A COMPARATIVE STUDY OF CLINICAL DEFINITIONS AND MEASURES OF ANTISOCIAL PERSONALITY (PSYCHOPATHY)

Submitted by

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I certify that all material in this thesis which is not my own work has been identified and that no material is included for which a degree has previously been conferred upon me

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Table of Contents

Section I: Academic ........................................................................................................... 1

Essay 1: Discuss the issues and concerns in the provision of group therapy for older adults ................................................................. 2

Essay 2: Can a connectionist model of oral reading inform accounts of the cognitive distortions observed in personality disorder.....17

Essay 3: Discuss the use of a Gentle Teaching approach with people with learning disabilities who show challenging behaviours. Are any of the techniques used in Gentle teaching common to those used in applied behaviour analysis? ................. 31

Essay 4: To what extent can people with learning disabilities benefit from the full range of therapies that are used with the general population ........................................................... 42

Essay 5: Discuss the contribution that clinical (cognitive) neuropsychology can make to the assessment of a neurological disorder ......................................................................................... 53

Section II: Clinical .......................................................................................................... 67

Placement summaries and contracts ................................................................................. 68

Case study summaries ........................................................................................................ 89

Section III: Research ....................................................................................................... 105

Literature review: Personality disorder and antisocial behaviour: the law, clinical definitions, and standardised measures ..................... 106

Substantive research: A comparative study of clinical definitions and measures of antisocial personality (psychopathy) ................... 132

Minor research: Pilot study for a cognitive and behavioural intervention for memory problems occurring in older adults ......................... 183

Acknowledgments ............................................................................................................. 256
SECTION I: ACADEMIC
ESSAY 1

DISCUSS THE ISSUES AND CONCERNS IN THE PROVISION OF GROUP THERAPY FOR OLDER ADULTS
Discuss the issues and concerns in the provision of group therapy for older people

Epidemiological studies suggest that there are high rates of mental health problems among the population of older adults. For example, the prevalence of depression in people living at home who are over the age of 65 has been estimated to be 13.5% (Lindesay et al., 1989). Studies indicate comparable figures for the prevalence of anxiety disorder (Livingston et al., 1990). In addition, chronic confusional states have been estimated to affect 2.1% of people aged 65-69 years, rising to 17.7% of people over the age of 80 years (Kay & Bergmann, 1980). Although pharmacological interventions have proven to be effective (e.g. Strauss & Solomon, 1983), their use is often complicated by their impact on existing medical conditions, or medication prescribed for concurrent illnesses (Cohen-Cole & Stoudemire, 1987). Moreover, other studies have suggested that reliance solely on chemotherapies may produce poor outcomes in many cases (Rockwell et al., 1988).

The above findings suggest that there is a need to develop effective and cost efficient alternatives or adjuncts to medical interventions. Moffat, Mohr, and Ames (1995) note that a wide range of psychological approaches have been advocated for use with older adults. They suggest that where staff are few and resources limited, delivering interventions in a group permits more patients to receive treatment. Moreover, MacLennan et al. (1988) suggests that in many cases group interventions should be the treatment of choice because groups encourage the identification of common problems and the examination of diverse solutions; they reduce the shame of having a mental health problem and render them more socially acceptable; they also reduce social isolation and loneliness, which are common problems among the older population.

I believe that the extent to which group interventions will fulfil these objectives depends upon the development of an empirically validated model of group dynamics, an awareness of the specific needs and beliefs of older adults, and an assessment of the theoretical, empirical, and ethical weaknesses and strengths of different group approaches. The first part of this essay examines the efficacy, ethics, and theoretical basis of a range of group therapies offered to older adults. The remainder of the essay reviews some of the literature about group dynamics, and highlights some of the
characteristics of older populations that might influence these dynamics.

Evidence for the efficacy of intervention groups for older populations

Leszcz (1987) notes that a wide range of groups have been offered to older adults. She suggests that these groups have addressed a wide range of themes including: loss of physical and cognitive capacities; loss of functions and tasks; loss of self-worth and self-esteem; loneliness and isolation; depression and demoralisation; dependency-autonomy conflicts; and, intrafamilial disputes. Leszcz states that these issues have been addressed using a variety of types of group approaches. She argues that these approaches can be broadly categorised as 'verbal-centred' groups for the cognitively intact (e.g. psychodynamic, life-review, homogeneous, carers, and cognitive-behavioural groups), 'verbal-centred' groups for the cognitively impaired, and 'activity/creativity-centred' groups. The remainder of this essay reviews the ethical, theoretical and empirical basis for the approaches subsumed under these categories.

'Verbal-centred' groups for the cognitively intact

(i). Cognitive-Behavioural Therapy (CBT) groups

Cognitive-behavioural therapists propose that distortions in thinking underlie psychological symptoms (e.g. Beck, Rush, Shaw & Emery, 1979). Consequently, the immediate goal of CBT is the recognition and correction of these distortions. This goal may be accomplished by a variety of techniques, such as graded task assignments, cognitive rehearsal, assertiveness training, role-playing, and mood graphs (Gallagher & Thompson, 1982).

Although negative cognitions can occur at any age and quite regardless of a person's actual life situation, later life is accompanied by many changes that could facilitate the development of cognitive biases (Yost et al., 1986). However, depression and anxiety need not be the inevitable reaction to these changes. Thus, cognitive-behavioural therapists emphasise the importance of a person's interpretation of their life circumstances in the development of mental health problems. Yost et al. (1986) suggest that the emphasis on cognition makes this approach particularly suitable for dealing with
negative life events that are both unchangeable and continuously present. Moreover, traditional cognitive-behavioural interventions focus on current concerns and skill building which potentially makes it attractive to older adults who may believe they are too old to change (Steuer & Hammen, 1983).

The efficacy of CBT groups in the treatment of depression is supported by a growing number of systematic studies. For example, Steuer and Hammen (1983) described the cases of four depressed older adults who were treated within a CBT group. They report improvements in pre- and post-group scores on the Hamilton Rating Scale for Depression (Hamilton, 1967) and the Beck Depression Inventory (BDI) (Beck et al., 1961) for all four patients. However, Steuer et al. note that the extent of improvement was related to scores on neuropsychological assessment, and differences in cultural beliefs between ‘young-old’ (60-74 years) and ‘old-old’ (75 years or over) adults.

The sample size reported by Steuer and Hamilton (1983) is extremely small, making interpretation and generalisation difficult. However, Leung and Orrell (1993) report outcome measures from a sample of twenty-seven patients diagnosed with depressive disorders who participated in a brief CBT group intervention. They found that patients diagnosed with Major Depressive Illness demonstrated significant improvements in their General health Questionnaire (GHQ) and BDI scores. Moreover, these improvements were still present one year after the group had ended. However, Leung and Orrell’s findings were less optimistic for patients receiving diagnoses of dysthymia, and cyclothymia. They also note that their findings suggest that poor outcome is associated with a long history of personality dysfunction.

(ii). Psychodynamic psychotherapy groups
Kohut’s (1984) conceptualisation of ‘narcissism’ and self-psychology is particularly relevant to individuals with the challenge of maintaining the sense of self in the face of the narcissistic injuries of aging, the loss of ‘central functions’, and ‘self-object’ relationships (Leszcz, 1987). Moreover, Grotjahn (1978) suggests that psychodynamic therapy is particularly suitable for elderly populations because their constricted social lives give ‘emotional primacy’ to transference issues.

Steuer, Minte and Jarvik (1982) compared the outcomes of psychodynamic group therapy, and cognitive behavioural interventions with older populations. Their subjects were community volunteers who met the DSM III
criteria for 'Major Depressive Disorder'. Both groups demonstrated statistically significant decrement in observer-rated and self-reported depression and anxiety. Leszcz (1987) argues that these findings indicate that both interventions are equally effective. However, there are theoretical and empirical grounds for selecting cognitive-behavioural over psychodynamic interventions with older adults. First, cognitive-behavioural interventions are more closely allied with research and theory in mainstream psychology. Second, Steuer et al. (1982) found pre and post group self-ratings on the Beck Depression Inventory revealed greater improvements for patients in the cognitive-behavioural group compared with those in the psychodynamic group. Third, cognitive-behavioural interventions traditionally focus on the 'here and now'. This has the advantage of avoiding the ethical dilemma of whether to raise former unpleasant life events which the patient can no longer modify. Finally, Grotjahn (1978) offers the 'emotional primacy' to transference issues of older adults as an important indication for psychodynamic interventions.

(iii). Life-review group therapy
Butler (1975) postulates that older age is associated with 'identity consolidation', intimacy, and the resolution of problematic issues associated with older age. He argues that older adults strive to attain these goals through the naturally occurring process of 'life-review'. He suggests that this process combines 'reminiscence', 'longitudinal perspective', and 'appreciation of the present'. Butler's intervention, which he called 'life-review' therapy, consists of encouraging (a) reminiscence of one's life, (b) absolution from lingering past guilt, (c) articulation of positive personal values, and (d) resolution of interpersonal conflicts.

Leszcz (1987) notes, however, that reminiscence can be counter-productive. She notes that for some patients reminiscing may result in a further preoccupation with the past, and/or guilt over irreparable mistakes. Leszcz notes that this is particularly likely to be the case with patients who are depressed or withdrawn. Life-review therapy can also be criticised (a) for the empirically unsubstantiated assumption that the process of 'life-review' is an inevitable stage in the aging process, and (b) the lack of data relating to its efficacy.

(iv). Caregivers' support groups
Caregivers' groups have developed in response to the increasing number of
cognitively impaired and dementing individuals cared for at home by their families (e.g. Lazarus et al., 1981). There is a great deal of evidence indicating that the carers of older confused people and stroke victims can experience significant levels of stress (e.g. Gilleard, 1984). Leszcz (1987) states that carers' support groups attempt to minimise this stress by: (a) providing information, for instance about available support services and benefits; (b) working through grief and promoting appropriate disengagement; (c) helping and encouraging carers to address their own needs; and (d) providing advocacy for carers and patients in their dealings with health professionals, and social services.

Several studies have examined the benefit of carers' support groups. To date these studies have indicated only a somewhat modest effect (Mattson, 1994). For example, Boutselis (1987) looked at the benefits of problem-solving training groups, and general support groups, for carers of older confused people. Although, carers valued both approaches, there was little change in measures of stress for either approach compared with a waiting-list control group.

'Verbal-centred' groups for the cognitively impaired

Memory problems are viewed as an almost universal feature of the dementias (Miller & Morris, 1993). Memory loss is usually considered to progress from mild lapses through to severe disorientation, failure to recognise friends and family, and an apparently almost complete breakdown of new learning (Woods, 1994). This part of the essay reviews group-based interventions for the disorientation that occurs as a result of the memory impairments associated with dementia.

(i). Reality orientation (RO)
RO sessions take the form of small structured groups, which use a variety of activities and materials to engage the patient with the wider world (Woods, 1994). The assumption is that mitigating the disorientation which accompanies dementia will alleviate the levels of distress experienced by the sufferer (Morton & Bleathman, 1991).

Holden and Woods (1988) reviewed 17 controlled trials of RO groups. They concluded that RO sessions produce a small but significant effect on measures of verbal orientation, compared with not treatment, or structured social
(ii). Reminiscence groups
Reminiscence therapy has been used with individual and with groups (Woods, 1994). Photographs, music, archive recordings, and items from the past are used to stimulate a variety of personal memories.

Evaluative studies of reminiscence therapy with people with dementia have yielded a mixed picture (Wood, 1994). Thus, Head, Portney and Woods (1990) found an increase in interaction in one group, compared with an alternative activity, but a group in another day-centre failed to show any additional benefit of reminiscence therapy. A similar pattern of inconclusive findings is also reported by Baines, Saxby and Elhert (1987).

It was also noted earlier that reminiscence may have counter-productive effects depending on the disposition of group members.

Activity- and Creativity-centred Groups

Leszcz (1987) notes that there are a broad range of activity- and creativity-centred groups. She states that “these groups provide opportunities for individuals, whose verbal skills may be diminished, to express and rekindle a sense of self through the artistic or creative process, enhanced by working together and creating” (p. 535). However, Leszcz does not provide any evidence to support this statement. Moreover, there is a danger that the activities employed in these groups could infantilise the group members.

Group dynamics and older people

Bender and Lewens (1990) state that there are far greater similarities than there are differences between the dynamics of intervention groups involving older and younger members. The first section of this essay has two objectives, first to provide a brief review of the literature on group dynamics, and second to highlight ways in which these group dynamics might be influenced by cultural and epidemiological factors relating to older adults.

Munich (1993) argues that the theory of group dynamics are an amalgam of
at least three separate disciplines: psychology, social psychology, and sociology.

Much of the psychological literature on intervention groups has concentrated on psychodynamic accounts of group processes. For example, in his review Munich cites Freud (1921), Bion (1961), and Slater (1966). He suggests that these accounts help to explain changes in group members' allegiances to the group itself, other members' of the group, and its leader. Convincing evidence for the theoretical assumptions made by these accounts is, however, absent.

Other psychologists have concentrated on the influence of members' cognitions upon group functioning. For example, Heslin and Dunphy (1964) found that members' perceptions of the progress towards the group's goal has a significant impact on their satisfaction with the group, and the degree of factionalism and inter-member aggression. Munich (1993) reviews data that indicate members' satisfaction is also mediated by the perceived freedom to participate in group interactions. Finally, Deutsch (1949) highlights the link between cooperation between group members and the congruence between group and individual goals.

Social psychologists have tried to bridge the gap between the individual and group process. For example, Tuckman (1965) reviewed 50 articles on group development. His conclusion was that all intervention groups pass through the sequential stages of 'forming, storming, norming, and performing'. During the 'forming' stage group members are testing each other out and making efforts to establish dependent relations with each other and the leader. From the point of view of group dynamics the members tend to be orientating themselves to the goal of the group. As the group enters the 'storming' phase the group members experience conflict, and an observer may record an emotional response as the predominant group reaction to its task. The 'norming' stage is characterised by group members trying to enhance cohesion with other members, and the predominant group dynamic is 'open-exchange'. The 'performing' stage of the group involves individual members adopting roles that are related to the group's goal. The group dynamic is the emergence of solutions and insights.

An alternative to Tuckman's model of group dynamics is provided by Tajfel (1978). Tajfel's theory was originally proposed to explain intergroup
behaviour, however, I believe that it can also account for many aspects of intervention groups. Tajfel's model has the advantage of being consistent with the large body of experimental research on intergroup processes.

Tajfel proposes that social situations can be characterised as lying on a continuum from the extremely interpersonal situations to the extremely intergroup. Towards the interpersonal extreme individuals relate to each other purely as individual, without regard to their membership of any group or groups. Towards the intergroup extreme, the individual attributes of the participants lose relevance, interactions being based purely on people's membership of different groups. The major common features of behaviour in intergroup as opposed to interpersonal situations are a shared 'ingroup' affiliation of the individuals concerned (note the similarity to Tuckman's 'performing' stage), and a shared interpretation of the relations between the ingroup and outgroup as applied to the particular situation.

Tajfel argues that the extent to which an individual chooses to maintain or seek membership of a group depends upon his/her perception of the contribution it makes to positive aspects of his/her self-esteem. If a group does not satisfy this requirement, the individual will tend to leave it unless: (a) leaving the group is impossible; or, (b) leaving conflicts with important values which are themselves a positive part of his/her self-esteem. If leaving the group presents either of these difficulties, there are at least two solutions available: (a) to change one's own attributions about the group so that its unwelcome features are either justified or made acceptable; or, (b) to accept the situation for what it is and engage in action which would lead to desirable changes, for instance, by attempting to steer the group in a more acceptable direction. These latter two processes presumably underpin the 'storming' process observed by Tuckman (1965). However, Tajfel's interpretation suggests that rather than an inevitable stage in group formation, these processes only occur where there is a conflict between the attitudes of group members, and their perceptions of the characteristics and objectives of the group.

Sociological investigations of group dynamics focus on processes and structures that are intrinsic to groups irrespective of their format or content (Munich, 1993). Agazarian and Janoff (1993) argue that one sociological theory that has a natural application to group dynamics is 'general systems theory' (vanBertanmanffy, 1968). Consequently, they suggest that group
processes operate through a hierarchy of systems (i.e. group, sub-group, and member), and that changes to the dynamics at one level influence the dynamics at other levels.

Agazarian and Janoff apply systems theory to psychodynamic accounts of group and individual processes. These accounts have been criticised because of their lack of empirical support. However, systems theory is equally applicable to cognitive accounts of group dynamics. Thus, it has been suggested that member’s attitudes affect the functioning at the sub-group, and group levels. For example, a mismatch between individual and group goals increases the likelihood of fractionism (Deutsch, 1949).

Conclusions and implications for clinical practice

Despite Bender and Lewen’s (1990) reassurance that group dynamics are essentially similar for groups involving younger and older populations the above discussion has emphasised the importance of cognitive factors in determining group dynamics. Consequently, when planning a group it is important to assess the attitudes of potential group members and leaders. This assessment should be particularly sensitive to any ageist beliefs held by the leader, to any age related cultural beliefs held by group members (e.g. about manners, etiquette, dress), and to the expectations of group members about the style and purpose of the group, and the likely outcomes of being a group member.

In addition to cultural and psychological factors, group interventions with older adults can also be affected by sensory and cognitive impairments. The likelihood of a person having some kind of impairment to sight and/or hearing increases with age. As well as affecting the registration of new information, sensory impairments may also affect social skills, such as turn-taking in conversation. Consequently, the pre-group assessment should investigate whether a person has a sensory impairment, and if so, whether they wear glasses or use a hearing-aid. The effects of sensory impairments can also be compensated for by choosing a quiet room for group meetings, strategic arrangement of furniture, use of visual aids and/or microphones, and using clear signals to indicate when it is not appropriate to interrupt.
The incidence of stroke and other organic pathology (e.g. Alzheimer's Disease) also increases with age. The cognitive impairments produced by these conditions not only affect information processing, but can also reduce people's confidence and make them anxious about participating in group meetings. Evidence for neurological impairment should be sought during pre-group assessments. Appropriate action should then be taken during group meetings to minimise information processing deficits, and if necessary the person should be reassured that their difficulties will be dealt with in a sympathetic way.

Finally, issues relating to the efficacy, theoretical underpinnings, and ethics, of different group approaches to psychological interventions with older adults were reviewed. It was found that these approaches differ in the extent to which they satisfy the needs for psychological interventions to be ethical, and theoretically and empirically founded. For instance, cognitive-behavioural therapy groups have the advantage of being focussed in the present, therefore, avoiding the need to dwell on distressing past events. Moreover, it was noted that there is a growing body of evidence indicating the efficacy of cognitive behavioural groups.
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ESSAY 2

CAN A CONNECTIONIST MODEL OF ORAL READING INFORM ACCOUNTS OF THE COGNITIVE DISTORTIONS OBSERVED IN PERSONALITY DISORDER?
Can a connectionist model of oral reading inform accounts of cognitive distortions in personality?

DSM-IV defines personality disorder (p.d.) as an enduring pattern of inner experience and behaviour that deviate markedly from the expectations of the individual's culture, is pervasive and inflexible, has onset in adolescents or early adulthood, is stable over time, and leads to distress or impairment. Similarly, ICD-10 diagnostic guidelines suggest that p.d. represents an abnormal behaviour pattern which is enduring, pervasive and clearly maladaptive to a broad range of personal and social situations.

Several authors (e.g. Beck & Freeman, 1990; Young, 1990) propose that the maladaptive behaviours observed in p.d. are maintained by distorted processing of incoming information. For instance, Young (1990) argues that existing cognitive structures, called schema, bias attention towards information that is consistent with active schema and away from information that is inconsistent with them. He proposes that the consequence of this bias is that the processing of novel information is distorted towards previous interpretations. The notion of distorted information processing is central to all cognitive models of p.d.

There is a consensus amongst cognitive psychologists, neuropsychologists, computer scientists, linguists and philosophers that models of human cognition should specify (a) all the forms of representation involved in processing an input or producing an output, and (b) the processes which translate one form of representation into another (e.g. Marr, 1982; Aitkenhead & Slack, 1990). Judged against these criteria current cognitive models of p.d. are unsatisfactory (Teasdale & Barnard, 1993). For instance, they fail to adequately specify the representational form of schema and the processes through which they influence the interpretation of incoming information.

The current essay introduces an analogy between oral reading and p.d. Cognitive accounts of oral reading suggest that the errors observed in surface dyslexia arise from the distorted mapping of written words into their spoken output forms. These accounts suggest that distortions reflect the over application of rules, developed from previous experience, which specify correspondences between graphemes and phonemes (e.g. Marshall & Newcombe, 1973). Cognitive accounts of oral reading have been implemented
in the form of a connectionist computer simulation (Patterson, Seidenberg & McClelland, 1989). Given that accounts of surface dyslexia and p.d. both emphasise the importance of previous experience in producing cognitive distortions, the present essay investigates whether connectionist models, similar to those used to model oral reading, could aid the development of a detailed model of cognitive distortions observed in p.d.

Seidenberg and McClelland's (1989) model of oral reading

Patterson, Seidenberg and McClelland (1989) note that one of major problems experienced learning to read single words in English arises from the complex pattern of correspondences between written and spoken English. They state that whilst letter strings (graphemes) usually correspond to phonemes, many correspondences are completely arbitrary. For instance, -OLO- in COLONEL, and -PS in CORPS. Consequently, students of English not only have to learn a set of rules outlining 'grapheme-to-phoneme' correspondences, but also a relatively large set of exceptions to these rules.

The problems caused by exception words were illustrated by Backman et al. (1984). These researchers investigated the effects of regularity on the development of word naming. Their main findings were that younger and less skilled readers (a) have more difficulty with exception words, and (b) exhibit more regularisation errors. They also found that the frequency with which a word is likely to be encountered influences the occurrence of errors. Thus, older children were more likely to make regularisation errors on low frequency as opposed to high frequency exception words.

Seidenberg and McClelland (1989) describe a connectionist model designed to simulate data from studies of word naming. This model consists of a network of interconnected processing units. There are 400 units used to code graphemic information, 200 hidden units, and 460 units used to code phonological information. There are connections to all graphemic units to all hidden units, and from all hidden units to all phonological units. In addition, there is a set of connections from the hidden units back to the graphemic units. The connections between units carry weights that govern the spread of activation through the system. It is these weights that encode

1 Hidden units do not perform a representational function, but serve to increase the efficiency of processing, and the flexibility of the model (Seidenberg & McClelland, 1989).
what the system knows about the correspondences between written and spoken English. The architecture of the model is outlined in Figure 1.

The phonological codes for words are represented as patterns of activation distributed across a number of representational units. Details of the precise nature of these representations are provided elsewhere (e.g. Seidenberg & McClelland, 1989). For the purposes of the present essay, it is sufficient to acknowledge just two characteristics of these units. First, each graphemic and phonological unit represents only some of the features of each word. Second, each unit is activated by any word that contains these features. For instance, a graphemic unit encoding the letter string ARD will be activated equally by the words LARD, CARD, HARD.

Each word processing trial begins with the presentation of a letter string. The simulation encodes this input into a pattern of activation across the graphemic units. This activation in turn contributes to the activation of the hidden units. The amount of activation received by each hidden unit is the product of the level of activation of each graphemic unit and the weight on the connections from these units to each of the units in the hidden layer. Activation within the hidden units is then used to compute the patterns of activation for phonological units, and new activation for the graphemic units. These are computed following the same procedure as described above.

When the model is first initialised the connection strengths (and biases) are assigned random values between -0.5 and +0.5. Consequently, initially the hidden units compute an entirely arbitrary pattern of activation. This means that they send random patterns of excitatory signals to the phonological units and back to the orthographic units. At this point these two outputs are compared to the correct (target) patterns that the model should have produced. The target for the graphemic feedback pattern is simply the graphemic input pattern. The target for the phonological output is the pattern representing the correct pronunciation of the letter string. The difference between the target activation and its actual activation is computed. The learning procedure consists of an algorithm which modifies the strength of each weight. The extent of this modification is in proportion to the size of that the change will have on the overall discrepancy between

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2 The hidden units also receive activation from 'bias terms'. The important points to note here are that (a) the function of 'bias term' is to aid computation, and, (b) it does does not contribute to the knowledge stored in the system, per se. The function of 'bias terms' is discussed in detail by Rumelhart, Hinton & McClelland (1986).
Figure 1: Diagrammatic representation of the units and connections in Seldnerberg and McClelland's (1989) implemented model of parallel reading.

460 Phonological units

200 Hidden units

400 Graphemic units

400 Graphemic units

400 Graphemic units
Oral reading and personality disorder

The link between p.d. and oral reading may initially appear tenuous. However, closer analysis reveals several important commonalities. First, the development of reading and social functioning both involve the extraction of rules about regularities within incoming information. It can be argued that both p.d. and some disorders of oral reading are caused by the failure to learn these rules. Second, disruptions to oral reading (dyslexia) and social functioning (personality disorders) can both have learnt and neurological etiologies. Third, p.d. and some impairments to oral reading are caused by the over application of learnt rules. These proposed similarities are discussed further in the remaining text.

The development of reading and social functioning both involve the acquisition of rules about regularities within incoming information. In the case of oral reading, the rules may relate to inferences about correspondences between a language's written and spoken forms. Skinner (1969) argued that children's inferences about these correspondences are shaped by other people's responses to their attempts to sound words out.

In the case of social functioning, the rules may relate to the child's inferences about regularities within the elements of social situations (e.g. what happened, where, when and who was involved). Bandura (1973) argued that these inferences are influential in determining a person's behaviour in a given context. Similarly to oral reading, it seems likely that the child's inferences will be shaped by other people's reactions to the child's behaviour.

It was noted above that Seidenberg and McClelland's (1989) model eventually achieved the same pattern of performance as a skilled reader. Thus, they demonstrated that it was capable of pronouncing all words in the training set. Seidenberg and McClelland note that the attainment of this end state is dependent upon the composition of the training set. They note that during the learning phase the model was presented with a representative sample of English. This raises the question of what the models output would have been if the input it received during the learning phase was skewed. Seidenberg
experience. It has already been suggested that a skewed learning history would lead to distortions to pronunciations. Thus, by analogy it can be argued that prolonged experience of child abuse would distort a person's perception of social information. However, it should be acknowledged that the effects of adverse early experiences may be modified by other more positive experiences.

The second proposed similarity between oral reading and p.d. was that both p.d. and dyslexia can arise from learnt (or functional) and neurological causes. It has already been noted that unskilled readers exhibit tendencies to pronounce exception words to rhyme with familiar regular words. In addition, there are now a vast number of reports describing impairments to oral reading acquired by skilled readers as the result of brain injury. These impairments are termed the acquired dyslexias. Several different types of acquired dyslexia have been identified (e.g. Ellis & Young, 1988). The primary distinguishing feature between these types of dyslexia is the type of errors (paralexia) made by patients in reading words aloud (Patterson, Seidenberg, McClelland, 1989). Thus, patients differ in their abilities to pronounce: familiar vs. unfamiliar words; words vs. non-words; and, regular vs. exception (or irregular) words (e.g. Ellis & Young, 1988). For instance, phonological dyslexia typically involves the mispronunciation of unfamiliar and non-words (e.g. Funnell, 1983). In contrast, surface dyslexia the mispronunciation of exception words and irregular non-words and the sparing of regular familiar words and non-words (e.g. Marshall & Newcombe, 1973).

With respect to p.d. it has already been noted that several theories propose that behavioural rigidity arises from the biasing of incoming information towards existing interpretations. In addition, high rates of neuropsychological abnormalities have been observed in a range of populations known to include significant numbers of people with p.d. These include: aggressive and violent offenders (Miller, 1987); sex offenders (Galski et al., 1990); and, psychopaths (Cleckley, 1976). However, the interpretation of these data is complicated by several factors. First, the sample populations were not defined according to the presence or absence of p.d. Second, similar patterns of impairment have been observed across a range of psychiatric diagnoses. For instance, Hill et al. (1994) found equal rates of neuropsychological morbidity across a group of patients with p.d. and a group with major mental illness. However, Hill et al. observed that the two
groups differed in the types of errors they produced on the recall of designs from the revised version of the Wechsler Memory Scale. Whereas 'severe rotational' errors were more common amongst patients with Axis I diagnoses, patients with a diagnosis of Antisocial Personality Disorder (ASPD) produced significantly more errors involving perseveration and over-replication of information. Hill et al. note that an inability to constrain responding or to 'shift set' are features which are recognised to have frequent associations with frontal lobe dysfunction (e.g. Luria, 1980). The observation of markers of frontal lobe damage provides an alternative account for the rigid, pervasive and enduring personality characteristics observed in some people with ASPD. However, not all of the patients in Hill et al.'s population of antisocial personalities exhibited symptoms of frontal lobe damage.

Ellis and Young (1988) note that cognitive neuropsychology represents a convergence of cognitive psychology and neuropsychology. Therefore, cognitive neuropsychology should offer a means of integrating neuropsychological and functional accounts of p.d. However, some definitions of cognitive neuropsychology imply that its practitioners concern themselves with impairments caused by organic lesions only. For instance, Coltheart (1986) defines cognitive neuropsychology as the explanation of the patterns of impaired and intact cognitive performance seen in brain injured patients in terms of damage to one or more of the components of a theory or model of normal cognitive functioning. This essay proposes that the scope of cognitive neuropsychology should be expanded to include 'functional' as well as organic lesions. It is suggested that this expansion will enable the approach to account for interactions between functional and organic factors in the etiology of patients' difficulties.

The final putative similarity between p.d. and oral reading was that p.d. and surface dyslexia both arise from the over application of learnt rules. In the case of surface dyslexia the rule may state that the usual correspondences between orthography and a phonology dictate that a particular string of letters should be pronounced in a particular way. Thus, cognitive neuropsychologists propose that the errors observed in surface dyslexia arise from the misapplication to exception words of rules specifying the normal correspondences between graphemes and phonemes (e.g. Ellis & Young, 1988).
Patterson, Seidenberg and McClelland (1989) demonstrated that 'damage' to Seidenberg and McClelland's model results in the over application of rules about grapheme-to-phoneme correspondence. Before this demonstration the model was trained in the same way as described above. 'Lesions' were then made at three different locations within the model. The lesion cites were the weights on the connections between graphemic units and hidden units, the hidden units themselves, and the connections between hidden units and phonological units. Lesions were inflicted by zeroing a proportion of the connections or units at the lesion cite. Patterson et al. found that all three types of lesions produced errors characteristic of patients with surface dyslexia. Thus, damaging the model increases the frequency of regularisation errors.

Given the suggestion that both surface dyslexia and p.d. reflect the over application of learnt rules, the demonstration that a connectionist model of oral reading can simulate the oral reading performances of surface dyslexic patients suggests that a similar model may be useful in explaining p.d. Moreover, the ability of the model to simulate the oral reading of both normal and neurologically impaired subjects suggests that it might help to integrate cognitive (e.g. Beck & Freeman, 1991) and neurological (e.g. Hill et al., 1994) accounts of p.d.

Summary and conclusions

The proposals outlined in this essay arose from a comparison between the cognitive processes involved in oral reading and p.d. It was noted that this comparison yields several similarities. For instance, (a) accounts of disorders of oral reading and personality both emphasise the role played by cognitive distortions in the etiology of symptoms, and (b) both disorders of oral reading and personality are associated with neuropsychological impairment, and skewed previous experience. On the basis of these similarities it was suggested that Seidenberg and McClelland's (1989) connectionist model of oral reading might help to account for several empirical findings about p.d. These suggestions are summarised below.

1. Connectionist models may provide a framework to guide the development of detailed accounts of the cognitive distortions observed in p.d.
2. Connectionist models might help to account for the association between
neurological damage and p.d.
3. Connectionist models may help to integrate functional (e.g. Beck and Freeman, 1991) and neurological accounts of p.d. (e.g. Hill et al., 1994). Thus, Seidenberg and McClelland's model demonstrates that both the effects of experience and organic damage on a person's behaviour can be simulated within a single model. It can be hypothesised that this kind of analysis may also inform the debate about the influences of neuropsychological (e.g. Frith, 1992) and cognitive (e.g. Chadwick, Birchwood & Trower, 1996) variables on the etiology of schizophrenia.

Finally, it is necessary to acknowledge that the above discussions concentrate on a cognitive processing in p.d. They do not offer, for instance, detailed suggestions about the roles played by emotions and/or situational variables in the development of p.d. However, it is speculated that one way in which these factors may influence the model is via their effects on the learning process. Thus, the environment generates instrumental and vicarious learning contingencies. In addition, these contingencies may be mediated by their impact on affective states. For instance, people may be motivated to interpret information in ways that limit unpleasant cognitive states (e.g. Festinger, 1957) or maximises positive affective states.
References


ESSAY 3

DISCUSS THE USE OF A GENTLE TEACHING APPROACH
WITH PEOPLE WITH LEARNING DISABILITIES WHO
SHOW CHALLENGING BEHAVIOURS. ARE ANY
OF THE TECHNIQUES USED IN GENTLE TEACHING
COMMON TO THOSE USED IN APPLIED
BEHAVIOUR ANALYSIS?
Discuss the use of a Gentle Teaching approach with people with learning disabilities who show challenging behaviours.

Are any of the techniques used in Gentle Teaching common to those used in Applied Behavioural Analysis?

Emerson et al. (1987) define challenging behaviour as behaviour of such intensity, frequency, or duration that the physical safety of the person or others is likely to be placed in serious jeopardy. In people with severe/profound learning disabilities the estimated prevalence of physical assault is about 14%, and self injurious behaviour about 13.5% (Jacobsen, 1982). Emerson (1990) argues that people who exhibit severe self-injurious behaviour are at risk of disadvantage through exclusion, neglect, and abuse. For instance, Emerson cites a study which revealed that 2.5% of the ward staff in Montreal institutions indicated that their typical responses to an episode of self-injury was to hit the client (Maurice & Trudel, 1982). Emerson also cites evidence indicating that 40 to 50% of all people who self-injure receive psychoactive medication. He states that this is "deeply worrying" given that there is little evidence for the efficacy of the most commonly used medications. Concerns have also been raised about the potentially abusive nature of psychological interventions for people who display challenging behaviour. One area that has been the focus of particularly intense debate is applied behaviour analysis. This debate has concerned ethical, moral, legal, and philosophical issues concerning the use of aversive procedures in the treatment of people with learning disabilities who display challenging behaviour (Jones & McCaughey, 1992). Opponents of applied behavioural analysis have described the approach as: "sinful" (Conneally, 1989, p. 5); a "culture of death" (Brandon, 1989, p. 14); and, "deliberate torture" (McGee, Menolascino, Hobbs & Meousek, 1987).

McGee and his colleagues claim to provide an alternative approach to challenging behaviour that overcomes the objections to applied behavioural analysis (e.g. McGee, Menolascino, Hobbs & Meousek, 1987). They describe their solution, which they term Gentle Teaching, as a non-aversive method of reducing challenging behaviour that aims to teach ‘bonding’ and ‘interdependence’ through ‘gentleness’, ‘respect’, and ‘solidarity’. This essay critically reviews the principles, and techniques advocated by this approach. However, the essay begins by (a) briefly outlining the main features of applied behaviour analysis, and (b) considering the validity of criticisms about the ethical status of applied behaviour analysis.
Applied behaviour analysis

Applied behavioural analysis is the application of learning theory to behaviour modification. The two cornerstones of learning theory are classical and operant conditioning. Classical conditioning is the process whereby new stimuli gain the power to elicit reflex responses. Operant conditioning is the process whereby the frequency, intensity, speed, or magnitude of a spontaneously emitted behaviour is increased or decreased by the consequences of that behaviour (Walker, 1984). These processes are probably two of the most widely researched paradigms in academic psychology. They also provide the rationale for many of the interventions advocated by applied behaviour analysts. Walker (1984) notes that these interventions include the following:

(a) punishment - presentation of an aversive event or the removal of a positive event following a response;
(b) extinction - cessation of reinforcement of a response;
(c) time out - removal of all positive reinforcers for a certain period
(d) positive reinforcement - presentation of a positive event or the removal of a negative event following a response;
(e) shaping - the attainment of a target behaviour by reinforcing small steps or approximations toward the target behaviour, and eventually the target behaviour itself.

LaVigna and Donnellan (1990) state that the selection of a particular intervention should be based on a thorough assessment of the reinforcers maintaining a problem behaviour. They suggest that this assessment should consist of seven components: description of the behaviour, background, antecedent analysis, consequence analysis, motivation analysis, ecological analysis, and evaluation of the function served by the behaviour. LaVigna and Donnellan describe a number of techniques designed to assist assessment. These include ABC charts, the Motivational Assessment Scale (Durand & Crimmins, 1988), the ‘hassle log’, and scatterplots (Touchette, MacDonald & Langer, 1985).

LaVigna and Donnellan (1986) note that critics of applied behaviour analysis typically focus on the ethical status of aversive techniques associated with the approach (Curvo, 1992). Contrary to these criticisms these authors have published a compendium of commonly used non-aversive behavioural management techniques. They propose, that unlike aversive strategies, the
techniques outlined in their book are constructive in nature, enhance human dignity, and possess social validity. Most of the techniques they describe concentrate on the provision of positive reinforcement contingent upon the performance of desirable behaviours. Some of these techniques are summarised below.

1. Positive programming
The essential element of this approach is that the goal of an interventions is to add to a person's behavioural repertoire. The techniques used in positive programming include shaping, chaining, modelling, and prompting (Kazdin, 1984).

2. The differential reinforcement of alternative (competing) responses
Lavigna and Donnellan define this approach as consisting of "the differential reinforcement of those behaviours that are topographically different from the target behaviour" (p. 41). In practice the approach requires the selection of a more desirable behaviour or set of behaviours that mutually exclude the occurrence of the undesirable target behaviour. LaVigna and Donnellan refer to this requirement as the 100% criterion.

3. The differential reinforcement of other behaviours
This approach involves the reinforcement of the learner for engaging in any response other than the target behaviour for a specified period of time. For instance, if the target behaviour is shouting, reinforcement could be scheduled for after every five minutes during which the client did not shout.

4. Stimulus control
This approach involves the manipulation of the antecedent conditions surrounding the occurrence of a behaviour. The rationale is that certain (discriminative) stimuli indicate that certain behaviours will be rewarded. Thus the learner is more likely to exhibit these behaviours in the presence of these discriminative stimuli. Conversely, they are less likely to occur in their absence.

5. Instructional control
The objective of this approach is to create a situation where a response occurs in the presence of or following the presentation of a command, direction or request. Thus instructional control is an example of stimulus control where the stimulus is a deliberate signal. The strategy for
establishing instructional control is the differential reinforcement of the response when it occurs following the presentation of the signal. Reinforcement is not delivered if the response occurs in the absence of the instructional stimuli. These non-instructed responses are reduced, therefore, through the process of extinction.

LaVigna and Donnellan note that within each of the above techniques the timing, frequency, and amount of reinforcement (i.e. the reinforcement schedule) can be systematically manipulated to achieve or enhance therapeutic effects. For instance, they note that the likelihood that a behavioural change will be maintained can be increased by systematically escalating the number of responses required to secure reward.

**Gentle Teaching**

Jones and McCaughey (1992) note that the term Gentle Teaching was first used in several papers written by McGee in 1985. These original papers have been followed by a host of articles about Gentle Teaching (e.g. McGee, Menolascino, Hobbs & Meousek, 1987; McGee & Gonzalez, 1991). These articles outline a number of principles which guide the practice of Gentle Teaching. These principles are reviewed below.

1. The principle of unconditional value
McGee and his supporters stress the importance of 'unconditional valuing', which they define as high frequency and non-contingent value giving. They propose that the central tenet of this principle is that a person's value is intrinsic in their status as a human being, and is not contingent on the deeds they do or the presence of appropriate social behaviour.

Whilst it is undeniable that all therapists should behave in a way that demonstrates respect for their clients, it is important to note that applied behavioural analysts argue that it is not the provision of unconditional value, per se, but the pairing of events expressing value with desirable behaviours that is effective in reducing challenging behaviour. Moreover, according to the principles underpinning applied behaviour analysis, pairing a challenging behaviour with a positive event will increase, rather than reduce, the likelihood of that behaviour being repeated.
2. The principle of bonding
McGee and colleagues state that the goal of Gentle Teaching is the establishment of a reciprocal interaction comprising of mutual valuing and affection. They call the establishment of this relationship 'bonding'. The assumption underpinning this principle is that the ability to respond to another individual affectionately is absent in many devalued people. Consequently, one of the goals of gentle teaching is to demonstrate that human interactions and relationships can be rewarding. McGee and Gonzalez (1990) propose that in order to satisfy this principle it is necessary to emphasise the need for caregiver change prior to, and alongside, changes in the client. They suggest that caregivers should (a) increase the frequency of behaviours like value giving, elicitation of valuing, warmly helping, and protecting, and (b) reduce the frequency of behaviours that include the use of punishment, or displays of domination.

3. Challenging behaviours are seen as a means of communication
McGee and colleagues assume that the emergence of disruptive or destructive behaviours are a means of communicating distress, discomfort, or anger (e.g. McGee, Menolascino, Hobbs & Menousek, 1987).

McGee, Menolascino, Hobbs and Menousek (1987) outline a number of the techniques used in Gentle Teaching. These techniques are briefly reviewed below. This review has two main objectives: (a) to summarise the techniques; (b) to contrast them with techniques used in applied behaviour analysis.

1. Ignore-Redirect-Reward
According to McGee and his supporters the primary goal of the techniques used in Gentle Teaching is to make reward happen. The Ignore-Redirect-Reward strategy is used to direct caregivers actions towards warm, affectionate, and rewarding behaviours that eventually lead to value sharing. The strategy requires caregivers to give as little attention as possible to disruptive or destructive behaviours so that they teach mutually valuing interactional behaviours. In addition, caregivers are required to guide the person towards rewardable interactions so that they can replace the negative and non-participatory behaviours.

This technique is an example of differential reinforcement of other responses. The 'Ignore' part of technique corresponds to the withholding of positive reinforcement following undesirable behaviours, and 'redirection'
refers to the positive reinforcement of other behaviours by the provision of warmth, affection, and rewarding behaviours.

2. Environmental control and teaching in silence
McGee and colleagues acknowledge that it is not always possible to withhold or minimise attention following an undesirable behaviour. Therefore, they suggest that it is necessary to interrupt behaviours if they are about to become harmful. They argue that if it is necessary to interrupt a person once, future efforts should focus on prevention. They suggest two ways of preventing the onset of disruptive behaviours are environmental control, and teaching in silence.

Environmental control involves the identification of environmental precursors to disruptive behaviours, and adjustment of the environment to remove or minimise the effects of these precursors. This technique is a restatement of the applied behavioural analysis stimulus control strategy.

The rationale behind teaching in silence is that cajoling a reluctant client to participate can reduce the rewarding power of verbal communication. For example, McGee, Menolascino, Hobbs and Menousek (1987) note that instructions often turn into demands, demands can turn into bribes, bribes can turn into threats, which in turn may lead to confrontation. Instead of coaxing, cajoling, bribing, to threatening the client McGee et al. suggest that non-verbal gestures should be used initially, and that friendly rewarding dialogue should be withheld until the client is participating in the desired activity.

Teaching in silence is as an example of differential reinforcement of alternative behaviours. Thus, the withholding of friendly rewarding dialogue represents the removal of reinforcement, and its provision when the client is participating in the desired activity is equivalent to the reinforcement of a desirable alternative behaviour.

3. Fading
McGee, Menolascino, Hobbs and Menousek (1987) argue that a critical issue is the degree of support that a client requires at any one moment in order to create, enhance, and maintain equitable interaction between them and the caregiver. They suggest that the level of support is often intense in the initial stages, but as interactions become more equitable the degree of
support should be decreased. For instance, they state that whereas initial
interactions might focus on rewarding any correct response, as more
participation occurs caregivers should reduce the frequency of rewards
until the client participates with no direct support.

Fading appears to be an unsystematic equivalent to the systematic adjustment
of reinforcement schedules suggested by applied behavioural analysts (e.g.
LaVigna and Donnellan, 1986).

Conclusions and implications for
clinical practice

Supporters of the Gentle Teaching claim that the approach outlines a number
good practices. For instance, the use of non-aversive techniques, and
encouraging caregivers to consider the impact of their own behaviour on
the behaviour of their clients or relative. In contrast to the criticisms of
applied behaviour analysis offered by McGee and his colleagues, these issues
are also addressed in the literature about applied behavioural analysis. For
instance, Skinner (1953) advocated the use of non-aversive methods in
preference to punitive regimens. In addition, a number of articles provide
thorough reviews of the influence of the beliefs and values of carers on the
effectiveness of behavioural interventions (e.g. Gump, 1977; Bernstein,
1982).

Another claim made by McGee and his colleagues is that Gentle Teaching
offers offer alternative intervention techniques for people with learning
disabilities who display challenging behaviour. Comparisons between the
Gentle Teaching techniques presented by McGee, Menolascino, Hobbs and
Menousek (1987), and non-aversive behavioural techniques outlined by
LaVigna and Donnellan (1986), reveal that the former techniques represent
restatements, or specific examples, of techniques already employed by
applied behavioural analysts.

Finally, I suggest that applied behaviour analysis has a number of
advantages over Gentle Teaching. Thus, applied behavioural analysis:
(a) proposes that the selection of an intervention strategy should be guided
by a thorough assessment;
(b) offers a range of assessment strategies;
(c) offers a range of theoretically and empirically founded non-aversive intervention strategies, which can be individually tailored to the needs, strengths, and weaknesses of the client; and,
(d) offers systematic methods for evaluating the effectiveness of interventions, and modifying them to match changes in the needs of the client.
References


ESSAY 4

TO WHAT EXTENT CAN PEOPLE WITH LEARNING DISABILITY BENEFIT FROM THE FULL EXTENT OF PSYCHOLOGICAL THERAPIES THAT ARE USED WITH THE GENERAL POPULATION?
these cognitions, (g) generating alternative thoughts, and (h) practising these strategies in role plays, reviews and real settings.

Lindsay and Kasprowicz (1987) demonstrated that training in the use of positive-self statements increased self-esteem and confidence in four out of a group of five subjects with mild learning disabilities. It is important to note, however, that the clients in this latter study were not suffering from depression.

The above studies demonstrate that with careful modifications and simplifications cognitive-behavioural techniques can usefully be applied to clients with learning disabilities. However, although the initial findings are encouraging, Lindsay et al. (1993) note that there are a number of important issues that need to be addressed by future research. Firstly, whether the therapeutic benefits observed in individual case studies can be replicated in well controlled clinical trials, and secondly which, if any, aspects of the above interventions can be successfully employed with clients with more severe learning disabilities.

**Anxiety**

It appears as though the majority of papers written in the last twenty years on the treatment of anxiety disorders in learning disabilities have concentrated on the use of relaxation techniques. Early researchers report the potential usefulness of ‘abbreviated progressive relaxation training’ (APR) in reducing anxiety in adults with mild and moderate learning disabilities (e.g. Harvey, 1979). However, Lindsay and Baty (1986) note that group comparison studies (e.g. Luiselli, 1980) have failed to provide firm evidence for the efficacy of this approach.

Lindsay and Baty propose that one of the reasons for the disappointing results for the application of APR is that the technique requires individuals to concentrate on internal states of muscular tension and release. They argue that this may require a conceptual awareness which may be difficult for people with more severe learning disabilities to achieve. Consequently, Lindsay and Baty advocate the use of ‘behavioural relaxation training’ (BRT). This technique was developed by Schilling and Pope in 1983. BRT requires the therapist to model both relaxed and unrelaxed behaviours in ten areas of the body, and then encouraging the client to imitate the relaxed positions. The therapist then provides simple direct feedback on the accuracy of the
Lindsay and Baty investigated the use of BRT techniques with three learning disabled adults who were diagnosed to be suffering from anxiety problems. Two of these clients had moderate learning disabilities, and the third severe learning disabilities. They report that all three clients showed consistent relaxation effects which were reflected in reductions in pulse rates, and lower observer ratings of anxious behaviours. Moreover, Lindsay and Baty briefly mention data collected from another seven adults who also revealed relaxation effects following BRT.

Williams (1990) notes that there may be a conflict between the potentially time consuming nature of BRT and the high number of learning disabled individuals with anxiety difficulties. Williams attempted, therefore, to employ BRT in a group setting. The group consisted of five individuals for whom high levels of anxiety and low tolerance to stressful situations were thought to be a particular problem. This group met for ten sessions. Sessions 1-5 consisted of the teaching of the ten postures suggested by Schilling and Poppen. The remaining sessions provided members with the opportunity to practice the postures, to identify the specific aspects of relaxation which were most difficult for them, and to use the group to overcome these problems. Williams reports that the beneficial nature of the group was indicated by the systematic increase in the mean amount of time the group members spent exhibiting relaxed behaviours within the sessions. However, he notes that it was not possible to assess whether the benefits revealed within the group setting generalised to other situations. Moreover, Williams does not provide background details for each of the group members. Consequently, it is not possible to judge from this study the extent to which group relaxation training generalises across different degrees of disability.

Although it was noted above that many studies have concentrated on the use of relaxation training, several studies report the use of other cognitive-behavioural techniques to treat phobic and obsessive-compulsive disorders in people with learning disabilities. Thus the usefulness of graded exposure (systematic desensitisation) has been suggested in case studies of the treatment of extreme fear of heights (Guralnick, 1993), travelling by car (Mansdorf, 1976), and boarding escalators (Runyan, Stevens and Reeves, 1985). Allen (1989) notes, however, that single case studies do no more than
indicate the potential benefits of CBT in treating phobias.

A larger scale study has been reported by Peck (1977). This study reports a controlled investigation of the effectiveness of different components of the desensitisation procedure. The subjects for this investigation were 80 adults with mild learning disabilities. All of these subjects had been found to be afraid of either rats or heights. The four treatment conditions used were: (1) contact desensitisation (i.e. using in vivo approach in which the therapist also participated); (2) vicarious symbolic desensitisation (i.e. using videotaped rather than real life situations); (3) fantasy desensitisation (imagination only); and, (4) placebo-attention control (in which the adults were given a harmless pill and told to relax while watching a cartoon). The results revealed an advantage for contact desensitisation, although none of the interventions yielded statistically significant improvements when compared to the control condition.

The above studies all report primarily behavioural interventions, however, Lindsay and Kaprowicz (1987) investigated the use of a more cognitively mediated treatment of social anxiety. They note that Michenbaum (1974) suggested that performance difficulties are maintained by negative self-statements which people say to themselves before and during a sequence of interaction or behaviour. Consequently, Lindsay and Kaprowicz assessed the benefits of conversational skills training with additional self-instructional training on the confidence of 5 adults with learning disabilities. They report that the combined intervention resulted in improvements in a self-report measure of confidence for all five adults. However, Lindsay and Kaprowicz paper does not distinguish whether the clients' enhanced confidence resulted from the skills training, the self-instructional training, or some other non-specific aspect of the intervention.

**Psychotherapy**

Bender (1993) argues that there are a number of barriers preventing access to psychotherapeutic services for people with learning disabilities. He proposes that these include the misleading assumption that people with learning disabilities do not have the cognitive abilities required to benefit from psychotherapy, and the narrow minded use of pharmacological interventions by psychiatrists and behavioural interventions by clinical
Despite Bender's condemnation of existing services, there have been a number of papers espousing the use of psychotherapy with people with learning disabilities. For example, the potential for using group psychotherapy as a means to enhance 'personal development' is suggested by a number of therapists (e.g. Hodgetts, 1986; Humphreys, Hill & Valentine, 1990; McGovern, 1990). However it is important to note that none of these studies employed objective measures of outcome. Moreover, it appears as though the group members were mainly people with mild or borderline disabilities. Consequently, the utility of psychotherapy with less able clients is unclear.

One area where psychotherapy has been strongly advocated is bereavement (e.g. French & Kuczaj, 1992). Emerson (1977) found that about 50% of people with learning disabilities in his study who suddenly, and for no apparent reason, started presenting with emotional and management difficulties had experienced the death of or loss of someone close prior to the onset of symptoms. In addition, Kitching notes that many of the coping strategies available to the general population are not always available to people with learning disabilities. For instance, people with learning disabilities may not have such ready access to confiding relationships.

Waitman and Conboy-Hill (1992) disagree with the suggestion that bereaved people with learning disabilities need psychotherapy. Instead, they suggest that acknowledgement, sensitive listening and support may be the best ways to facilitate adjustment to the loss. They offer a number of strategies that might be useful in offering this support. However, they do not provide empirical data to support the efficacy of these strategies.

Skills building - The case for Assertiveness Training

Winchurst, Kroese and Adams (1992) moot that successful integration into the community depends upon the mastery of a number of interpersonal skills. They propose that one of the most important of these is assertiveness. Winchurst et al. argue, however, that the assertiveness skills of people with learning disabilities are often deficient. Moreover, they suggest that the inability of many learning disabled clients to assert control over their
environments can result on the one hand in passive or even apathetic acceptance of external control, and on the other, challenging behaviours (e.g. physical aggression to self or others).

Millner and Dalby (1992) report the feedback on an assertiveness training course involving 7 people with mild to moderate learning disabilities. The course consisted of 10 weekly sessions. A number of training methods were used in these sessions. These methods included group discussion, handouts, brainstorming, group exercises, role plays, sharing in pairs, and video. The above techniques were used to address topics like what is assertiveness, body language, feelings, saying 'no' and 'yes', dealing with criticism, and asking for what you want. At the end of the course Millner and Dalby concluded “that subjective evidence indicates that most clients on the course took steps toward more assertive behaviour” (P. 25).

The putative benefits of assertiveness training reported by Millner and Dalby are supported by reports of the assessment of a similar intervention (Winchurst, Kroese & Adams, 1992). However, it is important to note that both of these studies used subjective measures of efficacy. Moreover, neither study attempted to isolate which aspects of assertiveness, and which methods of training, were most useful in promoting assertive behaviour.

The application of behavioural principles to the management of challenging behaviours

LaVigna and Donnellan (1986) report a number of case studies in which non-aversive behavioural strategies were used to treat people with learning disabilities who displayed challenging behaviour. These case studies include the use of: differential reinforcement of other behaviour schedules to decrease self-injurious behaviours (Peterson & Peterson, 1968); and a differential reinforcement of low rates of responding schedule to reduce rates of disruptive behaviour (Dietz & Repp, 1973).

LaVigna and Donnellan note that there are a number of ethical considerations that should be born in mind when applying these techniques. These considerations include the relative benefits and costs to the client of
behaviour change, and their ability to consent to the intervention. Lavigna and Donnellan also stress the importance of preceding any kind of intervention with a thorough functional analysis.

Conclusions and implications for clinical practice

The above discussions indicate that there is scope for using a wide range of psychological interventions with people with learning disabilities. However, it is important to note that many of the studies reported were inadequately controlled, used small sample sizes, and assessed benefits to people with mild and moderate learning disabilities only. Thus despite initially encouraging findings, future studies are needed to address these shortcomings.
References


offered to people with a mild or moderate mental handicap. Mental Handicap, 20, 21-26.


ESSAY 5

DISCUSS THE CONTRIBUTION THAT CLINICAL (COGNITIVE) NEUROPSYCHOLOGY CAN MAKE TO THE ASSESSMENT OF A NEUROLOGICAL DISORDER
Discuss the contribution that clinical (cognitive) neuropsychology can make to the assessment of a neurological disorder

There are two broad approaches to clinical neuropsychological assessment (Ellis & Young, 1988). The first is psychometric assessment. This approach is one in which the performance on one or more tasks of a group of patients of a given type is contrasted with the performance of another group of patients of a different type or with a group of ‘normal’ controls. Differences in test scores are interpreted as indicating differences in functioning. The Weschler Adult Intelligence Scale Revised (WAIS-R) (NAME) is a classic example of this approach. The WAIS is probably the most commonly used neuropsychological assessment. Findings from the WAIS have been used to derive a theory of intelligence that implies a division between performance and verbal intelligences. Theories derived from psychometric tests have been criticised because of their lack of explanatory power (e.g. Blackburn, 1983). For instance, the concepts of verbal and performance intelligence are of dubious relevance to psychological explanations of differences in human ability.

The second approach is cognitive neuropsychological assessment. The strength of this approach is that it integrates neuropsychological assessment with a large body of empirical research and cognitive psychological theory. Rather than, or in addition to, comparing a patient's performance on a test with a large control group, cognitive neuropsychologists contrast a patient's performance with that predicted by a model of cognitive functioning. The models used in this procedure are derived from empirical studies of cognition.

Blackburn (1983) notes that a distinction can be made between psychometric measurements that describe response dispositions, and theories that attempt to account for these dispositions (i.e. cognitive neuropsychology). He notes that these two types of practice are not mutually exclusive, and consequently may be combined in clinical assessment.

The present essay concentrates on cognitive neuropsychological assessment. The first part of the essay outlines several important premises underpinning the cognitive neuropsychological approach. The second part of the essay illustrates how cognitive models can guide clinical neuropsychological assessment and the interpretation of data from these assessments. The final
section of the essay demonstrates how data from cognitive neuropsychological assessment can be used to improve cognitive models.

**Cognitive neuropsychology**

Cognitive neuropsychology has two basic aims (Ellis & Young, 1988). The first is to explain the pattern of impaired and intact cognitive performance seen in brain injured patients in terms of damage to one or more of the components of a theory or model of normal cognitive functioning. According to this approach, the interpretation, design and selection of tests is guided by cognitive theory. The second aim of cognitive neuropsychology is to draw conclusions about normal, intact cognitive processes from the pattern of impaired and intact capabilities seen in brain injured patients. Consequently, cognitive neuropsychological assessment is not only guided by cognitive theory but may also shape this theory.

Caramazza (1984 & 1986) and Caramazza and McCloskey (1988) note that cognitive neuropsychologists make a number of assumptions about cognitive functioning. Thus, it is assumed that:

i) the cognitive system is composed of modules each of which carries out a specific function independently of other parts of the system (the 'assumption of modularity' (Fodor, 1983));

ii) a brain lesion can selectively damage one or two modules without impairing the independent functioning of other modules ('the assumption of fractionability' (Caramazza, 1984));

iii) the performance of a brain-injured patient reflects the total cognitive apparatus minus those systems which have been impaired ('the assumption of subtractivity' (Saffran, 1982)). Caramazza (1984) notes that assessments should also consider other possible sources of variations in performance. Thus he suggests that the performance of a patient will reflect four factors. First, the contribution attributable to the 'true' effect of the hypothesised disruption to one or more processing modules. Second, normal individual variation in performance. Third, the effects of compensatory strategies. Fourth, effects that result from disruptions to processing mechanisms other than the hypothesised component.

iv) the organisation of the cognitive system is similar in different individuals ('the assumption of universality' (Caramazza, 1986)).
Finally, cognitive neuropsychologists suggest that it is often inappropriate to group patients together under a syndrome or diagnosis. The syndrome approach implies that all patients with a specific pattern of symptoms will possess exactly the same cognitive impairments. Cognitive neuropsychologists note that the same surface symptoms can arise from different underlying cognitive impairments (e.g. Ellis, Kay & Franklin, 1992). Consequently, cognitive neuropsychologists argue that a more fruitful approach to neuropsychological assessment is to consider each symptom individually rather than investigate clusters of symptoms representing diagnoses or syndromes (e.g. Ellis, Kay & Franklin, 1991). In addition to the theoretical rationale for the symptom based approach to assessment, Frith (1992) notes that it has several practical advantages for neuropsychological research. For instance, he notes that it is almost impossible to find a non-schizophrenic control group that is properly matched for drug treatments and institutionalisation. This difficulty is much reduced if researchers compare schizophrenic patients with and without a certain symptom.

The literature about the psychological processes involved in person identification provides a good illustration of the contribution cognitive neuropsychology can make to the assessment of a symptom of neurological illness or injury. This literature is summarised in the next section.

The case of person identification: An illustration of the cognitive neuropsychological approach to assessment of neurological patients

Cognitive psychologists have found that in comparison with other types of biographical information, people's names are particularly hard both to learn, and to recall once learnt. For example, McWeeny, Young, Hay and Ellis (1987) used well-controlled stimuli to show that the names of unfamiliar individuals took longer to learn than their occupations. Young, McWeeny, Ellis and Hay (1986) showed that it took subjects longer to name a famous face than it did to classify it by occupation. Even when response demands of the two tasks were equated, naming of famous faces took longer than classifying them by occupation (Young, Ellis & Flude, 1988).

Traditionally these results have been interpreted within the framework of Bruce and Young's (1986) model of face identification. This model proposes
that name information and other kinds of biographical knowledge are stored in separate memory systems. Moreover, Bruce and Young argue that names can only be retrieved for faces after a series of discrete processing steps, involving recognition of the face, retrieval of semantic information, and finally access to name generation, a stage specific to proper names.

However, two recent models of face identification suggest that data both from ‘normal’ subjects can be explained without drawing a distinction between the storage of name and semantic information. The first of these accounts is provided by Burton and Bruce (1992), and the second by Cohen (1990). Both attribute the difficulty in name retrieval to the structure of semantic memory, rather than to the representation of names per se.

Burton and Bruce (1992) propose an Interactive Activation and Competition (IAC) model of person identification. This account stresses the effect of uniqueness on the recall of semantic information. The IAC model of name retrieval consists of three pools of representations: (a) ‘Face recognition units’ compare view and expression independent representations of a stimulus face with stored abstract representations of previously encountered faces; (b) output from face recognition units is passed in cascade to ‘Person identity nodes’ which act as gateways to semantic representations; (c) biographical information is stored in ‘semantic information units’. Each semantic information unit represents an attribute and is connected to all person identity nodes for which that piece of semantic information is associated.

One important aspect of the IAC model is the existence of reciprocal connections between ‘person identity nodes’ and ‘semantic information units’. These feedback connections allow an active semantic information unit to provide reactivation of all person identity nodes to which it is connected. This in turn serves to increase the amount of activation passing from person identity nodes to that semantic information unit. This means that a semantic information unit that is connected to many person identity nodes will receive a greater amount of reactivation than one that is connected to few person identity nodes. These units, therefore, reach threshold more quickly than those linked to fewer person identity nodes. Consequently, Burton and Bruce (1992) argue that the reason names are harder to recall than other pieces of semantic information is because they are usually unique to one person.
In contrast to Burton and Bruce's emphasis on uniqueness, several authors have proposed that names are more difficult to remember than other pieces of biographical information because of differences in 'meaningfulness' (Cohen, 1990; Lucchelli & DeRenzi, 1990; Semenza & Zettin, 1989; Cohen & Faulkner, 1986).

Cohen (1990) argues that the major difference between people's names and other kinds of person identity information is that names are relatively meaningless, and difficult to image. Cohen proposes that most pieces of biographical information are linked, either through their connotative meaning or the use of imagery, to previously acquired semantic representations. On the other hand, the comparative 'meaninglessness' of people's names prevents them from being integrated into pre-existing semantic networks.

According to Cohen and Faulkner (1986) the elaboration of biographical information into networks is beneficial because it produces multiple routes to retrieval. Alternatively, Cohen (1990) suggests that linking information together serves to aid recall by reducing the number of 'links' that need to be searched in order to find a required piece of semantic information.

Bruce and Young's account of person identification has been proven useful in explaining name retrieval deficits observed in acquired brain damage. According to this account name retrieval deficits can show a complete dissociation from impairments to semantic processing. Flude, Ellis and Kay (1989), for example, reported the case of patient EST, whom they claim was able to retrieve detailed semantic representations for familiar people and objects he could not name. Flude et al. characterised EST's proper name recall deficits as reflecting spared access to semantics, but with difficulties in accessing the phonological output forms of proper names.

Burton and Bruce also reinterpret EST's impaired recall of proper names (Flude, Ellis & Kay, 1989) in terms of their model. They hypothesise that EST's deficit can be explained as the result of an attenuation of the links between person identity nodes and semantic information units. They argue that if this reduction is the same for all links the relative activation of units will remain the same. This will mean that those semantic information units with the lowest level of activation (i.e. those representing more specific
information) will fail to reach threshold, whereas ‘well connected’ pieces of information will still be sufficiently activated to guide a correct response. Burton and Bruce note that the data from EST’s case suggest that EST may show some degree of impairment of semantic information about people.

Cohen’s proposals principally address the issue of the difficulties experienced by non-neurologically impaired subjects in learning and retrieving peoples’ names. However, Semenza and Zettin (1989) and Lucchelli and DeRenzi (1990) argue that ‘meaninglessness’ is also useful in explaining the effects of acquired brain damage on name retrieval.

Semenza and Zettin (1989) describe the case of patient LS who presented with a highly specific deficit affecting the recall of proper nouns following a head head injury. As evidence for their proposal that ‘meaninglessness’ influences recall of information, Semenza and Zettin point out that LS’s difficulties were not confined to the retrieval of people's names. Thus, whereas he quickly learnt pairs of semantically related words, he was very poor at learning pairings when the relationship between them was arbitrary. They also note that LS had difficulty learning numerical labels that were applied to certain items of hardware at work. Semenza and Zettin propose that LS’s poor performance on these tasks together with his impaired name retrieval indicate a common denominator: “the inability to deal (at the retrieval level) with purely referential non-descriptive semantic relations” (p679).

Lucchelli and DeRenzi (1990) describe patient TL who following a stroke presented with a specific deficit affecting the recall of people’s names. Similarly to Semenza and Zettin explanation for LS’s difficulties, Lucchelli and DeRenzi assert that TL’s deficits arise from the ‘meaninglessness of names. In support of this assertion they highlight TL’s inability to learn ‘meaningless’ associations between faces and names, and between colours and numbers.

Much of the evidence provided by Semenza and Zettin, and Lucchelli and DeRenzi for their explanations of their patients’ name retrieval difficulties was derived from learning tasks. Bruce, Burton and Walker (1994) question the validity of using learning tasks to assess the functioning of models of the ‘steady state’. They suggest that more appropriate data can be derived from the assessment of factors that mediate a patient’s ability and inability to
access different kinds of biographical information.

The above demonstrates how models of cognitive functioning can be used (a) to guide clinical assessments, and (b) to interpret the data provided by these assessments. Thus, Bruce and Young's (1986), Cohen's (1990) and Burton and Bruce's (1992) accounts of person identification have all been applied successfully to cases of proper name anomia. The next section demonstrates how data from cognitive neuropsychological assessments of clinical patients can be used to test hypotheses drawn from models of cognitive functioning.

**Neurological data as a test of cognitive theory**

Burton and Bruce's (1992) and Cohen's (1990) accounts of person identification make differing predictions about the types of information that will be available to neurologically impaired patients. Burton and Bruce note that "the important aspect of names in Cohen's account is that they are (usually) meaningless. In contrast, the important aspect of names in the IAC account is that they are (usually) unique", (Bruce & Burton, 1992, pp 55-56). Thus, according to the IAC model, name retrieval difficulties should be accompanied by deficits in the retrieval of other forms of highly specific biographical information. Cohen's proposal, on the other hand, predicts that the major factor influencing a patient's ability to retrieve biographical information is the 'meaningfulness' of that information. In order to distinguish between these accounts researchers would need to develop a task capable of differentiating between the effects of uniqueness and meaningless on retrieval of semantic information. To date cognitive psychologists have been unable to devise such a task (Harris & Kay, 1994). However, detailed cognitive neuropsychological assessment of two neurological patients has provided valuable information about the effects of uniqueness and meaninglessness on the retrieval.

The first of these patient, NP, was reported by Hanley (1995). Following a left temporal intra-cerebral clot displayed generalised word finding difficulties. For instance, she was able to name only five of the thirty pictures from the Graded Naming Test (McKenna & Warrington, 1983). Hanley noted that NP's naming of faces of celebrities was as poor as her retrieval of object names. For instance, despite being able to provide occupations for 32 of the target celebrities from the famous-faces line up (Flude, Ellis & Kay, 1889), Patient
NP recalled the names of only two celebrities. Patient NP's good recall of occupations relative to her poor memory for names appears to indicate a dissociation between her recall of names on the one hand, and other types of semantic information on the other.

This dissociation is predicted by the account of person identification provided by Bruce and Young (1986) but not by the accounts provided by Burton and Bruce (1992) and Cohen (1990). However, in order to provide a fuller test of Burton and Bruce's account of semantic memory Hanley also assessed NP's recall of more specific semantic information. For instance, he asked to identify 64 descriptions of famous people by identifying distinctive facial features (i.e. whether they had a beard, wore glasses, had long hair, or were balding), and by indicating whether their surnames began with the letters A to F, G to L, M to R, or S to Z. She correctly identified 22 of the people by distinctive facial characteristics, but only 2 by the initial letter of their names. In another task NP was shown photographs of the faces of 22 well-known people, all of whom have or used to have a famous spouse (e.g. John McEnroe and Tatum O'Neill). Following the presentation of each face she was asked to provide the celebrities name and to recall the identity of their spouse. NP successfully named only 5/22 of the celebrities from their faces. In contrast, she identified the spouses of 17/22 of the faces by providing their occupations. Again these data are consistent with the proposals of Bruce and Young but inconsistent with Burton and Bruce, and Cohen.

NP was also questioned about her knowledge of telephone numbers. In contrast to the predictions of Bruce and Young, she replied that the only telephone number she was able to retrieve was her own. Moreover, she stated that although she had never been good at telephone numbers, she knew at least 10 telephone numbers of other people before her illness.

The second patient, BG, was described by Harris and Kay (1995). Following a brain haemorrhage in 1987 BG complained of experiencing occasional word retrieval difficulties in spontaneous conversation. Consequently, her word retrieval was formally assessed using Ellis, Kay and Franklin's (1992) object naming test, the Boston Naming Test (Kaplan, Goodglass & Weintraub, 1983), and the Graded Naming Test (McKenna & Warrington, 1983). Her scores on all of these tests indicated a mild impairment of object naming. Thus, she named 38/60 of the stimuli from the former test, and 17/29 of stimuli from the latter test.
In contrast to BG's relatively mild impairment in retrieving the names of objects, she was demonstrated to have severe difficulty in recalling the names of familiar people. Thus when presented with black and white photographs of the faces of 60 famous people (e.g., John F. Kennedy, Neil Kinnock, John Lennon, Charlie Chaplin, John Major), she was able to name only 8 of them. According to Burton and Bruce this impairment should be associated with impaired retrieval of all other unique information known about familiar people. However, detailed assessment revealed that BG was able to provide unique semantic information about famous people she was unable to name (e.g., that the comedian, Tommy Cooper, died after a heart attack while he was on stage). Furthermore, she was also able to state detailed information about individual friends which is highly specific, and which applies only to one person of her acquaintance (e.g., a woman who had an eye taken out early last year because she had cancer). However, similarly to patient NP, Harris and Kay also demonstrated that BG was impaired at retrieving telephone numbers (and addresses). Thus, she was only to give telephone numbers for 1/10, and addresses for 2/10, of her relatives. Moreover, she could not provide an address or telephone number for any of her friends.

In Burton and Bruce's terms, retrieval of "any piece of semantic information unique to a known individual should behave similarly to name retrieval". In support of this assertion both patients NP and BG were impaired at recalling telephone numbers. However, both patients were able to produce information that appears to apply uniquely to one person, while still being unable to name the person. These observations are clearly contrary to Burton and Bruce's statement.

It is pertinent to consider why these patients exhibit a dissociation between their abilities to retrieve names, addresses and telephone numbers, on the one hand, and other kinds of unique information about people, on the other. Telephone numbers and addresses are often associated with just one person that we know. The other kinds of unique information provided by NP and BG is clearly richer in meaning and imageability (and probably other features as well), than names, addresses and telephone numbers. Consequently, these data support Cohen's and others suggestion that meaning and not uniqueness is the important variable influencing recall of information from semantic memory.
Summary

It was suggested that cognitive neuropsychology can provide a rich theoretical basis for clinical assessments of neurological symptoms. Assessment of impaired access to semantic memory was used to illustrate this suggestion. Moreover, it was noted that the link between clinical practice and theory is not one way. Thus, impairments to semantic memory were also used to illustrate how data from clinical assessments can be used to test cognitive theory.
References


SECTION II: CLINICAL
PLACEMENT SUMMARIES

&

CONTRACTS
CORE PLACEMENT 1

ADULT MENTAL HEALTH

Placement dates:

From 14 October 1994

To 5 May 1995

Placement Supervisor:

Dr. Julia Deadman-Spall

Placement location(s):
Clinical Psychology Department
Brecon House, Sutton Hospital,
Cotswold Road, Sutton, Surrey. SM2 5NF.

Wallington Resource Centre
77 Woodcote Road, Wallington,
Surrey. SM6 0PU.
INTRODUCTION

The client group

The trainee will work with a range of clients across the age span, covering late adolescence and young adulthood, middle and later ages up to the age of 65, within a range of settings and covering a range of issues spanning adjustment reactions and more severe mental health problems.

Aims of the Adult Placement

The overall aims of the placement are:

1. To provide a comprehensive first placement which is in accordance with priorities agreed by placement supervisors and the University of Surrey.
2. To complement the overall course philosophy and model of training.
3. To link closely to the academic teaching provided by the University and to influence the development of the programme each academic year.
4. To facilitate confidence and competence in the practice of psychology through a partnership between field supervisors and the University.
5. To provide useful information and feedback to the trainee, University and future supervisors to enable a high quality training experience.

Organisational Factors

The field of adult mental health encompasses an extremely wide range of theoretical models from the organic to the humanistic. Often these perspectives underpin services without being made overt and subject to critical debate and consensus. A group of service providers may work together without pooling their particular value systems and theoretical stance.

Much of this variation comes from the history of services and the different traditions within different professions. It may be useful to consider four different strands.

Firstly, there is the perspective that comes more from the political/cultural perspective of the day. Most services would see themselves as working to basic standards which relate to individualisation, dignity and respect, equality of access etc. Sometimes this would be formally expressed as based on the principles of normalisation or social role valorisation. This has now been influenced by a number of external factors - such as the NHS reforms, the Patient’s Charter initiatives and the focus on Equality of Access. This has impact internally as staff and users of the services work to translate these into operational realities. The development of quality programmes is extending this throughout Adult Mental Health Services and within the separate therapy professions.
Secondly, there is a much more local variation of services as a result of the NHS reforms. There are local interpretations and applications of policy within which psychology departments must adapt and fit - the most obvious being NHS Trusts and G.P. fund holding. Related to this is an increasing need to recognize the different systems that influence practice - factors such as demography and socio-economic variation. There are also locally determined systems of delivery developed in response to the requirements of the purchaser as a means of providing services - for example the growth of community teams. All these impact on the way that clinical psychologists practice.

Thirdly, different professions and different individuals within a profession will base their working practice on different models of care which would have as a basis a particular theoretical model of individual functioning. Thus within the total field of mental health the following may be manifest.

- Biochemical
- Neurological
- Organic
- Psychodynamic
- Cognitive Behavioural
- Behavioural
- Humanistic
- Developmental
- Systematic
- Sociological
- The Bio-Psycho Social Support Model

The fourth strand comes from the development of formal contracts for the psychology services with general managers, whether within the trust or directly managed unit. Increasingly psychologists are required to work within policies, procedures and protocols which come from negotiation with a non psychologist; in addition resource usage is now formally specified and directed from outside the profession.

**Principles and Values for Clinical Psychologists**

Clinical psychologists bring a particular perspective emanating from their training and expertise.

Firstly it will be client centred; i.e. it would be based on an individualised assessment and treatment for each person seen. It would ideally work with the client as an active collaborator not a passive person to whom treatments are applied.

Secondly it would utilize a psychological perspective distinct from the contribution of others. This would utilize research and theory relating to:

The relevance of a person’s development and the learning history and past experience on present functioning, adaptive and maladaptive behaviour, the part that perception, thoughts, beliefs, attributions and attitudes and unconscious factors play.

Thirdly it would concentrate less on pathology and classification but would aim to utilize normal and normative psychological processes.

Fourthly it would consider the relevance of different systems - past, present, future - cognition, behaviour and physiology, the individual person and their interpersonal and social context, in order to intervene in the particular way that is required.

Essentially therefore the clinical psychologist combines the scientific and humanistic perspective to help maintain and develop the independent and adaptive adult function of the client, either through work with the individual or through work with family, carers or systems.
RANGE OF CLIENT WORK

The trainee should have direct experience with the problem areas described below. Ten areas have been listed as compulsory but there may be overlap with clients presenting with several problems but it seems reasonable that the trainee should cover these in independent client work.

Anxiety Independent client work

Depression Independent client work

Obsessive compulsive disorders. Independent client work is desirable in the adult placement but if not achieved it is compulsory over three years.

Eating disorders. Independent client work.

Sleep disorders. Desirable.

Adjustment and adaption difficulties/bereavement. Independent client work.

Health. This is primarily a specialist area but it is desirable that the trainee sees at least one client who presents with somatic emphasis.

Problems of emotional control and adjustment, social skills and assertiveness, suicide and para suicide and personality disorder. It is desirable that one of these areas is covered.

Survivors of Sexual Abuse. This area of work is compulsory over the three years but may not be appropriate within the first adult placement for the trainee to deal with directly. This is because there is local variation in the level of complexity with which the client presents and there are likely to be trainee variables in how ready they are to take on such work.

Sexual and relationship problems/family problems. It is desirable that the trainee should take on such work in an adult placement but if not achieved it is compulsory over three years. This is because there is substantial variation in the referral patterns for such problems.

Substance Misuse. It is desirable that the trainee covers tranx withdrawal and alcohol dependency, but if not achieved it is compulsory within the three years.

Disability. It is desirable that the trainee observe or discuss a case which a colleague is treating. They will also visit services available and where possible meet with users of services.

Neuropsychology and Psychometric Assessment. The trainee will observe a clinical psychologist carrying out psychometric assessment, will conduct one with observation by a qualified psychologist and another independently. This will include a WAIS-R, Wechsler Memory Scale and other relevant tests such as NART, as required. They will also, if possible, observe one fuller assessment carried out by a psychologist expert in this area.

Acute Psychotic Disorders, Severe Depression and Longer Term Mental Health Problems. It is hoped that the trainee will spend approximately half a day a week in this area, the aim being to give them a basic experience of the client group and of the type of work undertaken by psychologists and the direct experience of working with the client group. It is anticipated that a high proportion would be observation. Experience would include attending ward rounds, visiting the ward, spending time with a C.P.N., observational experience of assessment approaches from other professions.

Clients with an acute psychotic episode and/or with severe depression. The trainee will attend ward meetings in relation to such clients, will observe a psychiatric interview with such clients and it is desirable that they carry out some direct work with such clients - an assessment, befriending or a limited intervention.
Rehab/continuing care. The trainee will observe psychology work in this specialty. They will also be involved in assessment and where possible a psychological intervention (e.g. cognitive behavioural work in relation to delusion, relapse prevention or behavioural management). The aim is to appreciate what can be achieved therapeutically by psychology knowledge and skills.

REQUIRED EXPERIENCE WITH THE CLIENT GROUP

Age

The trainee will see clients across the age span, covering late adolescence and young adulthood, middle and later ages up to 65. It will be expected that they will see at least one client from each of the three age bands.

Sex

The trainee will see an appropriate mix of male and female clients

Ethnic/cultural issues

The trainee will have some level of clinical contact with at least one client (and preferably substantial more) from a different cultural and/or ethnic background. This would include people from different ethnic backgrounds or with markedly different cultural practises. Such contact should ideally be assessment and/or treatment but if this is not feasible then observation of others work, case discussions etc. should be planned.

Settings

The trainee will carry out work in as wide a range of settings as is possible, including:

- Psychology Department and out-patient clinics;
- Community Mental Health Teams and Resource Centres;
- Primary Care Settings (Health Centres, GP practices);
- Day Centres, Hostels And Group Homes;
- In-patient wards (both acute long stay and rehabilitation);
- Home visits;
- Employment services.

This should include experience of non-NHS facilities - social services and voluntary agencies provision.
CORE PLACEMENT 2

LEARNING DISABILITIES

Placement dates:

From 18 May 1995
To 17 November 1995

Placement Supervisor:
Rosamund Roach

Placement location(s):
Department of Psychology
Homewood resource Centre,
Guilford Road, Chertsey, Surrey. KT16 0QA.
Contract For Core Placement
Learning Disability

Trainee: Daryl Harris
Supervisor: Rosamund Roach
Placement: Learning Disability
Location: Homewood Resource Centre

1. Basic Placement Requirements

Starting Date: April 1995
Finishing Date: November 1995
Placement days each week: Wed, Thurs, Frid
CORE PLACEMENT 3

CHILD & ADOLESCENT

Placement dates:

From 22 November 1995
To 19 April 1996

Placement Supervisor:

Nick Kirby-Turner

Placement location(s):

Clinical Psychology Department
Princess Royal Hospital,
Haywards Heath, Mid-Sussex.

Colwood Adolescent Psychiatric Unit
Princess Royal Hospital,
Haywards Heath, Mid-Sussex.
This Contract is designed to set the parameters for DARYL HARRIS
in the Child & Adolescent Psychology placement with
Nick Kirby-Turner in the Mid-Downs Health Authority

INDUCTION PROCESSES
For Daryl Harris to gain an understanding of the relationship of Child Psychology to services
in Child Mental Health, and also in Child Health & Child Protection Services. Specifically:

a) Observe Clinical Child Psychologists working in different settings
b) Observe an Educational Psychologist at work
c) Observe a Clinical Medical Officer conducting a developmental assessment
d) Observe a Juvenile Court
e) Attend a session in a playgroup
f) Visit Larchwood Children’s Unit
g) Visit the Family Therapy Clinic
h) Become familiar with issues surrounding Child Protection Assessment
i) Endeavour to observe children with Pervasive Developmental Delay

CLINICAL WORK
for Daryl Harris to familiarise himself with the range of assessment procedures and
therapeutic techniques by:

a) Outpatient work in the Psychology Department. A variety of cases, reflecting the full
age range, to illustrate the breadth of the speciality in terms of reasons for referral and
therapeutic approaches applicable. Opportunities for individual and family centred
work. Some joint work with Nick Kirby-Turner.

b) Inpatient work at Colwood Adolescent Unit. If possible participating in group work.
Individual work involving assessment and where appropriate intervention.

c) Teaching:
Presentation in the Child Seminar Series to other Child Psychologists. Also, as
opportunities arise, formal teaching of other professionals, possibly through case-
based teaching.

d) Research:
To discuss on-going research issues in child work.

PROFESSIONAL DEVELOPMENT
For Daryl Harris to endeavour to gain a perspective of service delivery issues through clinical
work and to explore issues of service development by some attendance at Departmental
Meetings and discussing issues as they arise.

SUPERVISION
At least 1.5 hours per week. Further supervision through informal meetings and via weekly
Child Seminars. Some direct observation of Daryl Harris’ work through joint session and the
use of the VCR.
CORE PLACEMENT 4

OLDER ADULTS

Placement dates:
From 25 April 1996
To 11 October 1996

Placement Supervisor:
Sara Turner

Placement location(s):
Psychology Department
Springfield Hospital,
London. SW17 7DF.

Jubilee Day Hospital
Springfield Hospital,
London. SW17 7DF.
OBJECTIVES,

1. To work with approximately 10 clients for treatment purposes and to cover the following parameters:
   - Age range (60 to 85 years)
   - Gender mix
   - Culture/ethnicity mix
   - Range of settings:
     - Hospital/assessment
     - Hospital/continuing care
     - Day centres
     - Day Hospitals
     - Social services
     - D.V's
     - Continuing care/Nursing home
     - Primary care

2. To gain experience of, and where possible, engage in direct work with people with a range of presenting problems. These are listed below:-
   - Functional problems
     - depression
     - anxiety
     - psychosis
   - Organic problems
     - CVA
     - dementia
   - Loss and life-span issues
     - bereavement
     - adjustment difficulties
     - mortality, retirement etc....
   - Behavioural problems
   - Abuse and sexuality
   - Drug dependency
3. - To gain some understanding of at least one therapeutic model specific to older adults (reminiscence, reality orientation, validation therapy).

4. - To utilise a range of assessment tools specific to older adults e.g:
   - CAPE
   - MEAMS
   - HAD
   - CAMCOG

5. - To work therapeutically both directly and indirectly (work with carers, families, systems).

6. To work within a multidisciplinary team and to have knowledge of the following professions, roles and contributions:
   - Psychogeriatricians
   - Geriatricians
   - Social workers
   - Occupational therapists
   - Physiotherapists
   - Community Psychiatric Nurses
   - Ward nursing staff
   - General Practitioners
   - Legal advisers working at the Springfield Advice and Law Centre

7. To become familiar with the contribution voluntary services to older adults.

8. To conduct a number of assessments of functioning (observational criterion, and normative) that do not necessarily lead to psychological therapy.

9. To conduct neuropsychological assessments.

10. To be involved in running a structured therapeutic group.

11. To engage in a teaching activity.
12. To use supervision to specifically focus on:
   - issues influencing the way interview sessions are structured and conducted e.g. location, nature of presenting problems, personality etc....
   - organisational issues...
     - observation of managerial roles
     - team working
     - issues around the development of multidisciplinary assessments, and the recording of data collected.
     - clinical audit
     - CPA, CM, and IPP systems
     - the role of purchasers, line managers, team managers etc...
   - issues of age appropriateness and ageism
   - suicide assessment, and peoples rights and issues around assessment of competency

13. To use audiotape to fine-tune therapeutic skills.
    Particular emphasis to be placed on the following:
    - Use of:
      - open ended questions;
      - linking statements;
      - silence
    - the development of a range of styles. For example, structured, formal and assertive, vs. informal and passive.

14. To conduct a piece of research requiring the assessment of the quality of service provision.

STRUCTURE

1. Placement days will accord with the University of Surrey timetable (typically 3 days per week).

2. Supervision will be 2 hours weekly, plus additional informal contact, opportunities to observe the supervisor etc.

3. There will be ½ days reading per week.

4. There will be a pre-mid-placement review to prepare for that meeting,
SPECIALIST PLACEMENT 1

FORENSIC PSYCHOLOGY

Placement dates:

From 16 October 1996
To 4 April 1997

Placement Supervisor:
Alison Beck

Placement location(s):
Shaftesbury Clinic,
Regional Secure Unit,
Springfield Hospital,
London. SW17 7DF.

Department of Forensic Psychiatry
St. George's Hospital,
London. SW17.
PSYCHOLOGY PLACEMENT CONTRACT: DARYL HARRIS

The placement is within the South Thames (West) Services for Difficult and Offender patients and is based in the Shaftesbury Clinic.

The aim of the placement will be to provide a broad experience of issues relating to Psychology and the Law, including the assessment and treatment of offenders. Specific areas to be covered include the following:

   A. The assessment and treatment of a range of patients referred for psychological treatment to Forensic Services. Presenting problems will include sexual deviations, anger management, malingering, personality disorder, perpetration of sexual and physical abuse and psychosis.
   B. Assessment experience will include functional analysis, personality, cognitive and neuropsychological assessment. Experience in the use of repertory grid will also be available.
   C. The drafting of Court and other reports and providing verbal and written correspondence about clients where necessary.
   D. Attendance at ward rounds and referral meetings. Negotiating psychological input.
   E. The trainee will have opportunities to observe other members of the team working, and to discuss their role with them.
   F. There will be opportunities to sit in with the supervisor and other psychologists observing various models of work. In addition the supervisor will sit in on at least one new assessment carried out by the trainee.
   G. To be familiar with working practices particular to a service for difficult and offender clients. To obtain a knowledge of issues involved in and the practice of security arrangements with this type of client. Also to obtain an introduction to the working and implications of the Mental Health Act (1983), and of the legal system and basic issues in criminal law.
   H. To expand academic and theoretical understanding of working with mentally disordered offenders.
2. **Academic Meetings.**

   A. There is a full academic programme including research meetings, journal club and case discussions. Attendance will be encouraged where possible in relation to other demands on time.

3. **Visits.**

   Visits will be arranged by the trainee to institutions providing a range of levels of security in the treatment of mentally disordered offenders such as - Henderson Hospital, Henry Rollin Hospital, Broadmoor Hospital, Prison, the Courts, and other facilities as appropriate.

4. **Other Meetings as appropriate.**

   1. Departmental and District psychology meetings.
   2. Regional special interest group meetings.
   3. Regional Support Alliance: a bi-monthly meeting hosted by one of the district close supervision units, to report on their work and present a case.

   Supervision will be for at least 1.5 hours a week. Discussions with other members of the team will also be encouraged, in order to gain an understanding of the various roles of different professionals.

   It is hoped that the trainee will gain experience of the various professional, legal, moral and ethical issues arising when working with this patient group.

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Signed: **Alison Beck**  
Chartered Clinical Psychologist

Signed: **Daryl Harris**  
Psychologist in Clinical Training
SPECIALIST PLACEMENT 2

DRUG & ALCOHOL MISUSE

Placement dates:

From
14 May 1997

To
20 September 1997

Placement Supervisor:
Hermine Graham

Placement location(s):
Camden & Islington Substance Misuse Service
122 Hampstead Road
London. NW1 2LT.

Alcohol Advisory Service for Camden & Islington
Greenland Road,
London. NW1.
Camden & Islington Substance Misuse Service
122 Hampstead Road
London NW1 2LT

Contract For Specialist Placement
Substance and Alcohol Misuse Psychology Service

Trainee: Daryl Harris
Supervisor: Hermine Graham
Placement: Substance & Alcohol Misuse
Location: CHADS / Hampstead Road Centre / Alcohol Services

1. Basic Placement Requirements

Starting Date: 7 May 1997
Finishing Date: 12 Sept 1997
Placement days each week: Wed, Thurs, Frid
Proposed date of mid placement review: 30 June 1997
2. **Aims of the placement**

To gain experience of providing clinical psychology input to a substance misuse service. This experience is aimed at facilitating the following:

(i) an induction to the provision of drug and alcohol services within Camden and Islington;

(ii) an induction to the services provided by the Hampstead Road Primary Care Unit;

(iii) the attainment of a broad knowledge base in the area of substance use;

(iv) the acquisition of direct and indirect experience of working with drug and alcohol misusers.

3. **Placement objectives**

(i) Increase knowledge about theory and treatments used in substance misuse services. For example, cycle of change, harm minimisation, relapse prevention, motivational interviewing, and groupwork.

(ii) The opportunity to practice the strategies and techniques used in these treatments.

(iii) To increase awareness of the effects of stimulant, depressant and hallucinogenic drugs, and alcohol. (With particular emphasis on the effects on offending behaviour).

(iv) To be able to understand and assess some of the links between personality and substance use.

(v) To improve management of clinical time.

4. **Means of achieving these objectives**

(i) Read core texts

(ii) Selection of clients to include those with (a) stimulant, depressant, and alcohol users; (b) offending behaviour; and, (c) personality issues.

(iii) Help to facilitate the running of a group.

(iv) Visits to outside agencies with particular emphasis on those with forensic links (e.g. Highbury Clinic, prison and special hospital substance use services, courts).

(iv) Discussions with other professions involved in the substance use services.

5. **Supervision**

Formal supervision of at least one hour a week with opportunities for informal consultation and teaching at other times.

Signed ........................................... Signed .................................
Date - ........................................... Date - .................................

Daryl Harris Hermine Graham
Psychologist in Clinical Training Clinical Psychologist

Page 88.
CASE STUDY 1

SOCIAL LEARNING THEORY AND STRUCTURAL FAMILY THERAPY INTERVENTIONS WITH THE FAMILY OF A CHILD EXHIBITING BEHAVIOURAL PROBLEMS
Referral and assessment
Alexander and his family were referred to outpatient child and adolescent psychology services by their health visitor.

Presenting problems
Alexander's parents outlined a number of difficulties they were having with him. These problems were: kicking; punching; abusive language; defiance; destruction of property; and, day-time enuresis (+ bed-wetting).

Background information
At the time of assessment Alexander was a four year old boy who has no siblings. Both parents described their upbringing as involving physical punishment. Whereas, Alexander's father indicated that he has adopted a similar parenting style, Alexander's mother recollected that she had rejected the use of physical punishment. Instead, she said that she preferred to negotiate and reason with Alexander. Alexander's parents stated that their marriage was unsatisfactory. His father said that he did not have much in common with his wife. His mother stated that communication between her and her husband was poor.

Social learning theory formulation
1. Poor communication between Alexander's parents prevented them from making decisions about which behaviours they would tolerate, and how to deal with undesirable behaviours. Consequently, Alexander received mixed messages about which behaviours are appropriate.
2. The use of physical punishment by Alexander's father provides a model for Alexander's own aggressive behaviour.
2. Attempts by his mother to negotiate with Alexander provide him with attention. Paradoxically the secondary gain this attention gives Alexander may serve to increase the frequency and/or intensity of problem behaviours.

Social learning theory intervention
Alexander's parents were asked to list presenting problems in the order in which they wanted to tackle them. They were then asked to keep records of the antecedents and consequences of a particular problem behaviour. During sessions this information was used (a) to identify reinforcers, and (b) to discuss ways of responding without providing these reinforcers. The solutions generated by the parents and myself included wherever possible
ignoring attention seeking behaviour (e.g. abusive comments), and time-out for more severe behaviours (e.g. kicking).

The parents were also encouraged to keep records of times when Alexander was behaving well. These records were used to identify strategies for reinforcing pro-social behaviours.

Finally, ‘externalising’ techniques were used to treat Alexander’s day-time enuresis.

**Outcome**
The above interventions proved effective in reducing the frequency of problem behaviours. However, despite improvement in Alexander’s behaviour, Alexander’s mother reported that her and her husband were still not collaborating in their roles as parents. Given the importance placed on parental communication in the formulation, I was concerned that continued poor parental communication might undermine progress.

**Systemic reformulation**
It was hypothesised that Alexander’s family is characterised by skewed boundaries (c.f. Minuchin, 1985). Background information suggested that the boundary between mother and son are too diffuse. In contrast, observations and the parents’ comments suggested that boundaries between husband and wife, and father and son, may be overly rigid.

**Systemic intervention**
The systemic formulation was discussed with Alexander’s parents. During this discussion Alexander’s father agreed to carry out several tasks designed to ‘soften’ the boundary between himself and Alexander, and both parents agreed to plan an evening a week during which they would do something together without Alexander.

**Outcome and follow-up**
Although the intervention appeared to have some short-term benefits, it did not appear to have had any significant lasting effects on the family’s boundaries. Consequently, in the final session I discussed with Alexander’s mother the possibility of her and her husband attending Relate, or family/couples therapy.
CASE STUDY 2

ASSESSING AND ADVOCATING FOR AN ADOLESCENT WITH SPECIFIC LEARNING DISABILITIES
Referral and assessment
Ben was admitted to a psychiatric ward with a tentative diagnosis of psychosis. Shortly afterwards Ben was transferred to an adolescent inpatient unit. Psychological assessment was conducted during his admission to this unit.

Presenting problems
The following problem areas were identified by Ben's parents, and staff and patients on the unit: poor diabetic control; an obsession with looking and dressing like an American policeman; difficulty seeing other people's points of view; controlling behaviour; social anxiety; poor social cognition/skills; and, school refusal. In contrast, Ben told me that he is socially confident and competent, and that his parents, and not himself, have difficulty seeing other people's points of view.

Background information
At the time of assessment Ben was 16 years old. Ben's parents told me that he has always had a terrible temper, and that if he didn't get his way he would keep “going-on” at them until they “gave-in”. They stated that Ben had few friends. They also told me that he is extremely anxious about new social situations, which he avoids. Staff and other patients reported several instances where Ben misinterpreted social cues, or acted inappropriately. Ben has had diabetes since the age of 11 years, at the time of assessment he was considerably over his ideal weight. He was bullied at secondary school about his weight, and his diabetes. He has a recent history of prolonged periods of refusing to attend school.

Ben's parents told me that he has a history of adopting different persona. The most recent of these characters is a fictional American policeman called Bufford T. Justice. Ben demonstrated an extensive knowledge about both Jacki Gleeson and the character Bufford T. Johnston. He tried to introduce this knowledge into conversations whenever possible. In addition, he insisted upon wearing an identical uniform to that worn by the actor Jacki Gleeson in these films. Finally, Ben was reported to be clumsy.

Diagnosis
No psychotic symptoms were observed following Ben's admission to the adolescent unit. Consequently, the accuracy of the original diagnosis seems questionable.
Ben was observed to have many, but not all, of the features of Asperger's Syndrome. These include: impaired appreciation of social cues; egocentricity; emotional blunting; unintentional play acting; an all absorbing and circumscribed interest which he attempted to introduce into all aspects of life; and, poor co-ordination.

Formulation
It was hypothesised that Ben has a specific learning deficit affecting his social cognition. It was argued that the idiosyncratic behaviours resulting from this learning deficit are likely to have engendered negative social experiences, such as bullying and teasing. Moreover, it was suggested that these experiences may have caused social anxiety, which served to further reduce Ben's social competence. Ben's need control his social environment may serve as a strategy for reducing this anxiety.

In addition, I hypothesise that Ben uses Bufford T. Justice as a role model to guide his own social behaviour, and to compensate for gaps in his own social knowledge and skills. Although this suggests that the persona performs a useful function, it may also have a number of negative consequences. First, Ben's weight and insistence on wearing a policeman's uniform may lead him to be teased or bullied. Second, Ben told me that he is reluctant to lose weight because he would lose his identification with Bufford T. Justice. Third, in order to maintain his weight Ben needs to eat fattening foods. It is suggested that Ben compensates for 'poor' diet by titrating insulin dosage. Comments made by Ben suggest that he implements these manipulations in a very imprecise way, leading to fluctuations in his blood sugar level.

Intervention
Research with young adults with Asperger's Syndrome indicates a poor prognosis, and does not support the effectiveness of short-term interventions (e.g. Frith, 1991). Frith (1991) suggests that young adults with a diagnosis of Asperger's Syndrome function best in a structured, organised, and sympathetic environment. Consequently, my treatment goal was to highlight Ben's need for a structured, organised, and sympathetic environment following his discharge from the unit.
CASE STUDY 3

COGNITIVE CASE CONCEPTUALISATION AND THERAPY WITH A PATIENT WITH LONG-TERM MENTAL HEALTH NEEDS
Referral and assessment

Danny has been attending a resource centre for people with long-term mental health needs for a period of ten years. He was referred to me by his case manager at the centre for an assessment of his suitability for psychological therapy.

Presenting problems

Danny told me that his current difficulties were (a) "negative" thoughts about other people, and (b) worries about his arthritis, psychiatric condition, and suicide. This statement was supported by entries in a thought diary kept by Danny during the intervention.

Background information

At the time of assessment Danny was 30 years of age. Danny stated that his mother is anxious, his paternal grandmother suffered from a 'psychotic illness', and his aunt was diagnosed as having schizophrenia.

Danny's medical notes reveal that he has a psychiatric history that spans over twenty years and includes 26 admissions to hospital. His initial admission was for schizophrenia, however, subsequent admission have usually been for depression.

Danny stated that immediately prior to his first admission he remembers being devastated when his first girlfriend ended their relationship to begin seeing somebody else. He also said that prior to this admission he felt under pressure to succeed and, therefore, he was working very hard.

Danny told me that about five years ago he was diagnosed as suffering from Arthritis. He said that although he was very concerned about this diagnosis, his GP had reassured him that his problems were minor, and that it was unlikely it would cause him significant disability in the future.

At assessment Danny scored 19 on the Beck Depression Inventory (BDI), and 22 on the Beck Anxiety Inventory (BAI). These scores are consistent with somebody experiencing a moderate degree of depression and anxiety.

Formulation

Formulation was given in terms of the stress diathesis model. It was suggested that the presence of a biological predisposition to mental health problems
was suggested by Danny’s reports about his family’s history of mental illness. Hypothesised psychological predispositions included high standards, resulting in increased risk of failure, and strenuous efforts to avoid failure. Danny stated that immediately prior to the onset of his illness he was under considerable stress from school work, and the break-up of a relationship.

It was also hypothesised that fear of failure was an important factor maintaining Danny’s current difficulties. Thus, it was suggested that Danny’s way of coping with his fear of failure was to set minimal goals for himself. It is possible that Danny uses his psychiatric condition, the medication he takes for it, and recent diagnosis of arthritis, to reconcile setting minimal goals with his need to succeed. Whilst it is accepted that Danny’s concern about pushing himself too hard may be partially true, it is suggested that it also has several negative consequences. First, it may have resulted reduced exposure to positive experiences and, therefore, contributed to his depression. Second, it may have helped to maintain his fears about failure by limiting opportunities to engage in tasks that foster a sense of mastery. Third, Danny suggested that his negative thoughts about other people are linked to a sense of bitterness about his own under achievement. This bitterness is partly the result of the true impact of his illness, but may also reflect his avoidance of setting realistic goals for himself.

**Intervention**

The primary objectives of the intervention were: to examine Danny’s beliefs about failure; to assess evidence for and against these beliefs; to discuss the role these beliefs play in maintaining intrusive thoughts about other people; to discuss the advantages and disadvantages of adopting alternative to avoidance; to think of ways of maximising the potential for beneficial change and minimising the potential for costs; to decatastrophise Danny’s beliefs about failure; and, to encourage Danny to view failure as a source of information to use in generating appropriate modifications to future goals.

**Outcome and follow-up**

Increased awareness of the links between his current difficulties and fear of failure, led Danny to plan ways of confronting his fear of failure by trying new activities. Danny asked his case manager to help him to implement these plans. Pre and post intervention scores on the BDI remained the same, however, a shift was observed in Danny’s scores on the BAI from 22 to 10.
CASE STUDY 4

BEHAVIOUR THERAPY WITH A PATIENT WITH OBSESSIVE-COMPULSIVE DISORDER
Referral and assessment
Gillian was referred to outpatient clinical psychology services by her GP for assessment of her suitability for psychological treatment.

Presenting problems
Gillian told me she said that in the last 18 months her daily life had been severely disrupted by compulsions to wash her hands, clothes, or "infected objects". Gillian listed a wide range of situations that triggered these compulsions. These triggers included picking up things from the floor, and handling shoes. Gillian was asked to keep records of triggers, and the frequency and strength of compulsions. She scored 3.1 on the contamination subscale Padua Inventory.

Background history
At the time of assessment Gillian was 33 years of age, and married with one son. She noted that whilst her father is 'happy go lucky', her mother has always worried about her health and family finances. Gillian told me that she gave birth to her first child about one year ago. She recalled that during pregnancy she was very anxious about harming the baby. She said that a particularly strong concern was that she might infect the foetus with toxoplasmosis. Consequently, she developed strong compulsions to wash her hands and clothes. Gillian stated that although she had a couple of anxiety free days following the birth of her son, compulsions to wash reappeared on her arrival home from hospital. Gillian told me that at this stage her compulsions were no longer associated with thoughts about contaminating her son.

Formulation
Gillian told me that concerns about contaminating her baby caused her considerable anxiety during her pregnancy. Several factors can be hypothesised to have contributed to these initial concerns. These include: Gillian's self acknowledged anxious disposition; her awareness of the increased health risks associated with pregnancy. Background information suggests that Gillian learnt two main strategies for dealing with the anxiety she experienced during pregnancy. The first strategy was to wash herself, to change her clothes, or to thoroughly wash food before cooking it. The second was to seek reassurance that her actions were unlikely to infect the foetus.
Gillian said that following the birth of her son her compulsions were no longer linked to worries about infecting her child. Instead, I hypothesise that they were maintained by two sets of associations forged during pregnancy. The first between particular places or actions and the symptoms of anxiety. The second between the enactment of compulsions and relief from anxiety.

**Intervention**

Following initial assessment Gillian and myself agreed a contract for six sessions. After the completion of these sessions six further treatment sessions were agreed, plus one follow up session.

The intervention technique was graded exposure with response prevention. The rationale for this technique is that exposure to a trigger without the occurrence of the associated response leads to habituation of the association between these two events.

Early sessions focussed on; (a) building rapport, (b) developing a shared understanding of Gillian's difficulties, (c) introducing the rationale for exposure, and (d) negotiating therapeutic goals.

The remaining sessions focussed on: (a) reinforcing the rationale for exposure, (b) promoting record keeping, (c) helping Gillian to learn how to use ratings of anxiety to set graded weekly goals, and (d) encouraging Gillian to view difficulties in achieving goals as a source of information to be used either in modifying the programme, or as input to problem solving. Throughout the course of the treatment Gillian was encouraged to take progressively more responsibility for the intervention.

**Outcome**

The follow up session was used to assess progress, and to discuss any problems that had arisen since the end of therapy. During this session Gillian reported considerable improvement in her quality of life, and a profound reduction in both the frequency and strength of compulsions, and anxiety associated with triggering situations. These comments were supported by reductions in her ratings of the frequency and strength of compulsions, and a reduction of 1 scale point in her score on the 'contamination' subscale of the Padua Inventory.
CASE STUDY 5

NEUROPSYCHOLOGICAL ASSESSMENT
Evidence for impaired planning is revealed by staff reports that David has difficulty in acquiring new skills involving complex sequences of actions. This ecological data is supported by test results. Thus, David performed poorly on the Picture Arrangement sub-test of the WAIS-R, and the RBMT Memory for an Appointment sub-test.

**Memory functioning**
Memory impairment was suggested by David’s poor performance on the: Story Recall, and Figure Recall, subtests of the AMIPB; Delayed Memory for Faces, and Memory for an Appointment, subtests of the RBMT. In addition, David obtained low to average scores on the Digit-Span subtest of the WAIS-R and Visual Memory Span task.

In addition, it was hypothesised that David’s memory is adversely affected by his difficulty in organising information.

**Perceptual and motor processing**
There was little evidence for impaired visual processing. However, David’s performance on the ‘speed’ task of the AMIPB Information Processing subtest suggested that his motor speed is considerably below average.

**Recommendations**
A number of recommendations were made on the basis of these results. These included the following:
1. Information should be presented to David in an organised way.
2. New tasks should be broken down into a set sequence of actions.
3. David should be encouraged to rehearse information. For example, by repeating it aloud, or to himself, and/or by thinking about it in more detail.
4. The of use external memory aids should be considered.
SECTION III: RESEARCH
LITERATURE REVIEW

PERSONALITY DISORDER AND ANTISOCIAL BEHAVIOUR: THE LAW, CLINICAL DEFINITIONS, AND STANDARDISED MEASURES
Personality disorder and antisocial behaviour: The law, clinical diagnosis, and standardised measures

Antisocial behaviour can be defined as behaviour that is combative, exploitative, predatory, and/or lacking in empathy, reciprocity, or social sensitivity (Beck & Freeman, 1990). These acts can rarely be attributed to a single causal factor (e.g. Blackburn, 1986). For example, Bandura (1973) demonstrated the interplay between situation, behaviour, and cognition in producing violent behaviour. Moreover, it is evident that many incidents of violence result from a complex sequence of interactional exchanges (e.g. Howells, 1976).

In addition to the influence of interpersonal variables, a number of authors argue that antisocial behaviour is heavily influenced by enduring personality characteristics (e.g. Blackburn, 1986; Beck & Freeman, 1990). These authors cite studies demonstrating stability of violent behaviour over time. For instance, Olweus (1979) reviews 12 studies which compared either ratings, peer nominations, and/or direct observations to monitor aggressive behaviour over periods ranging from six months to twenty-one years. He concluded that the average correlation between two recordings obtained at different intervals was 0.63. In addition, he noted that this correlation rose to 0.79 after an appropriate technical correction. Other researchers have sought to assess stability of violent offending over time. For example, Wolfgang (1975) identified a core of offenders who were responsible for three quarters of all homicides, rapes, robberies, and aggravated assaults. These offenders made up less than one fifth of known delinquents.

The view that people possess traits which mediate their behaviour in different settings and across time has not been without criticism. In particular, critics have argued that behaviour is highly variable from situation to situation (Pervin, 1989). Consequently, rather than emphasising internal predispositions some researchers have emphasised the importance of environmental contingencies (i.e. stimulus and rewards) as determinants of behaviour. This alternative perspective has been termed the 'situationalist position'. Its recent prominence is usually associated with the work of Mischel.

In 1968 Mischel published a review of a number of attempts to predict
behaviour from psychometrically determined traits or psychodynamic inferences about states or traits. He concluded that “with the possible exception of intelligence, highly generalised behavioural consistencies have not been demonstrated, and the concept of personality traits as broad response dispositions is thus untenable” (p. 146).

In later work Mischel (1973, 1977) emphatically rejected the purely situationalist approach. Instead of dismissing the influence of internal factors, he proposes that their effects are specific to particular situations. Blackburn (1983) notes, therefore, that Mischel’s major criticism of trait theory does not concern the existence of traits but the extent to which these traits predict behaviour in specific situations. Moreover, he suggests that this criticism can easily be countered by increasing the specificity of a trait. This is in essence the interactionist perspective.

Antisocial personality, and the law

The belief that personality can predispose a person towards antisocial behaviour has been incorporated in the legal statute. Thus, the 1983 Mental Health Act describes a class of individuals who suffer from a “persistent disorder or disability of mind (whether or not including significant impairment of IQ) which results in abnormally aggressive or seriously irresponsible conduct”. The 1959 Mental Health Act contains a similar definition. The legal term used in both acts to describe these individuals is ‘psychopathic disorder’.

The validity of the legal concept of psychopathic disorder has been criticised by a number of clinicians and researchers (e.g. Dolan & Coid, 1993). One of the major criticisms is that the legal concept implies that psychopaths represent a homogeneous group of offenders (e.g. Blackburn, 1988). This assumption is not supported by empirical data. For example, the Butler Committee stated that “The class of person to whom the term ‘psychopathic disorder’ relates is not a single category identifiable by any medical, biological, or psychological criteria” (Home Office/DHSS, 1975).

The legal concept of psychopathy has also been criticised because the definition “a disorder of mind ....which results in abnormally aggressive or seriously irresponsible conduct” permits the circular inference of a disorder
of mind” from the “abnormally aggressive or seriously irresponsible conduct” (e.g. Blackburn, 1988). Mayer-Gross et al. (1969) propose, therefore, that mental health Legislation effectively equates psychopathy with antisocial conduct.

Hare’s Psychopathy Checklist and Criminality

The hypothesised link between psychopathy and offending has been afforded some credibility by the work of Cleckley (1976) and Hare (e.g. 1980, 1991). Cleckley argued that psychopathy should not be equated with criminality. He proposed sixteen criteria which included personality traits such as egocentricity, superficial charm, and callousness. Cleckley’s criteria provide the basis of a twenty-two item checklist developed by Hare [Psychopathy Checklist (PCL) (Hare, 1980)]. The PCL was subsequently modified by the removal of two items to produce the Revised Psychopathy Checklist (PCL-R: Hare, 1991). The items in this checklist are scored on a 3 point scale based on a comprehensive review of file notes and information from a structured interview. A summary of PCL-R items is provided in Table 1.

Harris, Rice, and Cormier (1991) demonstrated that the PCL-R predicted post-release violent offending in a sample of 169 male forensic patients. They found that the violent recidivism rate for psychopaths was almost four times that of non-psychopaths. A significant relationship has also been demonstrated between the PCL-R and the nature of violent offences. Williamson, Hare, and Wong (1987) analysed official police reports of serious violent offences. They found that most of the murders and serious assaults committed by non-psychopaths occurred during a domestic dispute or during a period of emotional arousal. In contrast, the victims of psychopaths were likely to be unknown to them.
1. Superficial charm
2. Grandiose sense of self-worth
3. Need for stimulation/easily bored
4. Pathological lying
5. Manipulative
6. Lack of remorse or guilt
7. Emotional shallowness
8. Callousness
9. Parasitic lifestyle
10. Poor behavioural control
11. Promiscuous sexual behaviour
12. Early behavioural problems
13. Lack of long-term planning
14. Impulsivity
15. Irresponsibility
16. Failure to accept responsibility for own actions
17. Frequent marital failures
18. Juvenile delinquency
19. Violation of parole or other conditional release
20. Criminal versatility

**Table 1. Summary of the items from the PCL-R (Hare, 1991)**

Table 1. reveals that the PCL-R includes several items describing antisocial behaviour, such as 'juvenile delinquency' and 'criminal versatility'. The inclusion of these items contrasts with Cleckley's exclusion of items relating to criminality. Cleckley's distinction between criminal behaviour and psychopathic personality is supported by factor analytic studies of PCL-R data. Thus, Harpur, Hakstian and Hare (1988) report that analysis of PCL-R profiles of almost 1200 prisoners yielded two factors. They suggest that the first of these concerns personality traits (i.e. personal deviance), whereas the second factor reflects chronic antisocial and criminal behaviour (i.e. social deviance). Blackburn (1988) cautions that this suggests that among those categorised as psychopaths by the PCL-R some will be socially deviant, some personally deviant, and some both. He argues that it seems unlikely, therefore, that the PCL-R identifies a group that is homogeneous in personality deviation.
Clinical diagnosis and antisocial personality

In contrast to the PCL-R and legal definitions of psychopathy, the clinician Schneider (1950) explicitly excluded antisocial behaviour in his conceptualisation of 'psychopathic' personality disorder. According to Schneider psychopathic disorder refers to a heterogeneous group of individuals who can be divided into specific types or classes of personality disorder relating to different patterns of deviation from the 'average'. These types of personality disorder are characterised by excesses or deficiencies, and result in suffering to the patient or others. Schneider's typology has been highly influential in the development of the ICD-9 & 10 and DSM-II classifications for personality disorder (Blackburn, 1988).

The DSM-IV (American Psychiatric Association, 1994) contains eleven categories of personality disorders which are outlined in Table 2. With the exception of the exclusion of 'passive-aggressive personality disorder', and the inclusion of the category 'personality disorder not otherwise specified', the DSM-IV categories are the same as those contained in DSM-III-R. The ICD-10 (World Health Organisation, 1992) has eight categories (plus two subcategories). DSM and ICD categories of personality disorders are outlined in Table 2.

Table 2. illustrates that there are many correspondences between ICD-10 and DSM-IV. Despite these similarities, there is a fundamental difference in method between the two systems (Dolan, Evans & Norton, 1995). Whereas the DSM-IV specifies checklists of symptoms with definite criteria for each personality disorder diagnosis, the ICD-10 offers descriptions of prototypical cases of each personality disorder diagnosis which do not outline thresholds for each diagnosis.

In spite of Schneider's influence on the developments of DSM and ICD, both systems include a category explicitly linked to antisocial behaviour. DSM contains the category 'antisocial personality disorder' (ASPD). The criteria for a diagnosis of ASPD are listed in Table 3.

The ICD-10 equivalent of ASPD is dissocial personality disorder. The defining features of this diagnosis are presented in Table 4.
A. There is a pervasive pattern of disregard for and violation of the rights of others occurring since age 15, as indicated by three (or more) of the following.

(1) failure to conform to social norms with respect to lawful behaviors as indicated by repeatedly performing acts that are grounds for arrest
(2) deceitfulness, as indicated by repeated lying, use of aliases, or conning others for personal profit or pleasure
(3) impulsivity or failure to plan ahead
(4) irritability and aggressiveness, as indicated by repeated physical fights or assaults
(5) reckless disregard for safety of self or others
(6) consistent irresponsibility, as indicated by repeated failure to sustain consistent work behaviour or honour financial obligations
(7) lack of remorse, as indicated by being indifferent to or rationalising having hurt, mistreated, or stolen from another

B. Current age at least age 18 years.
C. There is evidence of DSM-IV Conduct Disorder with onset before age 15.
D. The occurrence of antisocial behaviours not exclusively during the course of Schizophrenia or a Manic Episode.

Table 3  DSM-IV criteria for antisocial personality disorder

Personality disorder usually coming to attention because of a gross disparity between behaviour and the prevailing social norms, and characterised by:
(a) callous unconcern for the feelings of others
(b) gross and persistent attitude of irresponsibility and disregard for social norms, rules, and obligations
(c) incapacity to maintain enduring relationships, though having no difficulty in establishing them
(d) very low tolerance of frustration and a low threshold for discharge of aggression, including violence
(e) incapacity to experience guilt and to profit from experience, particularly punishment
(f) marked proneness to blame others, or to offer plausible rationalisations, for the behaviour that has brought the patient into conflict with society.

There may be persistent irritability as an associated feature. Conduct disorder during childhood and adolescence, though not invariably present, may further support the diagnosis.

Table 4  Characteristics of ICD-10 dissocial personality disorder

Page 113.
Standardised measures of antisocial and dissocial personality disorders

Measures of antisocial personality disorder

Spitzer and Fleiss (1974) reviewed studies of the reliability of pre-DSM-III diagnoses of personality disorder. They concluded that the mean inter-rater (kappa) for clinical diagnosis of personality disorder was 0.32. The introduction of criteria in the DSM-IIIR field trials significantly increased inter-rater reliability (Spitzer, Forman & Nee, 1979). However, Perry (1992) notes that other studies continued to indicate low inter-rater reliability. These disappointing findings, together with the success of the Schedule for Affective Disorder and Schizophrenia/ Research Diagnostic System (Spitzer & Endicott, 1977), led to the development of both structured-interview and self-report assessments of personality disorder (Perry, 1992). The characteristics of the assessments most commonly used to measure DSM personality disorder clusters, and in particular ASPD, are summarised below:

Self-Report Instruments

Diagnostic Questionnaire - Revised (PDQ-R) (Hyler & Reider, 1984)
The PDQ-R contains 152 items assessing the 11 DSM-IIIR personality disorder diagnoses plus sadistic and self-defeating personalities. Each item requires a yes/no response, and the direction of some items is reversed to mitigate problems of response set (Perry, 1992). All questions relating to a particular disorder appear on the same page. Although this allows clinicians to assess single disorders, in this instance ASPD, it also increases the risk that a patient will pick-up a theme in a series of questions (Reich, 1989).

The Millon Clinical Multiaxial Inventory (MCMI) (Millon, 1983)
The original version of the MCMI consists of 175 true/false questions representing 20 scales. The MCMI purports to measure the same constructs represented in DSM-III. However, Millon's concept of personality disorder differs from DSM-III in that he separates personality disorders into 'basic personality patterns' and 'pathological personality patterns'. According to Millon 'basic personality disorders', which include ASPD, represent less severe forms of 'pathological personality disorders'. In addition to the two
groups of personality scales, the MCMI has separate groups of scales to facilitate differential diagnosis between enduring personality characteristics and more transient and changeable state clinical syndromes.

The MCMI-II (Millon, 1987) and MCMI-III (Millon, 1994) represent updated versions of the MCMI. These updates were designed to accommodate changes to Axis-II diagnoses introduced in DSM-III-R and DSM-IV, respectively. In all versions of MCMI items relating to a particular disorder are intermixed. Consequently, it is not possible to measure ASPD in isolation. The MCMI-II and MCMI-III include scales for aggressive/sadistic personality and for passive aggressive personality traits. Although these disorders do not appear in DSM-IV, they are of potential relevance to assessment of forensic patients.

Interview schedules

The Personality Disorders Examination (PDE) (Loranger, 1988)
The PDE is a semi-structured interview consisting of 328 items which are scored on a three-point scale. The 1988 version of the interview contains a number of questions with probes asking for examples or anecdotes following a positive answer. The PDE is organised into five topic areas: work; self; interpersonal relationships; affect; and, impulse control. The division of the interview into topic areas gives the interview a natural flow for the patient (Perry, 1992), and makes it easier for the clinician to administer (Reich, 1987). It does, however, prevent the administration of items relating to ASPD in isolation.

The Structured Clinical Interview for DSM-III-R Personality Disorders (SCID-II) (Spitzer & Williams, 1987)
The SCID-II consists of 120 items which are scored on a four-point scale (inadequate information - negative - sub-threshold - threshold). Specific probe questions are supplied in order to facilitate rating of each item. The interview questions are organised by diagnosis so that all of the criteria of a disorder are assessed together, making it easy for the interviewer to assess one disorder at a time (Perry, 1992). Spitzer and Williams (1987) suggest that in order to save time the PDQ-R should be used as pretest with positive self-report responses being followed-up by the appropriate SCID-II items.
The Structured Interview for DSM-III Personality Disorders (SIDP)  
(Pfohlel, Stangl & Zimmerman, 1982)  
The SIDP consists of 160 items grouped topically rather than diagnostically (Perry, 1992). Consequently, it is not easy to assess ASPD in isolation. When a knowledgeable informant is available the interviewer is encouraged to ask the informant some of the questions in order to check the validity of the patients' responses (Reich, 1989).

Diagnostic Interview for Personality Disorders (DIPD)  
(Zanarini, 1983)  
The DIPD has 101 questions which cover all the DSM-III personality criteria. The interview is grouped by personality disorder and subgrouped by criteria (Reich, 1989). This structure allows the clinician to assess ASPD in isolation.

Reliability  
The reliability of a diagnosis refers to its reproducibility between different settings. The most common indices of reliability are the level of agreement (a) between different practitioners (i.e. inter-rater reliability), and (b) the stability of a diagnosis over time (test-retest reliability).

The interpretation of the level of diagnostic agreement is influenced by the frequency with which the diagnosis is made in each setting (Perry, 1992). For instance, if two practitioners diagnose the presence of borderline p.d. in 40% and antisocial p.d. in 20% of a group of subjects, on the basis of chance alone they will both diagnoses borderline personality disorder in 16% of cases (i.e. 40% X 40%) and ASPD in only 4% of cases. The kappa statistic was devised by Cohen (1960) to take into account the varying base rates of different diagnoses. Kappa values greater than approximately 0.75 are generally taken to indicate excellent agreement beyond chance, values below approximately 0.40 are generally taken to represent poor agreement beyond chance, and values in between are generally taken to represent fair to good agreement beyond chance (Shrout, Spitzer & Fleiss, 1987).

Personality Diagnostic Questionnaire - Revised (PDQ-R)  
Hurt et al. (1984) assessed test-retest reliability over a one month period in a group of psychiatric outpatients selected for the presence of DSM-III Axis-II personality disorders. They reported the a kappa value of 0.74 for
agreement across time in diagnosis of ASPD.

The Millon Clinical Multiaxial Inventory (MCMI)
McCann and Dyer (1988) report the “stability coefficients” for a sample of 47 inpatients tested with the MCMI-II at admission and discharge. The values for the “basic personality disorder” scales range from 0.59 to 0.75. However, MCCann and Dyer do not give a specific value for ASPD.

The Personality Disorders Examination (PDE)
Loranger et al. (1987) reported high levels of agreement on the PDE for all diagnoses, and high inter-rater reliability for five diagnoses with sufficient base rates1 (median kappa = 0.8, range =0.7 - 0.96). Short-term (2 months) retest for four p.d. diagnoses with calculable kappa coefficients were ‘fair to good’ reliability (median kappa = 0.49, range = 0.37 - 0.56). However, no data relating to ASPD are presented.

The Structured Clinical Interview for DSM-IIIIR Personality Disorders (SCID-II)
Brooks et al. (1991) reported fair to good agreement between clinicians diagnoses based on joint interviews using the SCID-II (kappa ranged from 0.43 - 0.89). However, Brooks et al. do not provide data about interrater reliability for diagnosis of ASPD. First et al. (in press) present findings from a large multicentre retest reliability study of the SCID. These findings reveal a kappa value of 0.71 for diagnoses of ASPD.

The Structured Interview for DSM-III Personality Disorders (SIDP)
Stangl et al. (1985) reported good inter-rater reliability for the five disorders with calculable kappas (median kappa = 0.75, range = 0.45 - 0.90). Reich (1989) reports that Van der Brink et al. (1986) report ‘fair to good’ six month test-retest reliability data for a slightly modified version of the SIDP (any personality disorder = 0.62; histrionic personality disorder = 0.46; borderline personality disorder = 0.70; dependent personality disorder 0.44; passive-aggressive personality disorder = 0.40; schizotypal personality disorder = 0.14. However, it is unclear from Reich’s report whether these are correlation or kappa coefficients). Moreover, no data are reported relating specifically to the reliability of ASPD diagnoses.

1 Perry (1992) notes that in small samples, when a diagnosis occurs at a very low base rate, kappa coefficients have high variability.
Diagnostic Interview for Personality Disorders (DIDP)
Zanarini et al. (1987) reported interrater reliabilities for 43 subjects of
greater or equal to kappa coefficients of 0.86 for all disorders except paranoid
personality disorder (kappa = 0.52) and schizoid personality disorder (too few
diagnoses to measure). The median test-retest Kappas at less than one week
was 0.67 (range = 0.54 - 0.85) (Zanarini et al., 1987).

In summary, the available data indicate that the development of diagnostic
instruments has greatly improved the reliability of the DSM ASPD diagnoses.
(e.g. Reich, 1987). However, there are a number of reasons to be cautious
about this conclusion. First, many studies do not provide specific
information relating to the diagnosis of ASPD. Second, there is a lack of good
six month to two years test-retest data. This is of concern especially because
personality disorder is defined by the presence of enduring maladaptive
traits (Reich, 1987). Third, good reliability does not guarantee the validity of
a diagnosis (e.g. Spitzer & Fliess, 1974). The validity of DSM Axis II diagnoses
is considered below.

Validity

Validity data provide information about the extent to which a diagnosis is
useful in research and clinical practice. In the validation process the
inferences made from a diagnosis, and not the diagnosis itself, are assessed
(Milner & Campbell, 1995). There are a number of ways of assessing validity,
the most commonly used of these are concurrent, construct, and predictive
validity (Kline, 1993).

Concurrent validity

To demonstrate concurrent validity the scores from one test are correlated
with scores from another test of the same variable (diagnosis), both tests are
administered at the same time (Kline, 1993). When correlation coefficients
are used satisfactory concurrent validity is suggested by a coefficient of at
least 0.70 (Kline, 1993).
Table 5 summarises studies investigating agreement between standardised measures of ASPD. The kappa and correlation coefficients reported in these studies indicate ‘poor’ agreement between the: PDQ and SIDP; PDQ and clinical judgment; MCMI-II and clinical judgment; PDQ-R and PDE; and, MCMI-II and SIDP. In contrast, ‘fair to good’ agreement is indicated between the: PDE and SCID-II; and, PDQ-R and SCID-II.

In summary, with the exception of the SCID-II, the studies summarised in Table 5 indicate poor agreement between standardised measures of ASPD. This suggests that different instruments may not measure identical constructs.

**Construct validity**

The concept of construct validity was developed by Cronbach and Meehl (1955). It refers to the extent to which the underlying constructs assumed to be measured by a concept (diagnosis) are actually measured. Construct validity data provide verification of what initially was theoretically or intuitively assumed during the development of a concept (e.g. Millner & Campbell, 1995).

One of the most significant challenges to the construct validity of ASPD is the heterogeneity of individuals sharing the diagnosis (e.g. Blackburn, 1988; Blackburn & Coid, 1996). The poor concurrent validity of assessments of ASPD suggests that they are not measuring exactly the same thing. This
means that the composition of the population of patients diagnosed with ASPD will differ depending upon the assessment used. The use of different assessment tools by clinicians will lead, therefore, to at least some heterogeneity in the population sharing the diagnosis ASPD. Moreover, given the poor inter-rater reliability of clinical judgment (e.g. Spitzer & Fleiss, 1974) this heterogeneity will be greater when standardised assessments are not used.

Related to homogeneity is the extent to which ASPD patients form a group which is distinguishable from patients with other diagnoses. High rates of co-morbidity between ASPD and a range of other personality disorders indicate that many patients with ASPD posses personality traits related to other personality disorders (e.g. Dolan, Evans & Norton, 1995). This observation has led some researchers to suggest that attempts to identify mutually exclusive categories of personality disorder are misguided (e.g. Widiger, 1991; Blackburn & Coid, 1996). These researchers note that factor analyses of DSM axis-II diagnoses reveal recurring patterns of comorbidity (e.g. Widiger, 1991; Blackburn & Coid, 1996). They argue that these patterns are likely to reflect the organisation of underlying dimensions. For instance, Blackburn & Coid (1996) factor analysed dimensionalised SCID-II scores obtained from a sample of 86 special hospital patients and 81 violent and disruptive male prisoners. The analysis revealed four factors. Blackburn and Coid propose that one of these factors, antagonism, is closely linked to psychopathy. Tyrer and Alexander (1979) found a similar factor, which they termed ‘sociopathy’, in their factor analysis of ICD-8 diagnoses.

Predictive validity

Predictive validity refers to the ability of a test to predict some relevant outcome (Kline, 1993). Milner and Campbell (1995) distinguish between ‘post-hoc’ and ‘future’ predictions. Post-hoc predictions refer to the prediction of historical variables associated with a diagnosis. Future predictions refer to the prediction of a condition or event that has not yet occurred.

It was noted above that many of the criteria for ASPD are closely associated with socially deviant behaviour. This association suggests that a diagnosis of ASPD should be a good retrospective predictor of deviant behaviour. However, empirical data suggest that this is not the case. For instance, ASPD
diagnoses derived using the MCMI do not discriminate perpetrators of
domestic violence (e.g. Hamberger & Hastings, 1988) or sexual offenders (e.g. 
Langevin et al., 1988). Hart, Kropp, and Hare (1988) found a correlation of
only 0.20 between clinicians' diagnoses of ASPD and reconvictions in a
sample of 231 released offenders. Finally, Harris, Rice and Cormier (in press)
reported a correlation of only 0.26 was found between clinicians' diagnoses
of ASPD and future violent recidivism in a sample of 169 male forensic
patients. Diagnosis of ASPD has also been shown in well controlled studies to
be a poor predictor of treatment outcome (e.g. Blackburn, 1989).

Measures of dissocial personality disorder

The non-criterion based ICD approach relies heavily on clinical judgment
and does not easily convert to non-clinical diagnostic instruments (Dolan,
Evans & Norton, 1995). Notwithstanding this difficulty, Mann and colleagues
developed the SAP as a measure of ICD-8 personality disorders (World Health
Organisation, 1965), and Loranger et al. (1994) produced the International
Personality Disorder Examination (IPDE).

Standardised Assessment of Personality (SAP)
(Mann, Jenkins, Cutting & Cowen, 1981)
The SAP consists of a three stage interview with an informant. The first is a
general introduction. The second stage asks for a general description of the
patient's personality. A series of seven standard questions can be used to
guide this stage. These questions all probe information relevant to ICD-8
personality types. The third stage consists of groups of questions relevant to
one or more of the personality types identified in stage two. The third stage
enables the interviewer to confirm that the features of a specific personality
disorder are present, to establish their longevity, and to estimate their
severity.

Mann et al. (1981) report data from preliminary investigations of the SAP's
inter-rater reliability and inter-temporal reliability of information provided
by informants. These studies used small sample sizes resulting in low
frequencies of many diagnoses. Consequently, kappa coefficients could not
be calculated for many diagnoses, including antisocial (dyssocial)
personality disorder.
International Personality Disorder Examination (IPDE) (Loranger et al., 1994)

The IPDE is derived from the PDE. It surveys 150 criteria used in making personality disorder diagnoses according to ICD-10 and DSM-III-R criteria. The IPDE contains 157 items that are scored as follows: 0 = absent or within normal range; 1 = present to an accentuated degree; and 2 = pathological/meets criterion. The IPDE requires that a behaviour or trait be present for at least 5 years before it is considered a manifestation of personality. It also requires that at least one criterion of a disorder be fulfilled before age 25 years.

Loranger et al. (1994) carried out a multi-centre study of the interrater and test-retest reliability of the IPDE. The kappa coefficient for interrater reliability for a definite or probable diagnoses of dissocial personality disorder for 141 patients across all sites was 0.88. Investigations of test-retest reliability for diagnoses of dissocial personality disorder for 243 patients across all sites yielded a kappa value of 0.55.

Conclusions, and implications for clinical practice

A range of standardised assessments have been developed to assist in making DSM and ICD diagnoses. These assessments have greatly increased the interrater and test-retest reliability of diagnosis. However, it was noted that good reliability does not guarantee the validity of an assessment or diagnosis. Wing, Cooper and Sartorius (1974) suggest that the clinical utility of a diagnoses can be judged by the extent to which it facilitates:
(a) communication between professionals by providing a short-hand which clearly identifies a particular population of patients;
(b) clinical management by providing a rational guide to prognosis and treatment; and,
(c) research into causes, prevention and treatment.

The psychometric data and theoretical considerations outlined in this review allow some conclusions to be drawn about the extent to which antisocial and dissocial personality disorders fulfil these functions. Studies of the interrater reliability of clinical judgments about diagnoses of personality disorders (e.g. Spizter & Fleiss, 1974) reveal inconsistencies between different clinicians use of these diagnoses. These inconsistencies are not
only likely to cause confusion in clinical practice, but also complicate both the selection of subjects for research, and the interpretation of the findings from this research. This in turn may have contributed to the lack of conclusive findings about the etiology, prognosis, and treatment of antisocial and dissocial personality disorders.

Studies investigating the psychometric properties of standardised assessments for antisocial and dissocial personality disorder demonstrate that these assessments considerably improve interrater reliability. Despite good agreement between raters using the same assessment, other studies demonstrate that there is often poor agreement between different assessments designed to measure the same diagnosis. Thus, although clinicians and researchers using the same assessment can be reasonably sure that they will agree on diagnosis, communication between clinicians, and comparisons between research studies, using different assessment measures may still contain an unacceptable lack of precision.

Among the issues not addressed by this review are: (a) the link between diagnoses of antisocial and dissocial personality disorders, and (b) the relationship between these diagnoses and Hare's Revised Psychopathy Checklist. These issues are addressed in the next section.
References


Wing, J.K., Cooper, J.E. & Sartorius, N. (1974). *The Description and


SUBSTANTIVE RESEARCH

A COMPARATIVE STUDY OF CLINICAL DEFINITIONS AND MEASURES OF ANTISOCIAL PERSONALITY (PSYCHOPATHY)
Abstract

This paper investigated the psychometric properties of measures of antisocial personality disorder (ASPD), dissocial personality disorder, and psychopathy, in a sample of male patients detained in a maximum security hospital under the legal category of psychopathic disorder. Measures included: the Structured Clinical Interview for DSM-III-R Axis II disorders (SCID-II); PCL-R; ICD-10 criteria for dissocial personality disorder; clinical judgment; and, MMPI derived scales for ASPD and psychopathy. It was demonstrated that ASPD, and dissocial personality disorder items formed reliable unidimensional scales. In line with previous findings, PCL-R items formed two unidimensional scales. The first representing personal deviance, and the second social deviance. Comparisons between measures revealed that whereas participants' scores on dissocial personality disorder and psychopathy items were highly correlated, there was little agreement between scores on ASPD items and assessments of psychopathy and dissocial personality disorder. The relevance of these findings to clinical and diagnostic practice is discussed.
A comparative study of clinical definitions and measures antisocial personality (psychopathy)

Clinical definitions of antisocial personality

The term 'psychopathic' first appeared in mid 19th century Germany where it was used to denote persons who were 'psychologically damaged'. However, by the turn of the 19th century the use of the term was beginning to be restricted to mean 'unethical' (Blackburn, 1988). In Britain the inclusion of the category of 'moral imbecile' in the 1913 Mental Deficiency Act introduced the legal defence of moral insanity. This term only referred to mentally impaired offenders. Consequently, psychiatrists resorted to using the term psychopath to describe chronic offenders who were not mentally impaired but who were nonetheless assumed to be morally defective. This use was eventually formalised in the English Mental Health of 1959. This Act defined psychopathic disorder as “a disorder or disability of mind...which results in abnormally aggressive or seriously irresponsible conduct on the part of the patient, and requires or is susceptible to medical treatment”.

Despite a recommendation from the Butler Committee (Home Office/Department of Health and Social Security, 1975) to replace ‘psychopath’ with the term ‘personality disorder’ the term was retained when the 1959 Act was revised in 1983.

The legal definition of psychopathic disorder implies that the term denotes a group of offenders who are homogeneous in personality. This assumption has been proven repeatedly to be unfounded (e.g. Blackburn, 1975; Blackburn & Coid, 1996). For instance, Blackburn (1975) carried out a cluster analysis of the MMPI profiles of 56 violent offenders detained under the legal category of psychopathic disorder. He identified four different personality profiles. These four profiles have been described as: ‘primary psychopaths’ characterised by self-reports of impulsive, hostile, aggressive, and extroverted behaviour; ‘secondary psychopaths’ characterised by self-reports of impulsive, aggressive, hostile, socially anxious and withdrawn behaviour; ‘controlled’ or ‘conforming’ personality characterised by defensive, sociable, and unaggressive behaviour; and, ‘inhibited’ personality characterised by unaggressive, withdrawn, and introverted behaviour.

In contrast to the relatively narrow legal definition of psychopathic
disorder, Schneider (1950) proposed that the term refers to a heterogeneous group divided into ten specific types or classes. These types are hyperthymic, depressive, insecure, fanatical, lacking in self-esteem, labile in affect, explosive, wicked, aboulic, and asthenic. According to Schneider psychopathic personalities are those that cause ‘suffering’ to themselves or others. Another difference between the legal and Schneider’s conceptualisations of psychopathic disorder is that the latter excludes antisocial behaviour from the criteria of abnormal personality. Consequently, although Schneider’s conception of psychopathic personality includes individuals who break the law, it implies that the antisocial behaviour of these individuals is secondary to personality deviation (Blackburn, 1988).

Schneider’s typology of psychopathic personalities was highly influential in the development of ICD-8 and ICD-9. The ICD-10 diagnosis most closely associated with psychopathic personality is dissocial personality disorder (Widiger et al., 1994; Blackburn, 1988). This diagnosis replaced sociopathic personality disorder which appeared in earlier versions of ICD. Pichot (1978) notes that ICD-9 sociopathic personality disorder resembles Schneider’s affectionless type. However, Pichot points out that contrary to Schneider’s principle of classifying by personality deviation only, the criteria for sociopathic personality disorder include antisocial behaviour. The defining features of ICD-10 dissocial personality disorder are presented in Table 1.

Similarly to Schneider, Millon (1981) distinguishes between antisocial behaviour and personality deviance (Blackburn, 1988). Millon proposes a model of personality disorders in which personality deviance represents the pathological extremes of eight distinct ‘coping patterns’. The central premise of Millon’s model is that people are naturally driven to maximise pleasurable experiences and to minimise unpleasant or painful experiences. In addition, the model proposes that people can either develop instrumental strategies for attaining reinforcement, or can passively accept various life experiences and wait for pleasurable experiences to arise. Millon argues that eleven basic personality patterns are defined by examining ‘passive’ and ‘active’ personality types that develop a primary reliance on a particular source of reinforcement. For instance, excessive active pursuit of reinforcing experiences based almost exclusively on self-gratification and fulfilment leads to ‘antisocial personality’, and the seeking of reward through inflicting pain or discomfort leads to ‘aggressive/sadistic’
Personality disorder usually coming to attention because of a gross disparity between behaviour and the prevailing social norms, and characterised by:

(a) callous unconcern for the feelings of others
(b) gross and persistent attitude of irresponsibility and disregard for social norms, rules, and obligations
(c) incapacity to maintain enduring relationships, though having no difficulty in establishing them
(d) very low tolerance of frustration and a low threshold for discharge of aggression, including violence
(e) incapacity to experience guilt and to profit from experience, particularly punishment
(f) marked proneness to blame others, or to offer plausible rationalisations, for the behaviour that has brought the patient into conflict with society.

There may be persistent irritability as an associated feature. Conduct disorder during childhood and adolescence, though not invariably present, may further support the diagnosis.

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**Table 1 Characteristics of the ICD-10 dissocial personality disorder**

Millon's model of personality disorder forms the basis of the DSM-III Axis II disorders. The DSM-III diagnosis most closely associated with psychopathic personality is Antisocial Personality Disorder (ASPD) (Widiger et al., 1994; Blackburn & Coid, 1996). Blackburn (1988) notes that the final version of DSM-III departed from Millon's model in several respects. First, DSM-III included three categories of personality disorder (schizotypal, borderline & paranoid) which Millon viewed as severe variants of his basic patterns. Second, in contrast to Millon's emphasis on personality characteristics, the criteria for ASPD contained in DSM-III, -III-R, and -IV criteria for ASPD are predominantly socially deviant behaviours (Blackburn, 1988). The emphasis on behaviour in the DSM ASPD criteria was designed to facilitate the obtainment of reliable assessments (Spitzer, Endicott & Robbins, 1975). The DSM-IV criteria for a diagnosis of ASPD are listed in Table 2. These criteria are essentially the same as those contained in DSM-III-R, with the exception of the inclusion in DSM-III-R of criteria relating to parental irresponsibility, and failure to maintain a monogamous relationship for more than one year.
A. There is a pervasive pattern of disregard for and violation of the rights of others occurring since age 15, as indicated by three (or more) of the following:

1. failure to conform to social norms with respect to lawful behaviours as indicated by repeatedly performing acts that are grounds for arrest
2. deceitfulness, as indicated by repeated lying, use of aliases, or conning others for personal profit or pleasure
3. impulsivity or failure to plan ahead
4. irritability and aggressiveness, as indicated by repeated physical fights or assaults
5. reckless disregard for safety of self or others
6. consistent irresponsibility, as indicated by repeated failure to sustain consistent work behaviour or honour financial obligations
7. lack of remorse, as indicated by being indifferent to or rationalising having hurt, mistreated, or stolen from another

B. Current age at least age 18 years.
C. There is evidence of DSM-IV Conduct Disorder with onset before age 15.
D. The occurrence of antisocial behaviours not exclusively during the course of Schizophrenia or a Manic Episode.

Table 2 DSM-IV criteria for a diagnosis of Antisocial Personality Disorder

Another influential author who has argued for a distinction between personal and social deviance is Cleckley (1976). Cleckley argued that psychopathy should not be equated with criminality. He attempted to define psychopathic personality from the characteristics most frequently observed in clinical practice. These characteristics included a singular lack of guilt and remorse for their offences, egocentricity and impulsiveness, and a failure to learn from experience.

The preceding discussion indicates that ASPD, dissocial personality disorder, Cleckley’s (1976) definition of psychopathic personality, and the legal definition of psychopathy, place different emphases on personal and social deviance. Cleckley’s definition emphasises personal deviance over socially deviant behaviour. ICD dissocial (or formerly sociopathic) personality disorder represents a hybrid between personal and social deviance. The criteria for ASPD are more heavily biased towards social deviance. Finally, the legal definition of psychopathic disorder effectively equates
psychopathy with antisocial behaviour (Mayer-Gross et al., 1969; Blackburn, 1988).

The next section briefly reviews standardised assessments that have been developed to measure ASPD, dissocial personality disorder, and psychopathic personality. A more thorough review of literature relating to these assessments is presented elsewhere in this thesis. Consequently, the next section focusses on the assessments most relevant to the current research.

**Assessment of antisocial personality**

*Dissocial personality disorder*

Several assessment tools have been developed to assess ICD personality disorders. These include the Standardised Assessment of Personality (SAP: Mann, Jenkins, Cutting & Cowen, 1981), and the the International Personality Disorder Examination (IPDE: Loranger et al., 1994).

The SAP consists of an interview with an informant. The interview probes information relevant to ICD-8 personality types. Unfortunately, investigations of the SAP's inter-rater, and test-retest, reliability (Mann et al., 1981) used small sample sizes resulting in low frequencies of many diagnoses. Consequently, kappa coefficients could not be calculated for many diagnoses, including antisocial (Dyssocial) personality disorder.

The IPDE is a structured interview that surveys 150 criteria used in making PD diagnoses according to ICD-10 and DSM-III-R criteria. The IPDE requires that a behaviour or trait be present for at least 5 years before it is considered a manifestation of personality. It also requires that at least one criterion of a disorder be fulfilled before age 25 years. Loranger et al. report that the IPDE produces interrater reliability for a definite or probable diagnoses of dissocial personality disorder of 0.88 (kappa), and test-retest reliability of 0.55 (kappa).

*Antisocial personality disorder*

A number of structured-interview and self-report measures have been developed to aid diagnosis of DSM personality disorders. Self-report
instruments include the Personality Diagnostic Questionnaire - Revised (PDQ-R: Hyler & Reider, 1984), the first, second and third versions of the Millon Clinical Multiaxial Inventory (Millon, 1983; 1987; 1994), and Morey's MMPI scales.

Semi-structured interview schedules include the Personality Disorders Examination (PDE: Loranger, 1988), Structured Interview for DSM-III Personality Disorders (SIDP, Pfohel, Stangl & Zimmerman, 1982), Diagnostic Interview for Personality Disorders (DIPD: Zanarini, 1983), and Structured Clinical Interview for DSM-IIIR Personality Disorders (SCID-II: Spitzer & Williams, 1987).

Research indicates that the development of self-report instruments and semi-structured interviews has greatly improved reliability of diagnosis of ASPD (Reich, 1987). However, studies comparing diagnoses made by different instruments reveal poor agreement between the: PDQ and SIDP (Zimmerman & Corryell, 1990); PDQ, and clinical judgment (Hyler et al., 1990); MCMI-II and clinical judgment (Piersma, 1987); PDQ-R and PDE (Hyler et al., 1990); and, MCMI-II and SIDP (Jackson et al., 1991). In contrast, research indicates fair to good agreement between the SCID-II and PDE (k = 0.59)(Oldham et al., 1992) (k = 0.64)(Hyler et al., 1990), and the SCID-II and PDQ-R (0.42)(Hyler et al., 1990).

The SCID-II consists of 120 items which are scored on a four-point scale (? = inadequate information; 0 = negative; 1 = sub-threshold; 2 = threshold). Specific probe questions are supplied in order to facilitate rating of each item. The interview questions are organised by diagnosis so that all of the criteria of a disorder are assessed together, making it straightforward for the interviewer to assess one disorder at a time (Perry, 1992). The section of the SCID-II assessing ASPD contains 23 items. These items are summarised in Appendix 1. The items are divided into three sections. The first item assesses the patient's age and relates to DSM criterion C. The next 12 items assess childhood conduct disorder. These items relate to DSM criterion B. The remaining 10 items assess adult manifestations of ASPD. These items relate to DSM criterion A.

Several studies have demonstrated fair to good interrater reliability for many of the disorders measured by the SCID-II. For instance, Brooks et al. (1991) reported fair to kappa coefficients ranging from 0.43 to 0.89. Similar
findings are also reported by Renneberg et al. (1992) and Wonderlich et al. (1990). First et al. (in press) reported test-retest reliabilities ranging from 0.24 to 0.74 in a sample of 103 inpatients or outpatients, and 0.24 to 0.57 in symptomatic nonpatients. Test-retest kappa coefficient for ASPD in the patient group was 0.71, no data were presented for diagnoses of ASPD in the nonpatient group.

Cleckley's (1976) definition and Hare's (1980; 1991) Psychopathy Checklist

Cleckley's criteria for psychopathic disorder provide the basis of a twenty-two item checklist developed by Hare (1980: Psychopathy Checklist (PCL-R)). Hare (1986) subsequently shortened this checklist by removing two items to produce a revised version. The 20 items contained in this checklist, termed the Revised Psychopathy Checklist List (PCL-R), are summarised in Table 1 in Appendix II.

Hare, Hart and Harpur (1991) state that the reliability and validity of the PCL and PCL-R are well established. They note that, despite the subjective nature of most of the PCL-R items, each item has reasonable interrater reliability (range $r = 0.51-0.86$). They also cite several studies demonstrating good predictive validity. For instance, Harris, Rice, and Cormier (1991) demonstrated that the PCL-R predicted post-release violent offending in a sample of 169 male forensic patients. They found that the violent recidivism rate for psychopaths was almost four times that for non-psychopaths. A significant relationship has also been demonstrated between the PCL-R and the nature of violent offences. Williamson, Hare, and Wong (1987) analysed official police reports of serious violent offences. They found that most of the murders and serious assaults committed by non-psychopaths occurred during a domestic dispute or during a period of emotional arousal. In contrast, the victims of psychopaths were likely to be unknown to them.

In contrast to Cleckley's conceptualisation of psychopathy as personal deviance, the 20 PCL-R items assess both personal deviance (e.g. superficial charm and callousness) and antisocial behaviour (e.g. history of juvenile delinquency, and range of criminal activities). Cleckley's distinction between criminal behaviour and psychopathic personality is supported, however, by factor analytic studies of PCL data. Harpur, Hakstian and Hare (1988) report that analysis of PCL profiles of almost 1200 prisoners yielded two factors. They suggest that the first of these concerns personality traits
(i.e. personal deviance), whereas the second factor reflects chronic antisocial and criminal behaviour (i.e. social deviance). The items loading on each of these two factors are presented in Tables 3 and 4 in Appendix II. Harpur, Hare and Hakstian (1989) investigated correlations between total scores on factors 1 and 2. Interrater reliabilities averaged 0.80 for factor 1 (range = 0.75 to 0.83), an 0.88 (range = 0.86 to 0.89). They also assessed internal consistency of scores on factors 1 and 2 across the same samples. Alpha coefficients averaged 0.82 (range = 0.79 to 0.84) for factor 1, and 0.83 (range = 0.80 to 0.87) for factor 2.

The PCL-R manual (Hare, 1991) states that each item should be scored on a 3-point scale (0 = negative; 1 = maybe/in some respects; 2 = yes) based on a comprehensive review of information in the testee's file notes and a structured interview. The interview serves to corroborate file information and to collect information which may not be available in the file. The interview can also be used to score items that rely more heavily on the interviewer's impressions, such as glibness and superficial charm.

Wong (1988) suggests that researchers may not always be able to carry out an interview. For instance, he notes that the testee may refuse to be interviewed, or that in large scale studies high numbers of interviews may be unacceptably time consuming. In order to address this difficulty Wong investigated whether ratings on the PCL-R obtained without interview could provide a reliable measure of psychopathy in mentally disordered offenders. Wong collected PCL-R ratings for 56 forensic patients with and without the structured interview. Interrater reliability (Pearson r) of the ratings based on file information alone was 0.74. Wong proposes that this value indicates that reliable ratings can be obtained using file information alone. Moreover, he notes that there was not a significant difference between interrater reliability of ratings obtained from file information alone and ratings obtained from file and interview information.

Minnesota Multiphasic Personality Inventory (MMPI)

Originally devised by Hathaway and McKinley in 1940, the MMPI provides an objective means of assessing abnormal behaviour. A person undertaking the MMPI sorts 567 statements into one of three categories: true, false, or cannot say. The person's responses to these statements are scored on 4 validity scales assessing the person's test-taking attitude, and 10 clinical scales that
assess major categories of abnormal behaviour (Greene, 1980).

Clinical Scale 4, the psychopathic deviate scale, assesses social maladjustment and the absence of strongly pleasant experiences (McKinley & Hathaway, 1944). The scale was constructed empirically using a criterion group of young persons diagnosed as DSM-II 'psychopathic personality, asocial or amoral type'. The responses of this criterion group were contrasted with those of samples of the married control subjects, and college applicants. This procedure resulted in 50 items covering a wide array of topics including absence of satisfaction in life, family problems, delinquency, sexual problems, and difficulties with authority.

McKinley and Hathaway (1944) cross validated Scale 4 by examining the total scores on the scale obtained by samples of psychiatric inpatients, and prison inmates, all of whom had been diagnosed as psychopathic personality. A 'T-score' of 70 or above on Scale 4 was achieved by 59 percent of prisoners and 45 percent of inpatients. McKinley and Hathaway called this scale psychopathic deviate to indicate that it is not expected to differentiate all cases of psychopathic personality (Greene, 1980).

Lea (1986) used a sample 2034 MMPIs completed by patients detained in a maximum security hospital to develop a 19 item scale for psychopathy, termed the LPS. The LPS items are presented in Appendix III. These items were selected to reflect three broad dimensions hypothesised as predictive of psychopathic personality. These dimensions were: delinquency or disordered conduct before the age of 16; antagonistic attitude to authority; and, callous disregard for others and a correspondingly high propensity for violence. Psychometric evaluation of the scale indicated good reliability (Alpha = 0.84), high correlation with Morey's ASPD scale \( r = 0.91 \), and reasonable correlation with Scale 4 \( r = 0.60 \).

Morey, Blashfield, Webb, and Jewell (1988) developed a set of MMPI scales that assess DSM-III personality disorders. Although they present the findings of a preliminary validation study, they do not provide data relating specifically to ASPD.
Comparisons between definitions and measures of 'psychopathic disorder'

Blackburn and Coid (1996) state that DSM-IV regards ASPD as a synonym for psychopathic disorder. Similarly, ASPD and dissocial personality disorder are often considered to be closely related. For instance, in a well cited review Tyrer, Casey and Ferguson (1991) state that "There is good agreement between DSM-III-R and the draft version of ICD-10, with most of the differences between the two systems being minor ones of terminology." (p. 465). However, despite the assumed links between Cleckley's, ICD, and DSM, conceptualisations of 'psychopathic' personality, to date there is little empirical evidence indicating good agreement between diagnoses of ASPD, dissocial personality disorder, and scores on the PCL-R.

Hart and Hare (1989) assessed 80 male forensic patients using the PCL, and clinical judgments about the presence or absence of DSM-III ASPD. They found that PCL total scores, and factor 2 scores, were significantly correlated ($r = 0.45$ & $r = 0.59$, respectively) with diagnosis of ASPD. The association between factor 1 scores and ASPD was not significant.

Hart and Hare note that the categorical diagnoses, such as DSM axis II diagnoses, have been criticised for ignoring the large individual differences in the degree to which patients manifest the full range of symptoms of a given disorder (e.g. Widiger, 1991). Consequently, they also present correlations between PCL scores and DSM-III ASPD prototypicality ratings. Prototypicality ratings were made by two raters on a 10 point scale, with 1 indicating that the patient was very unlike, and 10 indicating that he was very like, the complete DSM-III description of the disorder. Correlations between prototypicality ratings and PCL total ($r = 0.71$), factor 1 ($r = 0.4$), and factor 2 ($r = 0.83$) scores were all significant at the 0.01 level.

Harpur, Hare and Hakstian (1989) investigated agreement between 319 prison inmates scores on the MMPI psychopathic deviate (pd) scale, total PCL, PCL factor 1 and PCL factor 2. Correlations between pd scores and total PCL ($r = 0.31$), and pd scores and factor 2 scores ($r = 0.25$), were modest but not significant. There was little agreement between pd scores and factor 1 scores ($r = 0.11$).

It was noted above that the IPDE provides both ICD-10 and DSM-III-R
personality disorder diagnoses. Loranger et al. (1994) investigated agreement between diagnoses derived from the IPDE for the two classificatory systems. Unfortunately, the low prevalence of dissocial personality disorder and ASPD prevented the calculation of a stable kappa coefficient.

The most extensive comparative study to be published recently was conducted by Widiger et al. (1994). These researchers investigated consistency between DSM-III-R ASPD diagnoses, ICD-10 dissocial personality disorder diagnoses, and scores on a shortened version of the PCL-R. Data were obtained from four sites containing populations of particular relevance to the diagnoses of ASPD. These sites were a prison, general psychiatric inpatient unit, outpatient methadone prescribing service, and a shelter for homeless people and substance misusers. In each site subjects were assessed using three semi-structured interviews. All four sites used a modified version of the International Personality Disorder Examination (IPDE, Loranger et al., 1994) to assess the 10 dissocial personality disorder items, and a variant of the PCL-R. Widiger et al. refer to the modified PCL-R as the Psychopathy Criterion Set (PCS). Each site used different semi-structured interviews to assess the DSM-III-R ASPD criteria. The methadone service used the Personality Disorder Examination (Loranger, 1988) and the inpatient unit the Diagnostic Interview for Personality Disorders (Zanarini, 1983). Widiger et al. do not provide details of the interviews used at the other two sites.

Widiger et al. present kappa coefficients indicating the level of agreement between the ASPD, dissocial personality disorder, and PCL-R assessments for each site, as well as coefficients indicating the overall agreement across all four sites. These coefficients are summarised in Table 3. Shrout, Spitzer and Fleiss (1987) suggest that kappa values above 0.75 can be taken to indicate excellent agreement beyond chance, values below approximately 0.40 poor agreement beyond chance, and values in between fair to good agreement. With the exception of the assessments of ASPD and dissocial personality disorder in the homeless and drug service, Table 3 reveals poor or at best fair agreement between diagnoses derived from different assessments.

Widiger et al. also report correlations between each participant's total scores on the IPDE, PCS, and on the respective assessment of ASPD. These correlations are also presented in Table 3. This table shows that agreement between the extent to which each participant displayed antisocial-
psychopathic tendencies is generally quite high. For instance, the correlations across all four sites were: 0.68 for DSM-III-R and ICD-10; 0.73 for DSM-III-R and PCS; and 0.79 for ICD-10 and PCS.

<table>
<thead>
<tr>
<th>Site and criteria</th>
<th>Kappa =</th>
<th>r=</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drug-homeless</td>
<td></td>
<td></td>
</tr>
<tr>
<td>DSM-III-R/ICD-10</td>
<td>0.62</td>
<td>0.79</td>
</tr>
<tr>
<td>DSM-III-R/PCS</td>
<td>0.49</td>
<td>0.86</td>
</tr>
<tr>
<td>ICD-10 / PCS</td>
<td>0.34</td>
<td>0.83</td>
</tr>
<tr>
<td>Inmate</td>
<td></td>
<td></td>
</tr>
<tr>
<td>DSM-III-R/ICD-10</td>
<td>0.41</td>
<td>0.42</td>
</tr>
<tr>
<td>DSM-III-R / PCS</td>
<td>0.25</td>
<td>0.48</td>
</tr>
<tr>
<td>ICD-10 / PCS</td>
<td>0.36</td>
<td>0.77</td>
</tr>
<tr>
<td>Methadone</td>
<td></td>
<td></td>
</tr>
<tr>
<td>DSM-III-R/ICD-10</td>
<td>0.11</td>
<td>0.42</td>
</tr>
<tr>
<td>DSM-III-R / PCS</td>
<td>0.07</td>
<td>0.48</td>
</tr>
<tr>
<td>ICD-10 / PCS</td>
<td>0.10</td>
<td>0.77</td>
</tr>
<tr>
<td>Inpatient</td>
<td></td>
<td></td>
</tr>
<tr>
<td>DSM-III-R/ICD-10</td>
<td>0.47</td>
<td>0.73</td>
</tr>
<tr>
<td>DSM-III-R / PCS</td>
<td>0.43</td>
<td>0.84</td>
</tr>
<tr>
<td>ICD-10 / PCS</td>
<td>0.46</td>
<td>0.76</td>
</tr>
<tr>
<td>All four sites</td>
<td></td>
<td></td>
</tr>
<tr>
<td>DSM-III-R/ICD-10</td>
<td>0.48</td>
<td>0.68</td>
</tr>
<tr>
<td>DSM-III-R / PCS</td>
<td>0.39</td>
<td>0.73</td>
</tr>
<tr>
<td>ICD-10 / PCS</td>
<td>0.36</td>
<td>0.79</td>
</tr>
</tbody>
</table>

Table 3. Agreement between DSM-III-R ASPD, ICD-10 dissocial personality disorder and PCL-R criteria in a study across four sites conducted by Widiger et al (1994)

(N.B.1 - kappa = agreement between diagnoses; and r = agreement between total scores
N.B.2 - PCS = Psychopathy Criterion Set [derived from the PCL-R])

The good agreement observed by Widiger et al. (1994) between scores on measures of ASPD, dissocial personality disorder, and the PCS is reassuring given that these concepts are assumed to measure the same construct (Harpur, Hare & Hakstian, 1989). However, there are potential problems with the study: First, each of the test sites used different interviews to assess ASPD. It was noted above that there is generally poor agreement between these measures. This finding not only makes comparison between different
measures difficult, but also raises questions about the validity of some of the interviews. Second, Widiger et al.'s study did not include a population of mentally disordered offenders.

These criticisms are addressed in the current research which assesses the degree of correspondence between measures of ASPD, dissocial personality disorder, and psychopathy, in a special hospital population. It was noted above that these concepts are often assumed to be closely related. If this assumption is correct, it is predicted that high correlations will be observed between rating of dissocial personality disorder, and scores on the PCL-R, SCID-II, Morey's ASPD scale, LPS, and MMPI Scale 4.
METHOD

Participants

Participants for this study were 40 male patients detained in a UK special hospital. These patients were the 40 patients most recently admitted to the hospital under the Mental Health Act (1983) category of psychopathic disorder. Table 4 presents demographic characteristics for each of the participants.

Procedure

ASPD was assessed using the relevant items of the SCID-II. These items are summarised in Appendix I. The SCID-II was chosen for this study for several reasons. First, because of its relatively good agreement with other measures of ASPD. Second, its design allows the assessment of ASPD independently of other personality disorders. Participants' responsible medical officers were contacted to seek their permission to invite the participants to take part in the interview. Permission was received to approach 33 of the participants. Of these 26 agreed to be interviewed.

The division in the SCID-II between items assessing adult and childhood manifestations of ASPD was used to generate two scores. The first of these was the sum of participants scores on conduct disorder items. The second the sum of scores on adult ASPD items. In addition, a diagnosis of ASPD was assigned to all patients who satisfied SCID-II criteria for a diagnosis of ASPD. These criteria are current age of at least 15, evidence for 3 or more of the conduct disorder items, and evidence of at least 4 of the adult ASPD items.

Dissocial personality disorder was assessed using a rating scheme developed from ICD-10 criteria. This scheme divides the dissocial personality disorder criteria into 11 items. These items are presented in Appendix IV. Ratings on these items were made following detailed analysis of participants' file notes. A rating of 1 was assigned where file notes contained direct references to information affirming an item, or repeatedly alluded to the presence of this item. A rating of 0 was given where file notes did not provide any evidence of the presence of the item. Ratings were obtained for 38 of the participants. The files for the remaining two participants contained insufficient information to complete the ratings.
PCL-R ratings were obtained for 38 participants using Wong's approach of assessing only file information. The files for the remaining two participants contained insufficient information to complete the ratings. Guidelines provided in the PCL-R handbook for rating file information were used to facilitate rating. For instance, with respect to item 1. 'glibness/superficial charm' Hare (1991) suggests that the rater should look when examining file notes “for comments that he [the person being tested] has a reputation for smooth talking, ‘the gift of the gab’, and so Forth.” (p. 17: Hare, 1991). The scoring criteria adopted in the present study were: 0 = no evidence of presence of criteria in file notes; 1 = presence of criteria implied but not explicit; 2 = documented evidence of criteria.

MMPIs had been completed by 26 of the participants. These inventories were used to compute scores on scale 4 - psychopathic deviate, LPS, and Morey's ASPD scale.

Finally, clinical judgments about diagnosis of ASPD made by a consultant forensic psychiatrist were available for 16 participants.

Analyses were conducted using SPSS for windows, and the Psychometric Analysis Package (PAP: Hammond, 1986).

\[1\] Brackets not contained in original text.
RESULTS

SCID-II

Mokken's homogeneity model was employed to assess the psychometric properties of the SCID-II adult ASPD items. Mokken's analysis is a non-parametric method cumulative stochastic scaling (CSS). This method was selected because of the small sample size. Mokken's analysis requires dichotomised input. Consequently, ratings of 2 on items were recoded as 1, and subthreshold scores of 1 were recoded as 0. The results of the analysis are summarised in Table 5.

<table>
<thead>
<tr>
<th>Item</th>
<th>Difficulty</th>
<th>Homogeneity</th>
</tr>
</thead>
<tbody>
<tr>
<td>record as parent</td>
<td>0.025</td>
<td>0.524</td>
</tr>
<tr>
<td>remorse</td>
<td>0.050</td>
<td>0.742</td>
</tr>
<tr>
<td>default on debts</td>
<td>0.150</td>
<td>0.391</td>
</tr>
<tr>
<td>monogamy</td>
<td>0.225</td>
<td>0.481</td>
</tr>
<tr>
<td>unrealistic plans</td>
<td>0.250</td>
<td>0.445</td>
</tr>
<tr>
<td>aggression</td>
<td>0.325</td>
<td>0.549</td>
</tr>
<tr>
<td>recklessness</td>
<td>0.325</td>
<td>0.406</td>
</tr>
<tr>
<td>work record</td>
<td>0.375</td>
<td>0.508</td>
</tr>
<tr>
<td>lying</td>
<td>0.375</td>
<td>0.569</td>
</tr>
<tr>
<td>law breaking</td>
<td>0.625</td>
<td>0.905</td>
</tr>
</tbody>
</table>

Table 5. Difficulty and homogeneity values for SCID-II adult ASPD items

This table indicates that the 10 SCID-II adult ASPD items form a unidimensional scale. Thus the difficulty values illustrate that items can be ordered along a continuum of difficulty (c.f. Guttman, 1944). The scale reveals that the most commonly endorsed item is law breaking, and the least commonly endorsed item is record as a parent. The scale also predicts that any participant who scores on the aggression item, for instance, will also score on all of the items on the scale which precede aggression.

The homogeneity values provide an index of how well each item fits the homogeneity model. It is conventionally agreed that a value of 0.30 or above suggests a good fit. All of the SCID-II adult ASPD items have homogeneity values above the agreed cut-off point. In addition, Mokken's rho (= 0.899) indicates that the scale has good reliability. This coefficient provides a more
appropriate and robust measure of internal consistency for unidimensional scales than Cronbach's alpha.

The scales properties were investigated further using multidimensional scaling (MDS). Participants responses to the SCID-II adult ASPD items were used to produce 1 and 2 dimensional MDS solutions. Comparisons between Kruskall's Stress Indices (0.5853 vs. 0.2128) and Guttman Lingoes Coefficient of Alienation 0.5597 vs. 0.2116) indicated that the 2 dimensional solution accounts for considerably more of the variance than the 1 dimensional solution. The two dimensional solution is represented in Figure 1.

![Figure 1. Two dimensional MDS solution for SCID-II adult ASPD items](image)

Figure 1. indicates that whereas there is a relatively strong association between participants responses to items probing relationship record, record as parent, lying, remorse, law breaking, and aggression, there is only a weak link between these items and recklessness, default on debts, and unrealistic plans.

In summary, Mokken analysis reveals that SCID-II adult ASPD items form a reliable undimensional scale. However, MDS indicates that a unidimensional solution leaves a considerable amount of variance unaccounted for. It is acknowledged that these interpretations are tentative because of the small sample size.
Dissocial personality disorder

Mokken’s homogeneity model was employed to investigate the psychometric properties of the 11 item dissocial personality disorder assessment. Item 4, incapacity to maintain enduring relationships, and item 5, absence of references to deficient social skills, or social anxiety, were omitted from the final scale because they did not fit the homogeneity model. Difficulty and homogeneity values for the remaining dissocial personality disorder items are presented in Table 6.

<table>
<thead>
<tr>
<th>Item</th>
<th>Difficulty</th>
<th>Homogeneity</th>
</tr>
</thead>
<tbody>
<tr>
<td>callousness</td>
<td>0.297</td>
<td>0.507</td>
</tr>
<tr>
<td>guilt</td>
<td>0.351</td>
<td>0.468</td>
</tr>
<tr>
<td>rationalisation</td>
<td>0.432</td>
<td>0.255</td>
</tr>
<tr>
<td>blame</td>
<td>0.459</td>
<td>0.379</td>
</tr>
<tr>
<td>learn</td>
<td>0.541</td>
<td>0.349</td>
</tr>
<tr>
<td>Irresponsibility</td>
<td>0.595</td>
<td>0.341</td>
</tr>
<tr>
<td>aggression</td>
<td>0.676</td>
<td>0.240</td>
</tr>
<tr>
<td>social norms</td>
<td>0.892</td>
<td>0.689</td>
</tr>
<tr>
<td>frustration</td>
<td>0.919</td>
<td>0.293</td>
</tr>
</tbody>
</table>

Table 6 Difficulty and homogeneity values for 11 item dissocial personality assessment

(N.B. item 4 - 'enduring relationships', and item 5 - 'social skills' are omitted)

The difficulty values presented in Table 6 demonstrate that, when items 4 and 5 are removed, the remaining items used to assess dissocial personality disorder form a unidimensional scale. Throughout the remainder of this paper this scale will be referred to as the Dissocial Personality Scale (DPS). Table 6 shows that one end of the DPS is occupied by low tolerance to frustration, and the other end by callousness. The scale reliability coefficient for the DPS is good (Mokken’s rho = 0.905). However, homogeneity values for several of the items fall marginally below the conventional cut-off point of 0.3. These items are low tolerance to frustration, low threshold for discharge of aggression, and proneness to offer rationalisation.

The scales properties were investigated further using MDS. Participants responses to the 9 items making up the unidimensional scale items were used
to produce 1 and 2 dimensional MDS solutions. Comparisons between Kruskall's Stress Indices (0.3168 vs. 0.1643) and Guttman Lingoes Coefficient of Alienation 0.3128 vs. 0.1637) indicated that the 2 dimensional solution accounts for considerably more of the variance than the 1 dimensional solution. The two dimensional solution is represented in Figure 2.

Figure 2 Two dimensional plots describing MDS solution for 11 items of dissocial personality disorder assessment

(N.B. item 4 - 'enduring relationships', and item 5 - 'social skills' are omitted)

Figure 2. reveals a distinction between items assessing socially deviant behaviours (e.g. disregard for social norms, irresponsibility, low threshold to aggression), and items sampling personal deviance (i.e. callousness, failure to learn, lack of guilt, and tendencies to make excuses, or blame others, for antisocial behaviour). Items assessing personal deviance are closely associated and fall above the dividing line. Items assessing social deviance are also closely associated and fall below this line.

In summary, Mokken analysis indicates that 9 of the dissocial personality assessment items form a reliable unidimensional scale. However, MDS suggests that a second dimension of social vs. personal deviance accounts for a proportion of the variance left by the unidimensional scale. It is acknowledged that these interpretations are tentative because of the small sample size.
PCL-R

Factor analytic studies demonstrate that the PCL contains two factors (Harpur, Hakstian & Hare, 1988). Factor 1 reflects personality deviance, and factor 2 chronic antisocial and criminal deviance. The PCL-R items loading on each of these scales are summarised in Appendix II. Research using the PCL shows that these items form reliable scales when interview and file information are used to rate them (Harpur, Hare & Hakstian, 1989). Wong (1988) suggests that reliable PCL scores can be obtained using only file information. Wong’s approach was adopted in the current research.

Mokken's homogeneity model was employed to investigate the psychometric properties of factor 1 and 2 ratings obtained using this approach. In order to satisfy the analysis' need for dichotomous data, ratings of 2 were recoded as 1, and scores of 1 were recoded as 0.

PCL-R factor 1

Item 2, grandiose sense of self-worth, was omitted from the final scale because it did not fit the homogeneity model. Difficulty and homogeneity values for the remaining factor 1 items are presented in Table 7.

<table>
<thead>
<tr>
<th>Item</th>
<th>Difficulty</th>
<th>Homogeneity</th>
</tr>
</thead>
<tbody>
<tr>
<td>glibness</td>
<td>0.025</td>
<td>1.000</td>
</tr>
<tr>
<td>shallow affect</td>
<td>0.325</td>
<td>0.268</td>
</tr>
<tr>
<td>manipulation</td>
<td>0.475</td>
<td>0.257</td>
</tr>
<tr>
<td>callous</td>
<td>0.575</td>
<td>0.466</td>
</tr>
<tr>
<td>lying</td>
<td>0.600</td>
<td>0.388</td>
</tr>
<tr>
<td>remorse</td>
<td>0.650</td>
<td>0.515</td>
</tr>
<tr>
<td>responsibility</td>
<td>0.650</td>
<td>0.569</td>
</tr>
</tbody>
</table>

Table 7 Difficulty and homogeneity values for PCL-R factor 1

(N.B. item 2 - 'grandiose sense of self-worth' is omitted)

The difficulty values presented in Table 7 demonstrate that, with the exception of item 2, grandiose sense of self-worth, the items making up PCL-R factor 1 form a unidimensional scale. Throughout the remainder of this paper this scale will be referred to as PCL-R scale 1. Table 7 shows that one end of PCL-R scale 1 is occupied by a failure to take responsibility for actions, and the other by glibness. The scale reliability coefficient for PCL-R scale 1
is good (Mokken’s rho = 0.841). However, homogeneity values for several of
the items fall marginally below the conventional cut-off point of 0.3. These
items are shallow affect, and manipulativeness.

PCL-R factor 2
Item 9, parasitic lifestyle, and item 13, lack of long-term planning, were
omitted from the final scale because they did not fit the homogeneity model.
Difficulty and homogeneity values for the remaining dissocial personality
disorder items are presented in Table 8.

<table>
<thead>
<tr>
<th>Item</th>
<th>Difficulty</th>
<th>Homogeneity</th>
</tr>
</thead>
<tbody>
<tr>
<td>stimulation</td>
<td>0.200</td>
<td>0.409</td>
</tr>
<tr>
<td>parole</td>
<td>0.375</td>
<td>0.541</td>
</tr>
<tr>
<td>juvenile delinquency</td>
<td>0.575</td>
<td>0.361</td>
</tr>
<tr>
<td>child behaviour problems</td>
<td>0.650</td>
<td>0.328</td>
</tr>
<tr>
<td>impulsivity</td>
<td>0.650</td>
<td>0.502</td>
</tr>
<tr>
<td>irresponsibility</td>
<td>0.675</td>
<td>0.508</td>
</tr>
<tr>
<td>behavioural control</td>
<td>0.750</td>
<td>0.680</td>
</tr>
</tbody>
</table>

Table 8 Difficulty and homogeneity values for PCL-R factor 2
(N.B. item 9 - ‘parasitic lifestyle’, and item 13 - ‘lack of long-term planning’ are omitted)

The difficulty values presented in Table 8 demonstrate that if items 9 and 13
are omitted the remaining factor 2 items form a unidimensional scale. This
scale is referred to as PCL-R scale 2 throughout the remainder of the paper.
One end of PCL-R scale 2 is occupied by poor behavioural control, and the
other end by need for stimulation. The scale reliability coefficient for this
scale is good (Mokken’s rho = 0.916). However, the homogeneity value for
PCL-R item 3, need for stimulation, falls below the conventional cut-off point
of 0.3.

MDS was used to further investigate the psychometric properties of PCL-R
ratings obtained using Wong’s approach. Ratings for the 20 PCL-R ratings
were used to compute a 2 dimensional solution. This solution is presented in
Figure 3. Kruskall’s Stress Index ( = 0.2456), and Guttman Lingoes Coefficient
(0.2437), indicate that a 2 dimensional solution accounts for an reasonable
proportion of the variance.
Figure 3: Two-dimensional MDS solution for PC items.
Figure 3. shows relatively close associations between items relating to socially deviant behaviour. These items are clustered together in the bottom half of the figure, and contain all of those loading on PCL factor 2. In contrast, items in the top half of the figure relate more to personal deviance. These items contain all of those loading on PCL factor 1.

In summary, Mokken analyses of PCL-R factor 1 and 2 items support the reliability of Wong's approach to rating the PCL-R. In addition, both Mokken analysis and MDS of the current data suggest that PCL-R ratings obtained using Wong's approach contain two dimensions that are equivalent to the factors observed in previous research (e.g. Harpur, Hare & Hakstian, 1989). These conclusions are presented tentatively due to the relatively small sample size.

Agreement between measures

Pearson's product moment correlation coefficients were used to compare participants' scores on the measures of ASPD, dissocial personality disorder, and psychopathy. The measures included in these comparisons were:

1. Participants scores on the:
   (a) dissocial personality scale;
   ASPD diagnoses derived from SCID-II responses;
   (b) SCID -II adult ASPD items;
   (c) SCID-II conduct disorder items;
   diagnosis of ASPD based on clinical judgment;
   (d) PCL-R scores (derived using Wong's approach);
   (e) PCL-R scale 1;
   (d) PCL-R scale 2;
   (e) MMPI psychopathic deviate scale;
   (f) Morey's MMPI ASPD scale; and,
   (g) LPS.

2. Diagnoses of ASPD made on the bases of:
   (a) SCID-II responses, and,
   (b) clinical judgment.

Correlation coefficients derived from comparisons between these variables
are presented in the top half of Table 9. Coefficients with significance values above 0.05 are presented in bold and suffixed with a *. Coefficients obtaining significance values above 0.01 are presented in bold and suffixed with **. The bottom half of Table 9 reports the number of cases employed in each comparison.

The correlation coefficients presented in Table 9 indicate reasonable agreement between a number of measures. Thus, highly significant (p > 0.01) correlations were observed between:

1. Participants' total scores on the:
   (a) dissocial personality scale and PCL-R;
   (b) dissocial personality scale and PCL-R scale 1;
   (c) PCL-R and PCL-R scale 1;
   (d) LPS and psychopathic deviate scale; and,
   (e) LPS and Morey's ASPD scale.

2. ASPD diagnoses made on the basis of SCID-II responses and ASPD diagnoses made by clinical judgment.

3. ASPD diagnoses made by clinical judgment and participants' scores on the PCL-R scale 2.

4. ASPD diagnoses made on the basis of SCID-II responses and scores on SCID-II adult ASPD items.

Table 9 also indicates moderate agreement (p < 0.05) between: the PCL-R and ASPD diagnoses made by clinical judgment; SCID-II conduct disorder items and ASPD diagnoses made by clinical judgment; and, SCID-II conduct disorder items and the LPS.

Finally, the bottom half of Table 9 reveals that sample sizes for many comparisons were low, and for some very low. It is acknowledged that this may influence the stability of some coefficients. Consequently, a high cut-off point, p > 0.01, is adopted in the discussion. In addition, interpretations of these data are presented tentatively.
|                | LFS | SCID-ASPD | SCID-con.dis. | SCID-II | MorreyASPD | Psych.deviate | PCL-R | PCL-26 | PCL-R | PCL-26 | PCL-R | PCL-26 | PCL-R | PCL-26 | PCL-R | PCL-26 | PCL-R | PCL-26 |
|----------------|-----|-----------|---------------|---------|------------|--------------|------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|
| 1946           | 0.907 | 0.612 | 0.544 | 0.545 | 0.705 | 0.046 | 0.185 | 0.321 | 0.227 | 0.596 | 0.241 | 0.614 | 0.687 | 0.565 | 0.473 | 0.455 | 0.614 | 0.565 |
| 1979           | 0.912 | 0.612 | 0.544 | 0.545 | 0.705 | 0.046 | 0.185 | 0.321 | 0.227 | 0.596 | 0.241 | 0.614 | 0.687 | 0.565 | 0.473 | 0.455 | 0.614 | 0.565 |
| 18             | 1.17 | 1.17 | 1.17 | 1.17 | 1.17 | 1.17 | 1.17 | 1.17 | 1.17 | 1.17 | 1.17 | 1.17 | 1.17 | 1.17 | 1.17 | 1.17 | 1.17 | 1.17 | 1.17 |
Discussion

Widiger et al. report high correlations between participants' total scores on standardised measures of dissocial personality disorder, ASPD, and psychopathy. Given that these concepts are thought to be closely related (Harpur, Hare & Hakstian, 1989), this observation is reassuring. However, Widiger et al.'s study did not include a population of mentally disordered offenders. This issue was addressed in the present paper which investigated agreement between measures of ASPD, dissocial personality disorder, and psychopathy, in patients detained in a maximum security psychiatric hospital.

The results reported in the present paper do not support Widiger et al's observation of relatively good agreement between total scores on measures of ASPD, dissocial personality disorder, and psychopathy. Comparisons between participants' scores on the PCL-R, Dissocial Personality Scale (DPS), and SCID-II adult items, revealed that the only measures to show reasonable agreement were the PCL-R and DPS (r = 0.640). The relatively large sample size (N=38) employed in this comparison suggests the association between the DPS and PCL-R may be fairly robust.

In contrast, poor agreement was observed between SCID-II adult items and Morey's ASPD scale, on the one hand, and the DPS and PCL-R, on the other. Similarly, non-significant correlations were observed between SCID-II diagnoses, and scores on the PCL-R and DPS. The lack of agreement between the SCID, and measures of dissocial personality disorder and psychopathy, suggests that the criteria for ASPD define a different population of patients to those identified by the PCL-R and dissocial personality disorder. This observation is worthy of further attention given that ASPD is often used synonymously with the other two concepts (Blackburn & Coid, 1996).

Although it is acknowledged that sample sizes were small, it is suggested that the lack of agreement between ASPD and dissocial personality disorder may have important implications for clinical practice. For instance, the Mental Health Act of 1983 requires a court to consider the opinions of two medics when considering a mental health disposal on the grounds of psychopathic disorder. Consequently, psychiatric diagnosis can be an important factor.

2 SCID adult items were used in correlations rather than total SCID scores because of concern that the relatively high number of SCID conduct disorder items could inappropriately bias scores. Given the high number of SCID items assessing conduct disorder, a participant could score highly on the SCID without displaying any of the adult manifestations of ASPD.
influencing whether a defendant receives treatment or a custodial sentence. Moreover, research indicates that in cases where a hospital order is considered inappropriate, such as where a patient is deemed untreatable, a psychiatric diagnosis of personality disorder can result in the judge passing a longer prison sentence than the defendant would otherwise have received (Solomka, 1996). Given the potential influence of medical evidence over disposal, it is worrying that the present study suggests that psychiatric recommendations may differ according to the clinicians preferred diagnostic system.

One factor that may have influenced the degree of consistency between measures of dissocial personality disorder, ASPD, and psychopathy, is the sources of information sampled by each of the measures. Thus, the SCID assesses information derived from structured interviews, the DPS and Wong’s approach to the PCL-R sample file information, and MMPI scales rely on self-report questionnaire data. Differences in sampling could help to account for some of the variance between measures. In addition, there are a number of problems associated with each method of data collection. File information is dependent on observation and reporting by third parties. This data may be subject, therefore, to biased or selective reporting by these individuals. In addition, it is difficult to rate items like glibness or superficial charm from file information unless specific references are made about the presence or absence of these characteristics. Self-report instruments are often criticised due to the problem of response bias. These biases include deliberate attempts by the respondent to present an image of them self which is not true, for instance by ‘faking good’. Structured interviews suffer from similar drawbacks to self-report instruments. The influences of these problems on the reliability of the data collected might also account for some of the variance between measures.

In contrast to poor agreement between measures of ASPD, dissocial personality disorder and the PCL-R, good agreement was observed between the LPS, Morey’s ASPD scale, and the psychopathic deviate scale. The good agreement between these scales might be expected given that they are all derived from the MMPI. Consequently, it is likely that there are considerable overlaps in the items contained in each scale. With the exception of a correlation significant at the 0.05 level between the LPS and SCID-II conduct disorder items, the three MMPI scale did not correlate significantly with any of the other measures. Although the sample sizes in the present study were
small, the results support those of Harpur, Hare and Hakstian (1989) who found non-significant correlations the psychopathic deviate scale, and the PCL-R. Taken together, these findings raise questions about the concurrent validity of these scales.

**Personal vs. social deviance**

The definitions of ASPD, dissocial personality disorder, and psychopathy place different emphases on personal and social deviance (Blackburn, 1988). Thus, whereas the items contained in the SCID-II are heavily biased towards social deviance, the DPS and PCL-R represent hybrid measures of personal and social deviance. Although evidence suggests that participants' responses to questions probing antisocial behaviour may be correlated with their responses to questions probing personality deviance, there are also empirical grounds for distinguishing between social and personal deviance (e.g. Hare et al., 1990; Harpur, Hare & Hakstian, 1989).

The distinction between personal and social deviance is supported by a number of observations made in the present study:

1. Multidimensional scaling of DPS items produced two regions that were interpreted as representing social and personal deviance;

2. Multidimensional scaling of PCL-R items produced two regions representing personal and social deviance; and,

3. DPS and PCL-R scores showed different patterns of correlations with personal and social deviance as measured by the PCL-R. Thus, both DPS and PCL-R scores correlated significantly with PCL-R scale 1, but not with PCL-R scale 2.

These findings support Blackburn's (1988) suggestion that items assessing personal and social deviance are drawn from different 'universes' of discourse. Blackburn argues that membership of the universe of social deviance neither entails or precludes membership of the universe of personal deviance, he states that a person may belong in either, neither, or both.

In addition, the different weights placed on social and personal deviance by
DSM, ICD-10, and the PCL-R, provides another account for the poor agreement between measures.

A number of criticisms have been made of the emphasis on behavioural characteristics in DSM criteria for ASPD (e.g. Blackburn, 1988; Millon, 1981). For instance, studies have observed considerable heterogeneity in the personality characteristics of patients with ASPD (e.g. Dolan, Evans & Norton, 1995). This observation suggests that a diagnosis of ASPD provides little information about the causes of antisocial behaviour. This in turn suggests that the diagnosis is of little use in determining appropriate intervention strategies. In addition, ASPD criteria are likely to provide poor measures of outcome. Thus, antisocial behaviour may occur with a relatively low frequency making it difficult to gauge progress. Moreover, the criteria for ASPD rely heavily on a history of antisocial behaviour, once obtained no amount of treatment can erase this history.

In defence of the DSM’s emphasis on behavioural criteria for ASPD, a number of studies have demonstrated good test-retest, and interrater reliability, for standardised measures of ASPD (e.g. Reich, 1987, 1989). Another potential advantage of using past behaviour in diagnosis is that a history of violent behaviour is consistently observed to be one of the best predictors of future violent behaviour (e.g. Monahan & Steadman, 1994).

In contrast, several researchers influential in the categorisation of personality disorder have argued that diagnosis should be made solely on the basis of personality deviance (Schneider, 1950, Cleckley, 1976, Millon, 1981). The advantages of this approach largely mirror the disadvantages of classifying solely by behaviour. Thus, identifying underlying psychological deviance would presumably help (a) to develop and target intervention strategies, (b) to differentiate between criminals who have different motivations for their offending, and (c) to develop measures of outcome.

Two potential problems with defining disorders by personal deviance are (a) that measurement of psychological variables may be less reliable than measurement of behaviour, and (b) that to date clinical variables have not provided accurate predictions of future behaviour (e.g. Monahan & Steadman, 1994). However, in defence of this approach reliable ratings for items assessing personal deviance have been obtained, for instance, using the PCL-R factor 1 items (e.g. Harpur, Hare & Hakstian, 1989), and the
International Personality Disorder Inventory (e.g. Loranger et al., 1994). Moreover, Hollin (1997) suggests that the true value of clinical variables in assessing the risk of recidivism has not been properly tested.

In summary, the results of the present study add to existing evidence indicating that personal and social deviance are related but distinguishable concepts. It was proposed that in terms of diagnosis each of these concepts may have advantages over the other. This suggests that in order to optimise the advantages of both approaches diagnostic criteria should include aspects of both social and personality deviance. Whilst the PCL-R and dissocial personality disorder both represent hybrids between personal and social deviance, the former assessment has the advantage of providing separate subscales measuring personal deviance, social deviance.

The validity of PCL-R ratings obtained without interview

Wong (1988) demonstrated that reliable PCL-R ratings can be obtained from file information alone. The present study provides additional support for the utility of Wong’s approach to rating PCL-R items. Factor analytic studies of PCL-R data obtained using the standard administration procedure have repeatedly demonstrated that the checklist contains two factors: factor 1, and factor 2 (e.g. Hare et al., 1990). Multidimensional scaling of PCL-R ratings obtained using Wong’s approach revealed a comparable structure to ratings obtained using the standard approach. Thus, MDS divided items into two regions: the first containing items making-up PCL-R factor 1; and, the second items making-up PCL-R factor 2. In addition, Mokken analysis revealed that (a) with the exception of item 2, grandiose sense of self-worth, file ratings for items making-up PCL-R factor 1 form a reliable unidimensional scale, and (b) with the exception of item 9, parasitic lifestyle, and item 13, lack of long-term planning, file ratings for items making-up PCL-R factor 2 also form a reliable unidimensional scale. The similarities between profiles obtained using the standard and Wong’s approach to PCL-R ratings supports the validity of the latter approach.

Dimensional vs. categorical approaches to diagnosis

Another issue in the diagnosis of personality disorder is the relative advantages and disadvantages of categorical and dimensional diagnostic systems (Kendell, 1975; Frances, 1982). Widiger (1991) suggests that the
categorical approach has three major advantages. First, he argues that it is easier to consider and discuss the presence of one, two, or three disorders than a profile of the degree to which all of the various disorders are present. Second, categorical systems are more familiar to clinicians. Third, clinical decision making tends to be categorical. Consequently dimensional systems might hinder decision making.

Widiger notes that there are also disadvantages to the categorical approach. One disadvantage is that it is difficult to identify nonarbitrary boundaries between a disorder, 'normal' functioning, and other disorders. He notes that the only cut-off points based on empirical findings are those for schizotypal and borderline personality disorders. The arbitrary nature of cut-off points means that it is questionable whether people falling near the boundaries of a diagnosis are adequately described by the designation of having or not having that disorder (Widiger, Sanderson & Warner, 1986).

Another disadvantage of categorical systems is that members and non-members of a category tend not to be heterogeneous with respect to the criteria that were used to make the diagnosis. Widiger notes that there are more than 848 different ways to meet the DSM-III-R criteria for ASPD. Yet only one diagnostic label is given to characterise all of these cases. Although this label has the advantage of providing a concise description of prototypical characteristics of the disorder, depending on the extent to which the patient fits the prototype, the label may be misleading and stereotyping (Cantor & Genero, 1986). In addition to the problem of heterogeneity within members of the category. Widiger also notes that many people who do not meet the criteria for a diagnosis will display some personality disorder symptoms.

Widiger (1991) notes that the disadvantages of categorical diagnostic systems are readily overcome by dimensional systems. Moreover, he comments that dimensional models also retain many of the advantages of categorical systems. For instance, where necessary or desirable a categorical label can be derived by adopting a cut-off point. The reverse translation is not possible.

The results of the present study indicate that the diagnostic criteria for ASPD and dissocial personality disorder fit dimensional models. Thus, Mokken analyses demonstrate that the defining features of these diagnoses form reliable scales, with a patient's position on each of the scales.
indicating severity of pathology. This finding is consistent, therefore, with other empirical evidence supporting a dimensional approach to personality disorder diagnosis.

Existing evidence for the advantages of dimensional personality disorder diagnoses is derived from at least two sources: comparisons between the reliability and validity of categorical and dimensional systems; and, factor analytic studies.

Widiger and Frances (1991) reviewed 14 studies in which data had been analysed both categorically and dimensionally. They conclude that in 13 out of 14 of these studies the reliability and/or validity data were better for the dimensional results. Moreover, Widiger et al. (1994) reported considerably better agreement between measures of ASPD, dissocial personality disorder, and psychopathy, when participants total scores were compared, as opposed to diagnoses based on commonly accepted cut-off points. The present study did not generate categorical PCL-R and DPS diagnoses. Consequently, it does not provide data with which to contrast categorical and dimensional diagnoses.

Tyrer and Alexander (1979) rated 65 patients diagnosed with ICD personality disorders and 65 patients with a diagnosis other than personality disorder on 24 personality attributes. Each attribute was rated on a 9 point scale. Factor analysis was applied to the ratings of the personality disorder and non-personality disorder groups separately to find out if similar factors loaded in both groups. The results of the factor analysis were similar in both groups of patients. In both personality disorder and non-personality disorder groups the two main factors, termed sociopathic and passive dependent, accounted for most of the variance. Tyrer and Alexander argue that the similarity between the groups suggests that personality disorders are the extreme of a multidimensional continuum.

Tyrer and Alexander’s sociopathic dimension contained traits such as egocentricity, callousness, impulsivity, and conscience defect. A comparable dimension has consistently been observed in other factor analytic studies of personality disorder (Blackburn, 1986). For instance, Blackburn and Coid (1996) factor analysed SCID-II data obtained from 81 violent prisoners and 86 patients detained in a special hospital under the legal category of psychopathic disorder. Four factors emerged from the analysis. Blackburn
and Coid propose that one of these factors could justifiably be labelled 'psychopathy' because it contained traits of mistrust, egocentricity, grandiosity, lack of empathy, irresponsibility, persistent rule violation, impulsivity, and stubborn resistance to the demands of others. Moreover, Blackburn and Coid provide evidence that this factor is inversely linked to the agreeableness dimension of the Big Five personality factors. These five factors have consistently been observed in the general population (e.g. Norman, 1963; McCrae & Costa, 1987). Consequently, Blackburn and Coid's data provide further evidence that personality disorders represent the extreme ends of universal personality dimensions.
References


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Appendix I

1. Current age at least 18

2. Before you were 15 did you often skip school?

3. Before you were 15 did you run away from home and stay out overnight?

4. Before you were 15 did you often start fights?

5. Before you were 15 did you use a weapon in a fight?

6. Before you were 15 did you ever force someone to have sex with you?

7. Before you were 15 did you ever hurt an animal on purpose?

8. Before you were 15 did you ever hurt another person on purpose (other than in a fight)?

9. Before you were 15 did you ever deliberately damage things that were not yours?

10. Before you were 15 did you set fires?

11. Before you were 15 did you lie a lot?

12. Before you were 15 did you ever steal things?

13. Before you were 15 did you ever rob or mug someone?

14. Is unable to sustain consistent work behaviour, as indicated by any of the following:
   (a) How much of the time in the last five years were you not working? (Criterion - six months or more in last five years.)
   (b) When you were working, were you often absent?
   (c) Did you ever walk off a job without having another one to go to?

15. Have you done things that are against the law?

16. Is irritable and aggressive as indicated by any of the following:
   (a) Since you were 15 have you been in any fights that came to swapping blows?
   (b) Have you ever hit or thrown things at your spouse/partner?
   (c) Have you ever hit a child, yours or someone else's, so hard that he or she had bruises or had to stay in bed or see a doctor?

17. Have you ever owed people money and not paid them back?

18. Fails to plan ahead, or is impulsive, as indicated by one or both of the following:
   (a) Other than being on a vacation, have you ever travelled around without knowing where you were going to stay or work?
   (b) Was there ever a time when you had no regular place to live?

Summary of SCID-II ASPD items (continued overleaf)
19. Has no regard for the truth, as indicated by any of the following:
   (a) Have you done a lot of lying since you were 15?
   (b) Have you ever used an alias or pretended you were someone else?
   (c) Have you often 'conned' others to get what you wanted?

20. Is reckless regarding his or her own or others' safety as indicated by either of the following:
   (a) Did you ever drive a car when you were drunk?
   (b) How many times have you gotten a ticket for speeding? (Criterion - recurrent offences.)

21. Has anyone ever said that you weren't taking proper care of a child of yours?

22. What's the longest period of time you were sexually involved with one person without having sex with anyone else? (Criterion - monogamous relationship for one year or more.)

23. Do you feel it was OK for you to have (stolen, hit, hurt, defaces?other antisocial act)?

Summary of SCID-II ASPD items (continued)
1. Superficial charm
2. Grandiose sense of self-worth
3. Need for stimulation/easily bored
4. Pathological lying
5. Manipulative
6. Lack of remorse or guilt
7. Emotional shallowness
8. Callousness
9. Parasitic lifestyle
10. Poor behavioural control
11. Promiscuous sexual behaviour
12. Early behavioural problems
13. Lack of long-term planning
14. Impulsivity
15. Irresponsibility
16. Failure to accept responsibility for own actions
17. Frequent marital failures
18. Juvenile delinquency
19. Violation of parole or other conditional release
20. Criminal versatility

Table 1 Hare's (1991) Revised Psychopathy Checklist (PCL-R)
Appendix II

1. Superficial charm
2. Grandiose sense of self-worth
4. Pathological lying
5. Manipulative
6. Lack of remorse or guilt
7. Emotional shallowness
8. Callousness
16. Failure to accept responsibility for own actions

Table 2 Items loading on PCL-R factor 1

3. Need for stimulation/easily bored
9. Parasitic lifestyle
10. Poor behavioural control
12. Early behavioural problems
13. Lack of long-term planning
14. Impulsivity
15. Irresponsibility
18. Juvenile delinquency
19. Violation of parole or other conditional release

Table 3 Items loading on PCL-R factor 2

Page 180.
Appendix III

Q21. At times I have very much wanted to leave home.
Q31/Q311. During one period when I was a youngster, I engaged in petty thieving.
Q49. It would be better if almost all laws were thrown away.
Q56. As a youngster, I was suspended one or more times in school for cutting up.
Q118. In school I was sometimes sent to the Principal for cutting up.
Q145. At times I feel like picking a fist fight with someone.
Q181. When I get bored I like to stir up some excitement.
Q205. At times it has been impossible for me to keep from stealing or shoplifting something.
Q250. I don't blame anyone for trying to grab everything he can get in this world.
Q269. I can easily make other people afraid of me and sometimes do for the fun of it.
Q271. I do not blame a person for taking advantage of someone who lays himself open to it.
Q316. I think nearly anyone would tell a lie to keep out of trouble.
Q336. I easily become impatient with people.
Q419. I played hooky from school quite often as a youngster.
Q456. A person shouldn't be punished for breaking a law that he thinks is unreasonable.
Q465. I have several times had a change of heart about my life work.
Q471. In school my marks in deportment were quite regularly bad.
Q475. When I am concerned, I tell that portion of the truth which is not likely to hurt

The LPS psychopathy scale derived from MMPI items
1. Callous unconcern for the feelings of others indicated by references to a lack of empathy, or a pervasive disregard for the feelings, rights, and welfare of others.
2. Gross and persistent attitude of irresponsibility including poor work record, substance misuse, financial problems, poor record as a parent.
3. Gross and persistent disregard for social norms, rules, and obligations, including delinquency, and dishonesty.
4. Incapacity to maintain enduring relationships.
5. Absence of references to deficient social skills, or social anxiety.
6. Very low tolerance of frustration indicated by documented evidence of the participant experiencing frequent episodes of frustration or anger.
7. Low threshold for discharge of aggression indicated by reports of frequent outbursts of verbal and/or physical aggression.
8. Incapacity to experience guilt indicated by documented lack of guilt or remorse, and/or evidence of minimisation by the participant of the consequences of their antisocial behaviour.
9. Inability to profit from experience, particularly punishment including frequent prison sentences or fines.
10. Marked proneness to blame others for the behaviour that has brought the patient into conflict with society.
11. Marked proneness to offer plausible rationalisations for the behaviour that has brought the patient into conflict with society.

Items used to assess dissocial personality disorder
MINOR RESEARCH
AND
RESEARCH ON PLACEMENT

PILOT STUDY FOR A COGNITIVE AND BEHAVIOURAL INTERVENTION FOR MEMORY PROBLEMS OCCURRING IN OLDER ADULTS
Abstract

Objectives
The present study is a pilot study of a cognitive and behavioural group for older adults, with memory difficulties arising from a variety of possible etiologies. The objectives of the study were (a) to determine who might benefit from participation in the group, (b) to consider what types of intervention strategy would be beneficial to participants, and (c) to identify problems with the pilot study which might aid the development and assessment of future groups.

Subjects and procedure
The memory functioning of three patients, who presented to mental health services for older adults, was assessed before and after a seven week group intervention.

Results
Two of the three members of the group described gaining some benefit from the intervention. These comments were supported to some degree by improvements in their scores on pre and post intervention assessments. The third patient did not report benefiting from the intervention and was unable to spontaneously recall any content of group meetings at follow-up.

Discussion
Strengths and weaknesses of the design of the study, and structure and content of group sessions, are discussed. Weaknesses included: choice of assessment measures; absence of repeated pre intervention assessments; lack of longer-term follow-up assessments; and, the need to incorporate practice examples into group sessions.
Pilot study for a cognitive and behavioural intervention for memory problems occurring in older adults

The goal of this study was to initiate the development of a treatment group for older adults with memory problems. The remit for this group was (a) that it should fit easily into the daily programme offered by a day hospital which provides mental health services for older adults, and that (b) it should serve the needs of as many of the patients attending the hospital as possible. The first step taken in achieving this goal was to review the literature about memory problems occurring in older adults. This review also considered theoretical accounts of memory and memory disorders, and evidence relating to possible remediation strategies. The purpose of this review was to identify potential target groups for the intervention; the problems typically experienced by these target groups; and, suitable intervention strategies.

Memory problems in normal ageing, dementia, anxiety, and depression

Alzheimer's Disease
Memory problems are viewed as an almost universal feature of the dementias (Miller & Morris, 1993). Moreover, memory problems are often considered a relatively early indication of the onset of these conditions, with the majority of family members citing them as the earliest symptoms (Woods, 1989). The literature on memory functioning and dementia focuses on the pattern of impairment in Alzheimer's Disease (AD) (Miller & Morris, 1993). The memory disturbance in AD has an insidious onset, and progresses from mild lapses to confusion and confabulation. The deficits include semantic and episodic memories, and retrieval of more recent memories is typically affected before memories for remote events (Miller & Morris, 1993). In contrast, research shows that the following memory functions are relatively preserved in AD: implicit memory (e.g. Butters, Salmon, Heindel & Granholm, 1988); semantic cueing (Nebes, Martin & Horn, 1984); priming (Moscovitch, 1982); and, the articulatory loop (Morris, 1984).

Normal ageing
Cross-sectional and longitudinal studies suggest that memory declines as a
consequence of normal ageing (Woods & Britten, 1985). Thus, age related declines have been reported in semantic memory (Cohen & Faulkner, 1986; Rabbit, Maylor, McInnes, Bent & Moore, 1995), episodic memory (Maylor, 1991; Cohen, Conway & Maylor, 1994) and, prospective memory (Cockburn & Smith, 1991; Einstein, McDaniel, Richardson, Guynn & Cunfer, 1995).

However, a number of studies show that a sizable proportion of people decline very little as they age, or do not decline at all (e.g. Siegler & Botwinick, 1979).

**Depression**

Depressive illness is a common problem in older adults. Lindesay et al. (1989) reported a prevalence rate 13.5% for depression in people over 65 years living at home. There is now an abundance of well controlled studies indicating an association between depression and poor memory performance (Watts, 1995). For instance, Sternberg and Jarvik (1976) compared depressed patients with matched normal controls. They found that depression was associated with poorer immediate and delayed recall of word pairs, simple figures, and personal information about fictitious people. Findings from comparisons between memory functioning in normal and depressed subjects have been corroborated by studies contrasting the performance of depressed people when ill and when they have recovered (e.g. Stromgren, 1977). In contrast to impairments of other areas of memory, there is no evidence for an effect of depression on digit span.

**Anxiety**

Morgan et al. (1987) found a prevalence rate of about 11% for anxiety states in people over the age of 65. Research indicates that, similarly to depression, anxiety impairs memory performance. This research has typically focussed on the effects of anxiety on short-term memory, and in particular digit span (Watts, 1995). Idzikowski and Badley (1983; 1987) demonstrated, for instance, that experimental manipulation of public speaking anxiety, and parachuting anxiety, both produced a deleterious effect on digit span.

One especially relevant finding from studies of the effects of anxiety on longer-term memory is that anxiety reduces the likelihood of the use of structuring, or effortful, processing strategies (Meuller, 1976). In this respect anxiety memory problems are similar to those caused by
Atkinson and Shiffrin (1968) argue that memory consists of three stores. These are the sensory, short-term, and long-term stores. Following presentation of a stimulus, information enters the sensory store where it undergoes basic processes of identification before it passes into the short-term store (STS). According to Atkinson and Shiffrin, STS provides the basis for conscious mental activity. It also determines what information is attended to, how information is processed, and governs retrieval of existing information; and, it has limited capacity. Information in STS is vulnerable, and can easily be lost if some distraction or aversive event occurs. Atkinson and Shiffrin propose that once in STS, information can have one of two fates: it can be transferred to long-term store (LTS), or it can be forgotten. The effective transfer of information to LTS involves the formation of a permanent memory trace.

In addition to distinctions between sensory, short-term, and long-term memory stores, several researchers have distinguished between different types of LTS. For instance, Tulving (1985) distinguishes between episodic, semantic, and procedural LTS. According to this distinction, episodic memory is responsible for storing a record of events in our lives; semantic memory stores general knowledge about the world, concepts, rules, and language; and, procedural memory stores information that cannot be inspected consciously. These distinctions are supported by neuropsychological data. For instance, two patients with impaired semantic knowledge and spared episodic memory were reported by Warrington (1975).

Craik and Lockhart (1972) present an alternative to the multistore model. This account is called the levels of processing model. It is based on the assumption that the memory trace represents a record of the analyses carried out during conscious processing of new information (Parkin, 1987). Craik and Lockhart suggest that the relative strength of a memory trace is dependent on the type of processing which the individual performed on the information to be remembered at the time of learning. If a stimulus was processed only to a 'shallow' level, by restricting
attention to its superficial aspects, such as the sound of a word, then memory would be worse than if ‘deeper’ or more ‘elaborative’ encoding had been carried out, such as focussing on the meaning of a word. This account is supported by studies demonstrating that normal subjects show significant effects of manipulations designed to increase depth or elaborativeness of processing in memory tasks (e.g. Craik & Tulving, 1975).

**Accounts of memory difficulties**

**Alzheimer's Disease**
Morris (1996) suggests that one way of viewing episodic memory difficulties observed in AD is as a primary impairment of neurological structures supporting episodic memory overlaid by secondary deficits in areas that contribute to memory functioning. He states that the primary deficit can be related to damage to mesiotemporal lobe structures known to be involved in memory. Morris proposes that secondary deficits include not being able to ‘cluster’ words into a semantic framework to improve recall. He cites several studies that support this proposal. For instance, Corkin (1982) found that AD patients failed to make use of semantic orienting instructions, for example presenting a word then using the question “Is the word a type of bird?” to prompt semantic processing. Morris notes that these instructions normally provide much stronger memory for the word than others that cue phonological or orthographic processing, but not in AD.

**Normal ageing**
Kausler (1970) proposes that the memory difficulties experienced by some older adults arise from impaired consolidation caused by a reduction in the use of organisational strategies. Kausler’s proposal is supported by studies indicating that older adults are less likely to employ semantic (e.g. Denney, 1974), and imagery strategies (Hulicka & Grossman, 1967) when learning new information. Craik and Simon (1980) suggest that the failure of some older adults to use organisational strategies can be attributed to a deficit in processing capacity.

**Depression**
A number of explanations have been forwarded for memory impairments
observed in depression. Henry, Weingartner, and Murphy (1973) propose that poor memory in depression can be explained by reduced motivation. They note that errors of omission are particularly prominent in the test performances of depressed patients. However, Watts and Sharrock (1987) found that depressed and normal subjects differed as much in a cued recall test requiring minimal responses, as they did on free recall. Moreover, there is evidence that depressed patients are impaired even on recognition memory tasks (Watts, Morris & MacLeod, 1987). These tasks require little effort on the part of the subject. It is unlikely, therefore, that poor performance reflects motivational factors.

Another explanation for the memory problems observed in depression is that depression reduces the availability of processing resources (Ellis & Ashbrook, 1988). Ellis and Ashbrook suggest that one of the consequences of a reduction in resources is that depressed subjects are less likely to use strategies to structure information. This explanation is supported by inconsistencies in the literature between experiments that have and have not found an effect of depression on memory. Thus, Watts (1995) argues that studies that have failed to find an effect have often used highly structured material such as sentences or passages of prose. This argument is supported by Weingartner et al.'s (1981) demonstration that whereas depressed and control subjects differed little in their recall of words presented in clustered form, depressed subjects performed less well than controls when the words were not structured into clusters.

**Anxiety**

Eysenk (1977) argues that anxiety interferes with digit span because anxious thoughts occupy working memory and limit its capacity. However, Watts (1995) notes that preoccupying cognitions are also part of the pathology observed in depression (e.g. Beck, 1967). Eysenck's account of the link between digit span performance and anxiety predicts that performance should also be affected by depression. Contrary to this prediction, it was noted above that digit span performance is spared in depression.

One similarity between the effects of depression and anxiety on memory is that both disorders reduce the use of structuring, or effortful, processing strategies (Meuller, 1976). Eysenck and Calvo (1992) propose that anxiety reduces the amount of processing capacity available for task performance.
However, they argue that it is not diminished capacity, per se, that reduces the use of structuring, and impairs performance, because anxious patients may mobilise additional cognitive effort to compensate for depleted processing resources. Instead, they suggest that the greater degree of effort required to maintain performance at normal levels reduces the efficiency of processing. Consequently, as task demands rise, anxiety is likely to have an increasing effect on memory.

In summary, the effects of dementia, ageing, depression, and anxiety on memory all appear to involve a reduction in the efficiency of processes required to manipulate, and organise (or ‘chunk’) information to be remembered. Assuming this hypothesis to be true, it is plausible that memory difficulties arising from neurological damage, ageing, depression, and anxiety, may all be amenable to similar interventions.

**Interventions for memory difficulties**

**Normal ageing**

A number of studies have demonstrated the successful application of compensatory strategies for the memory difficulties experienced by some healthy older adults (Backman, Mantyla & Herlitz, 1990). These studies have typically included the use of imagery (e.g. Yesavage, Rose & Bower, 1983), and organisational (e.g. Sanders, Murphy, Schmitt & Walsh, 1980) strategies.

**Alzheimer's Disease**

In contrast to studies of ‘normal’ older adults, the use of imagery and organisational strategies have yielded small or non-existent improvements in patients with AD (Backman, Mantyla & Herlitz, 1990). However, other researchers have demonstrated the successful application of techniques which use preserved skills to compensate for memory deficits. For example, Karlson and colleagues (e.g. 1989) showed that motor action during learning improved cued recall of sentences not only in early AD, but also in moderately and severely demented patients. An important feature of this study was that the intervention strategy involved the use of motor action to enhance encoding, and cued recall to aid retrieval. Backman (1992) notes that dual support for encoding and retrieval is a common aspect of successful intervention strategies for
patients with AD. Finally, other studies indicate that external memory aids can be effective in the treatment of people with dementia (e.g. Josephsson et al, 1993; Bourgeois, 1990).

**Depression and anxiety**

Hertel and Hardin (1990) found that the inferior performance shown by depressed subjects on recognition memory tasks can be reversed by supplying subjects with structuring strategies. Other studies have focussed on memory processes which operate normally in depression. For instance, depressed patients have been shown to recall imageable information as well as control subjects (Watts & Cooper, 1989). Prompting the use of imagery strategies has proven to enhance depressed patients’ memory for prose (Watts, MacLeod & Morris, 1988). Watts (1995) notes that these manipulations have only been employed in experimental settings. He states that so far there has been relatively little discussion of how these kinds of strategies could be used in a clinical setting to help depressed patients improve their memory performance.

Whereas remediation studies have largely ignored memory impairments in anxiety and depression (Watts, 1995), a number of studies have demonstrated that cognitive-behavioural therapy (CBT) is an effective treatment for adults with depression (e.g. Latimer & Sweet, 1984), and anxiety disorders (Hawton, Salkovskis, Kirk & Clark, 1989). Moreover, there is now increasing evidence that individual (e.g. Knight, 1986; Morris & Morris, 1991), and group (Leung & Orrell, 1993), CBT can be successful with older people.

CBT involves the development of a formulation which summarises the patient’s problems and the factors that serve to maintain them. Although a formulation is specific to an individual patient, the general premise is that a ‘trigger’ results in the occurrence of a ‘negative automatic thought’ (NAT). The NAT then induces a response which may serve to reinforce the belief underpinning the thought. This response is termed a maintaining factor. Maintaining factors can be physiological reactions, and/or affect, and/or behavioural responses to negative affect/physiological reactions. The links between triggers, NATs, and maintaining factors are illustrated in Figure 1.
The formulation serves to guide the selection of a treatment approach from a range of techniques. Some of the treatment techniques used in CBT are summarised below:

(a) Education about anxiety and depression which helps to normalise a patient's experience, and to foster a sense of control over symptoms.
(b) Cognitive restructuring which involves the patient monitoring, and identifying, negative automatic thoughts (NATs), reality testing and challenging these NATs, and developing alternative beliefs or attributions.
(c) Thought stopping, and distraction, which involve focussing attention away from NATs.
(d) Relaxation.
(e) Problem solving to identify coping strategies for situations which trigger NATs.
(f) Activity scheduling used to ensure the experience of positive affect, and/or a sense of mastery.
and without dementia (e.g. Jacoby & Levy, 1980). Kitwood argues that it is highly unlikely that the lack of correlation between neuropathology and severity of dementia is solely due to error variance. Consequently, he asks the question “what brings about the change from normal to demented functioning in an individual, granted a certain degree of degeneration of grey matter?”. He acknowledges that the answer could be the insensitivity of bio-medical techniques or an obscure pathogen yet to be discovered, however, he argues that there is also a strong case for considering psychological variables.

Watts, and Kitwood’s, arguments suggest that patients with memory problems associated with anxiety, depression, normal ageing, and early dementia, may all benefit from an intervention designed to facilitate adaptive responses to their problems. Literature on the efficacy of CBT suggests that this intervention might usefully incorporate CBT techniques. There is also evidence that certain mnemonic techniques may be helpful. However, the literature suggests that people with AD may not derive as much benefit from some of these techniques as other groups of patients.

The idea of a memory group for a range of people with memory problems is appealing for several reasons. First, it could help to maximise the efficiency of scarce clinical resources. Thus, it takes fewer staff to run one group with heterogeneous participants, than several groups with homogeneous participants. Second, it was noted above that differential diagnosis of AD is notoriously difficult, particularly in the early stages of the disease. A heterogeneous memory group reduces emphasis on need for an accurate diagnosis. In addition, the information gathered during group sessions may be useful in refining probable or possible diagnoses of dementia.

The present study provides a preliminary investigation of the practicalities and usefulness of a 7 week group intervention for older adults with memory problems. The intervention combines a range of mnemonic, and CBT strategies. Mnemonic strategies included the use of external aids, imagery, self-cueing, and methods of organising information. The CBT techniques were psychoeducation about CBT formulation, thought monitoring, thought challenging, thought stopping, and controlled breathing relaxation. Details of the intervention are
Objectives of the study

(1) To determine who might benefit from participation in the group
(2) to consider what types of intervention strategy would be beneficial to participants.
(3) To run a pilot programme to identify problems with the pilot study which might aid the development and assessment of future groups.

Method

Subjects

General practitioners and other health care workers for older adults were asked to refer patients who had complained of memory problems. The National Adult Reading Test (NART) (Nelson, 1982), the Middlesex Elderly Assessment of Mental State (MEAMS) (Golding, 1989) and the Information/Orientation subtest of the Clifton Assessment Procedures for the Elderly (CAPE) (Pattie & Gilleard, 1979) were used to screen referrals to the group for intellectual and cognitive deficits. Patients who failed more than four tasks from the MEAMS, and/or scored less than 8/12 on the CAPE, and/or obtained full scale WAIS equivalents of less than 80 were excluded from the study. Six patients were selected for the study. NART, MEAMS and CAPE scores for these patients are presented in Appendix II.

Of the 6 patients who were selected for the group, 3 (patients NA, DB & PF) completed the programme, 1 (patient RS) failed to attend any of the meetings, another (patient JM) missed over half of the meetings through illness, and 1 (patient MF) died shortly before the end of the programme. The results section only presents information about the 3 patients who completed the programme.

Procedure

Clinical constraints, together with the exploratory nature of the research, led to the use of a simplified version of an experimental design outlined by
Howard and Patterson (1989). This design consists of pre-treatment baseline assessments on target and control measures, which are followed by a single treatment phase, which in turn is followed by repetition of baseline measures. This approach predicts (a) that the effects of treatment X which is directed at variable A will be confined to A, (b) that other variables which are, as far as possible, independent of A will not be influenced directly by treatment X, and (c) changes in both A and B will reflect spontaneous recovery or decline, and non-specific therapeutic factors, such as therapist interest and support.

Measures

Subjects were assessed on a range of objective assessments both before the intervention and at a follow-up session one week after the last group meeting. Alternative forms of these assessments were used in pre and post assessments.

Objective target measures were selected to assess subjects' performances on areas of functioning targeted by the programme. These measures were the Logical Memory Test from the Wechsler Memory Scale Revised (WMS-R) (Wechsler, 1987), and Prospective Memory Task from the Rivermead Behavioural Memory Test (RBMT) (Wilson, Cockburn & Baddeley, 1985).

Objective control measures were unrelated to the content of group sessions. They consisted of pre and post tests using the Memory for Faces Task from the Rivermead Behavioural Memory Test, and the arithmetic, verbal fluency, and unusual views tasks from the MEAMS.

In addition to objective measures, participants were asked to estimate the frequency of various types of memory difficulties, their confidence in their memories, and the extent to which they became anxious or frustrated by their difficulties. These self-report measures were collected pre and post intervention. Appendix III contains a summary of the self-report measures used.

During the follow-up assessment participants' memory for the content of group sessions was assessed using free recall and forced choice tasks. The former task simply required the recall of as much information as possible about group sessions. The latter task required participants to judge
whether or not each of twelve statements about memory related to topics covered during group sessions. Six of the statements described topics covered in groups, whereas the remaining statements described aspects of memory not covered in sessions.

Finally, participants were asked to fill in a questionnaire asking their opinions about (a) the content, length and number of sessions, (b) the usefulness of the handouts, and (c) the aspects of the group that they found most and least helpful.
Results

The clinical context of the study meant that baseline and follow-up measures could only be collected on a single occasion. This restriction prevented the use of statistical analysis. Consequently, analysis is limited to inspection of scores on objective tests, self-report data, and comments made by participants. This information is presented in the form of 3 case studies.

Patient NA

Background information
NA is a sixty-four year old man who presented to his general practitioner complaining of increased "forgetfulness". He was referred to the older adults services where he underwent psychological and psychiatric assessments. The findings from these assessments were inconclusive and no firm diagnosis was offered. NA has a history of angina and arthritis.

NA told me that he was born in Pakistan where he lived until he moved to Kenya from whence he moved to the United Kingdom. He said that he remained in full-time education until the age of fifteen and that since leaving school he has undertaken a range of employment including factory work, repairing domestic appliances, interpreting, and teaching adult literacy classes.

Summary of pre intervention assessment
NA told me that he first noticed that his "memory and concentration began to slip" a couple of years ago. He said that he was distressed by this observation. He added that he gave up working as an interpreter and adult literacy teacher as a consequence of his memory difficulties. NA also complained of losing his place during religious ceremonies well known to him, getting words wrong, misunderstanding things, and that he often forgot names, the content of written articles, conversations and to pass on messages unless he was prompted by someone. These complaints were supported by his pre-intervention scores on (a) the delayed recall part of the Logical Memory Test which indicated poor retention, and (b) self-report measures of the frequency of memory difficulties. In contrast, to NA’s reported difficulties in passing on messages he performed faultlessly
on the Prospective Memory Task. Details of NA's pre and post intervention scores on objective and self-report measures are presented in Appendix IV.

Comments during group sessions
During group sessions NA suggested that his high expectations of his memory caused him to become anxious and preoccupied with negative thoughts about his memory. In later sessions he indicated that these thoughts distracted him and interfered with his concentration, and that the frustration and distress associated with them also affected his memory. In addition, NA stated that he attempted to cope with anxiety about his memory by pushing himself harder to remember things. For instance, he described how he tried to remember every detail of conversation or text. He acknowledged that this placed an unrealistic demand on his memory which consequently served to further undermine his confidence in his recall.

Summary of post intervention assessment
Comparisons between NA's pre and post intervention scores on the target measures show some signs of improvement, such as an increase in his delayed recall score on the Logical Memory Test (see Appendix IV). In addition, self-report measures indicate that rather than getting angry NA remains calm when he cannot remember something. In contrast to indications of improvement, other self-report measures of frequency and confidence measures reveal little evidence of improvement.

At the end of the group sessions NA told me that identifying links between thoughts, feelings, and forgetfulness had helped him to modify some beliefs about forgetfulness. For instance, he stated that when he cannot remember something he is more likely to think "so what, this is not the end of the world". NA also said that knowing other people had similar problems to his own helped him to develop more realistic expectations of his own memory.

NA correctly identified all of the target and distractor statements in the forced choice task. Indicating good recall of content of group sessions.

Finally, he said the programme consisted of the right number of sessions, the length of sessions was right, and the handouts were clear and helpful.
However, he added that he felt he did not fit into the group, and that it would have been helpful to have had practice exercises for mnemonic strategies.

**Discussion**

NA's comments suggest that he benefited both from the content of group sessions, and the experience of being in a group with other people with memory problems. NA's comments indicate that he found the most useful aspects of the group meeting other people with memory difficulties, and discussions about the links between thoughts, feelings, behaviour, and memory.

In line with NA's comments about the benefits of the intervention his performance improved on several objective target measures. NA also improved on RBMT Memory for Faces Task which was one of the control measures. This observation may indicate that any improvement arises from non-specific factors of the intervention, and/or generalisation of beneficial effects of to non target aspects of memory. However, any conclusions from pre and post intervention should be viewed as extremely tentative. Thus, changes in objective and self-report measures were slight. In addition, the lack of repeated pre and post measures undermines the reliability of the assessment measures used. The issue of how assessment could be improved in future studies is considered in the general discussion.

**Patient DC**

**Background information**

DC is a 79 year old man. He was initially referred to older adult mental health services in 1994. At this time he presented with complaints about his memory which initially appeared in the context of depression. His depression was alleviated with a combination of cognitive-behavioural therapy and Fluoxetine. In February 1996 DC was diagnosed as suffering from AD. This diagnosis was supported (a) by neuropsychological testing in June 1995 and January 1996 which indicated progressive impairments to frontal and memory functioning, and (b) a CT scan indicating a "modest generalised loss of cerebral cortical substance".
DC has a first class degree in history and was employed as a senior civil servant until retirement.

Summary of pre intervention assessment
DC told me that he had a history of memory difficulties extending back to 1994. He said that his difficulties mainly concerned forgetting to do things, the names of people he had known, and local street names. These complaints were supported (a) by his performance on the Prospective Memory Task of the RBMT, and (b) his responses to self-report measures which indicated frequent difficulties remembering people's names, what he has just read, and forgetting why he has just gone from one part of the house to another. DC's responses to self-report confidence measures suggested that he is least confident about being able to recall what he has just read, lists, and the reason for going from one part of the house to another. Finally, DC reported that he got angry/frustrated and very worried about his memory difficulties. Details of DC's pre and post intervention scores on objective and self-report measures are presented in Appendix IV.

Comments during group sessions
DC displayed good insight into his memory problems. For instance, he described a number of worries about the future which he said caused him considerable distress and anxiety. DC took copious notes about the content of group meetings. However, despite taking these notes, he complained about having little recollection of the content of the previous week's meetings. Moreover, he failed to learn any of the names of facilitators or group participants.

Summary of post intervention assessment
Comparisons between pre and post group assessments yield little, if any, evidence of improvement. DC's scores on the Logical Memory Test, and Memory for Faces Task were both lower at follow-up than pre-test. In addition, with the exception of 'confidence in remembering to do something', DC's self-report measures of his memory are consistently lower. The one positive finding was the shift in DC's self-reported anxiety about his memory difficulties from 'a lot' to 'a bit'. However, even this observation should be viewed with caution because of the dubious reliability of single pre and post intervention assessments.
Although DC attended all of the group meetings, he was unable to spontaneously recall any information about the content of the programme at post group assessment. However, he correctly identified two target statements in the forced-choice task. These statements referred to using imagery and associations to remember names, and the '4 W' technique. These observations do not appear to be chance responses because DC was able to provide information that corroborated his recognition of these aspects of the programme.

Casual observations of the notes made by DC during post intervention assessment revealed a number of phonological paralexia. Given that DC's verbal IQ is in the 'superior' range, it is hypothesised that these errors arise from acquired dyslexia secondary to his dementia.

Discussion
Pre and post intervention assessments suggest that DC is suffering from a rapidly progressing memory impairment. Moreover, casual observations of his writing suggest that DC's impairments extend to other areas of his cognitive functioning. Post intervention objective measures, and DC's comments, suggest that the present intervention may be of little benefit to patients with relatively severe and/or rapidly progressing memory impairments.

Patient PF

Background information
PF is an 81 year old lady. She was referred to older adult mental health services in December 1995 complaining of visual hallucinations. These hallucinations did not persist. However, PF remained anxious that they may recur. Consequently, she was referred to and treated by a psychologist. She was also prescribed Lofepramine. In January 1996 PF was diagnosed as suffering from mild dementia.

PF has marked hearing and visual impairments. Her visual impairment is partially corrected by wearing spectacles.

PF said that, with the exception of working in a NAFFI shop during World War II, she has not had steady employment.
Summary of pre intervention assessment
PF's pre intervention scores on the Logical Memory Test, and poor performance on the Memory for Faces, and Prospective Memory Tasks from the RBMT were all indicative of mild memory impairment. Moreover, self-report measures indicated that PF (a) often forgets names, words and phrases, the reason for going from one part of the house to another, and what she has just read, (b) worries a lot and gets very frustrated about her memory difficulties, and (c) is least confident about recalling names, and the reason for going from one part of the house to another. Details of PF's pre and post intervention scores on objective and self-report measures are presented in Appendix IV.

Comments during group sessions
During early group meetings PF repeatedly made comments indicating that she is highly self-critical following lapses in memory. During later group sessions she suggested that this criticism sometimes led to thoughts and feelings that increase her forgetfulness. For instance, she said that she used to worry that her neighbours would think she was “stupid” if she forgot what she wanted to say and that this made it more difficult for her to remember things.

Summary of post intervention assessment
Comparison of pre and post intervention self-report measures reveals the following. First, PF reported lower frequencies of difficulties for 7/8 areas of memory assessed. Second, she rated herself as more confident in her memory after the intervention for 5/7 items measuring confidence.

Comparison of pre and post intervention objective measures revealed a mixed picture. Thus, PF improved on the Memory for Faces Task, scored the same on the Prospective Memory Task, and scored more poorly on the Logical Memory Test.

PF correctly identified 4/6 target statements on the forced-choice task and made one false-positive response.

PF stated that the most useful aspects of the programme were the mnemonic strategies, that handouts were clear and helpful, and that the number of sessions was just right but that the sessions themselves were
too short.

Discussion

PF's comments, and self-report measures, suggest that she benefited from the group. However, objective measures failed to provide conclusive evidence of improvement. The lack of concordance between objective measures and self-report measures of the frequency of memory difficulties raises questions about the reliability of these measures.
General discussion

This paper describes a pilot study of a group intervention for older adults with memory difficulties. The remit for the group was that it should fit into the routine and structure of services offered by a mental health day hospital, and serve the needs of as many clients who use this service as possible. The pilot study had three objectives. These objectives are discussed below.

The first objective was to determine who might benefit from participation in the group. A review of the literature suggested that normal ageing (e.g. Woods & Britten, 1985), dementia (e.g. Miller & Morris, 1993), anxiety and depression (e.g. Watts, 1995), are all potential causes for memory problems in older adults. This review also provided several reasons for suggesting that people with these conditions could all benefit from a generic intervention. First, the literature indicated that a reduction in processing resources is central to memory difficulties caused by anxiety (Eysenk & Calvo, 1992), depression (Ellis & Ashbrook, 1988), and sometimes by normal ageing (Craik & Simon, 1980). Second, Watts (1995) argues that many patients who present with organic memory impairments will have developed depression and anxiety as a reaction to the perception of cognitive decline. He proposes that depression and/or anxiety may further exacerbate the patient's memory problems. Consequently, some people with dementia may benefit from interventions designed to treat memory problems associated with anxiety and depression.

The pilot study provides some support for the above suggestions. However, it is acknowledged that, due to the high drop out rate, the pilot study had a small sample size. Consequently, conclusions are made tentatively.

Two of the three patients who completed the programme reported benefiting from the group. The first of these patients, NA, reported memory problems that were confirmed by neuropsychological testing. Psychological and psychiatric investigations failed to identify the cause of these difficulties. However, NA's comments indicated that he was highly anxious about his memory difficulties. The second patient who reported benefiting from the intervention was PF. Prior to the intervention PF had been in treatment with a clinical psychologist for anxiety problems, and had received a diagnosis of mild dementia.
The third patient, DC, did not appear to benefit from the study. DC successfully fulfilled the screening criteria for the group. His pre intervention performance on the MEAMS did not indicate global cognitive deficits, and although his CAPE score was lower than NA’s and PF’s, it was above the cut-off point. In contrast, DC’s comments in group sessions clearly implied that his memory difficulties were more severe than those of the other participants. Moreover, at follow-up casual observations of DC’s handwriting revealed paraphasia indicative of wider cognitive deficits. These comments and observations raise two questions. First, whether or not the intervention is suitable for people with severe impairments. Second, whether the screening procedure is too insensitive. For instance, the cut-off point for the CAPE could be raised from 8/12 to 10/12.

Another issue in assessing who benefited from the pilot intervention was the sensitivity of the outcome measures. For instance, the prospective memory task is scored on a 3 point scale, and the memory for faces task on a 5 point scale. The limited ranges of these scales indicate that they may be sensitive only to relatively large changes in performance. Given the short duration of the group it seems unrealistic to expect large changes in functioning.

The second objective of the pilot study was to consider what types of intervention strategy would be beneficial to group participants. Two sets of studies summarised in the literature review were influential in guiding the selection of intervention strategies. First, it was noted that there is considerable evidence that CBT is an effective treatment for anxiety and depression. Second, research was cited indicating that memory problems caused by ageing, anxiety, and depression, are all amenable to interventions designed to increase the organisation, and manipulation, of incoming information. These interventions include imagery and organisational strategies. On the basis of these two sets of empirical findings, a combination of mnemonic and cognitive behavioural strategies were selected for the group. The mnemonic strategies focussed on enhancing the use of organisation, imagery, and self-cueing. The cognitive behavioural strategies included thought monitoring and challenging, thought stopping, and relaxation.
Participants' comments about the pilot study are generally support the rationale guiding the selection of intervention strategies. First, comments made by all three participants support Watts' argument that memory difficulties are anxiety provoking. Second, both NA and PF acknowledged that anxieties about memory difficulties increased their forgetfulness. In addition, feedback from two of the patients indicate that both the mnemonic and cognitive behavioural aspects of the intervention are helpful. Thus, NA stated that the most useful aspects of the intervention were the cognitive behavioural strategies, whereas PF said that she found the mnemonic strategies most helpful.

Pre and post intervention measures also provide some support for the rationale for, and efficacy of, the intervention. The rationale for the intervention was that memory functioning can be adversely affected by psychological factors. It can be predicted, therefore, that confidence measures will be linked to measures of memory difficulties. This prediction was supported by the association between changes in NA's self-report measures of confidence and his scores on objective measures. Similarly, PF's self-report measures of confidence and her estimates of the frequency of difficulties co-varied. These observations should be treated with caution for a number of reasons. First, the rationale also predicts associations that were not observed. Thus, NA's confidence scores were not associated with his estimates of the frequencies of his difficulties, and PF's confidence scores were not associated with her objective measures. Second, it has already been noted that the reliability of pre and post measures cannot be determined because of the lack of repeated measurements. Third, changes between pre and post intervention scores were small. Fourth, the small sample size means that it is difficult to generalise from these findings. Finally, a number of studies have yielded only weak correlations between self-report and objective measures of memory (Bennett-Levy & Powell, 1980).

The third objective was to identify problems with the pilot study which might aid the development and assessment of future groups. The pilot study suggests that there are a number of ways in which the intervention, and measurement of outcome, might be improved. These include the following.

1. The clinical context in which the study was conducted prevented
assessment of patients on several occasions before the intervention in order to establish a reliable baseline.

2. Clinical considerations also prevented the collection of longer term follow-up data. It was not possible to judge, therefore, whether the beneficial effects reported by two of the participants one week after the intervention were maintained over longer periods.

3. The pilot study had a sample size of only three. Consequently, despite evidence from two out of three of the case studies that the intervention was helpful, it is not possible to draw any firm conclusions about the efficacy of the programme.

4. NA suggested that practice examples would have helped him to acquire the mnemonic strategies.

5. DC failed to derive any benefit from the intervention. Despite comments made by this patient indicating that he was considerably more impaired than the other two participants, he still fulfilled all of the screening criteria. Consequently, consideration should be given to possible changes to these criteria.

6. A number of studies have yielded only weak correlations between self-report and objective measures of memory (Bennett-Levy & Powell, 1980). Bennet-Levy, Polkey and Powell (1980) demonstrated, however, that their Subjective Memory Questionnaire correlated significantly with the Rivermead Behavioural Memory Test. This finding suggests that these two measures could form useful pre and post intervention assessments. In addition, the RBMT has four forms which would allow the collection of multiple pre intervention baselines and immediate and delayed follow-up assessments. However, it was noted earlier that one drawback with RBMT subtests is that they may not be sensitive enough to measure pre and post group changes in functioning.

7. Given that the group focusses on the effects of anxiety and depression on memory it would have been useful to have included standardised measures for these variables in the pre and post intervention assessments. Gilleard (1996) states that depression in anxiety tends to manifest as somatic symptoms and lack of energy. Consequently, he argues that the
Hospital Anxiety and Depression Inventory (HAD) is a better measure of depression in older adults than the Beck Depression Inventory (BDI: Beck, 1987) because the latter tends to emphasises cognitive manifestations of depression.

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Appendix I

Structure and content of group sessions

The group met for seven weekly one hour sessions. The emphasis during group sessions was on the creation of an atmosphere within which participants could (a) discuss their memory difficulties, (b) discuss the impact of these difficulties on their cognitive, social, and emotional functioning, (c) receive ‘validation’ for their difficulties from other participants and group facilitators, and (d) learn about ways of coping with memory difficulties from each other and group facilitators.

Group sessions were semi-structured and each focussed on pre-determined but flexible goals. The content of each meeting was supported by written handouts.

The content of each session is summarised below:

Sessions 1 & 2
The first two sessions concentrated on helping participants to discuss the nature of their difficulties, the way they thought about these difficulties, the way these thoughts made them feel, the way they coped with these feelings, and the impact of feelings and coping strategies on their forgetfulness.

The goals of these sessions were to (a) allow the participants to ventilate negative experiences associated with forgetfulness, (b) validate these experiences, and (c) increase insight into how memory problems can be exaggerated, or maintained, by reactions to forgetfulness.

Session 3
This session began with a recap on the links between memory problems and resulting thoughts, feelings, and behaviour. The techniques already used by participants to cope with forgetfulness were then explored. These techniques were clustered into those which primarily influenced (a) cognition, (b) emotion, and (c) concentration, attention, and memory.

The goals of this session were (a) to reiterate the links between memory problems, thoughts, affect, and behaviour, and (b) to introduce ways of
dealing with the consequences of memory problems.

Sessions 4 & 5 Mnemonic strategies

These goal of these sessions was to introduce mnemonic strategies designed to help participants to remember appointments, names, what they had just seen or heard, what they had just got up to get, and whether or not they had done something. These strategies are summarised below. (Further information about each strategy is provided in Neil Matson’s self help guide ‘Coping with Mild Memory Problems for Older People’

- Remembering appointments:
  i. Writing things things down in diaries, and/or on calendars.
  ii. Using notes or an accomplice to remind participants to check their diary.

- Remembering names:
  i. After being introduced to somebody repeating their name several times either covertly or during conversation.
  ii. Writing and rehearsing lists of associations between names of familiar people and distinctive features
  iii. Creating visual images linking people’s names to either a distinctive feature or a bizarre or humorous image. For example, imagining someone called Ted hugging a giant teddy-bear.
  iv. Owning-up to difficulty remembering names and asking people to repeat their names.

- Remembering what you have just seen or heard:
  i. Rather than trying to remember everything about a conversation, TV programme, or book pick out the following key points:
    - what happened
    - when it happened
    - where it happened
    - who was involved
  ii. Use the ‘4 Ws’ (i.e. what, when, where, who) to cue recall of information about a conversation etc..

- Remembering what you have just got up to get, and whether or not you have done something:
  i. Try to reinstate the original context. For instance, by going back to

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1 This guide is available from Dr. Neil Matson, c/o Dept. Clinical Psychology, Exeter Community NHS Trust, Exeter, East Devon.
where the intention was formed or the action carried out.

ii. Creating bizarre or humorous images involving the completion of the task. For example, as you are locking the front door imagine you are using an enormous key, or before going to the bedroom to get a book imagine the book tucked-up in bed.

The above strategies were selected to offer a range of involvement from the participants. Thus, they vary from owning-up to memory difficulties and external aids on the one hand, to internal strategies such as imagery on the other. In addition, wherever possible the strategies chosen offered support both for encoding and retrieval. For example, writing something down in a diary increases both the level of processing at encoding and provides a cue during recall. Similarly, creating an image of a link between a physical feature and a person’s name increases processing during learning and cues recall. The rationale for this decision was Backman’s (1992) observation that dual support for encoding and retrieval is a common aspect of successful intervention strategies for patients with AD.

Although sessions 4 and 5 were more didactic than previous sessions, participants were encouraged to provide their own suggestions for strategies, to practice using new strategies, and to discuss examples where they had found the strategies helpful or unhelpful.

Session 6 Challenging unconstructive thoughts
This session began by asking participants to recap on the links between their memory difficulties, and their thoughts, feelings, and unhelpful coping strategies. The content of this discussion was then used to gently challenge participants unconstructive thoughts and coping strategies. Participants were invited to review evidence for and against thoughts about memory difficulties. They were also encouraged to consider the potential pros and cons of alternative interpretations of their difficulties.

The goals of this session was help participants to challenge the unhelpful beliefs about their memory difficulties.

Session 7 Coping with negative affect
The first part of this session introduced simple relaxation techniques, such as deep breathing (see Beck & Emery (1985) for more details). The content
of previous sessions was then reviewed. Finally, appointments were made for post intervention assessments and follow-up plans were discussed.
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Appendix III

1. Here is a list of common difficulties people have with their memories. Please indicate whether you experience these problems: never; rarely; sometimes; often; or all the time.

   a. Forgetting the names of people you know
   b. Forgetting where you have put things
   c. Forgetting what you have just read about
   d. Getting lost when out alone
   e. Forgetting what you wanted in a shop
   f. Forgetting to do things you said that you will do
   g. Thinking of a particular word or phrase
   h. The reason you were going from one part of the house to another

2. When you forget something do you: not worry about it; worry a bit; or worry a lot.

3. When you forget something do you: stay calm; get angry/frustrated; or get very angry/frustrated.

4. Please indicate on a scale of 0 (not at all confident) to 10 (very confident) your confidence in your ability to remember the following types of information:

   a. People's names
   b. Where you have put things
   c. What you have just read about
   d. Shopping lists
   e. To do things that you said you would do
   f. Words or phrases
   g. The reason you were going from one part of the house to another

Information gathered by self-report items

Page 222.
## Appendix IV

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Table 1. Summary of patient NA's performance on pre and post intervention assessments.
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Table 2 Summary of patient DC's performance on pre and post intervention assessments
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Table 3: Summary of patient PF’s performance on pre and post intervention assessments.

Page 225.
Acknowledgments

There are many people whom I would like to thank for their assistance over the three years of my clinical training. I am indebted to colleagues who have offered formal, and informal, supervision during clinical placements. In particular, I would like to thank Julia Deadman-Spall, Nick Kirby-Turner, Sara Turner, Alison Beck and Hermin Graham. I would also like to thank the current course team, and Sean Hammond, Mary Hill, Jane Sowerby and Darren Bishop for their guidance, and suggestions about the content of this portfolio.

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