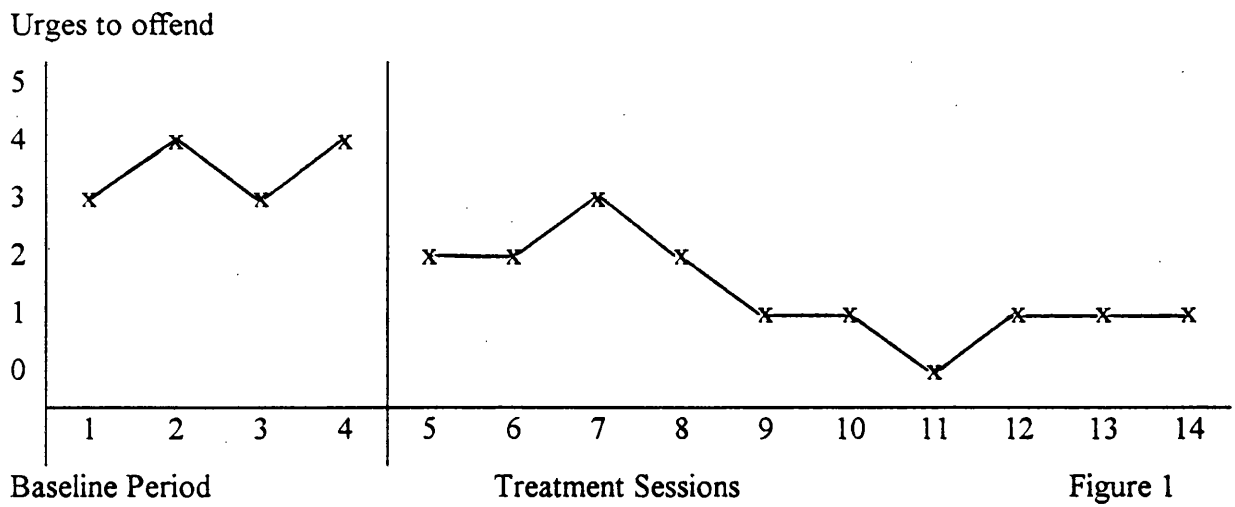


Figure 1 : Rating of Urges to Offend in Baseline Period and Treatment Sessions

## DISCUSSION

The cognitive-behavioural intervention in this case was developed on the basis of the subjects unique needs. Following quickly after the introduction of treatment the recorded rate of urges to offend reduced as compared to the baseline period. The subject also claimed that he had not exposed himself during this time.

It is difficult to say which aspects of treatment were important as the design was of the simplest AB kind. The author believes that the addressing of both cognitive and behavioural factors were essential for success, however, it is difficult to rule out that social/legal pressures, passage of time, therapist variables or other non-specific aspects also were important. The subject himself considered that noting exactly when he was aroused and knowing how to replace urges to indulge in offence behaviour with alternatives were equally important. The addition of positive consequences for imagined alternatives to offence behaviour were considered to be useful adjuncts by both subjects and author. Ultimately, future single and group subject research will provide further information on components of successful treatment.

It is hoped that this single research study will draw more attention not only to the problem of exhibitionism but also to the need for individualised assessment and management. The assessment of exhibitionist behaviour presented some difficulties, and the reliance on personal diary keeping means that the subject can underreport his offence behaviour. In addition, it was difficult to objectively define cognitive distortions although their presence was recognised and challenged through treatment. This also meant that any cognitive changes which did take place could not be validated via more objective measures. Finally, the subjects defaulted follow-up appointments made any kind of measurement of treatment effects impossible.

The potential for a multiplicity of treatment techniques is illustrated in the intervention package used . This author considered that cognitive procedures played a key role in treatment, and it appears to be addressing motivation and cognitive distortions should be an important part of any treatment procedure with exhibitionist offenders.

The presence of masturbatory fantasies is considered to be central to both the creation and maintenance of exhibitionst behaviour. These were difficult to address during treatment due to Mr W's vehement denial of their presence. Future research should address the assessment and management of these factors.

Non-attendance on follow-up appointments was a pertinent issue in this study and the issues which surround defaulted attendance by sex offenders under-researched areas. Clearly, there is a need for more information and consideration of enhanced external supervision following treatment. This is particularly important as the period after discharge is characterised by the highest recidivism rate for sex offenders (Jackson 1994)

Increased cognisance of these factors is central to advance both current research and future treatment of exhibitionists.

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# **SINGLE CLINICAL CASE RESEARCH STUDY**

**TREATMENT PROCEDURE AND OUTCOME  
FOLLOWING ASSESSMENT AND FORMULATION IN  
AN ELDERLY CLIENT-THEORETICAL AND  
PRACTICAL ISSUES**

**Selected Journal : British Journal of Clinical Psychology (Brief Reports Section)  
(Appendix 4)**

## **ABSTRACT**

This study highlights the importance of a thorough psychological assessment and formulation as the basis for treatment and management of a 77 year old client. Treatment procedures and outcomes are evaluated and the theoretical and practical implications for Clinical Psychologists working with the elderly are discussed.

Approximately 6% of the population aged over 65 years suffer from a moderate or severe dementia (Fraser 1987). The majority of these people are cared for in the community by family and friends (Gilhooly 1986) and research provides evidence that many carers experience significant levels of distress (Matson 1994). The clinical psychologist's role in health service provision for the elderly has traditionally been psychometric assessment. This role has now increased and expanded to include the treatment and management of the problems of the elderly and those who care for them. Assessment however, remains an important method of raising and testing hypotheses from a theoretical basis, and any practical treatment programme must be founded on both careful assessment and formulation (Woods 1992).

Salkovskis (1984) has suggested that the use of single case methodology is particularly useful for research in clinical settings. Clearly, any psychological treatment approach is unlikely to fulfil its potential if implementation is rote and impersonal. In the elderly population practically, the use of single-case methodology is often necessary by the fact that individuals with the same diagnosis often have different patterns and behaviours and neurological function. A major advantage of this single case approach is that it can be deliberately idiographic i.e., take the client personally into account.

This paper demonstrates an evaluation of the treatment procedure and outcome which were derived from a neuropsychological assessment

formulation of an elderly client, MW (Appendix 4.2 for an extended report). In summary, MW is a 77 year old woman who has been widowed 3 months. Since the death of her husband she has attended a day hospital for 2 days a week and her daughters have begun to provide intensive domiciliary support. They frequently contact the emergency services with various concerns about their mother. It was considered that careful management of her case would reduce these contacts.

On assessment, MW was found to be in the early stages of dementing process and was also mildly depressed. Treatment was developed on the basis of this and in 3 key areas :- individual intervention, family intervention and co-ordination of other services. Each procedure and its outcome will be discussed in turn.

MW received 7 treatment sessions and 1 follow-up session. In view of her cognitive difficulties, a behavioural approach was adopted for treatment of her depression (Gugel 1994). MW was encouraged to identify activities which she found pleasant and increased her participation in these. In addition to treatment sessions, nursing staff were instructed to initiate contact with her and also to include her in the daily social activities programme at the Day Hospital. These procedures were written into her Care Plan.

An adapted form of grief therapy was used to encourage MW to express and share her feelings about the loss of her husband (Perkins 1992). Carers and nursing staff were advised on this approach.

At one month follow-up, both MW and staff reported a significant increase in the amount and type of activities in which she participated. There was also a reported reduction in her agitation and wandering behaviour. Although not targeted directly, it is likely that her increased activities had an impact on these behaviours. MW's score on the Geriatric Depression Scale (Yesavage 1982) reduced to 10, placing her within the normal range.

These outcomes provide support for the theory that introduction of activities can help alleviate depressed mood and some problem behaviours in the elderly (Gilhooly 1986). In addressing bereavement issues, it appears that an individualised and flexible approach consistently followed by all involved with MW was most appropriate in allowing her to express her grief. This accords with Parkes (1992), who found that not all bereaved elderly clients require intensive formalised treatment.

At presentation, MW's daughters scored 10 and 8 respectively on the 30 item General Health Questionnaire (Goldberg 1978). They received 4 treatment sessions and 1 follow-up session. Treatment involved education on the presentation and prognosis of dementia, instruction in behavioural techniques for targeted behaviours, and anxiety management training. A

problem solving approach was adopted to maximise support from formal and informal contacts. No contact with the emergency services was made during this period. The daughters reported that the education and training they had received was of benefit in coping with their mother's behaviours and their own stress. At one month follow-up their scores on the GHQ were 8 and 6 respectively, this was a slight decrease but both scores reflect elevated rates of psychiatric morbidity. However, the long-term effects of such interventions are not usually immediately apparent and may have a preventive or delayed impact (Matson 1994).

The author initiated input from other health care professionals such as O.T. for a home assessment and installation of appropriate home safety devices and memory aids.

Provision of other supports from a variety of social services was also co-ordinated e.g. home help, meals on wheels, sitter service. These were selected on the basis of the assessment and interviews with the different parties and again were written into her Care Plan. The input from these services reduced MW's reliance of her daughters, and prolonged her independence in her own home. The daughters reported a subjective reduction in their burdens.

This case study presented an opportunity to investigate a treatment package which had been derived from a previous assessment and to measure the



effectiveness of the chosen treatment/management procedures by their real impact on client, carers and other professionals. Through relevant data sets and qualitative measures it is reasonable to conclude that worthwhile short-term changes in behaviours were possible and that the simplicity of the treatments involved may even make such interventions cost-effective. A 6 month follow-up will yield more information on whether these changes can be maintained and also if the identified needs are still met.

In this case, the Clinical Psychologist adopted a variety of roles - neuropsychological assessment, behaviour therapy, grief therapy, behavioural modification training, anxiety management training, consulting and co-ordination of services. It is this diversity of roles which present exciting theoretical and practical challenges to the Clinical Psychologist in working with the elderly.

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# **SINGLE CLINICAL CASE RESEARCH STUDY**

# **INTERVENTION PACKAGE FOR TREATING ADHD IN A 9 YEAR OLD GIRL : A CASE STUDY**

**Selected Journal : Clinical Child Psychology and Psychiatry (Appendix 5.1)**

## **ABSTRACT**

This paper presents a single case study of the treatment of Attention Deficit Hyperactivity Disorder (ADHD) in a 9 year old girl. The child had behavioural problems of a long-standing nature which were prevalent across different settings. Particular problems identified were in the areas of attention, impulse control and regulation of activity. The subject was treated using a comprehensive package of behavioural and cognitive techniques and the progress was evaluated using a single subject design. The findings revealed improvements in all areas at two month follow-up interview. The results suggested that the intervention package constituted an effective treatment for ADHD symptoms.

**Key Words:-** Attention Deficit Hyperactivity Disorder (ADHD), cognitive - behavioural techniques, single subject design, intervention package.

## **INTRODUCTION**

Attention Deficit Hyperactivity Disorder (ADHD) is the most recent term for a specific developmental disorder of both children and adolescents (Barkley 1991). Definitions and requirements for diagnosis have varied throughout the history of the disorder and the currently accepted criteria is advanced in DSMIV. The specifications reflect research findings that the disorder has a significant range of expressional and situational variation.

It is estimated that 3-5% of the population are affected by ADHD, the majority being males at a ratio of 3:1. The peak age for referral is between the ages of 8 and 10 years. ADHD children typically have chronic difficulties in the areas of attention, impulsivity and over-activity. These are prevalent across a variety of situations and the disorder typically follows a chronic course with most children displaying characteristics into young adulthood (Weiss 1979). Various aetiological theories have been offered for disturbed motor and attentional behaviours, but the cause or causes remain unknown. In a review of the literature Barkley (1990) concluded that although all theories are speculative there is evidence of a strong biological basis. This may be associated with a genetic disorder, birth complications or as a direct result of damage to the central nervous system.

Treatment requires a comprehensive assessment of the child integrated with a knowledge of developmental principles. Assessment can be difficult in view of the situational specificity of the disorder and many ADHD children who present badly at school, and/or at home can show exemplary behaviour during the clinical interview. Although all children can show fluctuations in their behaviour, ADHD children appear to be more deviant than their peers in levels of activity, impulsivity and disinhibited behaviour (Barkley 1990). In noting the paucity of

assessment tools in this area, Barkley and Du Paul (1990) developed a battery which measures these behaviours and situations where they occur. All tests provide age and sex normative data. It is recommended they be used in combination to assess the range of problem areas and behaviours displayed. Typically, ADHD children rate 1.5 standard deviations above the mean for their age and sex according to the normative data provided by these scales.

Observations of ADHD children have also been used for assessment purposes, Douglas (1980) suggested that hyperactive behaviours can be conceived of as operants and that treatment should address the high rates of unacceptable behaviours identified by strengthening incompatible but socially acceptable alternatives. This view has strongly influenced current multidimensional approaches. These restrict the child's environment by providing control eliciting stimuli by the involvement of persons who usually dispense rewards and punishments.

In school settings, behaviour therapy methods have been used to reduce activity levels and increase on-task behaviour (Ayllon et al 1975). Beneficial changes in a direction away from disruptive behaviour, poor co-operation with peers and poor attention through the use of reinforcement of desired behaviours were reported by O'Leary (1977). Zentall (1979) has also drawn attention to the importance of the timing of tasks and of the physical environment in preventing symptom presentation.

The treatment literature presents preliminary support for the use of parent training (Douglas 1980). Barkley (1980) developed a parental training and counselling programme specifically for children with ADHD and the guiding principles were to increase knowledge and to provide supervision in the use of specialised contingency management techniques. Home based contingency programmes have also been used to modify a wide range of problems at school,

e.g. Du Paul (1990) used a report card system where teachers monitored and rated specified classroom behaviours. Ratings were converted into token gains or losses proportionally. It is apparent that the effectiveness of any behavioural approach depends equally on an accurate assessment of behaviour and consistent contingent consequences.

Cognitive approaches have become an additional treatment focus in ADHD (Kendall 1984, Malik 1993). Skills such as self-monitoring and self-reinforcement have been used to improve maintenance of gains from behavioural programmes and to prompt appropriate behaviour in different settings. Rapport (1987) in a review of the literature stated that at best results of cognitive approaches are equivocal and their effects are not as strong or as generalizable as expected.

Treatment for ADHD via pharmacological agents has caused controversy with enthusiasts both for and against (Barkley 1987, Schrag and Divoky 1985). Current opinion in the UK is that drugs should be administered on a trial basis only if symptoms are severe enough to prevent psychological approaches from working on their own.

The issues raised here have important clinical implications in ADHD. It is clear that treatment must be guided by a thorough development, behavioural, psychological and educational assessments.

This case study describes the development, application and evaluation of a cognitive - behavioural intervention package designed to meet the needs of a child with ADHD.



## **METHOD**

### **Subject and Case History**

Y, the subject was a 9 year old girl referred to the Clinical Psychology Service by her family G.P. following parental concern about her behaviours.

Y was an only child, living with both parents. Her mother reported a healthy planned pregnancy and all developmental milestones were achieved at typical ages. Y was reported to have had problem behaviours across a variety of situations since the age of 5. In the home situation, she had difficulties in sustaining attention to tasks and displayed inconsistencies in following instructions. Chores were performed swiftly and accurately on some days, "slow and sloppy" on others. In addition Y shifted her activities constantly and frequently lost things.

Y presented as a polite young lady who spoke with a pronounced lisp. She was fidgety during interview, although not overly active and was distractable to visual and auditory stimuli. She said that she wanted to do better in school and that she could do this "by behaving".

Y's teacher described her as displaying marked inattention relative to other girls of her age. Particular difficulties were in sustaining attention to tasks, and in independent school work. She was described as "unable to concentrate" and "doesn't seem to listen". She was said to respond quickly to situations without waiting for instructions and also to blurt out answers to questions prematurely.

## **Measures**

### **Parents:**

Parents completed the ADHD Rating Scale (Du Paul 1990) (Appendix 5.2). This scale has 14 items describing ADHD symptoms. Items are rated on 4 point scale where (0) not at all to (3) very much. Items rated as 1 and above were summed to obtain a total score.

The Home Situations Questionnaire - Revised (HSQ (Du Paul 1990) (Appendix 5.3) was also completed. This identified specific problem settings and consists of 14 items. Items were rated as yes/no and on severity where (1) mild - (9) severe. Two scores were obtained, number of problem settings and mean severity.

### **School:**

The class teacher completed the School Situations Questionnaire - Revised (SSQ-R) (Du Paul 1990) (Appendix 5.4). This identifies settings where minor disruptive behaviours are present and consists of 8 items. Items were rated as yes/no and on severity where (1) mild - (9) severe. Two scores were obtained, the number of problem settings and mean severity.

All instruments have normative means and standard deviations by age and sex provided by the authors. In all instruments Ys score exceeded 1.5 standard deviations above the mean for her age and sex. These were all clinically significant scores.

### **In-School Observations:**

The author used the Restricted Academic Situation Coding Sheet (Barkley 1991) (Appendix 5.5) to observe Ys behaviour during maths problems. This was coded every 40 seconds for a total of fifteen minutes. For each interval the therapist scored any of five possible behaviours

1) Off-task 2) Fidgeting 3) Vocalisation 4) Plays with objects 5) Out of seat. The raw score of each behaviour was devised by counting the number of checks in that category divided by 40.

### **Cognitive - Behavioural Intervention**

On the basis of interview and assessment Y's major problems were difficulties in sustaining attention, poor impulse control and inability to regulate activity level to situational demands. These were present across a variety of situations. The aim of treatment was to develop a clear consistent system of behavioural management between the home and the school. The intervention package carried out by the author consisted of 6 1 hour sessions held fortnightly with Y and her parents, weekly contact with her school, plus one follow-up appointment 2 months later. The procedures employed are described below:-

### **SCHOOL**

#### **Environmental:**

Y's desk was moved away from other children to an area closer to her teacher. This reduced her access to peer reinforcement of her disruptive behaviour and allowed her other behaviours to be monitored more systematically.

#### **Scholastic:**

In her view of the progressive worsening of ADHD children's activity level and inattentiveness over the course of a day, academic subjects were scheduled in the mornings whenever possible. These were to be brief, accommodated to her attention span and feedback on accuracy was to be immediate and specific. Y was also encouraged in the use of her 5 step plan (below).

### **Immediate Positive Reinforcement:**

Emphasis was given to the reward of appropriate behaviour immediately. This was by praise, nods and smiles and statements supporting the behaviour.

### **Removal of Attention:**

Minor disruptive behaviour was ignored. If reprimands were considered necessary these were short and explicit. If several reprimands were needed these were backed up with the loss of a pleasant activity with clear explanation.

### **Diary Report Card:**

Home based programmes are effective in modifying behaviour problems at school. Central to Ys treatment plan was the provision of contingencies based on a daily school report card (Barkley 1991) (Appendix 5.6). Target behaviours were based on classroom behavioural observations. These were completion of work, staying in seat and following instructions. Appropriate behaviours were supported by praise. A special activity for 10 minutes was provided if she achieved all target behaviours. The daily report card was completed by the teacher and sent home with ratings of 'excellent', 'very good', 'good', 'fair', 'poor' and also a space for comments.

These techniques were used to aid the teacher to shift his focus of attention from unwanted behaviour to desired behaviour. By the reinforcement of success the aim was for Y to seek further success.

## **PARENTS**

### **Education:**

Ys parents were provided with education on the aetiology and presentation and of ADHD. The parents were advised on contingency management techniques. Training was provided on methods to communicate demands and the explanation of acceptable and unacceptable behaviours were also discussed.

### **Immediate Positive Reinforcement:**

Emphasis was placed on the immediate reward of appropriate behaviour e.g., following a job through. Praise, nods, smiles were given with statements supporting that behaviour.

### **Removal of Attention:**

Minor behaviour disturbances were ignored. If reprimands were considered necessary these were short and explicit. If several reprimands were used these were backed up by the loss of a special activity with clear explanation.

### **Daily Report Cards:**

The success of the school management programme required a clear system of translating daily reports into consequences at home. Home based management methods relied on teacher's reports of target behaviours. Daily and weekly rewards were negotiated with Y contingent on these reports as were additional response costs.

**Cognitive Techniques:- Y**

Individual sessions with Y addressed self-regulation difficulties at school. This was achieved through the use of scholastic type tasks and modelling procedures to demonstrate cognitive strategies. The aim was to teach problem solving skills, problem recognition, reflection, decision making and action. Self-help statements used were written down by Y to provide a personal thinking strategy. This she called "my 5 Step Plan" and is as follows:-

- 1. What do I have to do?
- 2. What way?
- 3. I better concentrate on what I'm doing
- 4. What answer have I to put down?
- 5. This time I've done well/How can I keep it up?

This list was kept beside her work to keep focused on her scholastic work and the teacher encouraged its use.

**RESULTS**

At 2 month follow-up appointments all instruments were re-administered and the results are presented in table 1.

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INSERT TABLE 1  
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The ADHD rating scale identified 14 symptoms, a reduction of 4. This remains a clinically significant score. The HSQ-R identified 9 symptoms, a reduction of 4. The severity rating remained constant. Scores remain deviant according to this scale. The SSQ-R identified 4

problem settings, a reduction of 2. There was an improvement in severity rating from 4 to 3. While the number of problem settings is deviant according to this scale, the severity ratings are not.

Table 1: Subject Scores on all Measures used at Pre-Treatment and at Follow-Up			
Measure	Norms by Age 9, Sex F	Pre-Treatment	Follow-Up
ADHD Rating Scale	(n = 94) M 11.23 SD 9.27	18	14
HSQ - R No of Problem Settings Mean Severity	(n = 52) M 4.62 SD 4.41 M 3.16 SD 1.81	13  5	9  5
SSQ - R No of Problem Settings Mean Severity	(n = 78) M 2.79 SD 3.13 M 3.18 SD 1.72	6  4	4  3

Key: ADHD - Attention Hyperactivity Disorder Scale; HSQ - R, Home and School Situations Questionnaire Revised; SSQR; School Situations Questionnaire Revised.



**Table 2      Restricted Academic Situation Coding for Subject at Pre-Treatment and  
at Follow-Up**

<u>Behaviour</u>	<u>Pre-Treatment</u>	<u>Follow-Up</u>
Off-task	28/40	20/40
Fidgeting	21/40	12/40
Vocalising	20/40	18/40
Plays with object	3/40	5/40
Out of seat	32/40	18/40
	Total 104/200	Total 73/200

Another in-school observation was carried out at the same time (Table 2). This noted a drop of 31 behaviour points from the pre-treatment score.

This noted a drop of 31 behaviour points from the pre-treatment score. Identified improvements were in the target areas of off-task behaviour, fidgeting and out of seat.

### **Interviews:**

Ys school reported improvements in both attention and self-regulation behaviours. Her work had improved in quality and Y was considered to be more effective in following instructions through. Y reported using her 5 step plan "in my head a lot" and said that it helped her to do her school work. She reported being happier in school and that she enjoyed "being good". She had been presented with an achievement award at the school assembly for her progress. Ys parents reported improvements in attention and impulse control and said that she was "much better" at following tasks through. They were satisfied with using the daily report card as the basis for their management of behaviour.

### **DISCUSSION**

While most data remained outwith the norms for age and sex there were improvements in most areas of the child's behaviour. After the introduction of multiple treatment techniques the child began to exhibit more appropriate behaviours in sustaining attention and impulse control. Regulation of activity was reported to be slower to change. This possibly reflects on the time taken for the child's family and school to learn new habits and for these to become fully effective and established. The author believes that a clear consistent system of behaviour management between the home and the school was central to treatment. Both parties agreed that knowing exactly with to do and how to act were important and this ensured a uniformity

of approach between them. In addition, this made the child globally aware of acceptable and unacceptable behaviours. In individual work with the child, problem solving skills which specifically addressed "self-talk" were important reinforcements to self-regulatory behaviour. Passage of time, therapist variables and other non-specific aspects may also have been important.

Maintenance of such behaviour management is crucial for long-term maintenance of change. It is likely that interventions would be required over the course of the child's education, given the developmentally handicapping nature of her behaviours.

This case study has drawn attention to the assessment and management of ADHD. Further information is now required on developmental aspects, age and sex specific norms for particular problem behaviours. The use of cognitive techniques was encouraging, and future research should concentrate on the role of the cognitive development factors and their implications for treatment in ADHD. Further, the author would suggest that the identification of parental adjustment to the difficulties of having a child with ADHD should be an important treatment. Certainly it is one area which has frequently been ignored (Barkley 1990) and thus perhaps only dealt with indirectly (e.g. through specific advice to engender confidence). Increased awareness of the above factors, both in assessment and treatment may improve upon current inventions, enhance others, and finally help address treatment failure in others.

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**SMALL SCALE SERVICE EVALUATION PROJECT**

# **CLIENT SATISFACTION WITH A PRISON CLINICAL PSYCHOLOGY SERVICE**

**Selected Journal - Clinical Psychology Forum (Appendix 6.1)**



## **INTRODUCTION**

Developing competition through market forces has placed pressure on health services to examine consumer views, and recent research indicates that consumer satisfaction is an important part of Clinical Psychology service evaluation (Bond et al 1992, McAulife and MacLachlan 1992). While client satisfaction alone is not a valid measure of a service (Lebow 1982) it is an important means of monitoring and improving the quality of care (Stallard and Chadwick 1991). This area is of central importance to the evaluation of any service provision.

Most previous research on client satisfaction has concentrated on in and out patients in NHS settings (Jones and Hodge 1991). The Department of Health and Social Security and Home Office (DHHSO) (1991) has remarked on the paucity of information on health and social service needs of offenders in penal settings. This is particularly important as this type of information is imperative in the planning of services for these clients and their subsequent evaluation.

In particular, there has been very little research which pertains to client satisfaction with a prison Clinical Psychology service. This is surprising in view of the significant increase in the amount of prisoners who report psychological difficulties (Cooke 1990) and the observation that the ratio of prisoners to psychologists can be as high as 100:1 (Day 1993). Clearly there is a perceived need and demand for such a service and therefore, the aspect of client satisfaction requires further investigation.

The author wished to answer three specific questions:

1. What was the perceived level of psychological distress with the clients of a particular prison clinical psychology service?
2. Are the clients satisfied with the service?
3. What aspects of the service are most useful/least helpful?

Information was obtained via pilot questionnaire which previously had been prepared by the Clinical Psychology Department.

## **METHOD**

**Setting:** The study took place in a Scottish prison which holds prisoners serving intermediate and long term sentences. The prison has a population of 228 males, all aged over 21. The Clinical Psychology service provides 4 sessions per week.

**Measures:** The questionnaire, Prisoners Rating of Psychology Service (PROPS), had been developed by team members. The questions were intended to cover the most important aspects of the service as identified by both the Patients Charter (1991) and the service itself. The author was requested to pilot this questionnaire (Appendix 6.2).

**Procedure:** The questionnaire was issued to all clients seen for more than one session during an eight month period. Anonymity was assured in order to maximise the number of returns. Data was analysed using the Statistical Package for the Social Sciences (SPSS/PC).

**RESULTS**

Data is presented in the form of percentages as recommended for client survey results (Firth - Cozens 1994). A total of 44 clients were seen during this period. 34 were issued with questionnaires of which 34 (100 per cent) were returned. Ten other clients were not issued with questionnaires, mainly because they were seen for only one session.

**CLIENT PSYCHOLOGICAL DISTRESS**

When asked to record on a scale of 1 to 5 (not at all distressed to very distressed) 4 (11.76 per cent) rated 1, none 2, 9 (26.4 per cent) 3, 18 (52.9 per cent) 4 and 3 (8.82 per cent) 5.

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INSERT FIGURE 1  
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**CLIENT SATISFACTION**

20 (58.82 per cent) agreed that they expected to wait longer to see the psychologist, 8 (23.52 per cent) did not and 4 (11.76 per cent) did not know, 27 (79.41 per cent) agreed that the psychologist understood their problems, 4 (11.76 per cent) did not and 3 (8.82 per cent) did not know.

20 (58.82 per cent) agreed that the psychologist explained things clearly, 8 (23.52 per cent) did not, and 4 (11.76 per cent) did not know.

20 (58.82 per cent) agreed that they could now deal more effectively with their problems, 8 (23.52 per cent) did not, and 6 (17.6 per cent) did not know.

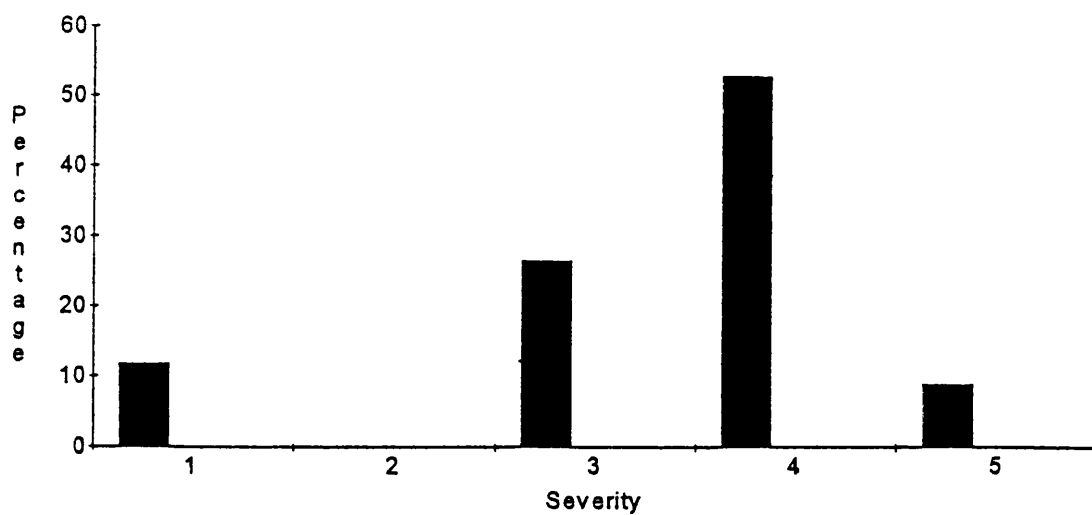


Figure 1: Clients Self-Reported Psychological Distress

8 (23.52 per cent) agreed they had about the right time available to discuss their problems, 18 (52.94 per cent) did not and 8 (23.52 per cent) did not know.

12 (35.29 per cent) agreed that they were worried that their problems might not be kept private, 18 (52.94 per cent) did not and 14 (41.17 per cent) did not know.

### **CLIENT COMMENTS**

To guide future development of the service, clients were asked to make comments about which aspects of the service they had found most useful or least useful. No comments were provided.

### **DISCUSSION**

The questionnaire was returned by 100 per cent of the sample, an excellent response rate. The respondents are considered to be representative of all clients seen within this period, although no demographic data or referral information was obtained. 88.12 per cent of clients rated themselves as experiencing some kind of psychological distress before they saw the psychologist. This is in keeping with Cooke (1990) who found “psychological problems in prisoners are experienced particularly intensely”.

It is clearly necessary to ascertain what particular difficulties are encountered and a reliable instrument should be used to do so. An appropriate measure would be the General Health Questionnaire (GHQ) (Goldberg 1978) which is a robust descriptive tool used to identify general levels of distress. This knowledge would aid in planning service provision which would be pertinent to clients needs. The GHQ is not a change measure however and would not be suitable for measuring outcomes.

Client satisfaction with the service provided generally positive results. There were high levels of agreement in the psychologist's interest (79.41 per cent), clarity of explanation and perceived efficiency agreements were somewhat lower at 58.82 per cent for both. This suggests that some clients did not know or were unsure about these aspects of their problems. Clearly more information is needed on these areas from clients who rated false or don't know. 52.94 per cent said that they were not concerned about breach of confidentiality. Given the general prison ethos of suspicion of authority in general, this figure is considered to be high. The results are fairly encouraging and reflect some appropriateness of the clinical approach. However, it is important to note that good levels of satisfaction are often found in consumer surveys of clinical psychologists (Canter 1989, Lebow 1983) and it is possible that the results obtained were due to the "halo effect" or even as a function of the questions asked.

The PROPS questionnaire has inherent difficulties and recommendations for service provision cannot be made on the basis of PROPS alone. The questionnaire has little rigor in terms of questionnaire construction and it is difficult to draw comparisons or conclusions about satisfaction on the basis of the questions asked e.g. Q2 asked about expectations and not whether clients were satisfied with the time it took to see the psychologist.

The questionnaire is restricted in the amount and type of questions asked and of the dimensions used. Clearly, more items should be carefully selected to ensure that items which are pertinent to particular areas of satisfaction are addressed. In addition, not enough discrimination is made between respondents to "no" and "don't know" on the answering key. The restrictions of this key could be alleviated by the use of a Likert type scale. This would both improve options and aid in analysis more rigorous. Finally, PROPS is not supported by

tests of validity and reliability, nor has it been subject to standardisation. Future research should incorporate a standard instrument which has been shown to be valid and reliable for use alongside a localised questionnaire. One such instrument which would be appropriate is the 63 item, 8 dimension Patient Satisfaction Questionnaire (PSQ) (Ware et al 1983).

On the basis of the information received from PROPS, less positive results were obtained for items relating to the time element than any other. For instance only 23.52 per cent thought there was enough time for discussion while an identical number were unsure. With the number of sessions allocated to the prison such views have implications for a change in service provision. There is clearly a demand for the service but also a need to work within the time allocated. The mobility of the client group at short notice is beyond the control of the prisoner or the psychologist and will always place constraints on service offered. To address this, the service could consider adopting short term therapy contracts with clients or methods like the “Two Plus One” procedure described by Barkham (1989). Here clients are given two appointments just after referral plus another follow-up 3 months later. There would be advantages for the prisoner client in providing an assessment so that worry concerning contact can be alleviated at an early stage also some self-help skills provided so that urgent cases could be identified and seen earlier than would normally be the case.

Comments were requested on the service received to guide future service provision. No comments were provided so it is difficult to ascertain satisfaction on any particular aspect of the service. The development of a more sophisticated method for eliciting practice based comments is necessary.

This study concentrated on the evaluation of a client satisfaction questionnaire. However, direct client contact is only a proportion of the prison psychologists work. To evaluate the service fully, it is necessary to ask a wider range of clients whether the service is meeting the needs e.g.referring agents and those for whom the psychologist acts in a consultative role.



## **CONCLUSION**

Through the piloting a pre-prepared questionnaire, the study has demonstrated that it is possible to obtain information on client distress and client satisfaction with the prison Clinical Psychology service. This information has some value and some tentative recommendations for service provision have been made. The study has a limited research design and is essentially a case study with little rigour in terms of questionnaire construction. This provides very little concrete objective data. The adoption of the recommended improvements would help to further examine current provision, guide future provision and help generate standards for practice.

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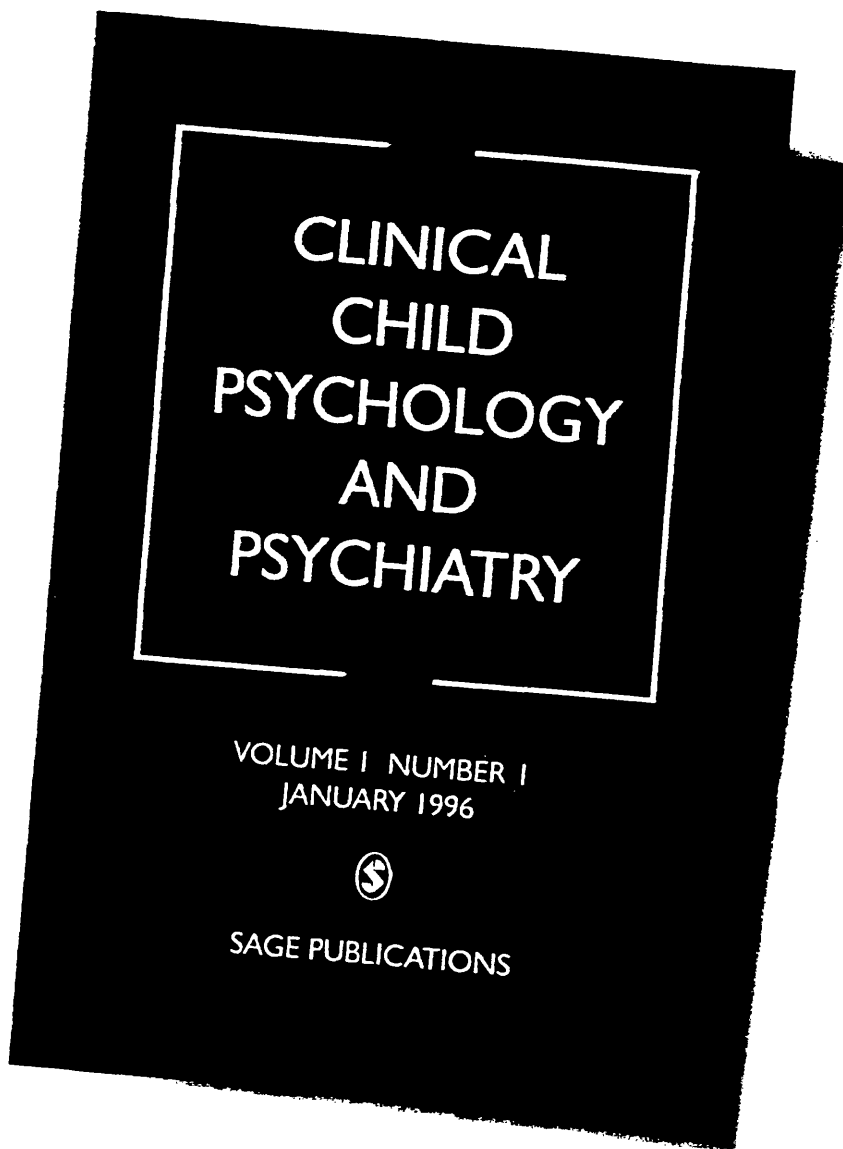
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# **APPENDIX 1**

# A Major New Journal for 1996

See inside for details about  
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Appendix 1.1



## Call for Papers

*"Clinicians working in clinical child psychology and psychiatry will welcome an initiative which holds promise of focusing primarily on practice relevant material."*

Professor I Kolvin, Chair of the ACPP

 SAGE Publications

# Clinical Child Psychology and Psychiatry

## *Why Clinical Child Psychology and Psychiatry?*

Child psychology and psychiatry has grown internationally into one of the biggest clinical, treatment and research areas in the social sciences and medicine, as reflected in the vast proliferation of relevant books, journals and learned societies in recent years. Yet none of the existing academic and scientific journals of child psychology and psychiatry offers fully comprehensive coverage of clinical and treatment issues, and those journals that are clinically oriented tend to be specific to one therapeutic modality.

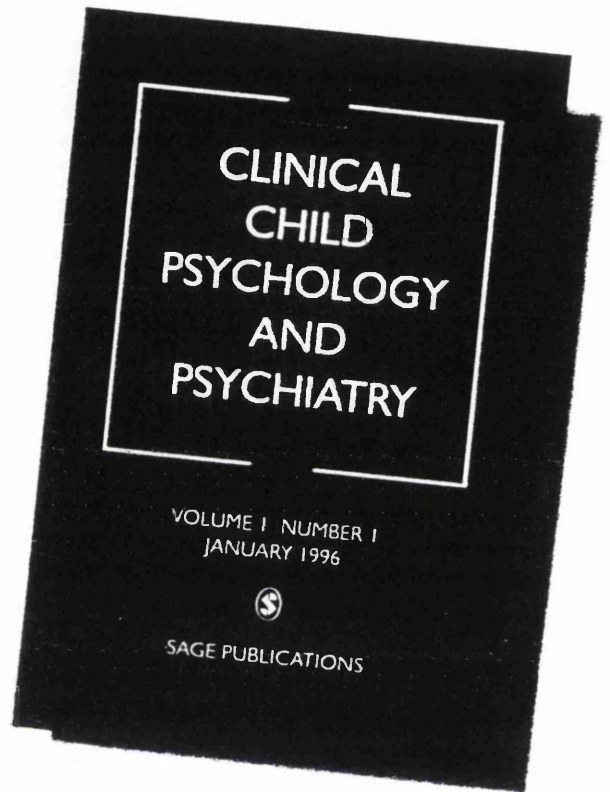
## *A Major New Journal for Clinical and Treatment Based Work*

To meet this need, and to complement existing research focused journals, we are pleased to announce that in 1996 SAGE Publications will be launching *Clinical Child Psychology and Psychiatry* - a major new journal that will bring together clinically oriented work of the highest distinction from an international and multidisciplinary perspective.

*Clinical Child Psychology and Psychiatry* will advance theory, practice and clinical research in child and adolescent psychology and psychiatry and related disciplines. The focus will be on clinical practice, including related topics such as the ethics of treatment and the integration of research into practice.

*Clinical Child Psychology and Psychiatry* will be published quarterly in January, April, July and October.

First issue: January 1996



## *Multidisciplinary*

*Clinical Child Psychology and Psychiatry* will be multidisciplinary, including work by and of interest to:

- child psychologists
- child psychiatrists
- child psychotherapists
- nurses
- social workers
- other professionals in the fields of child and adolescent psychology and psychiatry

## *Every Issue will Include:*

- an editorial
- annotations
- original articles
- short papers (including case illustrations and descriptions)
- book reviews
- commentaries and correspondence

# Clinical Child Psychology and Psychiatry

Editor Dr Bryan Lask

Department of Psychological Medicine, Great Ormond Street Hospital for Children, Great Ormond Street, London WC1N 3JH, UK  
Tel: +44 (0)171 829 8679 Fax: +44 (0)171 829 8657

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To ensure rapid and efficient processing of your contribution it would be most helpful if you could take careful note of the following information:-

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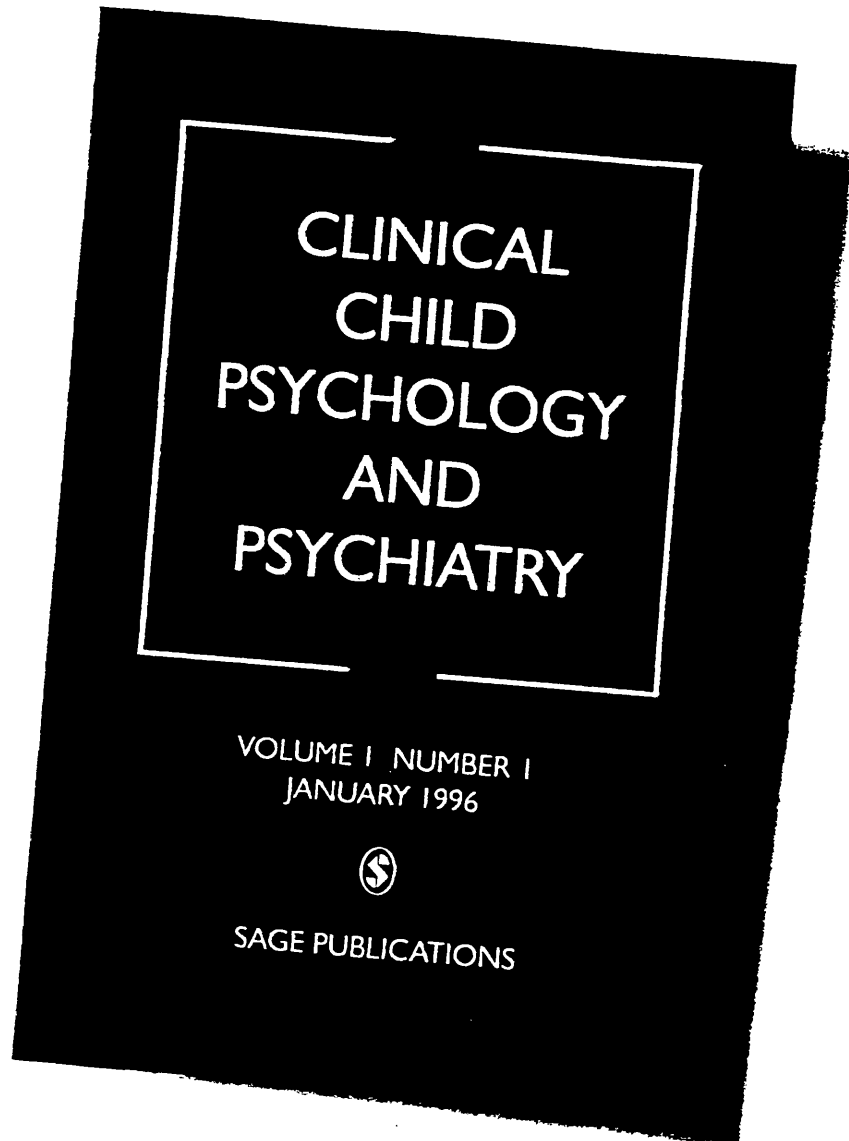
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## **APPENDIX 2**

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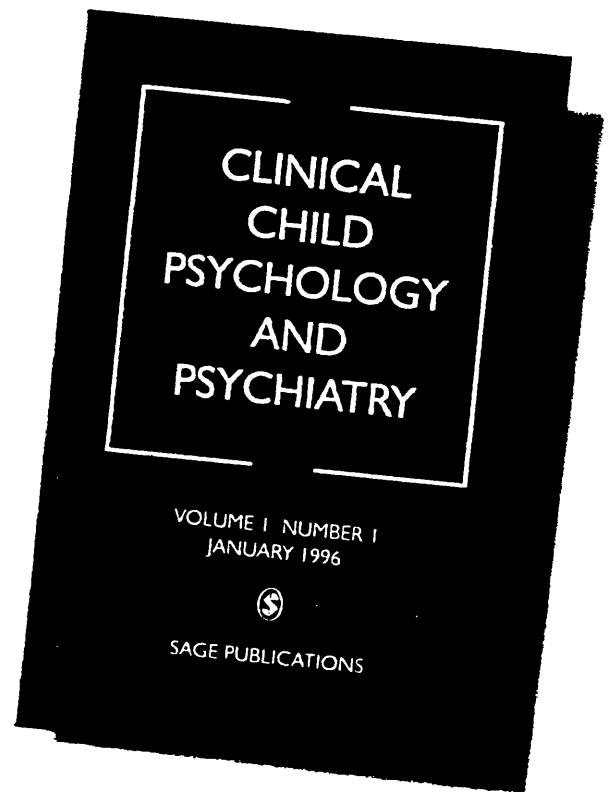
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Name: \_\_\_\_\_ Age: \_\_\_\_\_ Birthdate: \_\_\_\_\_  
 Grade in school: \_\_\_\_\_ Sex: \_\_\_\_\_ Today's date: \_\_\_\_\_

# CDI



Maria Kovacs, Ph.D.

Kids sometimes have different feelings and ideas.

This form lists the feelings and ideas in groups. From each group of three sentences, pick one sentence that describes you *best* for the past two weeks. After you pick a sentence from the first group, go on to the next group.

There is no right answer or wrong answer. Just pick the sentence that best describes the way you have been recently. Put a mark like this **X** next to your answer. Put the mark in the box next to the sentence that you pick.

Here is an example of how this form works. Try it. Put a mark next to the sentence that describes you *best*.

Example:

- ☐ I read books all the time.

☐ I read books once in a while.

☐ I never read books.

When you are told to do so, tear off this top page. Then, pick the sentences that describe you best on the first page. After you finish the first page, turn to the back. Then, answer the items on that page.

*Remember, pick out the sentences that describe you best in the PAST TWO WEEKS.*



# CDI

## Item 1

- ☐ I am sad once in a while.
- ☐ I am sad many times.
- ☐ I am sad all the time.

## Item 2

- ☐ Nothing will ever work out for me.
- ☐ I am not sure if things will work out for me.
- ☐ Things will work out for me O.K.

## Item 3

- ☐ I do most things O.K.
- ☐ I do many things wrong.
- ☐ I do everything wrong.

## Item 4

- ☐ I have fun in many things.
- ☐ I have fun in some things.
- ☐ Nothing is fun at all.

## Item 5

- ☐ I am bad all the time.
- ☐ I am bad many times.
- ☐ I am bad once in a while.

## Item 6

- ☐ I think about bad things happening to me once in a while.
- ☐ I worry that bad things will happen to me.
- ☐ I am sure that terrible things will happen to me.

## Item 7

- ☐ I hate myself.
- ☐ I do not like myself.
- ☐ I like myself.

## Item 8

- ☐ All bad things are my fault.
- ☐ Many bad things are my fault.
- ☐ Bad things are not usually my fault.

## Item 9

- ☐ I do not think about killing myself.
- ☐ I think about killing myself but I would not do it.
- ☐ I want to kill myself.

## Item 10

- ☐ I feel like crying every day.
- ☐ I feel like crying many days.
- ☐ I feel like crying once in a while.

## Item 11

- ☐ Things bother me all the time.
- ☐ Things bother me many times.
- ☐ Things bother me once in a while.

## Item 12

- ☐ I like being with people.
- ☐ I do not like being with people many times.
- ☐ I do not want to be with people at all.

## Item 13

- ☐ I cannot make up my mind about things.
- ☐ It is hard to make up my mind about things.
- ☐ I make up my mind about things easily.

## Item 14

- ☐ I look O.K.
- ☐ There are some bad things about my looks.
- ☐ I look ugly.

*Remember, describe how you have been in the past two weeks.....*

*Item 15*

- ☐ I have to push myself all the time to do my schoolwork.
- ☐ I have to push myself many times to do my schoolwork.
- ☐ Doing schoolwork is not a big problem.

*Item 16*

- ☐ I have trouble sleeping every night.
- ☐ I have trouble sleeping many nights.
- ☐ I sleep pretty well.

*Item 17*

- ☐ I am tired once in a while.
- ☐ I am tired many days.
- ☐ I am tired all the time.

*Item 18*

- ☐ Most days I do not feel like eating.
- ☐ Many days I do not feel like eating.
- ☐ I eat pretty well.

*Item 19*

- ☐ I do not worry about aches and pains.
- ☐ I worry about aches and pains many times.
- ☐ I worry about aches and pains all the time.

*Item 20*

- ☐ I do not feel alone.
- ☐ I feel alone many times.
- ☐ I feel alone all the time.

*Item 21*

- ☐ I never have fun at school.
- ☐ I have fun at school only once in a while.
- ☐ I have fun at school many times.

*Item 22*

- ☐ I have plenty of friends.
- ☐ I have some friends but I wish I had more.
- ☐ I do not have any friends.

*Item 23*

- ☐ My schoolwork is alright.
- ☐ My schoolwork is not as good as before.
- ☐ I do very badly in subjects I used to be good in

*Item 24*

- ☐ I can never be as good as other kids.
- ☐ I can be as good as other kids if I want to.
- ☐ I am just as good as other kids.

*Item 25*

- ☐ Nobody really loves me.
- ☐ I am not sure if anybody loves me.
- ☐ I am sure that somebody loves me.

*Item 26*

- ☐ I usually do what I am told.
- ☐ I do not do what I am told most times.
- ☐ I never do what I am told.

*Item 27*

- ☐ I get along with people.
- ☐ I get into fights many times.
- ☐ I get into fights all the time.

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Remember to fill out the other side

# HOW-I-FEEL QUESTIONNAIRE

Developed by CD Spielberger, CD Edwards, J Montuori and R Lushene

## STAIC FORM C-1

NAME: \_\_\_\_\_ AGE: \_\_\_\_\_ DATE: \_\_\_\_\_

**DIRECTIONS:** A number of statements which boys and girls use to describe themselves are given below. Read each statement carefully and decide how you feel *right now*. Then put an X in the box in front of the word or phrase which best describes how you feel. There are no right or wrong answers. Do not spend too much time on any one statement. Remember, find the word or phrase which best describes how you feel right now, *at this very moment*.

- |                      |                                          |                                     |                                         |
|----------------------|------------------------------------------|-------------------------------------|-----------------------------------------|
| 1. I feel . . . . .  | <input type="checkbox"/> very calm       | <input type="checkbox"/> calm       | <input type="checkbox"/> not calm       |
| 2. I feel . . . . .  | <input type="checkbox"/> very upset      | <input type="checkbox"/> upset      | <input type="checkbox"/> not upset      |
| 3. I feel . . . . .  | <input type="checkbox"/> very pleasant   | <input type="checkbox"/> pleasant   | <input type="checkbox"/> not pleasant   |
| 4. I feel . . . . .  | <input type="checkbox"/> very nervous    | <input type="checkbox"/> nervous    | <input type="checkbox"/> not nervous    |
| 5. I feel . . . . .  | <input type="checkbox"/> very jittery    | <input type="checkbox"/> jittery    | <input type="checkbox"/> not jittery    |
| 6. I feel . . . . .  | <input type="checkbox"/> very rested     | <input type="checkbox"/> rested     | <input type="checkbox"/> not rested     |
| 7. I feel . . . . .  | <input type="checkbox"/> very scared     | <input type="checkbox"/> scared     | <input type="checkbox"/> not scared     |
| 8. I feel . . . . .  | <input type="checkbox"/> very relaxed    | <input type="checkbox"/> relaxed    | <input type="checkbox"/> not relaxed    |
| 9. I feel . . . . .  | <input type="checkbox"/> very worried    | <input type="checkbox"/> worried    | <input type="checkbox"/> not worried    |
| 10. I feel . . . . . | <input type="checkbox"/> very satisfied  | <input type="checkbox"/> satisfied  | <input type="checkbox"/> not satisfied  |
| 11. I feel . . . . . | <input type="checkbox"/> very frightened | <input type="checkbox"/> frightened | <input type="checkbox"/> not frightened |
| 12. I feel . . . . . | <input type="checkbox"/> very happy      | <input type="checkbox"/> happy      | <input type="checkbox"/> not happy      |
| 13. I feel . . . . . | <input type="checkbox"/> very sure       | <input type="checkbox"/> sure       | <input type="checkbox"/> not sure       |
| 14. I feel . . . . . | <input type="checkbox"/> very good       | <input type="checkbox"/> good       | <input type="checkbox"/> not good       |
| 15. I feel . . . . . | <input type="checkbox"/> very troubled   | <input type="checkbox"/> troubled   | <input type="checkbox"/> not troubled   |
| 16. I feel . . . . . | <input type="checkbox"/> very bothered   | <input type="checkbox"/> bothered   | <input type="checkbox"/> not bothered   |
| 17. I feel . . . . . | <input type="checkbox"/> very nice       | <input type="checkbox"/> nice       | <input type="checkbox"/> not nice       |
| 18. I feel . . . . . | <input type="checkbox"/> very terrified  | <input type="checkbox"/> terrified  | <input type="checkbox"/> not terrified  |
| 19. I feel . . . . . | <input type="checkbox"/> very mixed-up   | <input type="checkbox"/> mixed-up   | <input type="checkbox"/> not mixed-up   |
| 20. I feel . . . . . | <input type="checkbox"/> very cheerful   | <input type="checkbox"/> cheerful   | <input type="checkbox"/> not cheerful   |

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## HOW-I-FEEL QUESTIONNAIRE

## STAIC FORM C-2

NAME: \_\_\_\_\_ AGE: \_\_\_\_\_ DATE: \_\_\_\_\_

DIRECTIONS: A number of statements which boys and girls use to describe themselves are given below. Read each statement and decide if it is *hardly ever*, or *sometimes* or *often* true for you. Then for each statement, put an X in the box in front of the word that seems to describe you best. There are no right or wrong answers. Do not spend too much time on any one statement. Remember, choose the word which seems to describe how you usually feel.

- |                                                            |                                      |                                    |                                |
|------------------------------------------------------------|--------------------------------------|------------------------------------|--------------------------------|
| 1. I worry about making mistakes                           | <input type="checkbox"/> hardly ever | <input type="checkbox"/> sometimes | <input type="checkbox"/> often |
| 2. I feel like crying                                      | <input type="checkbox"/> hardly ever | <input type="checkbox"/> sometimes | <input type="checkbox"/> often |
| 3. I feel unhappy                                          | <input type="checkbox"/> hardly ever | <input type="checkbox"/> sometimes | <input type="checkbox"/> often |
| 4. I have trouble making up my mind                        | <input type="checkbox"/> hardly ever | <input type="checkbox"/> sometimes | <input type="checkbox"/> often |
| 5. It is difficult for me to face my problems              | <input type="checkbox"/> hardly ever | <input type="checkbox"/> sometimes | <input type="checkbox"/> often |
| 6. I worry too much                                        | <input type="checkbox"/> hardly ever | <input type="checkbox"/> sometimes | <input type="checkbox"/> often |
| 7. I get upset at home                                     | <input type="checkbox"/> hardly ever | <input type="checkbox"/> sometimes | <input type="checkbox"/> often |
| 8. I am shy                                                | <input type="checkbox"/> hardly ever | <input type="checkbox"/> sometimes | <input type="checkbox"/> often |
| 9. I feel troubled                                         | <input type="checkbox"/> hardly ever | <input type="checkbox"/> sometimes | <input type="checkbox"/> often |
| 10. Unimportant thoughts run through my mind and bother me | <input type="checkbox"/> hardly ever | <input type="checkbox"/> sometimes | <input type="checkbox"/> often |
| 11. I worry about school                                   | <input type="checkbox"/> hardly ever | <input type="checkbox"/> sometimes | <input type="checkbox"/> often |
| 12. I have trouble deciding what to do                     | <input type="checkbox"/> hardly ever | <input type="checkbox"/> sometimes | <input type="checkbox"/> often |
| 13. I notice my heart beats fast                           | <input type="checkbox"/> hardly ever | <input type="checkbox"/> sometimes | <input type="checkbox"/> often |
| 14. I am secretly afraid                                   | <input type="checkbox"/> hardly ever | <input type="checkbox"/> sometimes | <input type="checkbox"/> often |
| 15. I worry about my parents                               | <input type="checkbox"/> hardly ever | <input type="checkbox"/> sometimes | <input type="checkbox"/> often |
| 16. My hands get sweaty                                    | <input type="checkbox"/> hardly ever | <input type="checkbox"/> sometimes | <input type="checkbox"/> often |
| 17. I worry about things that may happen                   | <input type="checkbox"/> hardly ever | <input type="checkbox"/> sometimes | <input type="checkbox"/> often |
| 18. It is hard for me to fall asleep at night              | <input type="checkbox"/> hardly ever | <input type="checkbox"/> sometimes | <input type="checkbox"/> often |
| 19. I get a funny feeling in my stomach                    | <input type="checkbox"/> hardly ever | <input type="checkbox"/> sometimes | <input type="checkbox"/> often |
| 20. I worry about what other think of me                   | <input type="checkbox"/> hardly ever | <input type="checkbox"/> sometimes | <input type="checkbox"/> often |

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# Coopersmith Inventory

Stanley Coopersmith, Ph.D.  
University of California at Davis

Please Print

Name \_\_\_\_\_ Age \_\_\_\_\_

School \_\_\_\_\_ Sex: M \_\_\_\_ F \_\_\_\_

Grade \_\_\_\_\_ Date \_\_\_\_\_

Directions

On the next pages, you will find a list of statements about feelings. If a statement describes how you usually feel, put an X in the column "Like Me." If the statement does not describe how you usually feel, put an X in the column "Unlike Me." There are no right or wrong answers.



Like Me		Unlike Me	
<input type="checkbox"/>	1. Things usually don't bother me.	<input type="checkbox"/>	30. I spend a lot of time daydreaming.
<input type="checkbox"/>	2. I find it very hard to talk in front of the class.	<input type="checkbox"/>	31. I wish I were younger.
<input type="checkbox"/>	3. There are lots of things about myself I'd change if I could.	<input type="checkbox"/>	32. I always do the right thing.
<input type="checkbox"/>	4. I can make up my mind without too much trouble.	<input type="checkbox"/>	33. I'm proud of my school work.
<input type="checkbox"/>	5. I'm a lot of fun to be with.	<input type="checkbox"/>	34. Someone always has to tell me what to do.
<input type="checkbox"/>	6. I get upset easily at home.	<input type="checkbox"/>	35. I'm often sorry for the things I do.
<input type="checkbox"/>	7. It takes me a long time to get used to anything new.	<input type="checkbox"/>	36. I'm never happy.
<input type="checkbox"/>	8. I'm popular with kids my own age.	<input type="checkbox"/>	37. I'm doing the best work that I can.
<input type="checkbox"/>	9. My parents usually consider my feelings.	<input type="checkbox"/>	38. I can usually take care of myself.
<input type="checkbox"/>	10. I give in very easily.	<input type="checkbox"/>	39. I'm pretty happy.
<input type="checkbox"/>	11. My parents expect too much of me.	<input type="checkbox"/>	40. I would rather play with children younger than I am.
<input type="checkbox"/>	12. It's pretty tough to be me.	<input type="checkbox"/>	41. I like everyone I know.
<input type="checkbox"/>	13. Things are all mixed up in my life.	<input type="checkbox"/>	42. I like to be called on in class.
<input type="checkbox"/>	14. Kids usually follow my ideas.	<input type="checkbox"/>	43. I understand myself.
<input type="checkbox"/>	15. I have a low opinion of myself.	<input type="checkbox"/>	44. No one pays much attention to me at home.
<input type="checkbox"/>	16. There are many times when I'd like to leave home.	<input type="checkbox"/>	45. I never get scolded.
<input type="checkbox"/>	17. I often feel upset in school.	<input type="checkbox"/>	46. I'm not doing as well in school as I'd like to.
<input type="checkbox"/>	18. I'm not as nice looking as most people.	<input type="checkbox"/>	47. I can make up my mind and stick to it.
<input type="checkbox"/>	19. If I have something to say, I usually say it.	<input type="checkbox"/>	48. I really don't like being a boy.
<input type="checkbox"/>	20. My parents understand me.	<input type="checkbox"/>	49. I don't like to be with other people.
<input type="checkbox"/>	21. Most people are better liked than I am.	<input type="checkbox"/>	50. I'm never shy.
<input type="checkbox"/>	22. I usually feel as if my parents are pushing me.	<input type="checkbox"/>	51. I often feel ashamed of myself.
<input type="checkbox"/>	23. I often get discouraged at school.	<input type="checkbox"/>	52. Kids pick on me very often.
<input type="checkbox"/>	24. I often wish I were someone else.	<input type="checkbox"/>	53. I always tell the truth.
<input type="checkbox"/>	25. I can't be depended on.	<input type="checkbox"/>	54. My teachers make me feel I'm not good enough.
<input type="checkbox"/>	26. I never worry about anything.	<input type="checkbox"/>	55. I don't care what happens to me.
<input type="checkbox"/>	27. I'm pretty sure of myself.	<input type="checkbox"/>	56. I'm a failure.
<input type="checkbox"/>	28. I'm easy to like.	<input type="checkbox"/>	57. I get upset easily when I'm scolded.
<input type="checkbox"/>	29. My parents and I have a lot of fun together.	<input type="checkbox"/>	58. I always know what to say to people.

Gen	Soc	H	Sch	Total
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> x2 = <input type="checkbox"/>



Form A



Form B

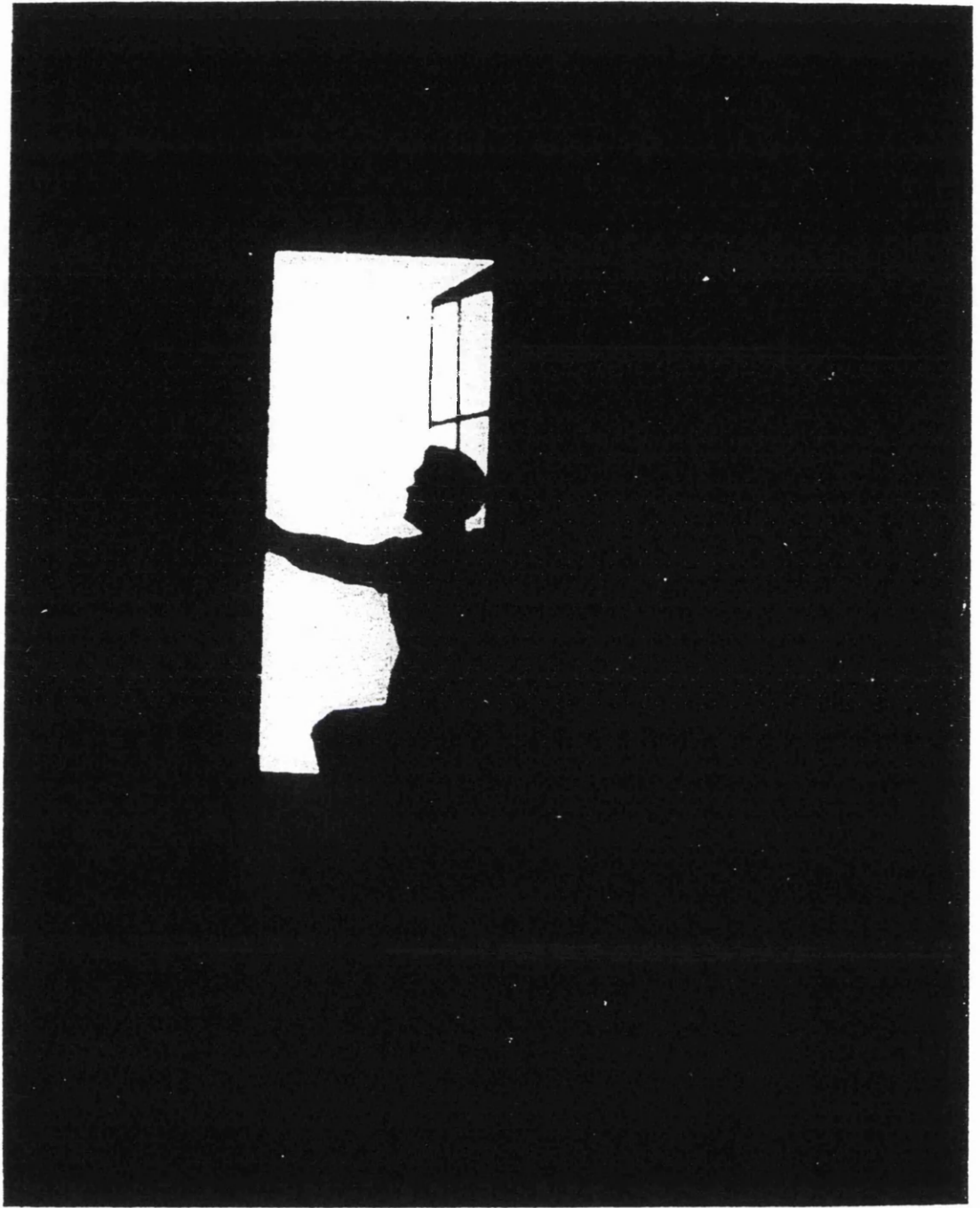




Form C

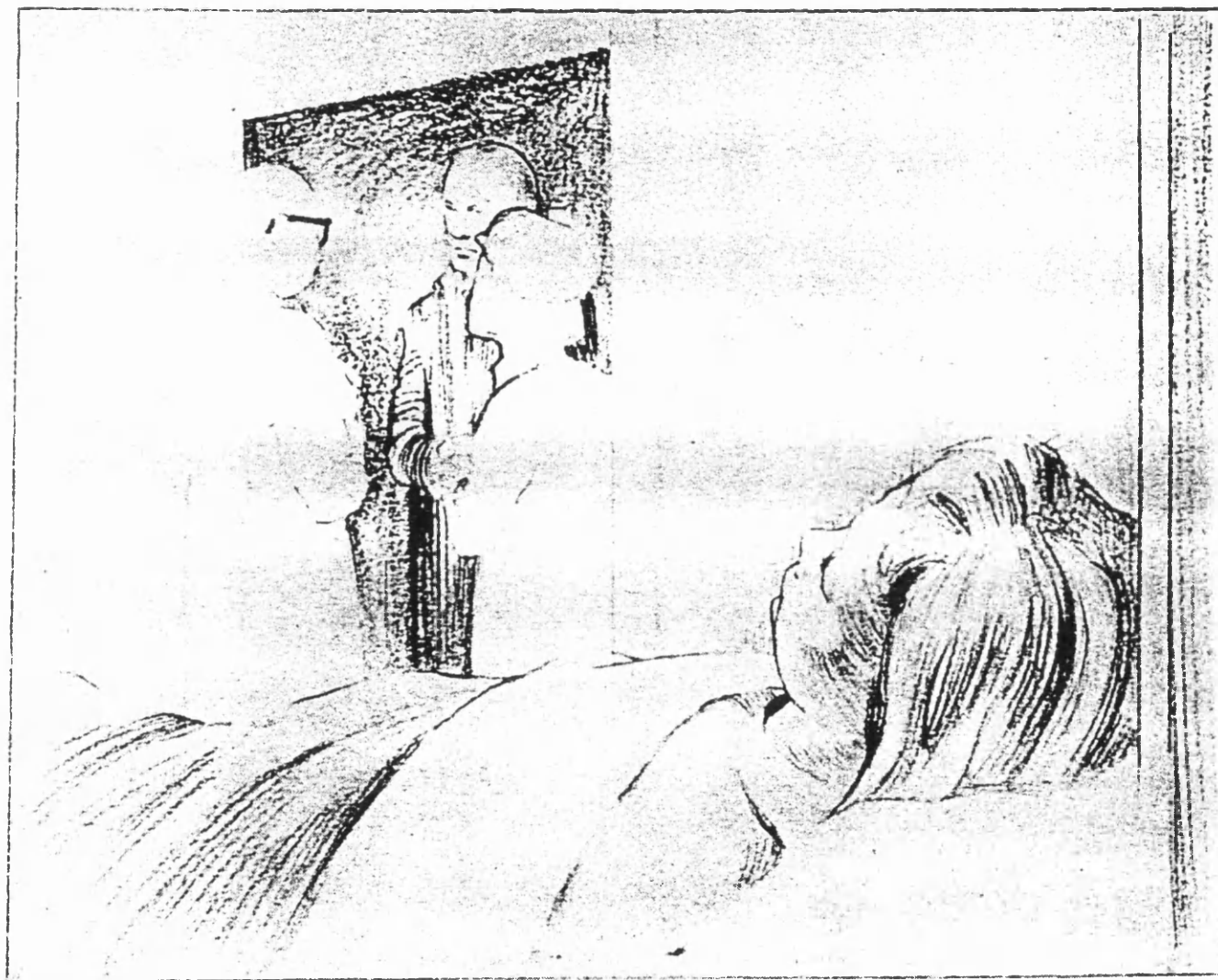


Form D



Form E

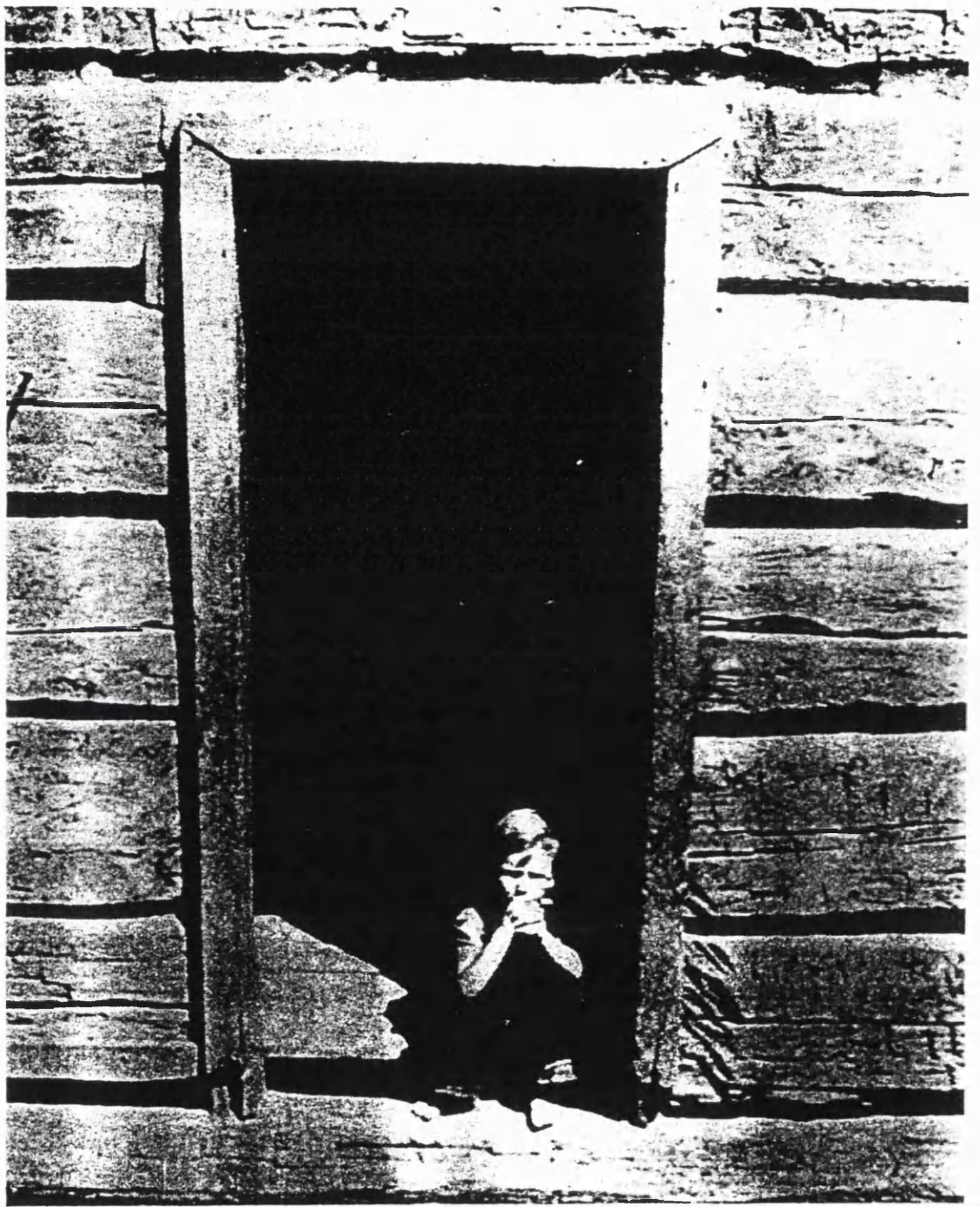




Form F



Form G



Form H

## **PROJECTIVE PICTURES SCORING SYSTEM**

**(Eugenia H Waechter )**

The framework of the scoring system is based on anxiety as expressed by the ill child, and the problems he anticipates and his insecurities about present and future events. The major interest in analysing the content of the scores is in terms of the type of anxiety expressed and the pictures are chosen to elicit a wide range of imagery related to different types of anxieties with which children may deal when they are ill. These threats to security, or fears may be related to loneliness or separation from meaningful adults, to body intrusion, or to mutilation or death. Clues in the picture relate to the place of threat, to body image, to darkness, or to activities aimed at regarding body integrity or functioning.

### ***Procedure of Administration***

#### ***Description of Pictures, Giving Code Letter and Score***

- Form A: Two boys in adjoining beds (Designed by the author)
- Form B: Small child in hallway outside closed door (Designed by author)
- Form C: Boy in front of mural depicting operation (TAT 8BM)
- Form D: Small child in bed, nurse nearby with back turned (Designed by author)
- Form E: Figure outlined in open window (TAT GF)
- Form F: Child in bed, parents and doctor outside door (Designed by author)
- Form G: Woman entering room, face on hand (TAT GF)
- Form H: Small child sitting in doorway of cabin (TAT 13B)

### *Procedure*

Pictures are to be shown to each child individually by the experimenter. Instructions are to be given as follows: "Tell me a story about this picture. Make the story as exciting or as interesting as you can. Include in the story:

1. What is happening in the picture?
2. What has happened before?
3. What are the people thinking?
4. What will happen? How does the story end?



## **CATEGORIES IN SCORING**

### ***Threat Imagery***

The story must contain reference to a threat to body integrity or to physical or psychological security. There must be some actual threat in the story, or action taken to avoid a threat, real or unreal someone in the story is threatened by disease from within or by environmental threat to body intactness (accidents, fire etc.) Any imagery in the story involving statements of loneliness, illness, mutilation or death is sufficient to score the story. Negative affective states such as sadness unrelated to body integrity or loneliness are not sufficient to score the story. All imagery is scored from the viewpoint of the threatened individual.

### ***Mutilation***

A statement directly expressing or implying body intrusion, bleeding or breaking of skin is scored as mutilation. Broken bones or falls from which bruising is probably the result or crippling conditions are not to be scored as mutilation.

### ***Loneliness, Mutilation or Death Themes***

These themes are scored separately. The purpose is to determine the predominant expressed fear of the child telling the story. The main theme of the story may relate to loneliness or separation, mutilation, or death and dying. A story is to be scored only once for theme.

## **PERCEPTION OF CASUALTY**

### ***Source of Threat***

Imagery in the story may indicate directly the child's perception as to the source of threat to body functioning integrity. Stories will be scored in terms of perception of the causality of the threat. Stories will be scored for a mere statement that someone is ill, even though diagnosis is mentioned, without direct reference to casualty as emanating from the individual himself or from the environment. Causality to be scored in terms of the major threat if there is more than one in the story.

### ***Internal Causality (Self)***

The hero in the story has enacted some behaviour in the past that directly or indirectly results in body mutilation or malfunctioning.

### ***External Causality***

Someone or something in the environment has caused body mutilation or malfunction or has engaged in behaviour that results in a threat to life. The source of threat is outside the person threatened, that is, emanates from the objective or human environment. Source of threat may also be perceived as supernatural. If human behaviour is seen as resulting in divine retribution, it will be scored as self-causality.

## **OUTCOME**

### ***Relief Outcome***

The threatened individual in the story gets well, successfully avoids an accident or body mutilation. There is a positive end to the story.

### ***Anxiety Outcome***

The threatened individual in the story dies, never goes home from hospital, succumbs to the accident, or never regains body intactness. There is a negative ending to the story. External or internal forces continue to operate that will result in the person being worse off in the future.

### ***Doubtful Outcome***

Statement of uncertainty or ignorance as to whether a character in the story maintains or regains body integrity, whether he can go home from the hospital, or whether he will ever get well. Doubtful outcome will also be scored if the narrator changes the outcome of the story while telling the story from the viewpoint of the threatened individual, or if no certain ending to the story is given.

## **SCORING**

The scoring system, utilising the form reproduced below, is designed to determine both total amount of pre-occupation with threat to body integrity and functioning. Each theme is scored only once per story, despite the fact that other imagery may appear within a story. Each category of imagery, is also scored only once per story. If no imagery is present, related to a threat to body integrity or security, it is scored as unrelated imagery, -1, and is not scored

further. Each thema is to be scored +1, and threat imagery and each subcategory are also scored +1.

The total score represents the number of times threat imagery and each of the subcategories listed above are scores in the record of a particular subject. This total score is thus an indication of gross pre-occupation with illness related concerns or anxieties. Actual words should be present whenever possible for scoring a category.

Score Form for Waechters Adapted Picture Test

	IMAGERY				THEMA			CAUSALITY		OUTCOME			
	Unrelated Imagery	Loneliness	Mutilation	Death	Loneliness	Mutilation	Death	Internal	External	Relief	Anxiety	Doubtful	Story Scores
Form A													
B													
C													
D													
E													
F													
G													
H													
Column Totals													Total Score

(Waechter 1968/1971)

**STAFF QUESTIONNAIRE** (Goldman and Christie 1993)

Please comment on the type of communication within the family about illness course.

The following range of responses are available.

**O = Open Conversation**

The child and family discuss the illness course openly within the family.

**A = Acknowledgement**

The child and family know and know each others knows but don't discuss it much.

**P = Prevented**

The illness course is not discussed by the child. Discussion is blocked by the family, though it is felt that the child knows and wants to talk.

**N = Not Discussed**

The illness is not discussed by the child. It is felt that the child knows and chooses not to talk about its course.

**I = Ignorance**

The illness is not discussed by the child. It is felt that the child does not know about its course.

**U = Unknown**

The Care Officer is not sure enough to designate

## **APPENDIX 3**

NOTES FOR CONTRIBUTORS

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## Notes for contributors

### Submission

Authors should submit three complete copies of their text, tables and figures, with any original illustrations, to Dr Paul Bowden, Journal of Forensic Psychiatry, Maudsley Hospital, Denmark Hill, London SE5 8AZ.

It will be assumed that authors will keep a copy. Submission of a paper to the journal will be taken to imply that it presents original, unpublished work not under consideration for publication elsewhere. By submitting a manuscript, the authors agree that the exclusive rights to reproduce and distribute the article have been given to the publishers, including reprints, photographic reproductions, microfilm, or any other reproductions of a similar nature, and translations, though the copyright is retained by the author.

The submission should include the author's name, the department where the work was done and an address for correspondence, if different.

### The manuscript

Submissions should be in English, typed in double spacing with wide margins, on one side only of the paper, preferably of A4 size. Articles should normally be between 3000 and 8000 words in length and preceded by an abstract of less than 200 words. **Shorter research reports of less than 1500 words are welcomed.** Tables and figures should not be inserted in the pages of the manuscript but should be on separate sheets. They should be numbered consecutively in Arabic numerals with a descriptive caption. The desired position in the text for each table and figure should be indicated in the margin of the manuscript. Permission to reproduce copyright material must be obtained by the authors before submission and any acknowledgements should be included in the typescript or captions as appropriate.

### Photographs

Photographs should be high-contrast black and white glossy prints and have an explanatory legend. Permission to reproduce them must be obtained before submission, as for tables and figures.



### References

The Harvard system uses the name of the author and the date of publication as a key to the full bibliographical details which are set out in the references.

When an author's name is mentioned in the text, the date is inserted in parentheses immediately after the name, as in 'Dell (1982)'. When a less direct reference is made to one or more authors, both name and date are bracketed, with the reference separated by a semi-colon, as in 'several authors have noted this trend (Griew, 1984; O'Donovan, 1984; Ashworth, 1987)'.

When the reference is to a work of dual or multiple authorship, use only surnames of the abbreviated form, as in 'Friar and Matthews (1980)' or 'Fisher *et al.* (1974)'.

If an author has two references published in the same year, add lower case letters after the date to distinguish them, as in 'Bullard (1980a, 1980b)'.

For direct quotations of 40 words or more, which will be printed as prose extracts, page numbers are required. Always use the minimum number of figures in page numbers, dates etc., e.g. pp. 22-4, 105-6 (but using 112-13 for 'teen numbers) and 1968-9.

### Format of reference lists and bibliographies

Submissions should include a reference list in alphabetical order whose content and format conform to the following examples. Note: elements of information are separated by a full stop; authors' names are given in full; page numbers are required for articles in readers, journals and magazines; where relevant, translator and date of first publication of a book, and original date of reprinted article, are noted.

Book	Walker, N. (1977) <i>Behaviour and Misbehaviour: Explanations and Non-explanations</i> . Oxford: Blackwell.
Multiple author	Gibbens, T. C. N. and Prince, J. (1962) <i>Shoplifting</i> . London: Institute for the Study and Treatment of Delinquency.
Two references in same year/ translated text	Jaspers, K. (1963a) <i>General Psychopathology</i> (7th edn). Trans. Hoenig, J. and Hamilton, M. Manchester: Manchester University Press.
Article in edited volume	Pernanen, K. (1976) 'Alcohol and Crimes of Violence'. In Kissen, E. and Begleiter, H. (eds) <i>Biology of Alcoholism</i> (Vol. 4). <i>Social Aspects of Alcoholism</i> . New York: Plenum Press.
Article in journal	Wong, M. and Singer, K. (1973) 'Abnormal Homicide in Hong Kong'. <i>British Journal of Psychiatry</i> , 123: 295-8.

Article in *The Observer* (1985) 'The Obscene Telephone Caller'.  
 newspaper 1 September 1985: 35.

Law reports should be in a separate list arranged alphabetically.

#### Law reports

In reference to law reports in the text care should be taken to distinguish between round and square brackets.

From the year 1891 onwards and where there is more than one volume per year the date is placed in square brackets: eg *DPP v Camplin* [1978] in the text and *DPP v Camplin* [1978] 1 AL ER 168 in the legal reference list.

For cases before 1891 and where volumes are serially expressed the date is in round brackets: e.g. *R. v Dix* (1982) in the text and *R. v Dix* (1982) 74 Cr App R 306 in the reference list.

The title of law reports is underlined to indicate that it will appear in italics. (The 'v' is in Roman.) Where there is a volume number it follows the brackets. An abbreviated form of the source of the law report follows, and then the page reference.

#### Legislation

Acts of Parliament and other legislation are referred to in the text only and appear in their shortened form: e.g. Mental Health Act 1959, with no comma before the date.

#### Proofs

Page proofs will be sent for correction to a first-named author, unless otherwise requested. The difficulty and expense involved in making amendments at the page-proof stage make it essential for authors to prepare their typescripts carefully: any alteration to the original text is strongly discouraged. Authors should correct printers' errors in red; minimal alterations of their own should be in black. Our aim is rapid publication: this will be helped if authors provide good copy, following the above instructions, and return their page proofs to the editor on the date requested.

#### Offprints

10 offprints and a copy of the journal will be supplied free of charge.

WEEKLY DIARY OF TARGETS - URGES TO OFFEND/OFFENCE BEHAVIOUR

WHERE - DATE & TIME	WHAT HAPPENED BEFORE?	WHAT HAPPENED DURING?	WHAT HAPPENED AFTERWARDS?	COMMENTS

### **ASSESSMENT OF MOTIVATION INSTRUCTIONS TO THE INTERVIEWER**

(Briggs 1994)

It is suggested that after some degree of rapport has been established with the client, and the purpose of the interview has been made explicit, the following questions be asked of the client.

It is recommended that a questioning rather than a confrontational interviewing style be adopted.

#### **Questions**

"What have you been told about the sort of treatment and counselling that might be offered here?"

"One of the main reasons for you being here is because of committing sexual offences. Have you tried to control your behaviour in the past? If so, what did you try to do to stop yourself offending? Why do you think you were not successful in controlling your behaviour?"

Do you feel that you will ever be able to control your behaviour in the future? What will be the most difficult thing to achieve?"

Who wants you to change? Why?

Who does not want you to change? Why?

If you were to commit yourself to work to help you control your sexual behaviour, what benefits do you think this will bring you both short-term and long-term? List as many of these as possible. Similarly, what disadvantages do you think you might experience, both in the short-term and the long-term, if you started to work on your offending behaviour?

When we talk about your offences, are there issues that you find it very difficult to talk about?

What expectations do you have of me? What should I expect of you?

It is recommended that record be made of the substance of this interview against which any changes can be monitored.

## **APPENDIX 4**

## NOTES TO CONTRIBUTORS

1. The *British Journal of Clinical Psychology* publishes original contributions to scientific knowledge in clinical and health psychology. Topics covered reflect the broad role of clinical and health psychologists and include descriptive studies as well as studies of the aetiology, assessment and amelioration of disorders of all kinds, in all settings and amongst all age groups. Empirical investigations from any theoretical perspective of the relation of intrapersonal and interpersonal processes to disorder are welcome, as are studies of the delivery of health care in hospital or community settings. Relevant populations include people with psychiatric and neuropsychological disorders, and people with learning difficulties. Studies with samples not currently experiencing any disorder may be considered if they bear directly on clinical theory or practice.

A separate Health Psychology Section of the Journal has now been created in recognition of the growing importance of the applications of psychology outside the traditional psychiatric domain. Submissions are encouraged of clinical and experimental research on the development and management of medical conditions. Empirical research into psychosocial responses to illness, and the behaviours that put health at risk, is also welcome.

2. The following types of paper are invited:

- (a) Papers reporting original empirical investigations.
  - (b) Theoretical papers, provided that these are sufficiently related to empirical data.
  - (c) Review articles which need not be exhaustive, but which should give an interpretation of the state of the research in a given field and, where appropriate, identify its clinical implications.
  - (d) Brief Reports and Comments (see paragraph 6).
- Case studies are normally published only as Brief Reports. Papers are evaluated in terms of their theoretical importance, contributions to knowledge, relevance to the concerns of practising clinical psychologists, and readability. Papers generally appear in order of acceptance, except for the priority given to Brief Reports and Comments.

3. The circulation of the Journal is worldwide, and papers are reviewed by colleagues in many countries. There is no restriction to British authors, and papers are invited from authors throughout the world.

4. The Code of Conduct of The British Psychological Society requires psychologists 'Not to allow their professional responsibilities or standards of practice to be diminished by considerations of religion, sex, race, age, nationality, party politics, social standing, class or other extraneous factors'. The racism of apartheid is incompatible with the Society's Code and the Society therefore condemns apartheid and resolves to avoid all links with psychologists and psychological organizations and their formal representatives that do not affirm and adhere to the principles in the clause of its Code of Conduct. In cases of doubt the Journals Office asks authors to sign a document confirming their adherence to these principles.

5. Papers should be prepared in accordance with The British Psychological Society's *Style Guide*, available at £3.50 per copy from The British Psychological Society, St Andrews House, 48 Princess Road East, Leicester LE1 7DR, England. Contributions should be kept as concise as clarity permits, and illustrations kept as few as possible. Papers should not normally exceed 5000 words. A summary of up to 200 words should be provided, but a shorter abstract with shorter papers. The title should indicate exactly but as briefly as possible the subject of the article, bearing in mind its use in abstracting and indexing systems.

- (a) Contributions should be typed in double spacing with wide margins and only on 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) The Journal operates blind review; authors are required to eliminate clues to their identity. Information revealing authorship (such as authors' names and institutional affiliations, and personal acknowledgments) must be confined to removable front page, and the text must be free of such clues as identifiable self-citations ('In our earlier work...') and the names of localities or institutions. The paper's title should appear at the top of the first page of 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 title of the paper. They should be carefully drawn, larger than their intended size, suitable for photographic reproduction and clear when reduced in size. Special care is needed with symbols: correction at proof stage may not be possible. Lettering must not be put on the original drawing but upon a copy to guide the printer. Captions should be listed on a separate sheet.

- (e) Bibliographical references in the text should quote the authors name and the date of the publication thus: Hunt (1993). They should be listed alphabetically by author at the end of the article according to the following format:

Moore, R. G. & Blackburn, L.-M. (1993). Sociotropy, autonomy and personal memories in depression. *British Journal of Clinical Psychology*, 32, 460-462.

Steproe, A. & Wardle, J. Cognitive predictors of health behaviour in contrasting regions of Europe. In C. R. Brewin, A. Steproe & J. Wardle (Eds), *European Perspectives in Clinical and Health Psychology*, pp. 101-118. Leicester: The British Psychological Society.

Particular care should be taken to ensure that references are accurate and complete. 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 (see *BPS Style Guide*).
- (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 materials should be submitted to the Editor together with the article, for simultaneous refereeing.

6. Brief Reports and Comments are limited to two printed pages. These are subject to an accelerated review process to afford rapid publication of research studies, and theoretical, critical or review comments whose essential contribution can be made within a small space. They also include research studies whose importance or breadth of interest is insufficient to warrant publication as full articles, and case reports making a distinctive contribution to theory or method. Authors are encouraged to append an extended report to assist in the evaluation of the submission and to be made available to interested readers on request to the author. To ensure that the two-page limit is not exceeded, set typewriter margins to 66 characters maximum per line and limit the text, including references and a 100 word abstract, to 150 lines. Figures and tables should be avoided. Title, author name and address for reprints and data of receipt are not included in the allowance. However deduct three lines from the text each and every time any of the following occur:

- (a) title longer than 70 characters,
- (b) author names longer than 70 characters,
- (c) each address after the first address,
- (d) each text heading (these should normally be avoided).

A character is a letter or space. A punctuation mark counts as two characters (character plus space) and a space must be allowed on each side of a mathematical operator.

7. Proofs are sent to authors for correction of print, but not for introduction of new or different material. They should be returned to the Journals Manager as soon as possible. Fifty complimentary copies of each paper are supplied to the senior author on request: further copies may be ordered on a form supplied with the proofs.

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

9. The tendency is growing for articles to be reproduced abroad without permission. To protect the interests of authors and journals 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.

# **CLINICAL ASSESSMENT REPORT**

## **APPENDIX 4.2**



## **REASON FOR REFERRAL**

MW is a 77 year old lady who was referred for psychometric assessment by her Community Psychiatric Nurse (C.P.N.). Her daughters have frequently alerted the C.P.N. on-call and out-of hours services with various concerns about their mother. It was felt that careful management of this case might cut down on emergency contacts.

## **PRESENTING PROBLEM**

MW's daughters are concerned that she "disappears" from her home without telling anyone where she is going. They also report that she becomes agitated and expresses ideas of guilt and self-blame. She often telephones her daughters in the evenings for reassurance that they are still there. These behaviours began following the death of their father 3 months ago. They report that their father had "organised" MW for most of their married life.

Personal History - MW's previous employment was as a baker and she worked as such until her marriage. She was married for 55 years and has 2 daughters, who live nearby, and one son. Since her husband's death, her daughters have provided intensive informal support. MW has begun to attend a day hospital for 2 days per week.

Psychiatric History - MW suffered a major depressive illness following the birth of her first child 53 years ago and received multiple hospital admissions over a 9 month period. She was stabilised on medication until further episodes in 1981, 1989 and 1991. The precipitants of these are unclear.

Presentation - MW presented as a pleasant, polite lady of neat and tidy appearance. She was willing to talk but became tearful and upset when asked about her family and husband. She was fully co-operative during interview and testing procedure.

## **MEASURES OF ASSESSMENT**

In view of MW's previous psychiatric history and the nature of the presenting problem the aim of this assessment was to detect the presence of cognitive impairment and/or major depression. The clinical presentation of both can be remarkably similar in the elderly and therefore diagnostic accuracy was enhanced by the combination of different data from several instruments.

Care Staff (C.P.N. and Day Hospital Nurses) were interviewed based on interview sections of the Cambridge Mental Disorders of the Elderly Examination (CAMDEX) (Roth et al 1988). MW's general medical information was normal and no clouding of consciousness was identified. Her history excluded the presence of cerebrovascular and systemic disease. Care staff reported difficulties in daily living skills, such as inability to use money and tell the time. "Forgetfulness" and social withdrawal were also noted.

The Geriatric Depression Scale (Yesavage et al 1983) was administered. This is a 30 item self-rating scale which measures normal, mild, moderate and severe depression. MW's score of 17 placed her within the mild range of depression.

The Kendrick Battery for the Detection of Dementia (Kendrick and Mayes 1985). This test has two components, an object learning test (OLT) for measuring memory and a Digit Copying Test (DCT) for measuring psychomotor speed. The battery discriminates between

normal, depressed and dementing subjects. MW's age scaled scores identified her as "dementing" on both components. Diagnostic efficiency is increased by a change in function being detected, and the alternative battery will be repeated in 6 months time, to provide two scores for each test.

The Middlesex Elderly Assessment of Mental State (MEAMS) (Golding 1989) is a practical measure of memory skills. It is sensitive to the effects of organic impairment but resistant to the effects of depression. This requires the subject to perform a number of simple tasks, each of which test an aspect of current cognitive skill. MW had difficulties in the areas of orientation, naming, comprehension and spatial reconstruction. These areas are particularly sensitive to an organic dementing process (Erickson and Scott 1977). The total score of 7 indicated that a full neuropsychological assessment was required.

The National Adult Reading Test (NART) (Nelson 1982) was administered to provide an estimate of pre-morbid intellectual functioning. The test requires the subject to read aloud a list of 50 short phonetically irregular words and the accuracy of pronunciation is scored. The NART score can be compared with current verbal, performance and full-scale intelligence quotients as measured by WAIS-R.

The Wechsler Adult Intelligence Scale - Revised (WAIS-R) (Wechsler 1981) was administered to determine current level of cognitive functioning. The WAIS-R is a test of general intelligence and of general occupational and scholastic aptitude. The test encompasses a variety of verbal and visuospatial functions in 11 different subtests, 6 classified as Verbal and 5 as Performance function. The test is used to give Verbal, Performance and Full-scale intelligence quotients. Age scaled scores, were used to determine the extent to which MW

scores differed from expected test performances of other individuals in her age group (Ryan 1990). Table 1 provides a summary of descriptive information. MW's full scale IQ of 71 fell at the 3rd percentile in comparison with others of her age, and places her in the Borderline classification. The performance IQ exceeds the verbal IQ by 1 point, a difference that is not statistically significant at the 0.5 level. In Table 2, the verbal subtests performed best were Information and Vocabulary these involve overlearned behaviours of immediate memory recall. She had particular difficulty in recall of digits backwards, which is indicative of impaired concentration and difficulties in mental tracking. She also had difficulty with Similarities and Comprehension subtests, where her scores reflect wordfinding problems and poor verbal concept formation. None of the scores contributing to the IQ differed significantly from MW's average verbal score. Therefore, the verbal IQ appears to be a good summary of her abilities in this area.

MW's performance IQ of 73 falls at the 4th percentile. In the Picture Arrangement subtest she was unable to arrange cards into a logical sequence and left the pictures as presented. In the Object Assembly subtest she was unable to assemble pieces to make a whole. She had some problems in carrying out the Digit Symbol subtest MW's scores indicate difficulties in understanding, perceptual organisation, perceptual-motor skills as well as an inability to use visual images in thinking and processing visual material efficiently. None of the scores contributing to the performance IQ differed significantly from MW's average performance score. Therefore the performance IQ appears to be a good summary of her abilities in this area. Performance subtests are more sensitive than Verbal subtests to the effects of organic impairment (Lezak 1983) and MW's profile and age scaled scores are in keeping with this. Table 3 presents WAIS-R. Actual score and the NART information estimates of Verbal, Performance and Full-Scale Intelligence Quotients. The correlation between WAIS-R and

NART is 0.99 (Nelson 1991) and the significant differences between scores is indicative of a dementing process.

## **DISCUSSION AND FORMULATION**

The assessment results provided important information for differentiating between a dementing process and the presence of major depression.

The consistency between all test scores is indicative of impaired global functioning. This is demonstrated by deficits in short and long term memory, new learning, language, visuospatial function and executive action. Other disturbances of higher cortical function such as aphasias, and apraxias and constructional difficulties were also identified. Staff and family also reported an accentuation of personality traits and a decline in performance in daily living skills. Together the results provide evidence of a dementing process similar Primary Degenerative Dementia of the Alzheimer Type (DSMIV 1994).

While it is difficult to separate premorbid personality and emotional disturbance from the earliest symptoms of and reactions to a dementing process, it is possible to separate MW's profile from the presentation of functional depression in five key areas (Lezack 1983). Firstly, no vegetative symptoms of depression were identified (Kasznick 1981), she was unable to learn new information despite the provision of cues, whereas functionally depressed patients can usually learn via this method. Her speech structure and content were particularly impoverished, whereas these usually remain intact in depression. MW also had difficulties in drawing tasks and showed marked perseverations. These are distinct from the general apathy in such tasks of the depressed patient. MW was also unaware of the extent of her cognitive difficulties whereas most depressed patients are often acutely aware of their problems. The

above features and the reported insidious nature of their onset clearly distinguish a profile of organic dementia from the pseudodementia of depression (Golper and Binder 1981).

It is likely that MW's cognitive profile has mixed aetiology in which her pre-morbid dependant personality, the loss of her husband and subsequent disruptions in her lifestyle have left her emotionally upset and unable to cope independently. These factors interact with the behavioural effects of organic changes to produce a complex picture of impaired global functioning.

MW's family were previously unaware of any difficulties which she may have been experiencing prior to her husband's death. They now report high levels of both perceived burden and anxiety in managing her behaviours.

## **MANAGEMENT PROPOSALS**

The information on cognitive impairments and emotional status is essential for specific recommendations for future management. These are in 3 key areas:-

### **1. INDIVIDUAL INTERVENTION**

- i) MW's mild symptoms of depression may exacerbate her condition. In view of her cognitive impairments a behavioural treatment approach should be formulated e.g. increased participation in pleasant activities (Thomson 1987).
- ii) It is unclear to what extent she has coped with the death of her husband, therefore all care staff and family need to adopt a supportive role while she addresses bereavement issues (Parkes 1992).
- iii) To ensure her safety in the home an O.T. assessment may be of value. Depending upon the results of this, techniques for helping her memory may need to be devised.
- iv) MW may benefit from training in anxiety management techniques to help her to recognise and cope with her "agitated" behaviours (King 1991).

## **2. FAMILY INTERVENTION**

- i) It is likely that some of MW's behavioural problems have a relationship component. A joint session between MW and her family is necessary to encourage open communication of feelings and to promote discussion.
- ii) The family require information on the likely course and presentation of their mother's condition.
- iii) The family have expressed concern about their ability to cope with MW's behaviours. Training in the use of behavioural management techniques to modify target behaviours is required (Gugel 1994).
- iv) The family may benefit from the provision of personal stress reduction techniques (Zant 1987).
- v) The family should receive guidance to maximise support from formal services, carer groups, other family members and friends.
- vi) The family need to be acquainted with MW's treatment plan, with a view to supporting her where appropriate.



### **3. CO-ORDINATION OF OTHER SERVICES**

- i) An occupational therapy home assessment is required for further information relating to MW's day-to-day functioning and general safety in the home.
- ii) All relevant care staff require to be informed of MW's current assets and deficits to guide individualised goals in her personal care plan.
- iii) The indication of a dementing process means that social services require to be involved with regards to assessment of needs.
- iv) Other services e.g. sitter service, home help, meals on wheels should be contacted regarding the provision of support for current community living. It is imperative that the C.P.N. and all agencies involved liaise to provide a comprehensive package of care.

This is MW's first psychological assessment and for this reason results and the management proposals which follow must act as baseline. A further assessment in 6 months time is recommended. The clinical psychologist should continue to have a central role in assessment treatment and the co-ordination of services.

Table 1 - Descriptive Information

Scale	Sum of Scales Scores	IQ	Percentile Rank
Verbal	24	72	3
performance	13	73	4
Full Scale	37	71	3

Table 2 - Summary Scores on WAIS-R

Verbal Subtests	Scales Score	Age Scaled	Percentile Rank
Information	4	4	2
Digit Span	5	6	9
Vocabulary	5	6	9
Arithmetic	3	4	2
Comprehension	4	5	5
Similarities	3	6	9
Performance Subtests			
Picture Completion	4	7	16
Picture Arrangement	4	7	16
Block Design	3	5	5
Object Assembly	1	2	1
Digit Symbol	1	3	1

Table 3 - WAIS-R and NART Scores

IQ	NART Estimate	WAIS-R Actual Score
Verbal	93	72
Performance	98	73
Full Scale	95	71

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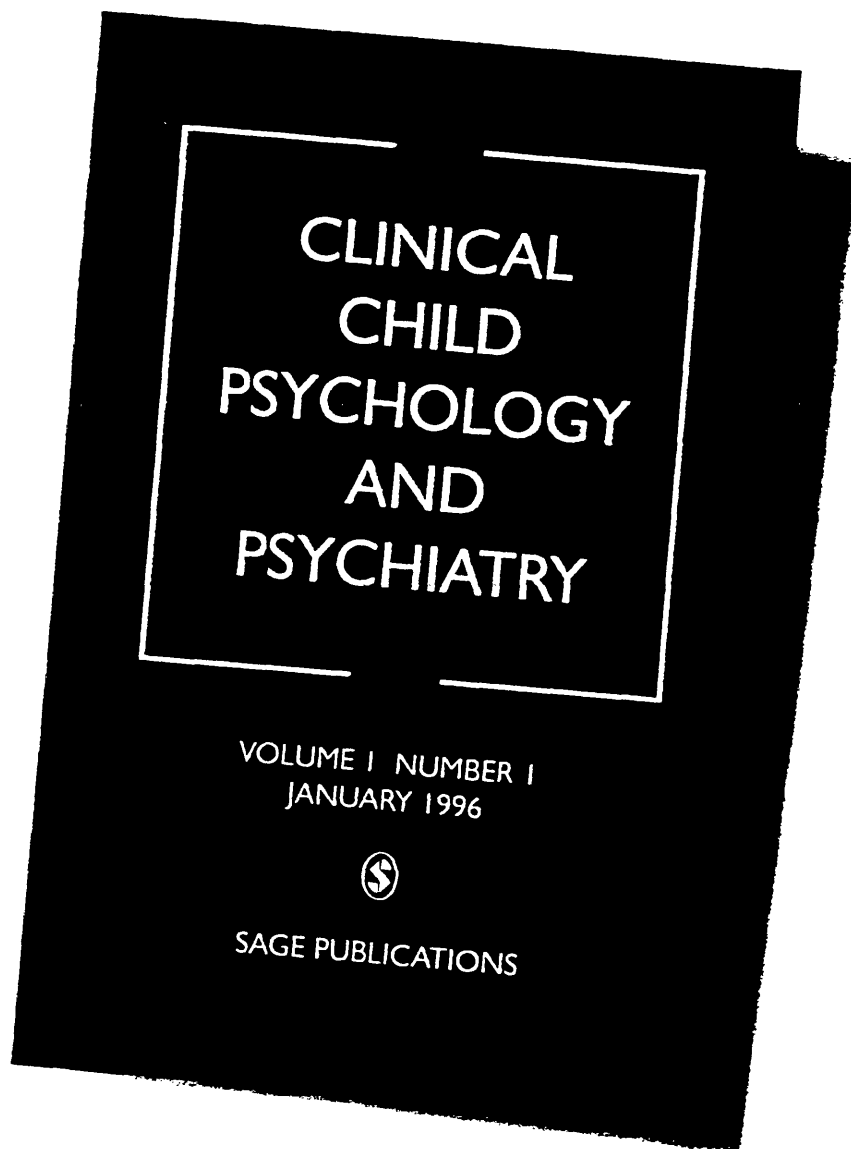
## **APPENDIX 5**



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Appendix 5.1



## Call for Papers

*"Clinicians working in clinical child psychology and psychiatry will welcome an initiative which holds promise of focusing primarily on practice relevant material."*

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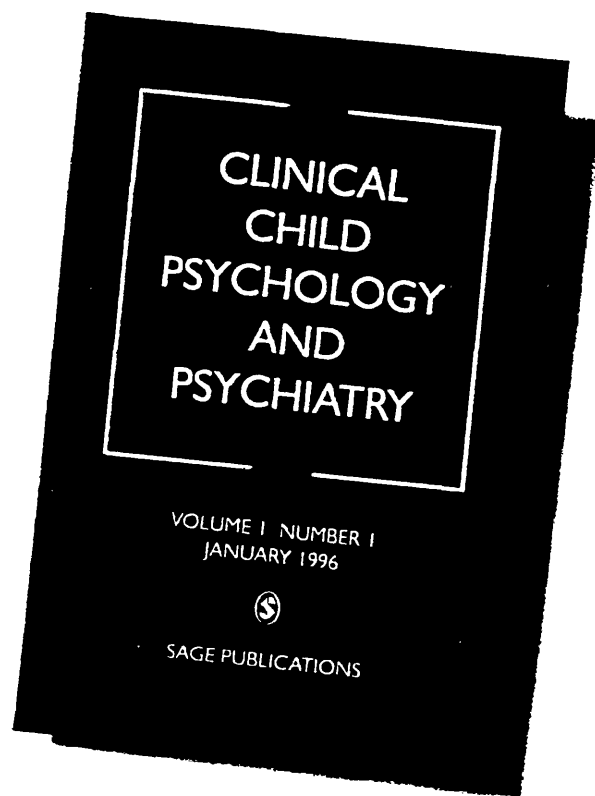
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# Clinical Child Psychology and Psychiatry

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Editor Dr Bryan Lask

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Tel: +44 (0)171 829 8679 Fax: +44 (0)171 829 8657

## INSTRUCTIONS TO AUTHORS

To ensure rapid and efficient processing of your contribution it would be most helpful if you could take careful note of the following information:-

Articles submitted for publication must be typed in double spacing throughout, on one side only of white A4 paper, with generous left and right-hand margins. There is no absolute limit on length, but 7500 words, including footnotes and references, is a useful target. An abstract of up to 150 words should precede the main text, accompanied by up to five key words.

Titles and section headings should be clear and brief. Lengthy quotations (exceeding 40 words) should be displayed, indented, in the text. British or American spellings may be used. British spellings should use the "z" spelling in those words where it has generally replaced the "s", eg organize. Indicate italic type by underlining, and use single quotation marks. Dates should be in the form "9 May 1994". Take out points in USA and other such abbreviations and do not use points after Dr, Mr, Mrs, etc. When referring to pagination and dates use the smallest number of numerals possible (eg 10-19, 42-5, 1961-4, 1978-85).

Tables and figures should have short, descriptive titles. All footnotes to tables and their source(s) should be typed below the

tables. Column heading should clearly define the data presented. Camera-ready artwork for all figures must be supplied. Artwork intended for same-size use should have a maximum size of 170:100mm (page depth: page width); oversized artwork should be prepared in the same proportion.

Essential notes should be indicated by superscript numbers in the text and collected on a single page at the end of the text. References cited in the text should read thus: Brown (1990: 63-4), Brown and Smith (1985, 1990). Use "et al" when citing a work by more than two authors, eg Brown et al (1991). The letters a, b, c, etc, should be used to distinguish citations of different works by the same author in the same year, eg Brown (1975a, b) All references cited in the text should be listed alphabetically and presented in full after the notes, using the following style:

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Books: Nelson, Richard R and Winter, Sidney G (1982). An Evolutionary Theory of Economic Change. Cambridge, MA: Harvard University Press.

Articles in Books: Sable, Charles F (1992). 'Studied Trust:

Building New Forms of Co-operation in a Volatile Economy',  
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Districts and Local Economic Regeneration, pp.215-50. Geneva:  
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Unpublished works: Pearce, David G (1987). 'Renegotiation-proof  
Equilibria: Collective Rationality and Inter-temporal  
Cooperation', Mimeo, Yale University.

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of blind refereeing, authors should supply a short biography of  
50-100 words, with a full mailing address, plus an electronic  
mail address where applicable, and telephone and fax numbers.

We regret that we will have to return to the authors for revision  
any articles that do not conform to the fundamentals of this  
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fully numbered and legible, together with all figures and tables

## ADHD RATING SCALE

Child's Name \_\_\_\_\_ Age \_\_\_\_\_ Grade \_\_\_\_\_  
 Completed by \_\_\_\_\_

Circle the number in the *one* column which best describes the child.

	Not at all	Just a little	Pretty much	Very much
1. Often fidgets or squirms in seat.	0	1	2	3
2. Has difficulty remaining seated.	0	1	2	3
3. Is easily distracted.	0	1	2	3
4. Has difficulty awaiting turn in groups.	0	1	2	3
5. Often blurts out answers to questions.	0	1	2	3
6. Has difficulty following instructions.	0	1	2	3
7. Has difficulty sustaining attention to tasks.	0	1	2	3
8. Often shifts from one uncompleted activity to another.	0	1	2	3
9. Has difficulty playing quietly.	0	1	2	3
10. Often talks excessively.	0	1	2	3
11. Often interrupts or intrudes on others.	0	1	2	3
12. Often does not seem to listen.	0	1	2	3
13. Often loses things necessary for tasks.	0	1	2	3
14. Often engages in physically dangerous activities without considering consequences.	0	1	2	3

*Note.* From *The ADHD Rating Scale: Normative Data, Reliability, and Validity* by G. J. DuPaul, 1990, unpublished manuscript, University of Massachusetts Medical Center, Worcester. Reprinted by permission of the author. This form may be reproduced for personal use.

## HOME SITUATIONS QUESTIONNAIRE—REVISED

Name of Child \_\_\_\_\_ Date \_\_\_\_\_  
 Name of Person Completing This Form \_\_\_\_\_

Does this child have problems paying attention or concentrating in any of these situations? If so, indicate how severe these attentional difficulties are.

<i>Situations</i>	<i>Yes/No</i> (Circle one)		<i>If yes, how severe?</i> Mild (Circle one) Severe									
	Yes	No	1	2	3	4	5	6	7	8	9	
While playing alone	Yes	No	1	2	3	4	5	6	7	8	9	
While playing with other children	Yes	No	1	2	3	4	5	6	7	8	9	
Mealtimes	Yes	No	1	2	3	4	5	6	7	8	9	
Getting dressed	Yes	No	1	2	3	4	5	6	7	8	9	
While watching TV	Yes	No	1	2	3	4	5	6	7	8	9	
When visitors are in your home	Yes	No	1	2	3	4	5	6	7	8	9	
When you are visiting someone else	Yes	No	1	2	3	4	5	6	7	8	9	
At church or Sunday school	Yes	No	1	2	3	4	5	6	7	8	9	
In supermarkets, stores, restaurants, or other public areas	Yes	No	1	2	3	4	5	6	7	8	9	
When asked to do chores at home	Yes	No	1	2	3	4	5	6	7	8	9	
During conversations with others	Yes	No	1	2	3	4	5	6	7	8	9	
While in the car	Yes	No	1	2	3	4	5	6	7	8	9	
When father is home	Yes	No	1	2	3	4	5	6	7	8	9	
When asked to do school homework	Yes	No	1	2	3	4	5	6	7	8	9	

-----  
 Office Use Only: No. of problems \_\_\_\_\_ Mean severity \_\_\_\_\_

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SCHOOL SITUATIONS QUESTIONNAIRE—REVISED

Name of Child \_\_\_\_\_

Name of Person Completing This Form \_\_\_\_\_

Does this child have problems paying attention or concentrating in any of these situations? If so, indicate how severe these attentional difficulties are.

Situations	Yes/No		If yes, how severe?								
	(Circle one)		Mild (Circle one)			Severe					
During individual deskwork	Yes	No	1	2	3	4	5	6	7	8	9
During small-group activities	Yes	No	1	2	3	4	5	6	7	8	9
During free-play time in class	Yes	No	1	2	3	4	5	6	7	8	9
During lectures to the class	Yes	No	1	2	3	4	5	6	7	8	9
On field trips	Yes	No	1	2	3	4	5	6	7	8	9
During special assemblies	Yes	No	1	2	3	4	5	6	7	8	9
During movies, filmstrips	Yes	No	1	2	3	4	5	6	7	8	9
During class discussions	Yes	No	1	2	3	4	5	6	7	8	9

-----  
Office Use Only: No. problems \_\_\_\_\_ Mean severity \_\_\_\_\_

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## RESTRICTED ACADEMIC SITUATION CODING SHEET

Interval #:	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15								
Off task																							
Fidgeting																							
Vocalizing																							
Plays w/obj.																							
Out of seat																							
Interval #:	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30								
Off task																							
Fidgeting																							
Vocalizing																							
Plays w/obj.																							
Out of seat																							
Interval #:	31	32	33	34	35	36	37	38	39	40	Total												
Off task											/40												
Fidgeting											/40												
Vocalizing											/40												
Plays w/obj.											/40												
Out of seat											/40												
											Total:		/200										
Child's Name:											Coder Initials:												
_____											_____												
											Date:												
											_____												
Week _____																							
Comments:																							

DAILY STUDENT RATING CARD

DAILY STUDENT RATING CARD

NAME \_\_\_\_\_ DATE \_\_\_\_\_

Please rate this child in each of the areas listed below as to how he performed in school today using ratings of 1 to 5. 1 = excellent, 2 = good, 3 = fair, 4 = poor, 5 = terrible or did not work.

Area	Class periods/Subjects					
	1	2	3	4	5	6
participation						
class work						
handed in homework						
interaction with other children						
teacher's initials						

Place comments on back if needed:

## **APPENDIX 6**

## 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. Reviewers will then communicate directly with authors.

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Please send all copy and correspondence to the co-ordinating Editor:

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**PRISONERS RATING OF PSYCHOLOGY SERVICE (PROPS)**

On a scale from 1 to 5 how distressed did you feel before seeing the psychologist?

1 (not at all distressed), 2,3,4, 5 (very distressed).

2. I expected to wait longer to see a psychologist.

True/False/Don't Know

3. I thought the psychologist understood my problems.

True/False/Don't Know

4. I think the psychologist explained things to me clearly.

True/False/Don't Know

5. I think I can now deal more effectively with my problems.

True/False/Don't Know

6. I think I had enough time to discuss my problems.

True/False/Don't Know

7. I am worried that my problems might not be kept private.

True/False/Don't Know

8. We would like any comments on the service you received from the psychologist.

Was there anything you found to be especially useful?

Please comment

Was there anything you found to be not useful?

Please comment