A PORTFOLIO OF ACADEMIC, CLINICAL AND RESEARCH WORK

"The Link Between the Eating Attitudes and Behaviour of Parents and the Eating Behaviour of their Children."

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SECTION I

ACADEMIC
ACADEMIC SUMMARY.

The five papers in this section discuss a range of topics drawing on a variety of theoretical models including Cognitive Therapy, Psychodynamic Therapy, Family Therapy and a transtheoretical model of behaviour change. Two of the papers contain issues pertaining to individuals with specific psychological and neurological difficulties, namely Parkinson’s Disease and Dementia. Two further papers contain material relevant to broader groups of clients, namely older adults and individuals with health related problems. Finally one paper is applicable to any individuals seeking psychological help.

The first paper aims to critically examine whether older adults differ from younger adults in their need for psychological involvement. A brief discussion of the aging process is given in order to highlight some of the differences between older and younger people. Similarities and differences between the two client groups are then discussed in relation to presenting psychological needs and therapeutic interventions.

Continuing the theme of work with older adults, the second paper examines the literature concerning the design of environments for people with Dementia. This paper highlights features in the physical, social and therapeutic environment which need to be given special consideration when working with and/or designing living accommodation for members of this particular client group.

The third paper also addresses issues relating to people with a specific neurological disorder. In this essay the contributions of neuropsychology to the assessment of clients with Parkinson’s Disease are discussed. This includes a discussion of both the uses and problems of neuropsychological assessment. Although this paper is related specifically to the assessment of people with Parkinson’s Disease, many of the issues raised are applicable to neuropsychological assessment in general.

The fourth essay also raises issues that are applicable to a wide range of clients. This paper contains a discussion of the selection criteria used to assess suitability for
Cognitive Therapy and Psychodynamic Psychotherapy. An examination of the similarities and differences between the criteria outlined by the two fields is undertaken.

Continuing the theme of the fourth paper, the fifth and final essay also examines a theoretical model. An outline of Prochaska and DiClemente’s transtheoretical approach to behaviour change is presented and its applicability to the field of health psychology is discussed.
"Are Older People Different from Younger People in their Need for Psychological Involvement?"

Discuss with Reference to Psychological Knowledge and Theories.
INTRODUCTION.

Although older adults (individuals aged 65 plus) now make up over 15 percent of the British population, the literature suggests that these individuals have been largely neglected by British Clinical Psychologists. In 17 separate contributions to "New Developments in Clinical Psychology" published by the B.P.S, work with the elderly did not merit a chapter but instead merely two passing references (Bender, 1986). Furthermore, Bender estimated that only 6 percent of British Clinical Psychologists work with the elderly. The neglect of this population does not stem from a lack of need. Finkle (1981) comments that older people are considered to have a higher incidence of mental health problems than other age groups. Given that life expectancy is slowly increasing and hence the number of individuals aged 65 plus is also growing, work with this age group for Clinical Psychologists is likely to become increasingly important.

In order that Clinical Psychologists may provide the most effective interventions to the elderly, they must consider whether or not these individuals differ in their need for psychological involvement from younger adults. This essay will examine this issue. Initially a brief outline of some of the changes associated with normal aging will be presented, followed by an outline of some of the main psychological problems experienced by this age group. Finally there will be a brief discussion of some of the main therapeutic approaches that have been implemented with older adults.

It is first crucial to consider certain factors whose combined impact prevents us from gaining a true picture of the psychological needs of older adults. Probably the most significant barrier arises due to ageist attitudes i.e. discrimination against older adults because of their age. These may be held by elderly people themselves as well as the professionals working with them (Day, 1988). They often serve to reduce the expectations for both health and happiness in old age. These attitudes may account for the under reporting of psychological problems by older people who, according to Levinson and Felkins (1979), are less inclined to use mental health services especially those provided on an outpatient basis. Furthermore, older adults come from a culture
in which psychological concepts were relatively unusual. Lasoski and Thelan (1987) assessed the attitudes of older and middle aged individuals to mental health services. Their results suggested that a lack of familiarity with psychological concepts may be partially responsible for the under utilisation of services by the elderly.

**THE AGEING PROCESS.**

The major factor distinguishing younger and older adults is age. It is therefore crucial to examine the process of normal aging which is defined by a number of biological and social factors. Normal aging may involve many changes for an individual both in terms of his/her physical and cognitive capacity and changes to social environment. These changes may have an important impact on the psychological wellbeing of the individual concerned.

**Internal Changes.**

One of the most noticeable changes occurring with age is the physical decline of an individual. The elderly population experience a high frequency of physical health problems. It is estimated that older adults occupy over half of the N.H.S. hospital beds (excluding maternity) at any one time (Garland, 1988). Older adults often experience some degree of sensory disability. Hearing loss, for example, is estimated to occur in 30 percent of the elderly.

Aging also seems to be associated with some decline in intellectual functioning particularly in terms of memory, abstract thinking and speed of processing (Church, 1983, Church, 1986, Coin, 1981). Gross (1987) reports that elderly people show a decline in intelligence as measured by the Weschler Adult Intelligence Scale. It is argued that this is mainly due to reduced memory span and slower response rates. Furthermore Walker (1982) found that failure rates on a test of ability to shift set, rose from 10 percent in those aged 60 to 64 to 92 percent in those aged over 80.
The Social Environment.

Aging often results in many changes to an individual’s social situation. Older people are more likely to experience bereavements of friends, siblings or spouses/partners. Such changes may not only result in a loss of emotional support but also changes to the financial situation and social status of the individual concerned. Potentially this may result in the narrowing of the individual’s social field and ultimately social isolation. Older adults often experience a loss of role and status. These changes are fuelled by external constraints e.g. age demanded retirement and policies which structure but limit pension. On average, older people earn less than half of that earned by younger adults. Overall these changes often cause older adults to fall behind younger people in terms of socioeconomic status.

Not all individuals going through the aging process will experience social changes. Furthermore, some younger adults may also experience the problems listed e.g. bereavement or loss of income. However, these problems are relatively more common for members of this age group. Although elderly people are more likely to experience bereavement or serious illness, it has been suggested that expected events i.e. those perceived as being on time for that stage of the life cycle, are less threatening (Sands and Parker, 1980, Palmore et al, 1979). Events occurring singularly often have few negative consequences but there appears to be an accumulative effect especially for individuals with few social resources.

PRESENTING PROBLEMS.

The psychological problems of adult life e.g. depression, anxiety, stress related disorders, sexual and marital problems and drug and alcohol misuse are, according to community surveys, at least as common in older adults (Murphey, 1982). However, there may be relative differences in terms of the aetiology and presentation of disorders for this age group. For example, depression in the elderly is often associated with chronic illness, sensory disability or losses when the individual concerned lacks the social resources to cope. Although these factors may also be
associated with the onset of depression in younger people, given that they occur less frequently for this age group, this is less likely. In addition, alterations in sleep, appetite and drive, which are felt to be signs of depression for younger adults, may for older people occur as biological consequences of aging. It has been suggested that life satisfaction and morale may be more appropriate measures of depression for this age group (Gilleard et al, 1981).

Older adults may experience long term problems originating from child or adulthood. However, the presentation of these difficulties may be affected by age-related changes. Alternatively disorders developing later in life may also be affected by the age of the client. For example, older adults developing psychosis in later life have already had the opportunity to develop their adult skills. This disorder may therefore be less debilitating than for individuals developing the condition in child or adulthood. Psychiatrists therefore distinguish late onset psychosis, Paraphrenia, from other early onset psychotic disorders.

Older adults experience a higher frequency of organic disorders than younger adults. Dementia, for example, appears to increase exponentially with age with rates rising from around 1 percent for those in their sixties to over 20 percent for those in their eighties. Similarly, a study in Baltimore showed that rates of psychosis rose from .35 percent for individuals aged 15 to 34 to 4 percent in individuals aged 65 plus. Furthermore, over half of the latter cases were associated primarily with an organic cause.

Goodstein (1980) identified a number of concerns which are frequently raised in therapy by older adults. These included fear of dependency, loneliness, disability and death. Colemann (1988) in contrast identified a number of themes commonly raised in therapy with both older and younger adults. These included self esteem, growth, a sense of control over events and environmental mastery.
THERAPEUTIC INVOLVEMENT WITH THE ELDERLY.

This section will begin with a consideration of the general adaptations that may be made to assessment and therapy when working with the elderly. In addition there will be a brief discussion of the ways in which some of the specific therapeutic approaches developed for work with younger adults, have been modified to suit work with older people. Finally a brief presentation will be made of some of the approaches developed specifically for work with older adults.

General Modification To Assessment.

There is some evidence to suggest that older adults tend to make errors of omission during therapy. Whilst obtaining a client history, the Clinical Psychologist may therefore need to take a more active enquiring role using his/her knowledge of the most likely problems e.g. issues around bereavement or retirement. The clinician should make a systematic enquiry into the individual’s feelings about death and will need to obtain a very clear picture of the client’s social network and daily activities. Although all these issues may also arise during an assessment with a young adult, owing to the life stage of the client, they are relatively more pertinent to members of this age group. The clinician may need to spend more time obtaining a thorough client history. In addition the pace of both assessment and therapy should be adjusted to ensure that the client has both adequate time to answer questions and to understand and process information given by the therapist.

General Modifications to Therapy.

Many changes associated with the aging process have implications for therapeutic work with older adults. The increased likelihood of health problems and physical or sensory disabilities may require the therapist to adapt the therapeutic environment and his/her own behaviour in order to maximise communication with such individuals. For example, when interviewing a client with sensory disabilities, the therapist may need to pay particular attention to lighting, noise levels and seating arrangements.
The therapist will need to be flexible in terms of session length and location. Individuals with disabilities may find it very difficult to attend an outpatient clinic and the therapist may therefore instead visit the client in his/her own home. Similarly, sessions may need to be shortened for clients who are in pain, highly medicated or tired.

Similar adaptations will need to be made by therapists working with the confused elderly. Such therapists may also need to modify their language, keeping sentences short and simple. If an individual is very confused, the therapist may decide to interview the client’s relatives/carers in order to ensure that reliable information is obtained. Alternatively, the therapist may wish to invite a person familiar with the client to attend sessions. This person may then be able if necessary to interpret and rephrase what the client himself wishes to say.

The clinician should always be aware of the cognitive changes associated with normal aging. The therapist working with older adults should aim to place less emphasis on abstract concepts and ideas and instead provide the client with more concrete notions. The therapist will need to take into account the client’s speed of processing, adjusting the pace of therapy accordingly, and if necessary, repeating and summarising regularly. Furthermore, the therapist must be aware of any memory difficulties experienced by the client. For some individuals it may be useful to write things down or to ask friends/relatives to prompt the client with information.

Unlike work with younger adults, symbolic giving and touch are both considered appropriate when working with this population. Some older adults have experienced multiple losses and the therapist may be able to substitute for these symbolically by using the interaction to boost the client’s self esteem. Some of the interview may be taken up with social conversation and the therapist may self disclose more readily than when working with younger people.

Therapeutic goals set with older adults need to be realistic and very specifically defined. Goals are often more narrow than those set with younger adults and total
reorganisation of personality is rarely attempted. In addition greater difficulties with the generalisation of skills gained in therapy to the natural environment may be anticipated with the elderly. Therefore greater emphasis is often placed on the involvement of friends, relatives or other staff who may help to encourage and consolidate the changes facilitated in therapy.

The role of the Clinical Psychologist when working with older adults is often less clear cut and may involve tasks not usually associated with Clinical Psychology in the adult field. In addition emphasis is often placed on team work with this population and the Clinical Psychologist may liaise with other professionals more frequently than in adult work.

Finally cultural factors are likely to have an impact on the relationship between therapist and an older adult. Older adults come from an era in which psychological concepts were more unusual. The therapist may therefore have to educate and prepare the client for therapy as a prerequisite to treatment. Furthermore, the clinician may have to modify her behaviour, presentation and therapeutic style to fit client expectations. The therapist must ensure that negative attitudes and beliefs about aging do not impinge on her work with this age group. She should also be aware that she may have greater difficulties in obtaining correct empathic understanding of older adults and should therefore take measures to combat this.

A clinician may need to make many of these adaptations when working with younger adults. However he/she is relatively more likely to have to make these modifications when working with older people.

**Cognitive Therapy With Older Adults.**

In a comprehensive review of the literature, Gallagher and Thompson (1982), found that individual Cognitive Therapy produces positive outcomes for clients, particularly those with depression. However there is uncertainty as to whether it is equivalent or superior to other forms of psychotherapy and/or pharmacotherapy.
A number of special issues have been identified when applying Cognitive Therapy to work with older adults (Emery, 1988) many of which have already been touched on above. Emery (1988) highlights the fact that a longer lifespan affects conceptualisation in various ways, for example explaining how lifelong choices may have reinforced or built up beliefs and assumptions held by the client. The author comments that the historical aspects of formulation and intervention with older adults should not just be tagged on to therapy. He suggests instead that Cognitive Therapy should be combined with a Life Review approach although the therapist should be aware of the negative memory bias associated with depression.

The aging process appears to be associated with a decline in abstract thinking. Beck’s Cognitive Therapy involves the use of a number of abstract concepts e.g. the recall of Negative Automatic Thoughts (N.A.T.s). Church (1983), when studying Cognitive Group Therapy with the elderly, found it difficult to encourage the group members to keep records of their N.A.T.s. Instead the focus had to be on more concrete practical events brought into the session and discussed.

Authors have suggested that there are aspects of Cognitive Therapy which appear to be suited to work with older adults. For example repeated summarising of material covered and eliciting feedback from the client to ensure that there is a shared understanding, are both key concepts in this approach. These techniques often compensate for comprehension and retention problems often experienced by the elderly.

**Family Therapy With Older Adults.**

Old age often involves many changes in roles and responsibilities both for the older adult and for members of his/her family. Such changes may often stimulate interpersonal conflict between family members. Psychological intervention with older adults and their families has taken two main forms. Many therapists have focused on the family members providing care by offering them Psycho-educational input to alleviate stress. This is usually provided to groups of carers where the main aims are
- acquisition of knowledge and skills, peer support and increased awareness and use of community support services. However this approach fails to include the older adult or address his/her needs directly.

The second type of work has involved the application of systemic principles to families with an older member (Roper-hall, 1992, Bembo, 1990, Green, 1989). This approach is particularly suited to work with older adults since they are often facing many life transitions including - becoming a grandparent, retirement, loss of partner, relocation, illness and dependency. Such transitions are likely to have an impact on the balance of the whole family. Family Therapy aims to foster better relationships and greater independence for older family members. The therapist hopes, according to Richardson et al (1994), to understand the family system with its rules and balances of power and then to mobilise the system by reconstructing its rules and encouraging the family to observe its own way of functioning.

Within both the Psycho-educational and Family Therapy approaches, clinicians have produced enervative application in a variety of settings with late life families. However to date there has been little empirical research conducted to evaluate the effectiveness of the application of these models to this client group.

**Behaviour Therapy With Older Adults.**

Knight (1986) comments that the Behavioural approach is potentially the most useful model for work with older adults since it looks to environmental variables rather than those variables within the individual to both understand problems and bring about behavioural change. This approach has been used particularly with clients in institutional settings and/or for managing people with Dementia. Garland suggests that the development of Behaviour Modification and treatment programmes is a key aspect of the Clinical Psychologist's role with the elderly. Church (1986) reports that experimental research shows that people with Dementia may benefit from Behaviour Modification and Skills Retraining. However, as with all the models outlined in this section, the research concerning the application of therapy to older adults is sparse.
Psychodynamic Psychotherapy With Older People.

Freud, the "father" of Psychoanalysis, argued that older people lack the cognitive flexibility to undertake Psychoanalysis, although it has since been suggested that this comment says more about Freud’s own defence mechanisms about aging. Davenhill (1991) highlights the tendency to deal with problems faced by older adults by manipulating their external world at the expense of ignoring the conflicts occurring simultaneously in their inner world. Davenhill (1991) identifies certain themes which, although not unique to this age group, are relatively more likely to arise during therapy with older clients. These include - life recollection and internal resolution of any conflicts, exploration of the implications of aging, loneliness and an unconscious fear of death. The latter issue in particular accounts for many of the psychotic and depressive break downs that occur in older people (Davenhill, 1991).

The use of Psychotherapy with older adults has undergone much debate. Some authors suggest that traditional Psychoanalysis needs modification in order to be applicable to this client group. For example a review by Church (1983) tentatively suggested that as therapy becomes more verbal and interpretive in nature, the elderly client will have increasing difficulty. Some authors have argued that Psychotherapy should be combined with Cognitive Therapy so that clients may be helped to deal with conflicts more effectively at a conscious rather than unconscious level but without discarding our understanding of unconscious motives.

The relationship between client and therapist is a critical element in Psychotherapy. Knight (19886) comments that the typical analytic transference relationship in which the client views the therapist as a parent, may alter when the client is older than the therapist. Often the client may instead view the therapist as a child or grandchild. In addition visiting clients in their own homes may pose particular problems for defining the relationship and setting therauputic boundaries. In turn Knight (1986) comments that the age of the client may equally affect the counter-transference
relationship. Negative stereotypes about old age, projections of relationships with older significant others and defence fantasies designed to protect the therapist from anxiety over death, dependency and illness may all interfere with the Counter-transference.

**Specific Therapies For Older Adults.**

A number of approaches have been developed specifically for working with older adults. Most of these have focused on working with individuals with organic brain syndromes particularly Dementia. These include Reminiscence, Reality Orientation and Validation Therapy. It could be argued that this group of individuals differ markedly in their need for psychological involvement from younger adults. However, although a lot rarer, some younger adults do experience Dementia and would benefit from these specific therapies. The difference therefore seems to occur due to the nature of the condition itself rather than the actual age of the client. Furthermore, many clinicians argue that traditional psychological approaches may be useful in working with clients with Dementia. Caroline Richardson for example argues that the internal world of people with Dementia has, until recently, been largely ignored. However such individuals face an overwhelming risk of developing emotional disorders. Psychotherapy, with its aim of alleviating internal distress, therefore seems appropriate psychological involvement for such individuals.

**CONCLUSIONS.**

Younger and older adults seem to share many similarities in their need for psychological involvement. The significant differences that do arise appear to stem mainly from the biological, cognitive and social changes associated with aging. Furthermore, many of the differences highlighted in this essay are relative ones. For example many younger adults experience multiple bereavements, physical health problems or isolation. This fact emphasises the need to view each older adult as a unique individual undergoing the universal process of aging but whose experience of that process will also be unique.
Preliminary results suggest that many of the psychological approaches used with younger adults, may be usefully adapted for work with older people. Similarly it seems that a number of useful approaches have been developed to work specifically with certain members of the age group. However there is a clear need for much further empirical research to establish the efficacy of such interventions.
REFERENCES.


Year 2. Psych.D. Clinical Psychology

Older Adults Literature Review

"The Design of Environment for People with Dementia."
INTRODUCTION.

The number of older adults with senile Dementia is widely documented to be increasing. The proportion of people affected by the condition multiplies exponentially with age. 5 to 10 percent of people aged 65 plus have some form of Dementia or serious confusion of organic cause. The proportion rises to 22 percent for those aged over 80 (Kay et al, 1970, Bergmann and Jacoby, 1982). According to Craig (1983) the number of individuals aged over 80 is expected to double by the year 2010 and therefore the number of affected individuals is expected to rise by 41 percent between 1977 and 2001 (Office of Health Economics, 1979). Given that community care policy is often more easily applied to people with physical disabilities coupled with the severe stress encountered by relatives caring for people with Dementia, (Levin et al, 1983, Gilhooly, 1984) an increase in the number of individuals with Dementia in residential and nursing homes for the elderly is somewhat inevitable. Therefore the type of environment that should be provided in such homes is a pressing concern.

The starting point for this review stems from the knowledge that behaviour and the environment are intimately related. Elderly people are typically more vulnerable to their environmental context than younger adults since their competence decreases with age. People with Dementia are often amongst the least competent of the elderly population and if they find themselves in deprived or stressful environments, their behavioural and affective responses will be more negative than necessary (Keen, 1989).

In the following review I will examine the literature pertaining to the design of environments for people with Dementia. The term "environment" will be considered under three headings - physical, social and therapeutic. Whilst reading this material it is important to bear two points in mind. Firstly some of the design issues discussed are particularly relevant to older adults with Dementia whilst other features apply more generally to the design of environments for the elderly as a whole. Secondly most of the literature available relates to the design of environments for people with
Dementia in residential settings. However many of the issues discussed may also be applicable to individuals living in their own homes.

**DESIGN OF THE PHYSICAL ENVIRONMENT.**

Mansa (1994) argues that when designing buildings for older adults, the prime consideration should be factors which are viewed as important by all adults e.g. privacy, dignity and independence. Added to this, the elderly have greater needs for comfort, convenience and security. Buildings are not inert structures but have assumptions about behaviour built into them i.e. they are designed with a purpose in mind. Therefore, according to Mansa (1994), it is possible to design a physical environment to suit the needs of this particular client group.

According to Keen (1989) the design of buildings involves three main considerations - size, shape and layout. The size of buildings designed to care for older adults has followed two main trends - the first appealing to economy of scale and the second based on the desire to provide accommodation that is deliberately domestic in scale. The latter and now more popular design is based on the notion that home-like care can only be provided in buildings similar in size to normal housing.

A second consideration is the shape of the building. Peace et al (1982) in a study of 100 local authority residential homes, found no obvious link between the shape of the building and the general nature of the service delivered. However, the shape does determine the internal organisation and layout of rooms. Mansa (1994) has commented that rooms with low ceilings are often perceived as oppressive and awkwardly shaped rooms may increase the confusion of older adults with Dementia.

In terms of layout, Netten (1989) conducted an investigation of the effect of layout of residential homes on the confused elderly. 13 homes were studied whose building layout fell under one of two designs - group design or communal design. In the former, activities of daily living were confined to a definable area for a particular subgroup of residents. In contrast in the communal homes all the residents used a
single dining area and central sitting rooms which were located away from their bedrooms. Such set-ups were characterised by long corridors. An assessment was made of each resident's ability to find his/her way around the home. In addition, Lipman's (1983) method of compiling a Schematic Route diagram was employed to make an assessment of the complexity of the building. This involved delineating functional areas within each house and the paths linking these zones. The overall results suggested that the group homes provided a more favourable design particularly for the physically frail confused elderly. This result in favour of group design may partially reflect the fact that, in a communal design, residents are forced into the central communal area of the home which they are likely to find confusing. In addition, according to Mansa (1994), people with Dementia are particularly confused by corridors, a characteristic of the communal set-up.

Netten (1989) found that the variables influencing the residents' ability to find their way around differed for the two forms of accommodation. Long corridors appeared to be an aid in group homes but a disadvantage in communal ones. Similarly simple decision points were advantageous in communal homes whilst complex decision points were advantageous in group homes. The author offers an explanation for these results using the concept of Meaningful Decision Points or landmarks. In a communal home a simple decision point might be a sitting room which, if actually used by the resident, might be a landmark for him/her. On encountering this landmark, the person will have to think about where he/she is going. If corridors are too long, the resident may forget where he/she is going before the next decision point is reached. In a group home a complex decision is where a bedroom and sitting room are positioned on a junction and the client must therefore choose between meaningful landmarks. An unhelpful design would involve a layout consisting of many meaningless decision points. In a communal home this might involve few identifiable zones, long corridors and lots of doors. In contrast in a group home an unhelpful design would be lots of short corridors within the group section forming a maize effect. The author does comment that these results should be viewed with caution given the exploratory nature of the study.
Linked with the above study, Mansa (1994) reported on a project in Wiltshire in which a unit for ten clients was built on to an existing residence. The new unit was designed so that bedrooms were grouped around and entered from a large central room. Staff in the unit reported that residents were calmed by always being in sight of the door to their bedroom or the toilet. Overall the residents in the new unit were felt to be more relaxed than those in the adjoining more conventional unit. Similarly in a specialised unit for the Confused And Disturbed Elderly (C.A.D.E.) in Australia (Atkinson, 1995), to reduce confusion and anxiety, the unit was designed so that the residents are able to see every room they need to find from a central living area. This set-up also means that staff are able to see the residents at all times allowing early intervention if and when problems arise. The authors comment that residents feel more secure when they can see a member of staff at all times.

Consideration should also be given to the interior design of buildings. Arrangement of space, use of furniture and equipment and ambient conditions, all affect the extent to which independent living skills are promoted for the confused elderly (Davies and Crisp, 1985). A number of authors have emphasised the need to ensure that residential and nursing homes are designed to be as home-like as possible (Keen, 1989, Handysides, 1993, Cleary et al, 1988). In the specialised C.A.D.E. unit, staff acknowledge that the unit is the resident’s home and all the facilities in a conventional house are provided along with familiar decor and space for personal belongings. Given that people with Dementia tend to remember the distant more than the recent past, wherever possible, furniture from the 40s and 50s is provided in the unit so that the surroundings are more in keeping with the reality of the clients. Linked with this, authors have recognised the need to design environments for the elderly bearing in mind the need for privacy and personal space (Davies and Crisp, 1985). Both Keen (1989) and Mansa (1994) have suggested that privacy has a spatial element and may be designed into a building e.g. with the provision of single rooms.

Mansa (1994) has commented that the internal layout of buildings may be designed to ensure that staff are amongst the residents as much as possible. This is achieved by minimal provision of staff accommodation. In the specialist unit for the confused
elderly described by Handysides (1993) the nursing station comprises a walk-in cupboard designed to prevent nurses from avoiding contact with clients. In addition residents and staff share facilities and eat together.

Dementia is characterised by orientation difficulties i.e. difficulties in relating to the environment, particularly knowing where one is in place and time. Davies and Crisp (1985) describe how the physical environment may be designed to promote maximum orientation for the confused elderly. They emphasise the need for distinctive landmarks at choice points and visual cues (e.g. sign posts, colour coding or pictograms) to indicate the function of important locations e.g. the toilet, bedroom or dining room. This principle is employed by the C.A.D.E. unit where important stimuli are highlighted so that they stand out from the background. Given that people with Dementia often experience difficulties processing information, the unit aims to reduce extraneous stimuli. So, for example, doors to exits, stores and cleaning cupboards are painted to merge with the background so as not to attract attention from residents. Given that many older adults and consequently a number of the confused elderly have visual or auditory disabilities, it may be possible to design the physical environment to compensate for these using redundant cuing. This involves making a message available using more than one modality (Keen, 1989, Davies and Crisp, 1985). For example, in the unit described by Handysides (1993) floors in different parts of the building feel and sound different e.g. wood in the hall, carpet in the lounge. It is important to note however that these cues will not necessarily be used without prior training and interference from previous associations may have to be overcome (Davies and Crisp, 1985).

A second key characteristic associated with Dementia is wandering. Clearly it is important that the physical environment for the confused elderly is designed so that clients are able to wander safely with the least disruption to other clients (Davies and Crisp, 1985, Keen, 1989). In addition, Mansa (1994) emphasises the importance of providing the confused elderly with access to a sheltered outdoor safe place, preferably with a circular path, where they can wander freely. In the C.A.D.E. unit, staff ensure that a clear path to all facilities has been defined by strategic layout of
furniture. Similarly in the specialised unit described by Handysides (1993) the need for secure boundaries on the site is recognised by staff to ensure that the residents do not reach the street and potentially cause harm to themselves.

Many older people, and therefore people with Dementia, experience both physical and sensory disabilities. A number of authors have suggested that the physical environment of residential settings may be designed to minimise the handicap incurred by such individuals. Mansa (1994), for example, highlights the need for wide doorways and larger rooms to cater for people with wheelchairs. In addition he further comments that such individuals may require specialised bathroom equipment e.g. hand/grab rails. As older adults often spend much of their time sitting or lying down, Mansa (1994) emphasises the fact that windows should be low with, wherever possible, stimulating views. Many older people experience a deterioration in sight and therefore benefit from increased illumination. In the above study conducted by Netten (1989) it was found that higher levels of lighting improved the residents' ability to find their way around in group home settings. Older people also have an increased likelihood of experiencing incontinence or of having other accidents e.g. in the kitchen. Therefore wherever possible surfaces should be easily cleaned, given that even severely disturbed people suffer shame from their mishaps (Mansa, 1994).

Peace and Willcox (1986) reviewed the legislation and central guidance for the design of local authority residential homes for the confused elderly. The main document they uncovered was devised by the Home Life Centre for Policy on Aging (1984) which makes a range of recommendations including - the desire for privacy and personal autonomy and that the building should be designed to minimise confusion and in a non-institutionalised fashion.

In summary the literature suggests that both the building itself and its interior should be designed with the physical and cognitive needs of the confused elderly in mind. However, as emphasised by Mansa (1994), despite all these alterations, the rooms should still look relaxed, warm and homely.
DESIGN OF THE SOCIAL ENVIRONMENT.

Social activity in the normal elderly decreases but older people who report involvement also express greater life satisfaction (Davies and Crisp, 1985). Therefore environments designed to promote social interaction and participation will be beneficial to most older adults. However the literature concerning the design of social environments for the confused elderly is sparse and instead most of the information presented below is drawn from the literature concerning older adults in general.

The physical environment has enormous impact on the social environment. Often chairs in residential homes are positioned around the edge of the room, an arrangement which makes it difficult for residents to see one another’s facial expressions so that cues for suitable conversation are reduced particularly for those with hearing problems (Church, 1986). However, according to Lichman and Slater (1979) interaction may be enhanced in small lounges for six to eight people or in larger rooms if chairs are grouped around a table. Davies and Crisp (1985) emphasise the fact that, for all older adults and therefore for the majority of individuals with Dementia, the changes in auditory discrimination associated with aging have design implications. Residents are more likely to be affected by background noise. Sound from the television or music is likely to limit conversation. This notion is additionally significant for the confused elderly who are even more likely to become distressed and confused if bombarded with a number of stimuli (Davies and Crisp, 1985). This implies that facilities for watching television should be separated from environments in which social interaction between clients is likely to occur.

According to Davies and Crisp (1985) residents’ feelings of control over their social environment increases when encounters are more predictable. This is achieved by reducing the number of potential users of the setting so that it is easier to recognise acquaintances and detect intruders. The authors further comment that the size of the group also affects both feelings of attachment and likelihood of conversation.

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Founders of the C.A.D.E. unit have emphasised the fact that people with Dementia find it difficult to cope with large numbers of people and the inevitable anxiety this incurs. Instead they work on the principle that a group of eight to ten people is the optimum size.

The founders of the C.A.D.E. unit have also emphasised the fact that residents will have a greater opportunity to maintain existing social networks if they are placed in small units in the local community. Larger central units are likely to put social and geographical distance between residents and their families and friends.

**DESIGN OF THE THERAPEUTIC ENVIRONMENT.**

Taft et al (1993) comments that although the majority of research has focused on designing appropriate physical environments for people with Dementia, the experienced clinician understands that staff approaches are as critical as architecture. The authors feel that writers in this area have lost sight of the crucial role that staff play in building a relationship and a culture which involves, supports and validates the human being. The authors describe five processes that affect the design of the therapeutic environment for people with Dementia. These ideas have been adapted from a model by Gunderson (1983) to suit the needs of the confused elderly. The table below outlines the five main processes which should be considered when designing a therapeutic environment for the confused elderly together with strategies for implementing these processes. It is important to note that although these processes have been separated out in this table, in reality these elements interact to form a whole greater than the sum of its parts.

**Table 1.**

<table>
<thead>
<tr>
<th>Therapeutic Process</th>
<th>Intervention Approaches</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safety</td>
<td>Provide safe environment for wandering, compensate for physical/cognitive losses, limit access,</td>
</tr>
</tbody>
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balance safety with autonomy.

**Structure**

Provide physical boundaries, mediate environmental stimuli, provide orientating cues and tasks, simplification, provide predictable frameworks for organising daily activities.

**Support**

Enhance personal choice, maintain continuity of staff, validate feelings, maintain communication.

**Involvement**

Provide social roles, maintain relationships, maintain meaningful activities.

**Validation**

Planned targeted interventions, reduce excess disabilities, full tolerance and acceptance of the individual.

A number of specific therapeutic techniques have been devised in order to provide an environment which is felt to be particularly beneficial to the confused elderly e.g. Reality Orientation and Validation Therapy (Morton and bleathman, 1988, Mckiernan and Yardley, 1989, Morton and Bleathman, 1990, Morton and Bleathman, 1991). However it is not possible to present a full discussion of these approaches in this document. It is important to briefly mention the Snoezelen, an environment which uses primary stimulation of all senses in a relaxed atmosphere. This environment has been designed to meet the needs and offer an opportunity for leisure for severely cognitive impaired individuals.
CONCLUSIONS.

In conclusion the literature suggests that there are a number of important factors which should be considered when designing the physical, social and therapeutic environment for the confused elderly. The implementation of these ideas should greatly improve the quality of life experienced by such individuals. It may be argued that the implementation of these recommendations would be extremely expensive. However, according to Mansa (1994), such changes need not involve extra cost but rather an improvement in the quality of thinking which takes place when designing the building and the service provided.

A number of the issues highlighted in this review are pertinent to all older adults and often reflect changes associated with the aging process. However other issues appear to apply particularly to the confused elderly. Although the three types of environment have been separated out for the purpose of this review, in reality they are very much interlinked and clearly have important ramifications for one another. As highlighted by Mansa (1994) for example, modifications to the physical environment will not be effective unless the principles associated are also endorsed by staff working in that environment.

All the research presented in this document relates to the design of residential care settings. However the majority of people with Dementia (80 percent) live in their own homes or with relatives (Handysides, 1993, Keen, 1989). Given the government’s emphasis on community care this number is likely to increase. Although many of the issues discussed in the review may well be pertinent to such environments, clearly there is a need for research into this area.

It seems that the literature relating to the design of environments for people with Dementia is sparse. The majority of that which does exist has been written by individuals who are involved in setting up or working in a specialist unit for the confused elderly. Although such work is beneficial, there is clearly a need for future empirical studies to support or dispute the recommendations made by such studies.
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"A Critical Discussion of the Contributions that Neuropsychology can make to the Assessment of Parkinson’s Disease."
INTRODUCTION.

Parkinson's Disease (P.D.) is the most common neuro-degenerative disorder with a prevalence of approximately 100 in 100,000 of individuals aged 80 (Lezak, 1985). P.D. is a progressive disease although the rate and degree of decline is highly variable and symptom severity shows short-term fluctuations (McCarthy and Brown, 1989). The four cardinal deficits associated with P.D. are muscular rigidity, tremor, hypokinesis (poverty and slowness of movement) and postural abnormality (Lezak, 1985). The presence of two or more of these symptoms is required for diagnosis. In addition P.D. is only diagnosed where there is no evidence, either from the client's history or a physical examination, of the presence of other diseases which may be etiologically relevant (Lezak, 1985).

P.D. is thought to originate from degeneration of pigmented cells in the brain stem, particularly the Substantia Nigra. The main form of treatment is based on neuropathology and neurochemistry, aiming to restore dopamine levels which are known to be deficient in individuals with P.D. There is no known evidence that modern therapy alters the underlying pathology of P.D. but instead it suppresses the clinical manifestations of the syndrome (Lezak, 1985).

Neuropsychological testing can make valuable contributions to the assessment of clients with P.D. However, such assessment in general and particularly for this client group has some associated problems, a number of which will be outlined below.

Before embarking on this essay it is first necessary to make two points which should be borne in mind. Firstly there are no neuropsychological tests available specifically for the assessment of P.D. clients. Instead clinicians tend to draw on the large pool of general test batteries available to them, for example the Wechsler Adult Intelligence Scale Revised (W.A.I.S-R). Therefore the results presented in this essay, unless specified otherwise, will be based on clients' performances on such general measures. Secondly, clinically relevant literature in this area is very sparse. The majority of information presented here has been drawn from general research
concerning the study of clients with P.D. Clearly however this literature forms the knowledge base about P.D. and therefore drives clinical investigations.

**THE GENERAL CONTRIBUTION OF NEUROPSYCHOLOGY TO THE ASSESSMENT OF CLIENTS WITH P.D.**

**Localisation.**

One of the key functions of neuropsychological assessment with some clients is to localise the area of the brain that has been damaged. Linked with this, Hodges (1994) emphasises the major role that neuropsychological tests can play in the cerebral localisation of higher mental functions. However P.D. is a neurological disorder primarily associated with neurochemical dysfunction mainly in the dopaminergic system. Structural pathology is very rare and therefore localisation is not possible.

**Diagnosis.**

Neuropsychological tests are generally not used in the diagnosis of P.D. since it is primarily a disorder of physical disability. However, there are a small number of neuropsychological tests which may be used in helping to detect early cases. For example individuals may show difficulties when asked to maintain a steady rhythmic movement which could be assessed with tests involving tapping sequences. In addition handwriting or attempts to draw parallel lines close together may reveal changes at an early stage (Lezak, 1985).

**Providing a test profile.**

Just about any aspect of cognitive functioning may be impaired in P.D. clients although some appear more likely to be damaged than others. Cognitive impairment in P.D. is often viewed on a continuum ranging from almost normal profiles to severe dementia. According to Boller (1980) at least three neuropsychological patterns can
be distinguished - normal cognitive functioning, the presence of specific cognitive
deficits and generalised intellectual decline.

Considerable interest has been focused on the frontal lobe functioning in clients with
P.D. Major afferent nerve projections arise from the dorso-medial nucleus of the
thalamus in the basal ganglia which link to the prefrontal cortex. This accounts for
the frontal lobe deficits that typically occur in the subcortical dementias e.g. advanced
P.D. These neuroanatomical facts have been supported by neuropsychological
assessments of P.D. individuals. Lezak (1985) compared 30 mildly disabled
individuals with P.D. with aged matched controls. The individuals with P.D. showed
no differences to the controls in terms of general intelligence, assessed using the
W.A.I.S., or on memory tests. However the P.D. group showed significant deficits
on frontal lobe tests demonstrating difficulties with shifting sets and producing a set
of perseverated responses. Hodges (1994) emphasises the fact that the
neuropsychological tests assessing frontal lobe functioning do not capture many of the
behavioural aspects of frontal lobe dysfunction. Therefore history taking from an
informant and clinical observations are particularly important in this area of
assessment.

In terms of memory, a study by Appollonio et al (1994) compared P.D. clients with
and without dementia and a group of control participants matched for age, gender and
educational level. The authors concluded that memory deficits in P.D. clients
primarily involve the conscious effortful strategic aspects of searching long-term
memory. Implicit or automatic memory which tends to require less focused attention
and fewer cognitive resources, appears to be relatively undamaged. The authors also
suggest that perceptual memory appears to be normal in P.D. clients. In addition
P.D. clients are consistently documented to have deficits in learning and remembering
new information (Appollonio et al, 1994).

Most authors have found a constellation of intellectual deficits in people with P.D.
Delis et al (1982) found in a single case study that fundamental cognitive abilities, for
example word definition, calculation and copying simple designs, were spared but
deficits were found in tasks requiring the use of higher cognitive functioning, for example explaining proverbs and solving complex nonverbal problems. The authors commented that changes in mental state in clients with P.D. tend to fall under four headings, namely intellectual processing is slowed and response latencies increase, personality and affective changes are common, diminished ability to manipulate acquired knowledge and mild memory impairment. In general P.D. clients appear to have greater difficulties on those tests which require reliance on internally generated strategies. Conversely clients appear to have fewer problems on tests where external cues or information is provided to help them perform.

The above information outlines the general trends in test profiles found when assessing clients with P.D. However authors have stressed the variation of cognitive impairment between clients. This emphasises the need for clinicians to administer a battery of neuropsychological tests to P.D. clients so that a unique test profile for each individual may be obtained.

Rehabilitation.

Neuropsychological assessment in general provides valuable information for client rehabilitation. The assessment of a client with P.D. using a battery of neuropsychological tests allows the clinician to build a picture of the strengths and weaknesses of that individual. This information is then very useful for devising a rehabilitation programme which will allow the client to build on his/her existing skills and to develop strategies to compensate for particular weaknesses. For example, a client who is found to have problems with his/her memory may be helped to acquire strategies to compensate for this.

Examining Changes over Time.

Cognitive deficits in clients with P.D. are not static. Instead the trend is towards progressive deterioration of cognitive abilities over time (Piccirilli et al, 1994). For this reason, neuropsychological assessment is a vital tool for estimating the extent of
cognitive deterioration over time for a particular individual. This is achieved by testing the client at various intervals in time and comparing the results against previous test performances in order to ascertain the extent and rate of cognitive decline.

Similarly neuropsychological assessment can be used to examine the impact of anti-Parkinsonian medication. Such medication, although extremely beneficial for some clients in alleviating physical symptoms, can also cause numerous side effects including confusion, depression and memory impairment. Neuropsychological tests can be used to assess whether pharmacological treatment is causing or exacerbating cognitive impairment. This is achieved by testing the client whilst on the medication to establish a baseline and then retesting after medication withdrawal.

**Subcortical Dementia in People with P.D.**

There is considerable controversy over the prevalence of dementia in people with P.D. and estimates range from 0 - 90 percent. The characterisation of the type of dementia experienced by clients with P.D., together with attempts to detect specific and/or selective deficits in the early stages of the disease, have been two major goals of neuropsychological research (Piccirilli, 1994).

Neuropsychological assessment of individuals with severe cognitive impairment produces a profile suggestive of subcortical dementia. This form of dementia is now applied to a range of basal ganglia and white matter diseases (Hodges, 1994). This form of dementia is characterised by the following attributes - impairment in attentional control and frontal lobe executive functioning; clients appear slowed up with a marked deficit in the retrieval of information; spontaneous speech is reduced and answers to questions appear slow and laconic; changes in mood, personality and social conduct are common; clients are often inert, indifferent and uninterested; memory is impaired mainly as a result of reduced attention and hence poor encoding of new information; recognition is typically much better than spontaneous recall; and
perceptual and visio-spatial ability tends to be impaired. Unlike people with Alzheimer's disease (i.e. cortical dementia) aphasia, agnosia and apraxia are characteristically absent at least in the early stages of subcortical dementia.

This distinction between the two dementias is controversial. Some authors feel that the intellectual deterioration seen in P.D. may result from cortical degeneration superimposed onto the subcortical degeneration responsible for the motor disturbance (Mayeux et al, 1983). Assessments of individuals with P.D. and marked cognitive impairment often reveal similar profiles to that outlined above (Delis et al, 1982). In addition Huber et al (1986) compared the neuropsychological test performance of three groups of individuals namely those with alzheimer's disease, those with P.D. and a group of controls. The results differentiated the two dementia syndromes and the pattern of performance was consistent with cortical and subcortical hypotheses. This debate is currently ongoing and neuropsychological assessment of clients with P.D. provides valuable information for furthering our knowledge in this area.

Research.

Neuropsychological assessment is an important vehicle for advancing our knowledge about P.D. Pillon et al (1989), for example, analysed the neuropsychological performance of P.D. participants in relation to motor symptoms to study the neuronal basis of cognitive disorders in P.D. The authors found that cognitive impairment correlated poorly with akinesia and rigidity (i.e. symptoms which respond strongly to levodopa) but the neuropsychological scores correlated strongly with axial symptoms such as gait disorder which respond little if at all to levodopa. The authors concluded from this study that much of the cognitive impairment in P.D. results from the dysfunction of non-dopaminergic neuronal systems.

A second strand of research conducted by Cooper et al (1994) investigated slowed response speed in 100 clients with P.D. using Simple Reaction Times and Cross-modality Choice Reaction Times. The authors concluded from this research that slowed response latency appears to be due to two separate factors. Firstly a non-
cognitive factor which is related to depression and impoverished motor control. The second factor is a cognitive analytical factor which delays all mental operations between the stimulus and the response.

Such research not only enhances our knowledge base about P.D. but can also be used to further our understanding about the neuropsychological functioning of healthy individuals.

**PROBLEMS WITH NEUROPSYCHOLOGICAL ASSESSMENT WITH CLIENTS WITH P.D..**

Many of the difficulties associated with the administration and interpretation of neuropsychological tests with individuals with P.D. are not specific to this disorder but rather are general issues associated with the assessment of people with physically disabling conditions. Clearly physical symptoms need to be taken into account when administering timed tests and those where accurate manual control is important, for example Object Assembly and Block Design on the W.A.I.S(R). All tests of performance may be affected by motor slowness. In addition, motor slowness affecting speech may account for slow response rates rather than diminishment of grasp or impairment of reasoning ability (Lezak, 1985). Scoring criteria may therefore need to be adjusted accordingly.

An additional consideration is that physical symptoms in P.D. are sensitive to physical and emotional stress. Tremor, for example, may be worsened by anxiety or excitement. Therefore such symptoms are likely to be worse during a more demanding task. Linked with this, a symptom associated with P.D. is marked fatigue (Lezak, 1985). The test administrator should therefore be sensitive to both these issues and should plan in regular breaks and terminate testing, rescheduling to meet the client at a later date if it is felt that either marked deterioration of physical symptoms or tiredness is interfering with the client’s test performance.

Idiopathic P.D. is a condition characterised by fluctuating states or On/Off phases.
In order to obtain a true reflection of the client’s cognitive abilities, he/she should be tested when his/her physical symptoms are at their least disabling i.e. when he/she is in the On phase. A study by Delis et al (1982) compared the neuropsychological performance of an individual with P.D. in the On and Off phases and found alterations in cognitive ability, although modest, between the two states. During the Off phase the authors noted a general deterioration of articulatory agility, decline in memory and increased perseveration. In addition, because of severe akinesia, it was impossible to administer any tests which required motor performance in the Off state. These results provide evidence in support of testing clients in the On phase where one is most likely to gain a clear picture of the individual’s actual abilities. However, if the psychometric tests are being conducted to assess the effects of medication, it might be useful to conduct testing in both the On and Off phases by using appropriate tests with alternative forms.

There are a number of other difficulties associated with evaluating the cognitive status of individuals with P.D. Motivational or emotional factors may, in some cases, account for failure to perform on tests rather than restriction of intellectual capacity. P.D. itself is associated with depression and it is one of the possible side effects of anti-Parkinsonian medication. Clients with P.D. are significantly more likely to be depressed than aged matched controls (McCarthy and Brown, 1989). The cause of this depression is unknown although according to McCarthy and Brown (1989) it is likely to be due to the presence of a permanent and severe disability. Clearly when conducting a neuropsychological assessment it is important to assess the client’s mood state and, if he/she is depressed, this should be borne in mind when interpreting the test results given that depression is known to interfere with cognitive functioning, particularly memory.

As highlighted above, anti-Parkinsonian medication causes many unwanted physical side-effects and may have a direct impact on cognitive functioning. When conducting a neuropsychological assessment with a client with P.D. it is therefore crucial to obtain information from the client about his/her medication e.g. type and dosage. In addition the clinician should also be aware when interpreting test results that the
medication may have had an effect on the client’s test performance.

Finally it is important to bear in mind that P.D. is a condition that tends to occur in older adults with the average age of onset around 55 years (Lezak, 1985). It is therefore crucial that age appropriate tests are selected for the assessment of this client group. In addition the client’s performance should be matched against age appropriate norms so that deficits on the psychometric tests are distinguished from difficulties typically experienced by the aging population.

CONCLUSIONS.

Due to the nature of the disease process in P.D. some of the traditional functions of neuropsychological testing, for example diagnosis, are not applicable to this client group. However, such testing has proved extremely useful in identifying individual clients’ strengths and weaknesses and for furthering the knowledge base about the disorder itself. In addition, given that P.D. is a progressive and often fluctuating condition, neuropsychological testing is also useful for identifying changes in cognitive functioning over time.

However, for many reasons, the results obtained from neuropsychological testing should be viewed with caution. The physical symptoms associated with the disorder and the pharmacological treatment prescribed are just two of the factors that may interfere with test performance.

In summary, neuropsychological assessment can contribute a great deal to both the assessment of P.D. and enhancing our knowledge about the condition as long as the reasons for testing are appropriate and the factors outlined in this essay are borne in mind when interpreting the test results.
REFERENCES.


"A DISCUSSION ON THE SELECTION CRITERIA USED TO ASSESS SUITABILITY FOR COGNITIVE THERAPY AND PSYCHOTHERAPY."
INTRODUCTION.

Over the past twenty years, there has been a trend towards the development of short-term therapies. Since not all individuals can benefit from such treatment, this change has emphasised the need for clinicians to assess suitability of clients prior to the commencement of therapy. The development of selection criteria has been led by Psychodynamic Therapists spurred on particularly by the introduction of brief Psychotherapy (Sifneos, 1979, Malan, 1976, Davanloo, 1980, Mann, 1973). In contrast, Cognitive Therapists have traditionally placed less emphasis on the systematic evaluation of client suitability than their psychodynamic counterparts. However this situation appears to be changing.

In this essay, a summary of the literature concerning selection criteria used in Psychotherapy and Cognitive Therapy will be presented followed by an attempt to highlight the similarities and differences between the two fields. Whilst reading this essay, it should be borne in mind that most of the literature in this area is applicable to the practice of short-term rather than longer-term therapeutic intervention.

PSYCHODYNAMIC PSYCHOTHERAPY.

A review by Bachrach and Leaff (1978) based on 24 papers suggested a large number of characteristics which are felt to reflect suitability for classic Psychoanalytic Therapy. Most suitable individuals are those whose functioning is generally adequate, who have good ego strength, affective reality testing and who are able to cope flexibly, communicate verbally, think in secondary process terms and regress in the service of the ego with sufficient intellect to negotiate the tasks of Psychoanalysis. Furthermore, their symptoms are not predominantly severe and their diagnoses falls within the neurotic spectrum. Such individuals are able to form a therapeutic alliance, are relatively free of narcissistic pathology, have good object relations with friends, parents and spouses and have been able to tolerate early depravation and separation without damage to object constancy. They are individuals who are motivated towards self understanding and relief of personal suffering. They have
good tolerance to strong emotions and are able to deal with surges of feelings without loss of impulse control. In addition their character and traits are suited to Psychoanalysis (i.e. they are psychologically minded) and their superegos are integrated and tolerated. Finally they are individuals mainly in their late twenties and early thirties who have not experienced past Psychotherapy failures. Bachrach et al (1991) highlight that of all the qualities listed, those related to ego strength and object relations are the most significant.

Clearly Bachrach and Leaff’s (1978) review identified a tremendous number of selection criteria and, if these were to be employed, the majority of individuals referred for therapy would be excluded. Furthermore, these characteristics were based mainly on the clinical experience of the authors rather than scientific research findings.

With the introduction of brief Psychodynamic Therapy, authors began to try to define in clear terms criteria which predicted suitability to such treatment. Sifneos, one of the first writers in this area (1979) argued that the following criteria were predictive of a good outcome in his approach - above average intelligence, a history of at least one meaningful relationship, an ability to interact well with the evaluator, motivation to change and a circumscribed chief complaint. In 1987 Sifneos extended his list of suitability criteria to include - psychological mindedness, no history of psychosis, substance misuse or major affective disorder and absence of suicidal tendencies, acting out or severe character pathology. Other authors list similar characteristics especially the exclusion of individuals with psychosis, severe personality disorders and acting out tendencies.

Clearly there is much overlap in the characteristics which have been deemed as important criteria for assessing suitability to both Psychoanalysis and brief Psychotherapy. However each author has articulated his/her own selection criteria in a slightly different way. A good summary is provided by Davanloo (1980) who first identified five selection criteria which assess client suitability to Psychotherapy in general:-
1. Shows evidence of ego strengths e.g. intelligence, sexual adjustment.
2. Has had at least one meaningful relationship in the past.
3. Has a capacity to interact with the therapist in the first session i.e. is able to form a positive transference.
4. Shows an ability to think in psychological terms i.e. is able to accept interpretations and shows a capacity for insight.
5. Has an ability to experience his/her own feelings and emotions.

The authors emphasise the fact that these factors are relative although a client's failure to meet one of the criteria may be counter-indicative to Psychotherapy. The authors go on to identify two further criteria which could be used for assessing client appropriateness for brief Psychotherapy namely -

1. The existence of a focal conflict.
2. The existence of a clear-cut and strong motivation to change.

Hogland (1993) highlights the fact that, although some clinicians implicitly use some of the selection criteria outlined above, limited research evidence for their utility exists. Evaluation of pretreatment quality of interpersonal relationships has been significantly correlated with outcome in several studies (Moras and Strupp, 1982, Horowitz et al, 1984, Noel et al, 1985, Piper et al, 1985, Husby, 1985, Luborsky et al, 1988, Piper et al, 1990) but the value of other criteria have only been modestly confirmed by some research (Garfield, 1986). Furthermore, variables from DSM-III have shown a more consistent predictive validity in treatment research (American Psychiatric Association, 1980). A review of the literature by Reich and Green (1991) concluded that individuals with personality disorders show poorer and slower responses to treatment than individuals without character pathology. Hogland (1993) comments that a measure of overall severity of mental disorder, axis 5 on DSM-III, has been shown to be an important predictor of outcome. In order to address these issues, Hogland (1993) studied the predictive power of the selection criteria proposed by Sifneos (1972) and Malan (1976) against axis 2 and 5 of DSM-III. The authors found that dynamic change two and four years after Psychodynamic therapy could be significantly predicted by patient characteristics although their ability to predict...
symptomatic change was far less significant. The most consistent predictors were axis 2 and 5 of DSM-III and suitability to Psychodynamic therapy as represented by quality of interpersonal relations. The Psychodynamic selection criteria were found to be highly inter-correlated and could be represented by one variable, quality of interpersonal relations. All the other selection criteria appeared redundant in that none of them predicted any additional outcome over and above this variable. Hogland (1993) concludes that as the goals of Psychotherapy aim towards long-term dynamic improvement in addition to symptom relief, his research supports the notion that suitability criteria should be based on an evaluation of the client beyond his/her illness.

**COGNITIVE THERAPY.**

As stated in the introduction, Cognitive Therapists have traditionally placed less emphasis on the assessment of client suitability. One of the first papers written in this area was by Beck et al (1979) who articulated criteria related to the assessment of depressed clients for suitability to cognitive therapy rather than pharmacotherapy. His criteria included - variable mood reaction to environmental events, failure to respond to antidepressants and diagnosis of major depression. Similarly Fennell and Teasdale (1987) found that clients with depression who strongly endorsed the Cognitive conceptualisation of depression, who reported a positive response to initial homework assignments and who, prior to treatment, achieved a higher score on a measure of depression, showed a more rapid response to Cognitive treatment. The authors concluded from these results that the process of change for slow and rapid responders to treatment may be different and that therefore the delivery of Cognitive Behaviour Therapy should be modified accordingly.

Both the above studies targeted a particular client group i.e. individuals with depression. More generally, Persons et al (1988) found that clients who achieved a low initial score on the Beck Depression Inventory, complied with homework assignments and showed no endogenous symptoms, were more likely to benefit from Cognitive intervention. The same authors also suggested that premature termination
was more likely when working with people with personality disorders. It has also been suggested that Cognitive Therapy may be most effective with clients who are engaged, involved and motivated for treatment and where there is a match between the cognitive model and client expectations of therapy. Support for these ideas has been provided in a number of recent studies, Beckham (1989), Burns and Nolen-Hoeksema (1991) and Burns and Nolen-Hoeksema (1992).

Safran et al (1993) noted that although the above selection criteria formed a starting point, there was no systematic framework for evaluating patient suitability for Cognitive Therapy. They therefore derived a semi-structured interview to assess client Suitability to Short-term Cognitive therapy with an Interpersonal Focus (the S.S.C.T.)

When developing the S.S.C.T. the authors attempted to reflect the treatment rationale proposed by Beck et al (1979) as well as incorporating many of the newer theoretical and technical developments that have taken place in Cognitive Therapy over the past fifteen years. These included the growing emphasis on the importance of the therapeutic relationship (Safran and Segal, 1990), the recognition of the importance of interpersonal manoeuvres and defensive information processing to maintain personal security and reduce anxiety (Safran and Segal, 1990) and the greater emphasis on the role of emotions in the change process (Mahony, 1991). In addition when devising the interview the authors were guided by the literature concerning the development of selection criteria devised by brief Psychodynamic Therapists.

Over a five year period, the authors devised a semi-structured interview based around nine selection criteria namely -

1. Accessibility of automatic thoughts i.e. an evaluation of the client's ability to access negative self critical thinking.
2. Awareness and differentiation of emotions i.e an assessment of the client's ability to distinguish between different emotional experiences and experience, in the session, emotions relevant to his/her problem.
3. Acceptance of personal responsibility for change.

4. Client compatibility with the Cognitive rationale i.e. the extent to which the client views the goals and tasks of Cognitive Therapy, described by the therapist, as relevant to him/her.

5. Alliance potential (in session evidence) i.e. the client’s potential capacity to form a therapeutic alliance within a short-term time frame.

6. Alliance potential (out of session evidence) i.e. an assessment of the client’s capacity to form a relatively trusting relationship within a short-term time frame based on evidence from his/her previous relationships.

7. Chronicity of problem i.e. duration of problem. It is hypothesised by the authors that chronic long-term problems represent the presence of enduring dysfunctional character styles which may not be amenable to change in the short term.

8. Security operations i.e. the extent to which the client employs defensive information processing strategies or interpersonal manoeuvres to reduce anxiety.

9. Focality i.e. the client’s ability to remain problem focused which is particularly important given the time limit.

Safran et al (1993) evaluated the S.S.C.T. and suggest that preliminary evidence support the reliability and construct and predictive validity of the S.S.C.T. The authors did comment that the Chronicity item did not discriminate between the clients that were and were not accepted for Cognitive Therapy and therefore the importance of this selection criteria needs to be explored further in the future. The authors conclude by highlighting the fact that the S.S.C.T. was devised particularly for Cognitive Therapy with an Interpersonal focus but that future research should focus on identifying how this measure might be altered to differentiate individuals who might benefit from Cognitive Therapy as opposed to other treatment approaches.
SIMILARITIES AND DIFFERENCES BETWEEN THE CRITERIA USED IN COGNITIVE AND DYNAMIC APPROACHES.

The initial selection criteria proposed by both Psychotherapists and Cognitive Therapists were linked very closely to the techniques used in the therapies they were aiming to assess suitability for. Fennell and Teasdale (1987) for example emphasised the fact that clients suitable for Cognitive Therapy should show an initial positive response to conducting homework assignments. Similarly many of the criteria presented in the literature review by Bachrach and Leaff (1978) on assessing client suitability for classic Psychoanalysis, were connected to dynamic concepts e.g. the ego and superego. At this time therefore there was little resemblance between the selection criteria articulated by the two approaches.

However, more recently, the literature suggests that there is now a great deal of overlap between the suitability criteria used by the two fields. There may be a number of explanations for this growing similarity and in reality it is likely to have occurred due to a culmination of factors. Firstly, as stated in the introduction, in both the Cognitive and Psychodynamic approaches there has been a move towards the provision of short-term intervention. Clearly not all individuals can benefit from such an approach and therefore therapists generally have had to think more carefully about assessing suitability for short-term treatment. There appear to be a number of common factors which suggest that a client is appropriate for short-term intervention. In particular both schools of thought stress the importance of a focal conflict or problem (Davanloo, 1980, Safran et al, 1993). Similarly both Safran et al (1993) and Davanloo (1980) emphasise the fact that clients suitable for short-term treatment must show motivation to change.

A second factor influencing the overlap between criteria stems from the fact that advances in both Cognitive and Psychodynamic approaches has led to a growing similarity between the ways in which therapists from both fields understand client situations and provide interventions. For example, Psychodynamic Therapists are now placing more emphasis on short-term interventions, something which in the past
was traditionally associated with Cognitive Therapy. Similarly, there is a growing emphasis in Cognitive Therapy on the importance of the therapeutic relationship (Safran and Segal, 1990) a concept which in the past has been traditionally associated with Psychodynamic Therapy.

The third and final factor relating to the similarity between the two schools is that the literature concerning selection criteria used in Psychodynamic Therapy, guided the development of selection criteria for Cognitive Therapy (Safran and Segal, 1990). It is therefore perhaps not surprising that there is so much overlap between the two approaches.

Arkowitz and Hannah (1989) compared the selection criteria used in Cognitive Therapy and Psychodynamic Therapy and suggested that both are similar concerning the degree to which clients must be able and willing to comprehend and verbally express themselves. In addition the authors suggest that both approaches emphasise applications to people with depression and anxiety although both have been extended to a variety of other clinical problems.

It is also important to highlight that there are key differences between the selection criteria proposed by the two fields. Given that the treatment goals and working strategies of Dynamic Therapy are in many ways distinct from those used in Cognitive Therapy, one would expect that clients will be required to engage in different treatment tasks and hence suitability for the two forms of treatment is likely to vary. For example Cognitive Therapists stress the notion that suitable clients should have access to their automatic thoughts. In contrast Dynamic Therapists emphasise the idea that clients should show signs of being able to form a positive transference with the therapist.

Further articulation of the differences between the two fields may enable clinicians in the future to match clients with the form of therapeutic intervention which is most suited to them. For example a preliminary study by Beutler et al (1991) found that whilst Cognitive Behavioural Therapy achieved its most effective interventions with
clients with externalising coping styles, Focused Expressive Psychotherapy yielded its best results with internally focused individuals. Future investigation into this area may prove extremely valuable to clinicians.

Finally in this section a number of criticisms may be launched at the selection criteria identified by the two approaches. Both models tend to select individuals with more acute psychological problems and exclude those with more chronic psychiatric difficulties. Both classical Psychoanalysis and brief Psychotherapy exclude individuals with severe personality disorder and psychotic conditions. Although recent developments in the field of Cognitive Therapy have involved devising strategies for working with clients with long term mental health problems, such individuals are not catered for in the suitability criteria which have been articulated by Cognitive Therapist. The literature suggests that a large number of individuals with acute, or transient, psychological problems will recover within six months to a year whether or not they receive psychological intervention. This therefore decreases the value of outcome studies conducted with such select clients. Furthermore, the exclusion of people with long term mental health problems will led to a self fulfilling prophesy that such individuals can not benefit from psychological intervention.

CONCLUSIONS

Much of the literature presented in this essay is not based on scientific research but rather the experience of clinicians. Although this is clearly valuable, future research needs to establish the validity of the criteria proposed. Studies in both areas have provided some positive evidence for the utility of certain criteria. However, much further research is necessary before any definite conclusions can be drawn.
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Specialist Essay

"AN OUTLINE OF PROCHASKA AND DICLEMENTE'S TRANSTHEORETICAL MODEL OF BEHAVIOUR CHANGE AND ITS APPLICATION TO HEALTH PSYCHOLOGY."
INTRODUCTION.

The introduction of the transtheoretical model of behaviour change (Prochaska and DiClemente, 1983) had a tremendous impact on the areas of health psychology and addictions (Prochaska, 1986, Stockwell, 1992). In a recent survey of multidisciplinary team members working with individuals with alcohol dependence, Prochaska and DiClemente's (1983) paper was the article that the majority cited as the most influential over them in the 1980s. Stockwell (1992) suggests that part of the reason for the popularity of the model stems from its simple elegance. In addition, the model was derived at a time when there was growing dissatisfaction in the field with traditional models of behaviour change.

In the following essay an outline of Prochaska and DiClemente's model of behaviour change will first be presented. This will be followed by a discussion of the application of this model to the field of health psychology. It should be borne in mind that Prochaska and DiClemente's model was, when it was initially proposed, applied mainly to smoking cessation.

THE TRANSTHEORETICAL MODEL OF BEHAVIOUR CHANGE.

Prochaska and DiClemente (1983) attempted to derive a comprehensive, transtheoretical model of behaviour change. They aimed to produce a model which would be applicable to various forms of problem behaviours and which could be utilised by various individuals, namely those in brief therapy, inpatients and self helpers. They hoped to incorporate aspects of numerous treatment approaches. The authors noted that most change theories were based on speculation of how professionals assumed people made changes rather than on research of how people actually change (Prochaska et al, 1993). The model was therefore derived from a study comparing the processes used by smokers attempting to quit on their own with those in two treatment programmes (Prochaska and DiClemente, 1982). A three dimensional model was derived outlining the stages, processes and levels of behaviour change.
Stages of change.

Prochaska and DiClemente (1983) suggested that behaviour change requires movement through discrete motivational phases over time. They developed a model suggesting that readiness to change is a continuous process evolving through a series of stages. Since its derivation, the stages of change have undergone minor modifications. The five stages of change currently hypothesised are pre-contemplation, contemplation, preparation, action and maintenance (DiClemente et al, 1991). For definitions of each stage see Table 1.

Prochaska et al (1985) comment that individuals move through the change cycle in various ways. Most people, rather than moving linearly through the five phases, show a more cyclical pattern whereby they may revolve around the cycle a number of times before maintaining their behaviour change and exiting the cycle. In addition, individuals may relapse in the cycle at any time, regressing to previous stages. Miller and Baca (1983) estimated that on average self changers make three serious revolutions through the cycle before sustaining a permanent change in behaviour.

Table 1.

The five stages of change involved in quitting smoking (Prochaska et al, 1993).

<table>
<thead>
<tr>
<th>Stage</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-contemplation</td>
<td>not thinking about quitting smoking at least in the next six months.</td>
</tr>
<tr>
<td>Contemplation</td>
<td>seriously thinking about quitting within the next six months.</td>
</tr>
<tr>
<td>Preparation</td>
<td>preparation to quit in the next month.</td>
</tr>
<tr>
<td>Action</td>
<td>0 to six months which occurs after the smoker has quit smoking.</td>
</tr>
<tr>
<td>Maintenance</td>
<td>Begins six months after abstinence and continues until smoking does not exist as a problem.</td>
</tr>
</tbody>
</table>
Processes of change.

The processes of change are hypothesised to be the covert and overt strategies that individuals use to modify their problem behaviour i.e. to move through the stages in the cycle of change. These independent variables were felt to be needed for change to occur within, between and without therapy sessions (Norcross and Prochaska, 1986a, and 1986b). In a comparative study of 29 major systems of therapy, Prochaska (1984) identified ten basic processes of change. For a list of the ten change processes see Table 2. Although the ten processes have their origins in very different systems of therapy, the authors highlight the notion that individuals are able to integrate these supposedly incompatible processes. A 40 item questionnaire was developed to measure the ten processes used by smokers (Prochaska et al, 1988). Analysis of this questionnaire yielded two secondary factors relating to the ten primary processes. The two factors were termed experiential and behavioural and each was found to be composed of five primary factors. The experiential factor relates to processes which involve cognitive and effective activities and the behavioural factor emphasises processes used by clients in the active phase of change.

The integration of the above two levels suggests that the processes assume different priorities to individuals according to the stage of change at which the individual is at. In a study of 872 smokers, Prochaska and DiClemente (1983) found for example that whilst smokers utilised consciousness-raising the most during contemplation, they used self re-evaluation, helping relationships and reinforcement management during the action phase and counter-conditioning and stimulus control during both action and maintenance. These data provide valuable information for improving the effectiveness of smoking cessation programmes and self help approaches. Rather than assuming that all smokers are ready for change, as is often the case in most behaviour programmes, a client may be assessed according to the stage of change he/she is in and, according to this assessment, appropriate change processes may then be selected as intervention strategies. Therefore whilst consciousness-raising might be utilised
with individuals in the contemplation stage, more behavioural strategies would be more applicable to those ready to make changes.

Table 2.

The ten processes of change proposed by Prochaska (1984).

1. Consciousness raising
2. Self re-evaluation
3. Self liberation
4. Social liberation
5. Stimulus control
6. Environmental re-evaluation
7. Counter conditioning
8. Reinforcement management
9. Dramatic relief
10. Helping relationships.

Levels of Change.

Prochaska (1986) comments that although it is possible to isolate some problem behaviours, more often they occur in a context of complex interrelated levels of human functioning. The levels of change represent a hierarchical organisation of five distinct but interrelated dimensions of psychological problems that are addressed in treatment, namely symptom situational, maladaptive cognitions, interpersonal conflicts, family system conflicts and intra-personal conflicts. Prochaska (1986) emphasises the importance in the process of change that both client and therapist are in agreement as to which level they attribute the problem and on which level(s) they are willing to work to change the problem behaviour.

Integrating the levels with the stages and processes of change provides a model for intervening hierarchically and systematically across a broad range of therapeutic content.

Two additional intervening variables have been hypothesised to affect behaviour change, both of which stem from important psychological theories. Social Cognitive
theory (Bandura, 1977) suggests that confidence in one’s ability to perform a specific behaviour, i.e. self efficacy, is strongly related to one’s actual ability to perform it. The concept of self efficacy has been incorporated in to the change model. Efficacy expectations were found to be highly related to ability to maintain smoking cessation and movement through the stages (DiClemente et al, 1985).

The second influential variable comes from the model by Janis and Mann (1977) which concerns decision-making. It was conceptualised as a conflict model with all relevant information entered on to a balance sheet of comparative potential gains and losses. The original model proposed four factors underlying the decisional-balance. However Prochaska et al (1985) constructed a 24 item decision-balance measure to study this across stages of change of 700 smokers. Two orthogonal components were revealed, namely the pros (reasons for) and cons (reasons against) smoking. Furthermore, highly predictable patterns were found when relating the pros and cons of decision-making to the stages of change in that the move from pre-contemplation to action involved an increase in pros for change and a decrease in the cons of change.

THE APPLICATION OF THE TRANSTHEORETICAL MODEL TO HEALTH PSYCHOLOGY

Thus far in this paper, the focus has concerned the transtheoretical model in general. Although the model was proposed as a general theory of behaviour change, it was actually derived and has undergone the majority of research in relation to individuals attempting to quit smoking. This immediately forging a relevance to health psychology where a proportion of the clients seen are referred for help with giving up smoking.

Furthermore, clinicians working in health psychology are often based in settings where individuals with physical illnesses, such as cancer, chronic obstructive airways disease, heart disease and emphysema, in which smoking is often a crucial etiological factor and continues to contribute to deterioration in the client’s physical health. Health psychologists are often called upon to run groups for such clients.
The application of the transtheoretical model to this area of health work has proved particularly useful for a number of reasons. Previous models of behaviour change have tended to be action orientated, expecting clients to quit smoking in the first few weeks. However, a study by Pallonen et al (1994) found that only 10% of participants were prepared to give up smoking in the next thirty days and could immediately benefit from participating in traditional cessation programmes. The transtheoretical approach allows one to extend smoking cessation programmes to the majority of individuals even if they are not currently prepared to quit smoking. The model emphasises the matching of the content of intervention to the smokers readiness to change. It therefore allows services to target the whole spectrum of smokers and could therefore have significant public health impact. Client centred stage matched counselling is likely to be more effective whereby the clinician can match the intensity and type of intervention provided to that individual and his/her position on the change cycle. A further consideration is that a large proportion of individuals prefer self change and report that if they were to quit smoking they would not attend a formal treatment programme (McAlister, 1975). Again there is a role in such circumstances for health psychologists who could be responsible in medical settings for the dissemination of self help information. Self help manuals have been developed for each of the five stages of change. A two year study by Pallonen et al (1994) suggested that manuals were able to accelerate the smoking cessation process although it was concluded that the manuals alone may not constitute a sufficient long-term intervention. However such interventions may, for some individuals, facilitate movement through the stages, hence motivating them to seek further assistance with behaviour change.

There is also evidence to suggest that the transtheoretical model is applicable to other areas of health psychology. A number of studies have shown that the model is applicable to other areas of health behaviour change, including weight control (Rossi et al, 1994), quitting a high fat diet (Bowen et al, 1994), HIV prevention (Prochaska et al, 1994c), condom use (Grimley et al, 1995), exercise acquisition (O’Connor, 1994) and physicians prevention of disease (Cohen, 1994). Some of these involve the cessation of negative behaviour and others the acquisition of positive behaviour.
As with smokers, Rossi (1992) in a random digit dial survey of 1067 individuals with a variety of fifteen health risk behaviours, found that only 10 to 20 percent of respondents were prepared to take action and 40 to 80 percent were in pre-contemplation. Again this emphasises the need for an approach that focuses on the stages that precede and follow action.

Prochaska et al (1994a) supported the generalisability of the stages of change, decisional-balance and their integration to twelve health behaviours. Furthermore in a follow-up study, Prochaska (1994b) suggested that two principles were associated with progression from pre-contemplation to action, namely an increase of one standard deviation in the pros of the health behaviour and a decrease of 0.5 standard deviation in the cons of the health behaviour. These results have implications for both clinicians working individually with clients and for the development of public health policies. In terms of individual work, the processes identified for causing movement through the change cycle, such as consciousness raising and self re-evaluation, may be utilised by clinicians to increase the perceived pros for the client of healthy behaviour change i.e. helping the individual to become aware of the benefits of cessation and the negative consequences of not changing. Similarly, health policies may be dedicated to increasing the pros of healthy behaviour change and the cons of not changing.

As well as smoking cessation, the transtheoretical model of change appears to have had a large impact on two other areas of health psychology, namely weight and dietary control and HIV prevention.

In terms of diet and weight control, health psychologists are likely to receive individual referrals and/or to run groups with individuals with such problems. Such issues are often more prominent for individuals with health problems, such as heart disease or diabetes, where the prognosis of the condition is made worse if the individual concerned also has a weight problem. A number of studies have demonstrated the utility of the change model to these areas. Studies of high fat consumption (Curry et al, 1992, Greene et al, 1992) found that pre-contemplators had a significantly higher fat intake than individuals in later stages. Adopting the
transtheoretical approach with individuals with weight problems allows the definition of concrete and easily measurable stages that may be applied to the whole population of overweight individuals at different levels of motivation. In addition the processes associated with the stages also provide direct implications for intervention. However, a study by Bowen et al (1994), suggested that the actual number and description of the processes used by individuals attempting to adopt a low fat diet varied slightly from those utilised by those giving up smoking. The processes most closely linked to methods of behaviour change, stimulus control and counter-conditioning, recombined to form a new process, namely nutritional and behavioural strategies. This change was hypothesised by the authors to be related to the dual nature of dietary behaviour and the fact that both of these changes would need to be made when adopting a low fat diet. The second difference was that self liberation disappeared as an independent factor. This suggests that the move to claim personal freedom is less clear for dietary change.

The second area of application in health psychology is in the promotion of safer sexual practises for preventing both unwanted pregnancies and the transmission of sexually transmitted diseases, particularly HIV. The main interventions provided by psychologists and other health professionals have involved devising programmes aimed at persuading individuals at risk to use condoms and other contraceptives. However few theories in this area are grounded in behaviour change (Fisher and Fisher, 1992) and there is therefore a lack of a systematic framework for intervention. A study by Galavotti et al (1995) supports the utilisation of the transtheoretical model in this field. However the authors highlight that the model does not address the fact that for this area in particular, behaviour is not under one person's control but instead the individuals use of contraception may well be affected by his/her partner's view on this subject.

In summary, preliminary evidence suggests that the transtheoretical model is applicable to a number of issues addressed by health psychologists. In clinical trials staged matched programmes have typically produced two and a half to three times the success, as judged by clinical criteria, of traditional action orientated programmes in trials of smoking (Prochaska et al (1992), high fat diets (Campbell et al (1994) and
preventative screening (Skinner et al, 1994). However much further research is needed before definite conclusions about the clinical utility of the model may be drawn. Many of the studies conducted thus far have been cross sectional investigations and there is a clear need for further longitudinal research. In addition, the model needs to be applied to new areas with caution. The data suggest that it is broadly applicable to many forms of behaviour although slight modifications to the model may need to be made so that it is specifically suited to the particular issue under investigation. However the flexible structure of the model lends itself to such modifications.

CONCLUSIONS.

Prochaska and DiClemente (1995) highlight the fact that in both the field of addictions and health psychology, the introduction of the transtheoretical model has enabled intervention programmes to reach, maintain and help many more people recover from self defeating or destructive behaviours. The question has been raised concerning why this model has had such impact on the field of health psychology but not on mental health. Prochaska and DiClemente (1995) report that the reason for this is partly accidental in that funding for their research was provided by the National Institute of Cancer Research and therefore the research has advanced mostly in the area of health promotion and in particular smoking. Prochaska and DiClemente (1995) also suggest that health psychology is a younger discipline driven more by data than doctrine, unlike the more traditional area of mental health. Finally they comment that in almost all areas of health promotion and addiction, traditional approaches have not reached the vast majority of individuals and have failed to produce behaviour change in the vast majority that they have reached.

In general the transtheoretical theory appears to have led to a paradigm shift in the field of health psychology. There has been a move away from an action paradigm that views change as occurring when action happens which is being replaced by a new paradigm which views action as only one of the stages that individuals progress through when overcoming chronic health problems. In conclusion, the transtheoretical
model has provided an insight into the global understanding of human behaviour change that can transcend specific behavioural problems.
REFERENCES.


British Journal of Addictions, vol. 87 (6), 830-832.
SECTION II

CLINICAL
CLINICAL SUMMARY.

The clinical section contains the following elements -

1. A list of the six clinical placements undertaken during the three years of clinical training.

2. The placement contract, drawn up between myself and the relevant clinical supervisor, for each of the six placements.

3. A summary of each of the five clinical case reports submitted with this portfolio but not bound into this volume.
CLINICAL PLACEMENTS.

Over the course of my three years of clinical training I have undertaken the following six placements.

1. Core Adult placement over 70 days, based at Kingston hospital under the supervision of Rhona Trotter.

2. Core Learning Disabilities placement over 71 days, based at Normansfield Hospital, under the supervision of Tony Ovenell.

3. Core Child and Adolescent placement over 74.5 days, based at the Royal Surrey County Hospital (for two days per week) under the supervision of Dr. Olwyn Wilson. In addition half a day per week was spent with the Family Therapy team at Kingston hospital under the supervision of Reta Harris.

4. Core Older Adults placement over 72 days, based at Barnes Hospital, under the supervision of Farzad Shamsavari.

5. Specialist placement in Health for two days per week over 7 months, based at Kingston Hospital under the supervision of Catherine Dooley.

6. Specialist placement in Bulimia for 1 day per week over seven months, based at the Richmond Royal Hospital, under the supervision of Benna Waites.

For a list of all the clinical logbooks and evaluations forms relating to these six placements, refer to the clinical appendix at the end of this document.
SUMMARY OF CASE REPORTS.

The following information relates to the five case reports submitted, along with this portfolio, as a requirement of the Psych.D. Clinical Psychology. A brief summary of each of the cases will be given below.

Case 1.

J., a male child aged 11, was referred to the Child and Family service due to compulsive washing. An assessment revealed that this behaviour had begun around three years ago and its commencement coincided with the separation and subsequent divorce of his parents after which J. had no contact with his father.

J. appeared to have obsessive thoughts about contamination. These were evoked by a number of triggers including being in public places, being at school and being near people whom he considered contaminated. In order to neutralise the anxiety provoked by these triggers, J. was carrying out compulsive washing rituals which involved either washing his hands, rinsing his mouth, bathing or washing his hair. J. reported that he was washing his hands around 50 times a day. In addition to the compulsive washing, reports both from J.'s school and previous therapists suggested that he also presented with behaviour problems and he was described as being very rude and obnoxious.

Intervention was based mainly on Cognitive Behaviour Therapy using the techniques of exposure and response prevention. J. set himself increasingly difficult goals each week and, with the assistance of his mother, a reward system was introduced to facilitate progress.

Towards the end of therapy, it became increasingly obvious that there were a number of relationship problems between J., his mother and brother and therefore the case was reformulated using the Structural model of Family Therapy.
J. made good progress during therapy and, at one time, had managed to reduce the frequency of his hand washing to five times a day. However J. was very angry about the fact that I would be leaving the department and at this time his compulsive washing began to increase again. He initially refused to see another therapist although changed his mind just before our sessions ended.

CASE 2.

The second case submitted comprised a report on a Social Skills group for children aged ten to fourteen. Six children attended the group, two girls and four boys, one of whom had a diagnosis of Asperger's syndrome. The group took place weekly over five sessions with each session lasting 90 minutes. All members attending the group had difficulties interacting with peers and adults. The aims of the group were -

1. To increase awareness of basic communication skills.
2. To consider alternative ways of responding in certain social situations.

The group was based on a model of social skills training articulated by Spence (1980). Prior to the group, each child was assessed by asking him/her to complete a questionnaire ascertaining his/her perceived confidence in dealing with certain social situations. A similar questionnaire was also completed by the child's parents. The results from these were used to design the group sessions. In addition the questionnaires were readministered after the group to assess the progress of each child.

The teaching element was based on the social learning model and aimed to increase the behavioural repertoire of each child by providing him/her with alternative strategies and skills for dealing with certain social situations. The strategies used to achieve this were instruction, modelling, practise and feedback. The social situations discussed included dealing with bullying and making friends.

Informal feedback from the group members suggested that they had all enjoyed
attending the group and had found most aspects relevant and useful to them. All five children who completed post evaluation questionnaires showed an increase in perceived confidence in dealing with at least one of the social situations represented.

CASE 3.

The third case report was also about a group although this time in the area of Learning Disabilities. The group members consisted of two females and three males aged 40 to 55. All the members lived in a residential home in the community where 24 hour staffing was provided. The group took place in the members’ home. A member of the house staff was present during each session.

The group contained individuals who were rarely interacting with one another. In situations where a conversation was initiated by a resident, this tended to be directed at staff. The varying abilities of the group members, particularly in terms of their communication skills, made it difficult for them to interact. Two of the members had good verbal skills and tended to dominate the group sessions. The other three less able members had limited verbal communication. In addition, one of the members has a diagnosis of Autism and so would be expected to have particular difficulties with social interaction and communication.

The overall purpose of the group was to encourage interaction between members. Four behavioural goals were set for the group as a whole, for example each week members of the group will pass around the biscuits offering one to the person sitting next to them. In addition individual goals were set for each of the members.

A range of topics were discussed within the sessions including issues related to group living skills for example the distinction between public and private places. Due to the poor verbal skills of some of the members, the sessions incorporated nonverbal materials such as photographs and magazine pictures.

All the initial goals set for the group were fully/partially achieved. By providing the
group with activities which necessitated some interaction (e.g. passing around biscuits) and methods of communication that everyone was able to utilise (e.g. pointing to pictures) the group members did begin to interact with one another. However, most of the interactions that did take place were somewhat superficial and only occurred with prompting (e.g. passing objects to one another when asked to do so). However the group served a useful purpose by providing space for the residents to come together and discuss general issues about living together and the plan was that the group should continue with a new facilitator after I left.

CASE 4.

The fourth case report concerned a psychometric assessment of a 61 year-old man with Parkinson’s disease. In addition, due to the complexity of the case, an assessment was also made of the client’s current life functioning.

An assessment of the client’s nonverbal intellectual abilities was made using the Coloured Progressive Matrices and Object Assembly and Block Design from the Wechsler Adult Intelligence Scale revised (W.A.I.S.r). Due to the client’s physical disabilities associated with the Parkinson’s disease, it was not applicable to administer a full W.A.I.S and the results from the tests administered were interpreted with caution.

An assessment of the client’s premorbid I.Q. was made using the Schonell Graded Reading Test. Digit Span, Vocabulary, Similarities and Comprehension (from the W.A.I.S.r) were administered in order to obtain an estimate of verbal intelligence.

The client’s overall test results suggest that he is of low average intelligence. Furthermore, comparisons between his estimate of pre-morbid I.Q. and current level of functioning, suggest that he has not experienced any intellectual decline. It was also recommended that further assessment should be made of the client’s memory and executive functioning.
In terms of current life functioning, the client reported attending a day centre two days a week but spent the majority of the rest of his time in his room. The client reported having felt depressed in the past and it was felt that this lack of activity may have been contributing to his low mood. In line with the client’s own wishes a recommendation was made that he should attend the day centre on an extra day per week. This would also provide some respite to his carer, his brother, who also has responsibility for caring for a third brother with learning disabilities.

CASE 5.

The fifth and final case report was written during my specialist placement in health. In many ways writing this case report was a unique experience for me since it was not written for the referrer but rather for the client herself.

Mrs. L. was referred to the Psychology department following a physical health problem for which she spent two weeks in hospital. Her symptom was an infection which left her feeling weak, tired, nauseous and depressed. Medical professionals were unable to arrive at a clear cut diagnosis for her physical symptoms and they were felt, at least in part, to be due to psychological stress.

The main aim with Mrs. L. was to encourage and enable her to take a detailed review of her life and current situation. In order to achieve this my approach during sessions tended to be nondirective. The issues arising from our discussions fell under five headings, namely issues relating to - her family of origin, health, schooling and occupation, her children and her marriage. Through discussing these issues, it became apparent to the client that her physical problems were, at least in part, due to stress.

A number of themes that transcended the five areas discussed were drawn out and, at the end of therapy, the psychological tasks that the client still needed to undertake were identified.
All this information was included in a report which was given to the client at the end of therapy. Mrs. L. reported that she found it extremely useful to see the issues we had discussed written in black and white. For her it provided confirmation of her own feelings and provided a structure for her life experiences.
KINGSTON AND DISTRICT COMMUNITY HEALTH UNIT
DEPARTMENT OF CLINICAL PSYCHOLOGY

PLACEMENT CONTRACT

Placement: First Year Adult Placement (6 months)
Trainee: Louise Byles
Supervisor: Rhona Trotter
Dates: October to April

Placement Aims

To gain an overview of the Adult Service including mental health and primary care in as wide a range of settings as possible. To gain theoretical knowledge and clinical experience with a wide variety and range of clients using different and contrasting therapy models; assessment tools and techniques.

Objectives

1. To observe others and work directly with a range of client groups including:
   a. individuals
   b. couples
   c. families
   d. at least one from each of the three age bands
   e. mix of male and female (treat or observe)
   f. including one from different cultural/ethnic background

2. To observe and gain direct and/or indirect experience in a range of settings including:
   a. CMHT (including rehabilitation and resource centres)
   b. Adult outpatients
   c. Primary Care (experience/observation)
   d. Systems
   e. Home visits (observation as minimum)
   f. Community Day Hospitals
   g. Inpatient Wards (acute, long stay and rehabilitation [Case work])

Where possible (to be advised):

h. Social/voluntary service settings
i. Alternative services (drop ins etc).
3. **Direct Clinical Work**

a. To develop interviewing and assessment skills, concentrating on the cognitive-behavioural model.

b. To assess and treat at least one client from approximately ten of the following problem areas:

i. Anxiety (independent work)
ii. Depression (independent work)
* iii. Schizophrenia (observation and assessment + Psychological intervention if possible.
iv. Obsessive-compulsive disorders (observation + independent work if possible)
v. Eating disorders (independent)
vi. Sleep disorders (as part of wider issue)
vii. Survivors of sexual abuse (observation)
* viii. Sexual and relationship or family problems (observation only)
* ix. Problems of emotional control and adjustment (not available), social skills and assertiveness (group observation (?) of, as part of wider issue), suicide and parasuicide (not appropriate in this placement), personality disorder (observation).
x. Adjustment/adaptation difficulties/bereavement (independent work).
xii. Health (observation one client with somatic emphasis)

* c. **Rehabilitation/Continuing Care**

Direct work with one client may not be feasible owing to transport difficulties.

d. **Clients and acute psychiatric episode and severe depression**

* Attendance at ward meetings to be arranged if possible in order to observe psychiatric interview and carry out direct work if this can be arranged.

* e. **Neuropsychology**

Trainee would be unable to administer a WAIS or other therapist administered test but should use and understand scoring and interpretation of self-administered tests.

f. **Disability**

Observation and discussion of one patient should be possible.
4. Trainee to observe a number of clients seen by supervisor and undertake several assessments jointly which may not lead to treatment.

5. Trainee should tape at least one assessment interview per week for discussion and feedback and use of the one way screen or at least one occasion will be arranged if possible.

**Professional and other requirements**

1. Attend weekly supervision (1 1/2 - 2 hours - normally Fridays).

2. Attend Adult meetings, Department meetings and weekly seminars (offering one topic).

3. Keep typed notes of assessments and therapy.

4. Obey confidentiality rules with regard to reader and including non-removal of patient files from the department.

5. Re non-verbal communication.

6. To make sure reader is available on a regular basis to provide service within the department.

7. Not to remain in the department after 5.00 p.m. unless specifically given permission to do so and accompanied.
PLACEMENT CONTRACT
People with Learning Difficulties
23rd April to 30th September 1994

Supervisor    Tony Ovenell, C.Psychol.
Trainee       Louise Byles

Aim of Placement

To provide an introduction to work with people with learning difficulties, including coverage of the critical competencies required to undertake basic grade work in the field. The placement will assume some prior knowledge as a result of Louise's experience as an assistant in the service.

Objectives

At the end of the placement:

Louise will be able to identify effective and efficient methods for achieving desired clinical/professional ends when working with people with learning difficulties.

Louise will be able to articulate a complex model for understanding the nature of psychological needs presented by people with learning difficulties.

Louise will be able to select an appropriate assessment model and tool(s) for use with individual clients. There will be at least one client requiring use of each of the WAIS-R, Leiter International Performance Scale, BPVS, a criterion referenced assessments (2 clients), a behavioural/cognitive behavioural model.

Louise will be able to recommend appropriate service responses on the basis of the assessments above.

Louise will be able to design and implement through others a behavioural/cognitive behavioural intervention.

Louise will be able to modify her communication skills, in order to exchange appropriate messages with people with learning difficulties.

Louise will be able to successfully communicate with carers/other staff.

Deliver a piece of staff training in a relevant area.

Louise will be able to articulate and apply at least one service ideology based upon a social model of disability.

Louise will be able to write appropriate correspondence and reports, as
required in the field.

Louise will be able to work effectively and efficiently within the service network used by pld.

Cowork a therapeutic/educational group

Method

Meetings with a range of professionals and service providers across the District

Attendance at Specialty, department and other meetings

Attendance at CTPLD meetings

Attendance at RSIG

Case work/observation of case work with 10 individuals requiring assessment/interventions in the areas outlined above, including one person with each of the following characteristics:

- complex needs requiring assessment
- severe/profound learning difficulties
- moderate/mild learning difficulties
- challenging needs
- interpersonal or sexual problem
- anxiety or mood disorder
- young adult
- middle aged adult
- older adult
- member of an ethnic minority

Completion of at least one teaching assignment and one piece of group work

Sitting in on at least one service planning/development forum.

One hours supervision weekly
South West Surrey Health Authority


Name: Louise Byles
Type of Placement: First year child and adolescent part core placement.

1. AIMS

To gain clinical experience of children with organic, cognitive, educational, emotional and behavioural problems in the pre-school and middle school age range. (Some adolescence and family therapy experience will also be available).

2. OBJECTIVES

a) To observe and work with a wide range of young children with developmental, behavioural and/or emotional problems.

b) To become familiar with a range of assessment tools and techniques.

c) To experience working within a team of other professionals and liaison with the wider network of professionals working with children.

3. CLINICAL WORK

a) To develop interviewing skills with young children and their parents.

b) To practise assessment and therapy with a range of pre-school and school age children individually, in groups and through parental management advice.

c) To liaise with other professionals working with the children including paediatrics, child psychiatry, speech therapy, physiotherapy, occupational therapy, nursery school teachers, special school teachers, educational psychologists, health visitors, ward staff, community nurses and general practitioners.
4. INDIRECT OR OBSERVATIONAL WORK

a) Observation of supervisor and other professionals working with children in the Children's Unit, The Opportunity Playgroup, The Child and Family Consultation Centre, and Child Mental Health Outpatients.

b) Visits to other centres including special schools, respite care, nursery schools, special units in normal schools, and normal schools.

c) Attend case conferences and network meetings where appropriate.

d) To research one particular topic from the clinical work and read material relevant to the clinical work.

5. PROFESSIONAL

a) To attend weekly supervision.

b) To attend speciality and professional liaison meetings where possible.

c) To keep accurate and up-to-date records of clinical work.

Olwen H.M. Wilson  Louise Byles
Supervisor         Trainee

Date: 11/11/54
OLDER ADULTS SPECIALIST PLACEMENT CONTRACT

Trainee: Louise Byles

Supervisor: Farzad Shamsavari

Dates: From 18.5.1995 to Autumn Term 1995

Base: Amyand House, Strafford Road, Twickenham

Supervision: 1-1½ hours per week

Study Time: ½ day per week

Placement goals:

1. Clinical work

1.1 Experience with the range of formal tests and check lists used for the assessment of cognitive functioning and dependency levels or neuropsychological assessment, of older people. In particular, familiarity with the following tests:

Camdex
Dementia Rating Scale
Meams
CAPE
Rivermead Behavioural Memory Scale
Adult Memory and Information Processing Battery
GHQ

1.2 Experience with formal and other (interviewing - observation) methods used for the assessment of functional or behavioural disorders in older adults. For example:

HAD
Beck Inventory
Self-Report measures
Functional analysis
1.3 Experience with different approaches to the treatment and rehabilitation of older adults, for example:

- Behavioural
- Cognitive
- Counselling
- Reminiscence
- Reality orientation
- Validation Therapy

1.4 Experience of work with:

- Individuals
- Couples
- Families
- Groups

1.5 Experience of observing and/or working in different settings:

- Residential homes
- Patient homes
- Day Centres
- Day Hospitals

This will include:

- Amyand House Day Hospital
- Twickenham Day Centre
- Halford Hall Day Centre
- Barnes Day Hospital
- Sheen Ward
- White Farm Lodge Residential Home

1.6 Experience in planning and setting up groups for clients and/or carers. Also experience in observing and offering feedback on groups which are already running.

1.7 Experiencing in collaborating with other professionals in client work.

2. Organisational work.

2.1 Attending the MHE clinical team meetings, business team meetings and working parties as appropriate.

2.2 Attending meetings of the department of psychology.

2.3 Attending the regional meetings of the Elderly Special Interest Groups.
2.4 Contributing to the training and/or supervision of staff in Amyand House Day Hospital.

Supervisor:
Dr. Farzad Shamsavari
Chartered Clinical Psychologist

[Signature]

Trainee:
Louise Byles
Clinical Psychologist in Training

[Signature]
LOUISE BYLES - SPECIALIST PLACEMENT IN HEALTH PSYCHOLOGY WITH CATHERINE DOOLEY

Date: December-June 1996

Days of the week: Wednesdays and Fridays

Aims of the placement: That Louise establishes confidence and competence in working with clients with primarily medical health problems and within a more of a medical context.

Objectives: That by the end of the placement Louise will:

a) Organisational awareness and skills

1. have developed awareness and sensitivity and some level of ability in modifying her presentation and roles to work within a medical setting.

2. be able with assistance to establish a new psychology service, requiring her to work closely with others who are interested in developing the service, clarify the aims and the possible provision and negotiate to some conclusion.

b) Clinical skills

3. be able to modify both general and specific therapeutic skills in handling the relationship, the process of therapy and strategic thinking with clients who present with medical health problems.

4. have developed expertise in offering cognitive-behavioural work in a more flexible and broader way.

5. be able to utilise a range of models including cognitive-behavioural work, exploratory psychotherapy and reportory grids.

6. have used specific approaches that relate to service at Kingston Hospital, such as a lifestyles assessment and utilisation of the assessment package.

Content/Structure:

1. Establishment, contribution to and evaluation of a group for people with diabetes and weight problems, jointly with the Specialist Diabetes Nurses, Dieticians. Supervised by Anna Iwnicki.
2. Regular service to the Chest Clinic, Kingston Hospital. This will include individual client work and clarifying with staff what psychological input they need and establishing procedures and services to meet this.

3. Out-patient work.

(2) and (3) to be supervised by Catherine Dooley.

Additional work if time permits:

- Stress Management group for people who have had cardiac problems, supervised by Sue Webb.
- Survey of ethnic minorities and health needs, supervised by Catherine Dooley.

**Clinical study time:** No particular time set, but to be fitted round the structure of the placement.

**Supervision** by Catherine Dooley, Wednesday afternoons 4.00 for one hour. Additional input from Anna Iwnicki and Sue Webb as required. Psychology Assistant Christy Wellings is available to help with admin. matters and in some of the clinical services, to be negotiated directly with Christy.
PLACEMENT CONTRACT

Placement: 3rd Year Specialist Placement in Bulimia

Dates: December 1995 - June 1996

Trainee: Louise Byles

Supervisor: Benna Waites

Placement Days: Thursdays

Supervision: 1 hour per week (normally 4pm)

Caseload: Approximately three patients at any one time plus co-facilitation of fortnightly psychotherapy group.

Main Aims of the Placement

1. To gain experience of and develop an understanding of the assessment and treatment of clients with bulimia and related disorders.

2. To gain experience of the running of the long term psychotherapy group for clients with bulimia, and to contribute to the understanding of the process and dynamics of the group.

3. To develop an understanding of issues involved in the development of a specialist service in eating disorders.

4. To develop awareness of the psychologist’s role in a multi-disciplinary team for clients with bulimia.

Induction

* To talk with the dietitian about her role.
* To meet other members of the bulimia team.

Signed: ..................................................
Benna Waites
Clinical Psychologist

Signed: ..................................................
Louise Byles
Clinical Psychologist in Training

Ref: BW020495.2
SECTION III

RESEARCH
RESEARCH SUMMARY.

The following section contains three research documents.

The first document pertains to a small scale service related study of the management of crises by members of three Community Teams for People with Learning Disabilities. An assessment is made of the types of crises experienced by the team members and their views on the effectiveness of the systems available for dealing with these. On the basis of the information gathered, recommendations for enabling the team members and service as whole to improve its management of future crises are made.

The second paper is a literature review regarding parenting by people with eating disorders, namely Anorexia Nervosa and Bulimia Nervosa. This is divided into two sections. The first section relates to the impact of a mother's eating disorder on her unborn foetus and newborn infant. The second section examines the literature concerning the effects of disordered eating attitudes and behaviours in parents on the development of their offspring.

The final paper in this section is an empirical study of the link between the eating attitudes and behaviour of parents and the eating behaviour of their children.
SMALL SCALE SERVICE RELATED RESEARCH STUDY

Psych.D. Year 2

"CRISIS MANAGEMENT BY MEMBERS OF A COMMUNITY TEAM FOR PEOPLE WITH LEARNING DIFFICULTIES."

This research formed part of a presentation at the TASH San Francisco conference 1995.
INTRODUCTION.

Definitions and Models of Crises.

Most people have at some time experienced a crisis either at work or in their personal lives. According to Beckingham and Baumann (1990) a crisis can be defined as "a Sudden and unanticipated or unplanned for event which necessitates immediate action to solve the problem". Wiener and Khan (1962) outlined eleven key attributes they felt were associated with crises. They saw a crisis as:

1. a turning point in an unfolding sequence of events,
2. a situation in which action is seen as necessary by those involved,
3. a situation which poses a threat to the goals and objectives of those involved,
4. a circumstance which is followed by an important outcome whose consequences and effects will shape the future of the parties to the crisis,
5. a convergence of events whose combination produces a new set of circumstances,
6. a time during which uncertainty about the assessment of the situation and its resolution increases,
7. a period in which control over events and their effects decreases,
8. a situation characterised by a sense of urgency which often produces stress and anxiety among those involved,
9. a time during which information available to participants is usually inadequate,
10. a situation characterised by increased time pressure for the participants,
11. a circumstance which raises tensions among the participants.

Although crises usually feel very chaotic to those involved, it has been suggested that they are in fact quite structured events with a beginning, middle and end (see Eliatamby and Missen unpublished). Furthermore, a number of models have been proposed to explain the path of a crisis. For example, Lagadec (1993) suggests that every crisis is in part an organisational one. He proposes that organisations always operate in one of three states: Normal Conditions, Disturbed and Crisis Dynamics.
During Normal Conditions most parts of the service function and everything holds together. At times episodes may occur which throw the organisation into a Disturbed state and action will then be taken by the system to return to Normal Conditions. A Crisis state will occur in a system if an event(s) occurs in an organisation that is already unstable or close to break down i.e. one that is in a Disturbed state.

A second model proposed by Regester (1989) distinguishes between managed and unmanaged crises. According to Regester an unmanaged crisis has three phases: Pre-Crisis, Crisis and Post Crisis (collapse). During Pre-Crisis any problems that occur within a system remain either unrecognised or their seriousness is denied e.g. high staff turnover. The dominant emotions during this phase are fear and anger and "finger pointing" begins. The Crisis phase is characterised by ambiguity, a loss of common purpose or cohesiveness amongst staff and value clashes amongst workers. Multiple problems occur which often remain unresolved due to the over-riding fear and anger which blocks their solution. In addition, there is a lack of mutual respect between front-line staff and senior managers. Finally, during Post Crisis the system collapses, everyone gives up and hope is lost. The situation is characterised by shock and uncertainty.

A third model, proposed by Pearson and Mitroff (1993), incorporates the notion that crises may be cyclical. This model, like the two presented above, outlines a crisis as a series of stages i.e. Normal state, Warning signs, Preparation/Prevention, Containment (i.e. Damage limitation), Recovery and Learning. The descriptions of each stage have many similarities to the other models described so far. However this is a particularly useful model for individuals working in human service organisations since it allows for the possibility of learning from past experience.

All the above definitions and models of crises have been drawn from the business world. To our knowledge, there is no literature concerning the management of crises by human service organisations other than the recent and currently unpublished text by Eliatamby and Missen. In their book, Eliatamby and Missen (unpublished) outline
their own model of a crisis based on a summary of their discussions with staff working in human service organisations. They build on the three phase model proposed by Regester (1989) and suggest a model which is particularly useful for staff working in human service settings. The authors comment that, Pre Crisis, there tends to be a lack of stability, preplanning, foresight, motivation, communication and a will to recognise and deal with problems. During this phase issues are left unresolved or ignored, resentment flourishes, clients become secondary and gossip and unprofessional behaviour creeps in. During the Crisis phase there is a total communication break down between the participants of the crisis and staff operate independently of one another. Client routines and expectations become disturbed and disrupted. Staff have differing views on the cause of the break down and there is often a lack of direction and conflict over goals. During Post Crisis there is no energy or drive to resolve the difficulties. There is often persistent staff absences and no belief in or respect for management. There is no acknowledgement of any responsibility but merely a desire to avoid a repetition of the past events by the removal of the person who has to shoulder the blame for the crisis.

Although to those involved crises usually appear to arise out of nowhere, the information presented above suggests that break down within a system begins some time before crisis point is actually reached. Eliatamby and Missen (unpublished) report that there are often a number of predictors or "warning signs" present in a situation some months before a crisis occurs. They define a "warning sign" as "an event, action or circumstance that should have alerted relevant individuals to the fact that there was a crisis pending" (Eliatamby and Missen unpublished). The authors go on to outline 13 "warning signs" which, in their experience, typically preceded crises in human service organisations namely:

1. Continued illness of a client which caused major stress.
2. A client experienced a sudden life event (e.g. bereavement) but was not given adequate support to understand or cope with this.
3. Inadequate monitoring of a client’s medication.
4. The client was becoming increasingly bored with his/her life but no alternative
activities were found.

5. Sudden changes in staff resulted in increased use of agency staff and lack of consistency in permanent staff.

6. A client needed input from a relevant professional (e.g. Physio Therapist) but no referral was made.

7. An intervention was provided by a professional but this was not adequately monitored and consequently proved ineffective.

8. Staff were not being provided with adequate support or training.

9. A client committed a crime. However, managers were either unaware of the situation or failed to give support or there were no clear systems or policies for dealing with the situation.

10. A client’s behaviour led to complaints by neighbours. However, managers were either unaware of the situation or failed to provide adequate support or there were no clear systems or policies for dealing with the situation.

11. Carers were becoming increasingly unable to cope with a client but professionals were not informed or were informed but did not listen.

12. Low morale in the staff team was not addressed.

13. One staff member made a complaint about another but this was not properly investigated.

Crises are often extremely anxiety provoking events for those involved. The participants usually see just the middle and end of the crisis and are rarely aware of the other aspects because they are not engaged in an impartial analysis of the situation. Crises are therefore often not managed in an objective manner. The above models highlight the potential damage that may occur in an organisation if a crisis is not managed appropriately and effectively. According to Eliatamby and Missen (unpublished) the traditional way of working in human services is to have several balancing acts and no safety net. In such systems action is taken only if that service breaks down and goes in to crisis. In order to improve the effectiveness of such organisations, one needs to anticipate and prepare for crises before they occur hence minimising the impact they will have on the system and the individuals involved.
The study aims to investigate the management of crises by members of the Richmond, Twickenham and Roehampton Community Teams for People with Learning Difficulties. The investigation was supported by the Challenging Needs steering group which is based at Normansfield hospital Teddington. The members of this group recognised that professionals working with People with Challenging Needs will often have to cope with crises in these individuals services.

In line with the models suggested above, in this investigation it is hoped that, by analysing the paths of previous crises, it will be possible to present recommendations to the service to enable them to improve the effectiveness of Crisis Management by Community Team members in the future. By identifying some of the most common "warning signs" or predictors of crises, it may be possible to present ideas for intervening in similar situation in the future hence preventing certain crises from occurring altogether. However it should be recognised that it is virtually impossible to totally eliminate crises from such a large organisation. However it may be feasible to put forward ideas for the introduction of systems and procedures that will ensure that, when certain crises do arise, they are managed in the most appropriate and objective manner possible.

The specific aims of the study were as follows:

1. To identify the types of crises experienced by Community Team members working with People with Learning Difficulties in the district and how these are currently managed.

2. To identify any "warning signs" which appear to precede the crises.

3. To identify the outcomes of crises.

4. On the basis of all the results obtained, to forward recommendations for future
service planning.

In addition, it was hypothesised that there would be a link between the number of years an individual had been working with People with Learning Difficulties and the number of crises he/she had experienced over the past year.
METHOD.

The Sample.

The sample consisted of Community Team members working with People with Learning Difficulties for the Richmond, Twickenham and Roehampton N.H.S. trust.

The trust has divided its provision of community care to People with Learning Difficulties into three areas, Richmond, Twickenham and Roehampton. Each area is served by a separate Community Team. Each team meets on a weekly basis to discuss cases within its catchment area.

Each of the three Community Teams is comprised of members from both health and social services. In terms of the health service provision, each team contains representatives from specialist health disciplines namely Physio Therapy, Occupational Therapy, Speech and Language Therapy, Psychology, Dietetics and Community Nursing. However, as there is not always three members of staff working in each of the health disciplines, certain health professionals provide a service to all three of the teams and hence attend meetings with each team on a rotational basis. In addition, each team contains at least one care manager from the provider section of social services. Finally, all three teams have a team administrator.

Measure.

A questionnaire was designed by Anna Eliatamby and Louise Byles which aimed to ascertain professionals’ experiences of crises in their work with People with Learning Difficulties (see Appendix A). The questionnaire contained 11 questions with a mixture of open and closed items. The content of the questionnaire was as follows:

1. Questions 1 - 4 were closed questions which were included to ascertain background information about the participant e.g. job title and age.
2. Questions 5 and 6 aimed to ascertain how many crises each respondent had experienced in a year and whether or not they knew who to contact in times of crisis.

3. In question 7, the respondents were asked to recall and describe in as much detail as possible, their most vivid memory of a crisis. They were then asked to use this experience to help answer the subsequent items.

4. In order to identify predictors of crises, the 13 "warning Signs" reported by Eliatamby and Missen (unpublished) as typically preceding crises occurring in human service settings were listed in question 8 and individuals were asked to tick any of the factors that they felt had preceded their crisis experience.

5. In questions 9 and 10 the participants were asked to comment on the outcome following the crisis. This included highlighting unresolved issues and identifying any positive changes that had occurred as a result of the crisis.

6. Finally, in question 11, the respondents were asked to comment on the adequacy of the current system for dealing with crises arising in their work.

**Procedure.**

The questionnaire was distributed to the team members at their weekly team meetings and was returned directly to Louise Byles by post or was collected at the team meeting the following week. Overall 26 questionnaires were distributed.

The majority of the analysis of the data involved calculating means and percentages. In addition, a Spearman's Rank correlation was calculated between number of years an individual had been working with People with Learning Difficulties and the number of crises he/she had experienced over the past year.
RESULTS.

This section of the report contains a summary of the data obtained from the questionnaire survey.

Of the 26 questionnaires distributed to the Community Team members, 15 (58%) were returned.

**General Participant Statistics.**

Of the 15 participants, 11 were females; 3 were males; and 1 participants did not respond to this question.

Only 10 of the 15 participants reported their age. The average age of these respondents was, to the nearest year, 29 (range 24 - 34 years).

A variety of professionals completed the questionnaire. Of the 12 Respondents who reported their profession, 3 were Psychologists; 3 were Speech Therapists; 2 were Care Managers; 1 was an Occupational Therapist; 1 was a Community Nurse; 1 was a Team Administrator; 1 was a dietician.

The 14 participants who responded to this question had been working with People with Learning Difficulties for an average of 6 years to the nearest year (range a few months - 20 years).

The 14 participants who responded to this item had experienced an average of just over 3 crises over the past year (range 0 - 6). The 15th respondent did not include the exact number of crises experienced but instead responded "too numerous".

A non-significant correlation ($r(s) = 0.4571$) was found between number of years working with People with Learning Difficulties and number of crises experienced over the past year.
General Crisis Data.

Of the 15 respondents, 13 (87%) had experienced at least 1 crisis over the past year.

13 out of the 15 respondents (87%) reported that they knew who to contact when crises arose at work. 2 participants (13%) reported that they did not know who to contact, both of whom had been working in the service for less than one year and had not experienced a crisis.

The following professionals were identified as people to contact during a crisis:

<table>
<thead>
<tr>
<th>Professional</th>
<th>Number of Respondents Identifying that Professional</th>
</tr>
</thead>
<tbody>
<tr>
<td>Duty Worker</td>
<td>3</td>
</tr>
<tr>
<td>Line Manager</td>
<td>3</td>
</tr>
<tr>
<td>Team Manager</td>
<td>2</td>
</tr>
<tr>
<td>Care Manager</td>
<td>2</td>
</tr>
<tr>
<td>G.P.</td>
<td>2</td>
</tr>
<tr>
<td>Relevant Manager</td>
<td>1</td>
</tr>
<tr>
<td>Resource-Service Manager</td>
<td>1</td>
</tr>
<tr>
<td>House Manager</td>
<td>1</td>
</tr>
<tr>
<td>Clinical Psychologist</td>
<td>1</td>
</tr>
<tr>
<td>Dieticians</td>
<td>1</td>
</tr>
<tr>
<td>Other Relevant Professionals</td>
<td>1</td>
</tr>
</tbody>
</table>

Types of Crises.

The following vivid memories of crises were recalled by the respondents:

- A sexual abuse allegation was made and there were no managers easily available to help deal with the situation.
- Abuse allegations were made to a Psychologist on a routine visit.
- Sudden death of a client.
- A client became aggressive in a meeting.
- A client became agitated in a meeting.
- A client ran out of medication.
- A client’s medication was withdrawn whilst he/she was at an assessment unit.
- Sudden move requested by an out of borough client.
- Parents or other relatives were no longer able to cope with caring for a client (recalled by three respondents).
- There was an urgent need for housing for a client.
- Staff complaints.

Predictors of Crises.

The following "warning signs" were identified by participants as preceding their experience of a crisis. The number in brackets represents the number of respondents who reported the "warning sign" as preceding their crisis.

- Staff were not being provided with adequate support or training (6).
- Carers were becoming increasingly unable to cope with a client. Professionals were informed but did not listen or were not informed at all i.e. communication break down (6).
- Inadequate monitoring of a client’s medication (5).
- Continued illness of a client which caused major stress (4).
- Sudden changes in staff resulted in increased use of agency staff and lack of consistency in permanent staff (3).
- A client needed input from a relevant professional but no referral was made (3).
- An intervention was provided by a professional but this was not adequately monitored and consequently proved ineffective (2).
- A client experienced a sudden life event but was not given adequate support to understand or cope with this (2).
- A client was becoming increasingly bored with his/her life but alternative activities were not found (2).

- A client's behaviour led to complaints by neighbours. However, managers were either unaware of the situation or failed to provide adequate support or there was no clear systems or policies for dealing with the situation (1).

The following additional factors were identified by participants as preceding their crisis:

- A lack of available management.
- A need for support for elderly parents and discussion of long term plans.
- A family did not understand a client's needs.
- There was a poor relationship between staff and residents and immediate local residents.
- Ineffective intervention and advice was given by the local police.
- An urgent need for housing was not met.
- A clear diagnosis was not established for a client.
- Noncompliance with treatment.
- Mental health problems were not addressed.
- A client was unable to recognise professional boundaries.

**Outcomes Following Crises.**

Of the 13 respondents who experienced a crisis, 5 felt that issues were resolved satisfactorily following the crisis; 7 felt that issues were not satisfactorily resolved; and 1 person was unsure.

The following were some of the unresolved issues identified by respondents:

- Inadequate report from a provider following the sudden death of a client.
- There was a lack of consistency in a staff team.
- An agreed package of care was not implemented.
There were continued communication difficulties with a G.P. regarding a client's medication.

The following resolutions to crises were identified:

- Respite.
- Medication monitoring.
- Medication reinstated.
- Move of a client.
- Carers offered counselling.

7 people felt that there were positive outcomes following the crisis, 4 people felt that there were not, 2 people did not respond to the question.

The following positive outcomes were identified:

- Staff were more aware of a client’s needs.
- The Community Team members were more aware of the problems.
- Client and carer were more receptive to support.
- Staff support was set up and in-service training was offered.
- Policies were developed.
- A parent’s needs were acknowledged.
- Occupation was reviewed.
- Strategies were discussed within the team for dealing with sudden arrival of distressed clients but no agreement was reached.

Comments on the System for Managing Crises.

Of the 13 participants who responded to this question, 3 people (23%) felt that there was an adequate system for dealing with crises that arose in their work; 4 people (31%) felt the issue was debatable; and 6 people (46%) felt that there was not an adequate system in place.
The following problems with and comments about the current Crisis Management system were made:

- There is a lack of policies and procedures e.g. regarding sudden death of a client, emergency admissions and accidents.
- The service lacks a senior duty managers system.
- There is poor planning in the service.
- The administrator feels cutoff.
- Crises are not avoided enough.
- More flexibility with regards to resources is needed.
- Keyworkers feel unsupported.

The following recommendations for improving the system were made:

- More basic information is needed about emergency G.P.s and chemists.
- There should be an improved relationship with the Mental Health service.
- Teams should formulate plans for families who may go into crisis, contingency plans are necessary.
DISCUSSION.

Introduction.

The purpose of this study was to investigate Crisis Management by the members of the Richmond, Twickenham and Roehampton Community Teams for people with Learning Difficulties. By analysing the paths of previous crises experienced by the participants, we hoped to be able to present recommendations to the service which would enable them to improve the effectiveness of crisis management by the team members in the future.

Overall, just under 60% of the Community Team members responded to the questionnaire distributed to them. The respondents came from a variety of professional groups and the majority of the participants were women. The amount of time the respondents had been working in the service varied greatly ranging from a few months to twenty years.

Only two of the fifteen respondents (13%) had not experienced a crisis over the last 12 months and both of these individuals had been working in the service for less than a year. Over the past year the respondents had experienced an average of just over three crises each with some individuals experiencing as many as six. A correlation was carried out between the number of years an individual had been working with People with Learning Difficulties and the number of crises he/she had experienced. However the nonsignificant result produced from this comparison suggests that there is not a link between these two variables.

Only three of the thirteen individuals who had experienced a crisis felt that there was currently an adequate Crisis Management system in place in the service. The remaining ten respondents (77 percent) felt that the system was definitely inadequate or that the issue was debatable. In addition, over half of the respondents felt that issues were not satisfactorily resolved following their experience of a crisis. Both these statistics suggest that there is a need to improve the effectiveness of the current
Crisis Management system.

In the following paragraphs, I will present a discussion of what I feel are the most significant issues highlighted by this investigation. In areas where there appears to be a flaw in the current Crisis Management system, I have endeavoured to offer a possible solution to the problem. The structure of the discussion does not reflect the design of the questionnaire used in the study or the models of crisis presented in the introduction. I have instead attempted to link together results which appear to pertain to a similar issue.

Major Issues Raised by the Investigation.

Only two of the fifteen respondents reported that they did not know who to contact in times of crisis. Both of these individuals had been working in the service for under a year. In order to overcome this problem, details about who to contact when a crisis occurs could be included in the induction package offered to all new members of staff joining the service.

Although the remaining thirteen participants reported that they knew who to contact when a crisis arose, there was no consistency in the answers to this item. In fact a variety of possible individuals were identified including Duty Worker, Line Manager Care Manager and G.P. The inconsistency in the responses to this item may stem from the fact that a range of different crisis situation were recalled by people in a variety of employment positions. Both of these factors may affect an individual’s decision as to who should be the first Port of Call when a crisis occurs. Alternatively the diversity in the responses might suggest that there is currently a certain amount of confusion regarding this issue. In fact it is likely that both of these factors have contributed to the lack of a consistent response to this question. It is suggested that, in order to clarify the situation, guidelines should be produced by the service detailing exactly who should be contacted if and when a crisis occurs. Clearly the person to be contacted may vary according to the type of crisis experienced and the employment position of the person experiencing it. However such issues should be addressed
within the guidelines.

The most common type of crisis, which was described by three respondents, arose when relatives were no longer able to cope with caring for a client. In addition, one respondent reported that a key factor preceding his/her experience of a crisis was the need for support for elderly parents caring for a client and the need for a discussion regarding the long term plans for the client. An excellent recommendation made by one of the respondents for improving the current system, was that Community Team members should formulate contingency plans for families who may go in to crisis. Such plans would help to alleviate some of the anxiety and stress that occurs when a carer is suddenly no longer able to cope and would ensure that the situation was handled in an appropriate and objective manner. In addition, it may be reassuring for the carer himself or herself to know that there are other alternatives available if he/she feels no longer able to provide care. In some cases, the mere existence of such alternative arrangements may be enough to prevent the crisis from occurring altogether.

A number of health issues were raised through the questionnaire. For example, two of the most common factors preceding crises, identified by five and four respondents respectively, were inadequate monitoring of medication and continued illness of a client. Another participant reported that a factor preceding his/her crisis was that mental health issues were not addressed with a client. Two of the crises reported involved difficulties around medication and one of the unresolved issues following a crisis involved continued communication difficulties with a G.P. regarding medication. Two very useful recommendations were made by a respondent which, if they were implemented, might help team members to deal more effectively with such crisis situations in the future. Firstly it was suggested that basic information should be provided to all team members regarding emergency G.P.s and chemists. This simple step might be enough in some cases to prevent a situation escalating into a crisis. Secondly it was suggested that attempts should be made to improve the link between the Learning Difficulties and Mental Health services. In fact steps are currently being taken to strengthen the relationship between the two services within
the district. These results clearly support the need to continue this networking process.

A key issue raised through this study is the need for the introduction of a senior duty manager system. One of the respondents reported being thrown into crisis when an abuse allegation was made to him/her and there was no manager easily available to help deal with the situation. In addition, two participants commented that a major flaw with the current system is that there is not a senior manager on duty who can be contacted if and when crises become difficult to manage. A new system should be introduced ensuring that an identified member of senior management is on duty at all times contactable by a bleep. Such a system would alleviate staff stress and anxiety by reducing the responsibility placed on them to deal with any crises that occur. Such a system may also ensure that, wherever possible, crises are dealt with immediately instead of having time to escalate.

Another matter raised by the questionnaire concerns the amount of support and training provided to staff. Poor staff support/training was highlighted by six respondents as preceding their experience of a crisis. Furthermore, two of the problems highlighted with the current Crisis Management system were that the team administrator felt cutoff and that keyworkers felt unsupported. On a more optimistic note, a positive outcome following one of the participant’s experiences of crisis was that staff support was set up and in-service training was offered to staff. The incongruity in the responses regarding this issue suggests that steps need to be taken to ensure that support and training is provided consistently to all staff. I would also suggest that all Community Team members should receive Crisis Management training. Such training would provide the opportunity for all the staff involved to analyse their own performances in times of crisis. On the basis of such information, the individuals would be helped to think through strategies for improving their performances in similar situations in the future.

On three occasions respondents reported that one of the factors preceding their experience of a crisis was that professional input was required for a client but a referral was not made to the relevant individual. Furthermore, two respondents
reported that a key Warning Sign preceding their crises was that a client experienced a sudden life event but was not given adequate support to understand or cope with this. Clearly crises for all of these respondents could potentially have been avoided if the clients concerned had been referred for appropriate professional support. In order to try to avoid such situations in the future, professional staff could provide carers (both care staff and relatives caring for clients) with clear information about the role of their profession and the type of help, advice and support they are able to offer. Such information could be disseminated by circulating a leaflet to the various group homes and families supported by the service. This would enable carers to seek suitable professional support at an appropriate point in time. In addition, it is important to note that a number of clients supported by the service live independently. Furthermore, many clients living in group homes and with relatives would potentially be able to seek professional help for themselves if required. It is therefore crucial that professional staff should also compile a leaflet that is accessible to clients. In designing such a document, particular attention should be paid to the language used and taped copies would also be required for people with visual disabilities or for clients who are unable to read.

Many crisis situations may be avoided or managed more effectively if policies are available to guide the individuals involved as to the necessary action which needs to be taken. Policies not only ensure that crises are managed effectively and appropriately but also increase the confidence and decrease the anxiety of the staff involved in implementing them. One respondent commented that, following a crisis involving the sudden death of a client, issues remained unresolved in that an adequate report regarding the death was not obtained from the Provider. The respondent concerned felt that the service would benefit from the introduction of a policy outlining the steps that should be taken in the event of a similar situation occurring in the future. Linked with this, it was also highlighted that there are currently no policies provided by the service for dealing with the emergency admission of a client or accidents to clients. The introduction of policies in these three areas would clearly be advantageous to the service.
So far in this document I have only outlined the problems with the current Crisis Management system. However, it is important to note that 7 respondents reported that there were some positive outcomes following their experience of a crisis, for example the provision of staff support/training and the development of policies. This suggests that the current system is a reactive one i.e. that change occurs following crises. However, by introducing some of the measures listed above, it is hoped that the service will be able to introduce proactive measure that will guard against at least some crises in the future.

Although one can implement measures to improve the effectiveness of Crisis Management, clearly it is virtually impossible to eliminate crises from the service altogether. However, as this document has demonstrated, one can learn a great deal by analysing past crisis situations. I would suggest that the monitoring and analysis of crises is an ongoing process by which one can ensure that such situations are dealt with in the most appropriate and effective manner and that, wherever possible, measures are implemented to avoid similar crises in the future. I would therefore suggest that new procedures are introduced to ensure that past crises are monitored and analysed on a regular basis. A possible forum for such discussions could be the Community Team meetings which are held on a weekly basis. However, I acknowledge that there are currently many issues which need to be discussed at these meetings. It is therefore suggested that an outside facilitator should attend one meeting with each of the three teams every three months to help the team members to analyse any crises or difficult situations that have occurred. Such analyses could follow a similar format as that suggested by the questionnaire used in this study. Following the analysis of a crisis, it might be useful to have a brainstorming exercise during which the team members could think through ways of managing that crisis situation more effectively in the future.

Methodological Criticisms.

Many methodological criticisms can be levelled at the data presented above. By asking our respondents to recall their most vivid memory of a crisis, it could be
argued that one is liable to obtain atypical information. It is likely that respondents will remember situations which were particularly difficult to deal with and not those in which the Crisis Management system worked effectively. This document may, therefore, paint a more negative picture of the current crisis system than is actually the case. However, as long as one bears this point in mind whilst reading this document, the method used is in fact a useful one for identifying and ironing out any problems with or points overlooked by the current system.

Further criticisms could be made concerning the sample selection and size used in the study. The sample consisted of Community Team members, all of whom worked in the same Trust. In addition, the sample contained only fifteen respondents. Clearly, both these factors reduce the significance of these results to other populations. However, the aims of the study were to comment purely on the Crisis Management system used within the particular Trust from which the sample was drawn and not to make any sweeping statements about the management of crises in general. The sample selection was therefore appropriate for this type of investigation. In addition, although the sample size was small, the views and experiences of just under 60% of the target population are represented in this document.

It is important to note that although it would be inappropriate to generalise the results from this study to other populations, the procedures used for conducting the investigation could be used by other services to conduct similar inquiries into the effectiveness of Crisis Management systems within their services. Future research could compare services in terms of any of the factors explored in this study. For example services could be compared according to the types of crises they experience. Such research could be elaborated to allow the transmission, between services, of ideas regarding the various methods used for effective Crisis Management.

CONCLUSIONS.

Most professionals working with People with Learning Difficulties will at some time have to deal with crises. However, to my knowledge, there has currently been very
little research conducted in this area. Many human service organisations currently manage crises in a reactive fashion. However, I believe that the effectiveness of Crisis Management may be vastly improved if proactive measures are introduced to help staff to anticipate and prepare for crises before they occur.

In the above investigation, an attempt was made to analyse Community Team members' past experiences of crises. On the basis of the information obtained, it was possible to forward a number of recommendations to the service. I believe that the implementation of these suggestions will improve the effectiveness of the current Crisis Management system in place in the service.

The analysis of past crisis situations is potentially a very useful tool for many human service organisations. The data obtained from such analyses will enable the service to take proactive steps to either avoid similar situations in the future or introduce procedures to ensure that, if similar situations do occur, they are dealt with in the most effective and appropriate manner with minimal disruption to those involved.
SUMMARY AND RECOMMENDATIONS.

Summary.

Just under 60% of the Crisis Management questionnaires, circulated to the Community Team members working with People with Learning difficulties for the Richmond, Twickenham and Roehampton N.H.S. trust, were returned. The questionnaires were completed by respondents from a variety of professional groups who had been working in the services for varying lengths of time ranging from a few months to twenty years.

Thirteen of the fifteen participants had experienced at least one crisis over the past year but only three of these individuals felt that there was an adequate Crisis Management system in place in the service.

A variety of different crisis situations were reported by the respondents and a number of common "warning signs" preceding crises were highlighted. Some respondents reported positive outcomes following their experience of a crisis but others felt that issues remained unresolved. Finally participants identified a number of problems with the current Crisis Management system and offered some very useful suggestions for improving its effectiveness in the future.

In light of all the information obtained through the study, I would like to make the following recommendations to the service. It is hoped that implementing the measures listed below will further improve the effectiveness of Crisis Management by members of the service in the future.

Recommendations.

1. Guidelines should be produced detailing exactly who should be contacted if crises occur. Such information should be circulated to all current Community Team members and should be given to any new members joining the service.
2. Contingency plans should be formulated by team members for relatives (who are caring for clients supported by the service) who may go into crisis.

3. All team members should be provided with basic information regarding emergency G.P.s and emergency chemists.

4. The service should continue trying to improve its links with the Mental Health Service.

5. A senior duty manager system should be introduced ensuring that a senior manager is on call at all times.

6. All Community Team members should receive training around Crisis Management.

7. Leaflets containing information about the role of each of the professional groups employed by the service should be circulated to all the group homes and families supported by the service.

8. The service should produce policies or guidelines for dealing with the following situations:

   A. Sudden death of a client.
   B. The emergency admission of a client.
   C. Where a client is involved in an accident.

9. The monitoring and analysis of crises should be an ongoing process. Each Community Team should hold a meeting every three months, aided by an external facilitator, to discuss past crises or difficult situations.
REFERENCES.


APPENDIX A.

CRISIS QUESTIONNAIRE.

Please note that any information obtained from this questionnaire will be treated in a highly sensitive manner. In your responses to the following questions, please do not include client names.

On completing the questionnaire, please return it to either Anna Eliatamby or Louise Byles in the Psychology department, Normansfield.

We would like to take this opportunity to thank you for the time and effort spent completing this form.

1. Gender?  M  F

2. Age?

3. Job Title?

4. How many years have you been working with People with Learning Disabilities?

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In the following questionnaire a "crisis" is defined as "a sudden unanticipated or unplanned for event which necessitates immediate action to resolve the problem" (Beckingham and Baumann 1990).

The following questions are related to your experiences of crises in your work with individuals with learning disabilities.

5. Have you ever experienced a crisis?

   Yes                      No

   If Yes, How many crises have you experienced over the past year?

6. Do you know who to contact in time of crises?

   Yes                      No

   If yes who?

7. Please describe, in as much detail as possible, your most vivid memory of a crisis?
8. With the above crisis in mind, please tick any of the factors listed below that you feel preceded the crisis.

a. Continued illness of a client which causes major stress.

B. A client experienced a sudden life event (e.g. bereavement) but was not given adequate support to cope with this (e.g. counselling).

C. Inadequate monitoring of a client’s medication.

D. The client was becoming increasingly bored with his/her life but no alternative activities were found.

E. Sudden changes in staff resulted in increased use of agency staff/lack of consistency in permanent staff.

F. A client needed input from a relevant professional (e.g. Physio, psychologist) but no referral was made.

G. An intervention was provided by a professional but this was not adequately monitored.

H. Staff were not being provided with adequate support/training.

I. A client committed a crime. However, managers were either unaware of the situation or failed to give support/there were no clear systems or policies for dealing with the situation.

J. A client’s behaviour lead to complaints by neighbours. However, managers were either unaware of the situation or failed to provide adequate support/there was no clear systems or policies to deal with the situation.
K. Carers were becoming increasingly unable to cope with a client but professionals were not informed/were informed but did not listen/communication break down.

L. Low morale in the staff team was not addressed.

M. One staff member made a complaint about another but this was not properly investigated.

N. Any other factors not listed (please specify)

9. Following the crisis, do you feel that issues were resolved satisfactorily?

Yes

No

Please expand.
10. Were there any positive outcomes following from the crisis e.g. introduction of new policies, staff training etc?

Yes  No

if yes please specify.

11. Do you feel that there is currently an adequate system for dealing with crises that arise in your line of work e.g. adequate duty system, policies, procedures, programme plans, keyworker systems etc?

Yes  No

Please expand.
LITERATURE REVIEW

Psych.D. Year 1

"THE EFFECTS OF BULIMIC AND ANORETIC MOTHERS EATING DISORDERS ON THEIR FOETUSES AND OFFSPRING."
The actual prevalence of anorexia nervosa and bulimia nervosa among pregnant women is unknown. Up to 85 percent of women with restricter-type anorexia are single and very few engage in regular sexual activity (Namir et al, 1986). In addition, starvation, a key feature of anorexia, often disrupts the delicate physiological-endocrine balance involved in ovulation, leaving sufferers infertile (Lakoff and Feldman, 1972). It is therefore not unreasonable to expect that the occurrence of pregnancy will be much lower than in the general population (Fahy, 1991). In fact Brinch et al (1988) in a follow-up study of 140 women with a previous formal diagnosis of anorexia nervosa found a lowered fertility rate. However, as the rate of unwanted infertility amongst the anoretic women was no higher than in the general Danish population, the authors commented that lowered fertility appeared to be due to the fact that many women did not want children.

There are no data concerning the prevalence of pregnancy in people with bulimia but given that most are at normal body weight and are more likely than people with anorexia to be married (Fahy, 1991, Woodside and Shekter-Wolfson, 1990) the prevalence might be expected to be much higher. Clearly further research is needed in this area in order to establish the exact prevalence of eating disorders amongst pregnant women.

One reason for the low fertility rate found by Brinch et al (1988) may be due to the psychological impact of the eating disorder on the young women. Conflicts about bodily changes, alterations in role, and concern about one's own mothering are all important psychological issues which are reported to rise to the surface during pregnancy (Bailey and Hailey, 1987). These concepts are all of paramount importance in the psychology of eating disorders (Johnson, 1991). Hence, fear of pregnancy and parenting may result in voluntary childlessness in women with bulimia and anorexia. Added to the above conflicts is the necessary weight gain involved in pregnancy which could potentially be extremely distressing for women with eating disorders. The normal healthy woman gains approximately 12.5 k.g. during
pregnancy (Hyten, 1980). Many women express negative feelings about this weight gain. Fairburn and Welch (1990) for example found that 28 percent of the normal prima gravida they studied expressed negative attitudes towards changes in shape and weight and 72 percent feared that they would not be able to return to normal weight following birth of the child. One might expect the figures to be much higher for people with eating disorders and in fact Lemberg and Phillips (1989) reported fear of loosing control during pregnancy to be much more common in patients with eating disorders.

Although the above physical and psychological limitations imposed by anorexia and bulimia make concomitant pregnancy rare, the literature shows that women with eating disorders can and do have children. The high prevalence of eating disorders amongst young women of child-bearing potential, coupled with advances in medicine, particularly improvements in fertility treatment, has led to an increase in the number of such women eventually becoming pregnant. In terms of both anorexia and bulimia there are a number of individual case and retrospective studies concerning pregnancy in such women (Namir et al, 1986, Lakoff and Feldman, 1972, Brinch et al, 1988, Hart et al, 1970, Ho, 1985, Strimling, 1984, Treasure and Russell, 1988, Weinfeld, 1988, Rand et al, 1987, Milner and O’leary, 1988, de Carle, 1960, Ramchandani, 1984, Ramchandani and Whedon, 1988, Willis and Rand, 1988, Feingold, 1988, Ford and Dolan, 1989, Price et al, 1986, Hollifield and Hobdy, 1990, Stewart, 1987, Lacey and Smith, 1987, Mitchell, 1991). Many of the data in this area are conflicting and to date few studies have been conducted. Some of the studies focus on the effects of pregnancy on the mother and her eating behaviour. However, in this paper, the literature concerning the impact of a mother’s eating behaviour on her foetus, newborn infant and developing child will be reviewed.
SECTION 1. PREGNANCY AND BIRTH.

In the first section of this paper the literature concerning the impact of a bulimic or anorectic mother’s eating disorder on her foetus and newborn infant will first be considered.

Many of the practices involved in both bulimia and anorexia, including limiting weight gain, binging, vomiting and use of laxatives, could potentially have detrimental effects on the developing foetus. Concern for the foetus can lead many mothers to abstain from behaviours such as drinking and smoking during pregnancy. Similarly, it appears that fear of harming the unborn child may lead to the suppression of symptoms in mothers with disturbed eating (Fahy, 1991).

Franko and Walton (1993) discussed 7 cases of pregnancy in bulimic women. In 3 out of the 7 case (Ramchandani, 1984, Ramchandani and Whedon, 1988, Willis and Rand, 1988) the bulimic symptoms remitted during pregnancy and in every case normal weight infants were delivered. There have been coinciding findings for women with anorexia. Rand et al (1987) reported 2 cases of pregnancy in anorectic women. Both mothers gained weight adequately during pregnancy and delivered healthy, normal weight infants. Both women did experience episodes of acute emotional distress particularly concerning changes in shape and weight. However, dieting and binging were moderated by both women purely due to concern for the baby’s health. Similarly, in a study of pregnancy in 6 restricter-type anorexics (Namir et al, 1986), all mothers showed a mitigation of anorectic behaviours during their pregnancies and all were able to nutritionally sustain their foetuses. All mothers tried to eat at least three meals a day and were conscious of not skipping meals. As with Rand et al’s (1987) study all mothers reported being concerned about their baby’s health. It is important to note that 7 out of 8 of the anorectic mothers in the two studies discussed (Namir et al, 1986, Rand et al, 1987) were in psychiatric treatment prior to and/or during pregnancy.

In a larger retrospective study, Lemberg and Phillips (1989) conducted a survey of
43 women with an active eating disorder, either bulimia, anorexia or a mixed condition, during the six months prior to their first pregnancy. The authors found that 88 percent of the women feared that their unborn child might be damaged owing to poor nutrition. The eating disorder symptoms were reported to improve in 70 percent of the participants during pregnancy and over half were largely in remission. The mean weight gain during pregnancy was above average. The mean birth weight for the infants matched the national average exactly and all babies were reported to be in good or excellent health. It is important to note that there was a significant number of women whose symptoms remained the same or deteriorated during pregnancy especially in terms of binging and vomiting which worsened in 18.6 percent of the cases studied. However, in contrast to other studies conducted in this area (see below), even the women with active eating disorders still gave birth to normal weight healthy babies. The authors suggest some caution in interpreting these results due to the fact that the sample was self selected. Individuals having traumatic pregnancy experiences or whose infants were seriously ill or had died, would clearly be less likely to volunteer to take part in such a study. This may perhaps account for why the study reports a better outcome than other research conducted in this area.

Other researchers have similarly suggested that there is a significant reduction in disordered eating during pregnancy for most anorectic and bulimic women (Brinch et al., 1988, Lacey and Smith, 1987, Blinder and Hagman, 1984). However, in contrast to the findings discussed above, not all authors have found that this necessarily results in healthy, normal weight babies. In addition, there are cases documenting the persistence and even worsening of symptoms throughout pregnancy (Stewart, 1987). It is clearly important to consider the possible negative impact that disordered eating can have on the foetus and newborn infant.

Low pre-pregnancy weight and limited weight gain during pregnancy have been associated with increased inter-uterine growth retardation, low infant birth weight and perinatal mortality (Abrams and Laros, 1986). According to Van der Spuy (1985) women who are underweight at the time of conception have a 19 percent chance of giving birth to low weight infants. Furthermore, the same author suggests that the
risk increases to 54 percent in underweight women who have artificially induced ovulation. Although much of the above data comes from studies of famine/concentration camps the findings suggest potential risks for the infants of anorectic women who are often underweight at conception, unwilling to gain adequate weight during pregnancy and, due to amenorrhoea, often have to engage in fertility treatment.

These findings are supported by a number of individual case and retrospective studies regarding pregnancy in mothers with anorexia. Treasure and Russell (1988) described the outcome of pregnancies in 6 anorectic women who managed to conceive despite being low in weight. The average weight gain for the women during pregnancy was only 8 k.g. (3 K.G. below the minimum recommended level). Serial Ultra Stenography was used to determine foetal growth and showed some foetal growth retardation during the last trimester of pregnancy. In addition, the abdominal circumference of all babies was below the third percentile at birth although all showed accelerated growth after birth. In 4 further case studies (Hart et al, 1970, Ho, 1985, Strimling, 1984, Weinfeld, 1988) mothers failed to gain adequate weight during pregnancy and there were complications of pregnancy and birth in every case. For example, in the case reported by Weinfeld (1988) the anoretic mother dropped to a low of 87 pounds during her pregnancy and had to be admitted to hospital on 4 occasions due to vomiting and food aversion. She eventually gave birth to a 1956 gram baby which was estimated to be 34 to 36 gestation.

Brinch et al (1988), in a Danish follow-up series, studied the reproduction patterns and parental functioning of 50 women with a former diagnosis of anorexia. The authors found that the rate of prematurity amongst the offspring and the percentage of infants born weighing less than 2500 K.G. was twice that expected from the background population. In addition, perinatal mortality was 6 times the expected level in Denmark. Out of the 86 children born to the 50 mothers, 7 died within the first week of life: 1 was stillborn, 1 was born with grave malformations and 5 died due to complications associated with premature delivery.
Women with bulimia, it may be argued, are less likely to be at a low pre-pregnancy weight. However, as with anorectic mothers, bulimic women may be unwilling to gain adequate weight during pregnancy. In addition, the practices associated with bulimia, e.g. binging, vomiting and use of laxatives, could potentially have damaging effects on the foetus. Use of laxatives and vomiting, for example, may cause electrolyte imbalance and since maternal and foetal electrolyte balance are similar, a disturbance may be detrimental to the foetus (Feingold, 1988). As with anorexia, there are a number of individual and retrospective studies suggesting that bulimic behaviour can have negative impact on the foetus and newborn infant.

As reported above, Franko and Walton (1993) discussed 7 cases of pregnancy in bulimic women. In 3 of these cases (Feingold, 1988, Ford and Dolan, 1989, Price et al, 1986) the bulimic symptoms continued throughout pregnancy. Each mother gained little weight during pregnancy and all mothers gave birth to low birth weight infants. In one extreme case cited by Ford and Dolan (1989), one mother became pregnant 7 times between the ages of 17 and 25. Persistent binging and vomiting was associated with 4 spontaneous abortions between 3 and 5 months gestation and 1 still birth at 7 months gestation. Amelioration of the bulimic symptoms during 2 pregnancies did result in 2 live births.

There are also a number of retrospective studies in this area. Lacey and Smith (1987) studied 20 active normal weight bulimics, all of whom had given birth within the last 2 years. The vast majority of mothers had reduced the frequency of binging and vomiting during pregnancy and all except 1 baby were born at full term at normal weight. However, the authors found a high incidence of foetal abnormalities, multiple pregnancies and obstetric complications. There were two sets of twins, 1 baby was born with a cleft palate and 1 a cleft lip. National figures sampled from the same year and with similar aged mothers found a prevalence of multiple births of 0.82 percent. In addition, cleft lip and palate were reported in 9.9 and 4.3 per 10,000 births respectively. The authors commented that it was impossible to draw any direct conclusions from the study due to the small sample size. In addition the role played by factors such as heredity, alcohol and drugs needs to be discounted and therefore
should be controlled for in future research. However, the fear that disturbed eating may damage the unborn foetus can not be dispelled by the study and clearly further investigation is warranted.

The only control study conducted in this area was reported by Mitchell (1991) who compared 38 pregnancies, in 20 active bulimics with 50 pregnancies in 31 controls. There were no significant differences between groups in terms of weight gained during pregnancy, weeks gestation and birth weight of the infants. The results suggest that the risk of foetal loss through miscarriage for the bulimics is almost twice as high as that for the controls i.e. 39 percent as compared to 17 percent. Although this is not a statistically significant difference, the authors justly feel that further investigation is necessary.

In contrast to the above studies, in the final case reported on by Franko and Walton (1993), Hollifield and Hobdy (1990) conducted interviews with 3 bulimic mothers, all of whom suggested that they did not reduce binging and purging during pregnancy and, where they did, they replaced them with other potentially more dangerous methods of weight control including exercise. Surprisingly, all mothers delivered apparently healthy normal weight babies.

The final study in this area was conducted by Stewart (1987) who interviewed 15 women with eating disorders about their pregnancies. 8 of the women were in remission, 4 had restricter-type anorexia and 3 were binging, purging and/or vomiting. The authors found that those symptomatic at conception gained less weight during pregnancy and had infants with lower birth weights and five minute APGAR scores. In addition, all complications associated with pregnancy and delivery and the two foetal deaths (1 spontaneous abortion and 1 uterine death) occurred in the women with an active eating disorder at the time of conception. Two infants experienced problems after birth, 1 respiratory distress and the other was jaundiced. Both of these infants were born to actively bulimic mothers. Overall, the authors suggest delaying pregnancy until the eating disorder is truly in remission.

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Conclusions.

Many of the studies conducted in this area suggest that the eating habits of both bulimic and anorectic mothers can potentially have detrimental effects on their foetuses and newborn infants. In addition, it appears that the risk to the babies of such women increases where the mother’s eating disorder symptoms continue throughout her pregnancy. However, there are a number of cases in which actively bulimic or anorectic women have given birth to normal weight healthy infants. The conflicting nature of the current data makes it impossible to draw any definite conclusions at this stage.

There are a number of problems associated with the design of much of the research that has been conducted in this area. Much of the data come from individual case reports on the basis of which it is inappropriate to draw any general conclusions. The remaining information reported comes from retrospective studies in which the subjective content of the information obtained coupled with possible recall errors, brings in to question the reliability and accuracy of such data. It may be, for example, that complications around pregnancy and birth are recalled more readily by women with eating disorders who are already concerned about adverse consequences. Alternatively, individuals may exaggerate their reports due to their own feelings of guilt. Either way biased information is obtained.

An omission from most of the research conducted thus far is the lack of a control group. Only one study in this area has used a control sample. However, even in this study participants were not matched for variables such as smoking and alcohol consumption during pregnancy. Such variables can also have detrimental impact on the foetus and, if not controlled for, may interfere with the results. Finally, most of the work reviewed is based on highly selected samples which may exaggerate the negative impact of eating disorders on the foetus and newborn infant.

There are still many unanswered questions around this topic. The information obtained suggests that further research is clearly warranted. Further advances could
be made by conducting controlled research preferably using larger sample sizes. In addition, it would be useful to conduct a prospective study with the inclusion of at least some objective measures.
SECTION 2. THE DEVELOPING CHILD.

The second section of this document contains a review of the literature concerning the impact of a mother's eating disorder on her developing child. Initially the potential effects of low birth weight and prematurity on the long term development of the child will be considered. However, the majority of this section contains information regarding parenting by mothers with eating disorders including the difficulties they experience and the way in which their attitudes and behaviour around food can affect their offspring.

A. The Long term Effects of Low Birth Weight and Prematurity.

Many of the above studies suggest that mothers with active eating disorders often give birth to low birth weight or premature infants. Clearly one important question which needs to be answered concerns the long term effects of such factors. Stewart (1992) suggests that low birth weight infants surviving the early weeks may suffer long term consequences i.e. continued delay in neurological and physiological development and impaired intellectual ability especially when associated with low inter-uterine growth before 26 weeks gestation. Similarly, Franko and Walton (1993) comment that low birth weight and premature delivery have been observed to continue to have negative effects on cognitive, sensory and physical development in children up to 14 years of age (Hunt et al, 1988). A study by Sobotkova and Mandys (1988) assessed 618 children at age 3 and 6 using the Stanford Binet test. Intellectual delay at 3 was associated with low birth weight i.e. below 2000 grams. Intellectual delay at 6 was associated with shorter gestation i.e. below 35 weeks and low 10 minute APGAR scores. In addition, intellectual delay at both age 3 and 6 was associated with low weight gain by the mother during pregnancy (below 8 K.G.). These results are only preliminary investigations. However, given that the above data suggest that mothers with bulimia and anorexia are at risk from delivering premature and/or low birth weight babies, these are key issues in the study of eating disorders. Further research is clearly necessary which should include a controlled prospective study of the medical and psychological impact of the mother's eating disorder on her
foetus and developing child.

B. Parenting by Parents with Bulimia and Anorexia.

Researchers generally agree that food habits are learned early in life and that the family is a central force in influencing the acquisition of these (Mogan, 1986). Through reinforcement, discouragement, and role modelling parents shape their children’s attitudes and habits around eating and food. For the active bulimic/anoretic mother many issues relating to her own eating difficulties, such as fear of food, will be in direct conflict with her duty to feed and nurture her child (Fahy, 1991). Consequently, children may suffer serious neglect. Given these issues, it is important to consider the impact of the behaviour and attitudes of a woman with bulimia or anorexia on her offspring.

It appears that, for some mothers with eating disorders, fear of harming their children can help them to overcome their difficulties. Lacey and Smith (1987) in their study of 20 active bulimics described how 6 women found pregnancy to have a positive influence over their eating. One woman reported "the need to be a good mother helped me stop it" (P. 779) and another "I have a horror of my baby witnessing my binging" (P. 779). Similarly, Lemberg and Phillips (1989) reported that 23 percent of bulimic and/or anoretic mothers were symptom free during the first year after child-birth. These mothers believed that, since having the baby, their meaning of life had changed and that they now had to remain healthy in order to care for the child. Finally Goldman (1988) reported the case of an anoretic woman who sought psychodynamic treatment for her own eating disorder following concern for her daughter who had stopped eating. She realised that, for her daughter’s sake, she would have to overcome her own eating difficulties and begin cooking and participating in family meals.

In all three of the above examples there is a clear demonstration as to how concern for offspring can lead to an improvement in the parent’s own eating pattern.
However, parenting does not have such a positive influence over all mothers and in fact, in some cases, can lead to a deterioration in symptoms (Stewart, 1987, Lacey and Smith, 1987). For example Lacey and Smith (1987) reported that 11 of their 20 bulimic participants thought that the stress of pregnancy and caring for a child caused a deterioration in their symptoms. One bulimic mother commented "it’s more of a problem now because I can not just throw away the baby’s food" (P. 779). In general, it appears that although mothering can have beneficial effects on the eating behaviour of some bulimic and anorectic women, for the majority symptoms continue.

For the bulimic mother, the elaborate and often rigid processes involved in planning and executing a binge can lead some parents to neglect their children for extended periods. Of the 20 bulimics studied by Lacey and Smith (1987) 6 admitted having their baby in the room during a binge and 7 admitted ignoring their child whilst preoccupied with vomiting. In one of the cases reported by Rand et al (1987) a bulimic mother was reported to be manipulating her child-care schedule after one year in order to binge and vomit. Stein and Fairburn (1989) published the first report purely concerning child-rearing by bulimic mothers. They found that of 5 mothers with children between 15 months and six years, 3 admitted ignoring their children for substantial periods of time whilst binging and vomiting. Furthermore, 2 mothers reported being constantly irritable during such episodes and found it difficult to cope with the child’s demands, often resorting to repeated smacking.

In response to Stein and Fairburn’s report, Fahy and Treasure (1989) published a letter detailing very similar child-rearing practises in 5 bulimic mothers. 3 of the 5 mothers reported sending their children to their rooms whilst they were binging. Again, the mothers found it very difficult to cope with interruptions to the binge with one mother admitting physically punishing her child if she interfered.

Some bulimic mothers also report problems feeding their children due to the close proximity to food that this involves. 3 of the 5 mothers discussed by Fahy and Treasure (1989) reported that feeding their children often precipitated a binge. The same authors also commented that one mother reported having no food in the house
and two others reported never cooking for their children at home. Similarly, Stein and Fairburn (1989), reported that 2 of their 5 mothers restricted the amount of food kept in the house as an attempt to control their own food intake but consequently had problems feeding their offspring.

Fahy and Treasure (1989) reported that none of their bulimic mothers showed any unusual attitudes towards their child's weight and shape. Furthermore, all offspring appeared to be developing normally. In contrast, Stein and Fairburn (1989) reported that 3 of their mothers had unnecessary concerns about the shape and weight of their children and, despite reassurance about its normality, were anxious to keep it down, hence affecting the child's feeding. In terms of the effects that these attitudes and behaviour had on the offspring, the authors found that 3 of the 6 children had feeding problems. 1 child had nonorganic failure to thrive and, despite repeated medical interventions, remained below the 3rd percentile for his weight. His sibling, in contrast, was severely overweight. A third was reported to be difficult to feed. Lacey and Smith (1987) found similar unusual attitudes towards the child's weight by some of their bulimic mothers. 7 of the 20 mothers reported being concerned that their babies were overweight. More worryingly, 3 mothers, 15 percent, were reported to be slimming their babies down within the first year. The G.P. records for these three babies showed them to be plump but well within the normal range. In the author's judgement the behaviour was a reflection of the mother's own psychopathology.

"The Independent" (1992) published an extremely interesting article detailing 3 personal accounts of the parenting difficulties experienced by mothers with eating disorders. One of the cases contained details pertaining to a bulimic mother who reported being obsessed with the weight of her 8-year-old daughter, Jemma. If she felt that Jemma was overweight she experienced strong feelings of rejection towards her. However, if Jemma had lost a few pounds her mother felt good but then guilty realising that her love for Jemma depended upon her weight. The mother described how Jemma appeared to derive comfort through eating as she herself had done at a similar age. She reported how Jemma often got into a panic around food and, if left a lone, would eat the lot. Here it is clear to see how history is repeating itself.
Jemma’s behaviour around food appears similar to that exhibited by a bulimic.

A number of case reports suggest that anorectic mothers also experience parenting difficulties which, in some cases, have adversely affected their offspring. They are less likely to experience the problem associated with binging and purging reported by bulimic mothers but, according to the clinical experience of Fahy and Treasure (1989) underweight mothers are more likely to experience undue concern about the weight of their children and may severely underfeed their offspring. Support for this idea comes from a single case study reported by Smith and Hanson (1972) of an anorectic mother who, in collusion with her psychopathic husband, starved to death her ten week old daughter. The baby had no internal injuries and death was reported to be due to failure to thrive attributed to poor feeding.

The association between an anorectic mother and death by starvation of her offspring has not previously been cited in the literature. Clearly this is an exceptional case with many other complex issues involved. However, there are other examples in the literature in which anorectic mothers have been reported to underfeed their children. It appears that sometimes the anorectic mother identifies so closely with her child that she can not feed it. Treasure and Russell, (1988) reported that the children of four anorexics attending their clinic have been investigated for poor growth which was felt to be due to poor feeding. In a Danish follow-up study of 50 anorectic mothers, Brinch et al (1988) found failure to thrive in the first year of life was reported by mothers in about 17 percent of the children. In a Dutch series Van Wezel-meijler and Wit (1989) reported that 7 children with anorectic mothers presented with stunted growth and low weight for their height. Medical evidence was gathered for all the children which suggested that growth disturbance was associated with underfeeding. Further support for this came from the mothers’ own reactions. 2 mothers were openly disapproving about the way their children were fed whilst in hospital and were disgusted at the amount of weight their offspring gained. In addition, none of the mothers were particularly worried about the growth retardation of their children. In some cases nutritional deprivation appears to have been accompanied by psychosocial deprivation. For example two children were often locked in their rooms with little
food on their plates.

Alternatively to identifying with her child and so having difficulties feeding him/her, Dr. Treasure in "The Independent" (1992) reported that some anoretic mothers find a focus for their obsession with food by cooking for their children and forcing them to eat. One of the cases reported in "The Independent" article details the experience of an anoretic mother who was overfeeding her ten-year-old twin sons. At the time of writing, the twins each weighed around ten stone and although the mother had been informed by the G.P. that she was killing her sons, she admitted that she was unable to stop feeding them when, for her, food equated to love. The mother commented on the thrill she herself got from feeding the children which was enough to make her feel full. Although the mother was at risk of losing custody of her children, she was unable to stop overfeeding them when "feeding them is just as vital to me as not feeding myself".

In terms of the effect that such attitudes and behaviour have on the offspring, as with bulimic mothers, there is very little information. Brinch et al (1988) found that of 86 children born to 50 anoretic mothers, 6 were reported to have eating/weight problems. 4 of these were reported to be markedly underweight, 1 was overweight and the final child had anorexia. In addition one child who became anoretic died at age 15. A further case cited by "The Independent" (1992) described a situation in which two children appeared to be modelling their anoretic mother's eating pattern. The mother reported that her two children, an 8-year-old daughter and 6-year-old son, were both refusing to eat and, at the time, were both already a stone underweight. The mother described how meal-times had become a battle. She commented that, although she herself did not eat breakfast, she would get up to get theirs. Breakfast, she reported, could take up to three hours during which time her daughter might eat 3 grape-nuts and her son a spoonful of cornflakes. The mother reported feeling guilty believing that she had brought the problem upon them. The children boasted to their mother how they turned down sweets at friends houses and the mother felt that they were always competing with her or between themselves over food. Again, it appears that this is a clear example of how the offspring of a mother with an eating disorder
may take on her behaviour and attitudes around food.

The largest study reported in this area was conducted by Woodside and Shekter-Wolfson (1990) who investigated parenting by people with anorexia and bulimia. Participants consisted of 10 mothers and 2 fathers who were attending treatment programmes in a day hospital. They reported that most experienced serious parenting difficulties and few individuals expressed happiness with this role. 2 mothers abandoned their children to the care of the father, 1 mother had no contact with her children for one year and another abandoned most of the parenting tasks to the children’s grandparents. In all cases either the eating disorder or fears about one's own ability to parent were identified as the main reasons for abandonment. In families where abandonment did not occur there were many examples of extremely distorted parent-child relationships including parents wearing their children’s clothes, children cooking for their parents and, in general, over-involvement of the child in the affected parent’s illness. In addition, 3 children had difficulties around eating themselves with two reported to have an eating disorder and the other was dieting.

Conclusions.

Preliminary research in this area suggests that some anoretic and bulimic mothers experience serious parenting difficulties which have a negative impact on their offspring. In addition, some children with bulimic or anoretic mothers do appear to mimic their parents’ attitudes towards and behaviour around food. There does appear to be a slight difference between the parenting difficulties experienced by bulimic and anoretic mothers. For bulimic mothers many of the parenting problems evolve around the mother’s need to binge and purge. In contrast, anoretic mothers appear to hold more distorted views of their children’s shape and weight and hence have a tendency to underfeed their offspring. This distinction is not steadfast and in fact the close link between the two disorders makes it likely that both sets of mothers will share similar parenting problems.

Any conclusions drawn from this section should be viewed with caution. Very few
studies have currently been conducted in this area and most of the data reviewed here comes from individual case reports on the basis of which it is impossible to draw any general conclusions. In addition, similar criticisms to those highlighted in section 1 can be levelled at the design of the studies. Most of the reports consist of anecdotal accounts and so encompass the problems associated with such information, particularly questions about its accuracy and reliability. Most of the cases represent the experiences of parents attending intensive treatment centres which are likely to attract severely ill individuals and hence not represent the experience of parenting for the average individual with an eating disorder. Finally, none of the studies reviewed included a control group. Clearly further controlled research is necessary to ensure that the experiences reported above are specific to mothers with bulimia or anorexia and not problems experienced generally by mothers. In addition, future studies need to control for other external variables, such as marital status, which may otherwise interfere with the data gathered. Although no overall conclusions can be drawn from this section, the data represented, coupled with the statement from Dr. Treasure in "The Independent" (1992) commenting that the offspring of parents with an eating disorder are ten times more likely to develop the condition themselves, suggests that further controlled investigation is necessary.
SUMMARY AND CONCLUSIONS.

Although the prevalence of pregnancy amongst bulimic and anorexic women is unknown, individual case reports and retrospective accounts suggest that such women can and do become pregnant. The effects of the mother's eating behaviour on her foetus and newborn infant are unclear, although a number of studies suggest the potential for damage particularly where the mother's disturbed eating continues throughout her pregnancy. Preliminary investigations further intimate that damage caused to the newborn infants, particularly prematurity and low birth weight, may cause continued delay in neurological and physical development and impaired intellectual ability. In addition, some bulimic and anorexic mothers appear to experience difficulties with parenting which, in some cases, have had negative impacts on their children. Furthermore, the offspring of such mothers sometimes appear to mimic their parent's behaviour around and attitude towards food.

Throughout this investigation a number of criticisms which can be levelled at these data presented have been highlighted. However, even with all these factors in mind, one clearly can not dispel any possible anxieties that bulimic and anorexic mothers may have regarding the detrimental impact of their illness upon their foetus and offspring. If nothing else, these data presented here do suggest that further investigation is warranted.

Given that the number of people suffering from eating disorders is believed to be increasing, ("The Independent", 1992) coupled with the fact that medical practices will continue to advance, enabling more women with eating disorders to conceive, this area of research will become significantly more important. Clearly it is crucial to inform obstetricians, G.P.s and, most importantly, the parents themselves about any potential damage that the mothers' disturbed eating may have upon their foetuses and offspring. In order to achieve this, researchers need to establish valid and reliable conclusions in this area. Further research is necessary which should include a longitudinal controlled investigation examining the effects of mothers' disturbed eating upon both their foetuses and offspring.
REFERENCES.


"THE LINK BETWEEN THE EATING ATTITUDES AND BEHAVIOUR OF PARENTS AND THE EATING BEHAVIOUR OF THEIR CHILDREN."
ABSTRACT.

The aim of this investigation was to study the relationship between the eating attitudes and behaviour of parents and the eating behaviour of their children.

The parent/guardian of 360 children, aged four to twelve years and attending a school in the Merton area, was sent a batch of questionnaires to complete. The first questionnaire, which aimed to measure selective or fussy eating, was completed by the parent regarding the eating behaviour of his/her child. The second questionnaire aimed to gather background information about each child and the eating patterns of his/her family. The final questionnaire was completed by the parent about his/her own eating attitudes and behaviour.

The main hypothesis of the study was that there would be a link between abnormal eating attitudes and habits in parents and selective eating in children. In addition an exploration of factors affecting selective eating in children was undertaken.

171 forms were returned, the majority of which were completed by mothers. The results provided no support for the main hypothesis. However a possible explanation for the results is provided using a model outlined by Gillian Harris (in press) from a paper which was obtained after this study had been conducted.

The results suggest that there is a link between selective eating in children and being vegetarian. However, due to the small number of vegetarian children surveyed, further investigation is needed before definite conclusions can be drawn. A monotonic relationship was found between selective eating in children and how often the parent eats the same food as the child at meal-times, for as frequency of eating the same food declined, selective eating in the child increased. However this link is likely to have arisen as a result of fussy eating in the child rather than being a cause of it.
INTRODUCTION.

It is generally documented that there is an increasing prevalence and a decreasing age of onset of eating disorders (DiNicola and Roberts, 1989). Since the first identification of Anorexia Nervosa, family pathology in various guises has been proposed as a possible risk factor for the development of an eating disorder (Hsu, 1983). Traditionally the focus has been on interactional patterns between family members. However an alternative and increasingly popular point of view seeks to examine the prioritisation of issues concerning weight, shape and eating behaviour within the family (Hill and Franklin, 1996). This stems from the hypothesis that parental overconcern with weight and eating behaviour may be passed on and adopted by children. This hypothesis acknowledges the role that the family play as the primary agency for socialisation and the role that mothers in particular might play in transmitting the nature and importance of the socio-cultural pressures on women (Hill and Franklin, 1996).

Children with Obesity.

There is some evidence from the literature on obesity that parental eating behaviour affects the eating behaviour of their offspring. Klesges et al (1983) studied the relationship between selective parental behaviours and infant relative weight gain in seven children aged 12 - 36 months. The results suggested that parents have significant influence over the weight of their children. Parental prompts and encouragement to eat correlated significantly with the relative weight of the child and hence, by inference, the child’s food intake.

Similarly, Agras et al (1988) comment that a number of studies have found that family meal duration is associated with higher relative weight of the child. This suggests that, in terms of obesity, at least one aspect, i.e. meal duration, is socially transmitted via the family. Agras et al (1988) conducted a laboratory study comparing the eating behaviour of twenty-nine children aged 18 months and their parents. They found that there was a strong relationship between parents and their
children with regard to caloric intake (meal content), active feed time (meal duration) and bite frequency (eating style).

**Parents with Eating Disorders.**

Anorexia and Bulimia are major sources of psychiatric morbidity amongst women of child bearing age (Fairburn and Beglin, 1990). There are a number of reports demonstrating a relationship between eating disorders in mothers and impaired development and growth in their children (Stein and Fairburn, 1989, Van Wezel-Meijler and Wit, 1989, Woodside and Shekter-Wolfson, 1990). Mothers with eating disorders may have particular difficulties with feeding their children. Stein and Fairburn (1993) cite a case study of a mother with a history of Anorexia who, due to her own attitudes towards food and body shape, found it very difficult to feed her baby with Cystic Fibrosis. The authors conclude that parents with a history of eating disorders may require special advice and support around feeding their offspring.

Linked with this, it is also interesting to consider the impact of the mother’s eating psychopathology on her view of the shape and weight of her offspring. Fahy and Treasure (1989) studied five bulimic mothers and found that although all of them had trouble with feeding their children, none of them showed any unusual attitudes towards their child’s shape and weight. In contrast, Lacey and Smith (1987) found that seven of the twenty bulimic mothers they studied were concerned that their babies were overweight and three mothers were reported to be slimming their babies down within the first year of life. Similarly, Stein and Fairburn (1989) found that three of the five bulimic mothers had unnecessary concerns about the weight and shape of their children and, despite constant reassurances about its normality, were anxious to keep their child’s weight down, hence affecting the child’s feeding. In terms of the impact of these abnormal attitudes to shape and weight on the offspring, Stein and Fairburn (1989) found that three of the six children reared by the eating disordered mothers had feeding problems themselves.

Case reports in the literature suggest that anoretic mothers may also experience extreme concerns about the shape and weight of their offspring. According to the
clinical experience of Fahy and Treasure (1989) underweight mothers are more likely to experience undue concern about the weight of their children and hence underfeed them. For example Treasure and Russell (1988) reported that the children of four mothers attending their clinic for people with Anorexia have been investigated for poor growth which was felt to be due to undernourishment. Similarly Van-Wezel-Meijler and Wit (1989) found that seven children with anorectic mothers presented with low weight for height and stunted growth. Brinch et al (1988) found that of eighty-six children born to fifty anorectic mothers, six had eating/weight problems themselves and one child in particular developed Anorexia and died at age fifteen.

A case study cited in "The Independent" (1992) details how an eight year-old girl and a six year-old boy modelled their anorectic mother's eating pattern. Both children refused to eat. The mother reported that they would boast to her about how they had managed to turn down sweets at friends houses and she felt that they competed with her and each other over food.

The majority of information in this area comes from case studies. However, Stein et al (1994) conducted a controlled observational study comparing two groups of mothers and their 12 - 14 month old infants. The index group contained mothers who had experienced an eating disorder during their post natal year and the control group contained mothers who were free from eating psychopathology. The authors found that the index mothers were more intrusive and expressed more negative tones towards their infants during meal-times than did the control mothers. In turn the emotional tone of the index infants was found to be generally more negative than that of the controls and there was greater conflict at their meal-times. In addition the index infants were lighter than the controls and their weight was found to be inversely related to both the amount of conflict at meal-times and the extent of their mothers concern about her own body shape. (For further details concerning parenting by parents with eating disorders see previous literature review (Byles, unpublished).

In summary it is difficult to draw any definite conclusions from this literature. Firstly the majority of information has been derived from case studies and little
controlled research has been conducted. However the literature seems to suggest that children reared by mothers with extreme concerns about body weight and shape and with abnormal eating behaviour may be at risk from developing abnormal eating behaviour themselves.

**Dieting Concerns and Feeding Disorders in Children.**

Thus far, the literature presented has focused on highly specific groups of individuals i.e. children with obesity and mothers with Anorexia and Bulimia. However it is important to establish whether or not feeding disorders, concerns about shape and weight and abnormal eating behaviour exist in children and, if so, is there any evidence to suggest that these abnormal eating attitudes and behaviours are, at least in part, learned from parents.

Several recent studies have shown that dieting in adolescent girls is a normative behaviour. For example the prevalence of wanting to lose weight or dieting in adolescent girls aged 15 or over often reaches 70 percent (Wardle and Beales, 1986). Puberty is considered to be the crucial event provoking this concern with body weight and shape. In addition eating disorders such as Bulimia and Anorexia also occur frequently in this age group. According to DSM-III-R (American Psychiatric Association, 1987) 1 in 250 people will experience eating disorder symptoms during adolescence.

Body shape dissatisfaction and dieting is not just the province of adolescents but has also been found in a significant proportion of prepubertal girls aged nine and over (Wardle and Beales, 1986, Maloney et al, 1989, Hill et al, 1992, Hill et al, 1994). A study using the Kids Eating Disorder Survey (Childress et al, 1993) on children aged 9 - 16 years (mean age 12), found that more than 40 percent of children suggested that they looked fat to others and wanted to lose weight and more than 41.4 percent had dieted. Concern about weight was found by the survey to occur in both genders although it occurred predominantly in girls.
In a recent article in "The Independent" (8/95) it was stated that researchers from Swansea University found that over a quarter of the five to seven year-olds they assessed wanted to be thin and one in six was dieting even though one third of them were already underweight. The article goes on to state that Dr. A. Hill at Leeds university has found, in a study of nine year-olds, that boys wanted to grow bigger whilst girls wanted to weigh less than they did. Similarly Hill and Pallin (1995) studied a group of 176 eight year-olds and concluded that many of them were already aware of dieting as a means of weight control.

Feeding disorders are also reported in very young children. Sanders et al (1993), for example, estimated that the parents of twenty-four percent of two year-olds, nineteen percent of three year-olds and eighteen percent of five year-olds have feeding problems. Douglas (1991) reports that eating problems in children are a common worry among parents. She identifies five different categories of common feeding problems in young children including food refusal, poor appetite and extreme faddiness. Douglas (1991) reports that the etiological factors for the development of feeding disorders in young children can include past history of medical problems influencing the child's feeding experience, fear of eating due to early adverse experiences associated with feeding e.g. vomiting, inappropriate modelling by parents around food, quality of the parent child relationship and dietary obsession/preferences in parents which can lead them to provide their offspring with a very restricted diet.

The combination of these results suggest that feeding disorders and concerns about shape and weight in preteen children do exist and clearly this is an area that warrants further investigation. Feeding disorders and abnormal eating behaviour in childhood can have profound affects on the growth and development of the child (DiNicola and Roberts, 1989, Walford and McCune, 1991, Chatoor et al, 1988, McCann et al, 1994). In addition it has been suggested that abnormal eating habits and attitudes in the child may predispose him/her to the development of eating disorders later in life (Marchi and Cohen, 1990). Rodin et al (1990), suggest that selective, or picky, eating which is a relatively common problem for children early in life, has been found to be a risk factor for the development of Anorexia.
Numerous etiological factors have been proposed to explain the origin of these difficulties and clearly every case is unique with its own individual etiological explanations. However, many researchers have emphasised the highly specific context of the family in which many of the child’s attitudes and behaviours are developed and the possible role that this may play in the evolution of feeding disorders and abnormal eating behaviour in children (Rodin et al., 1990).

The Link between Parent and Child Eating Attitudes and Behaviours.

Researchers generally agree that food habits are learned early in life and that the family is a central force in influencing the acquisition of these (Mogan, 1986). Social learning theory proposes that parents are important agents of socialisation who, through modelling, instruction reinforcement and discouragement, shape their children’s attitudes and habits around eating and food and influence their children’s body image and eating behaviour (Striegel-Moore and Kearney-Cooke, 1994). The importance of social learning factors in the family in the origin and maintenance of feeding behaviour is highlighted by many authors (Sanders et al., 1993, Iwata et al., 1982).

Striegel-Moore and Kearney-Cooke (1994) studied the attitudes and behaviours of 1276 male and female parents regarding the physical appearance of their children. All the parents studied were caring for a child aged between two and sixteen years. They found that the majority of parents were satisfied with their child’s physical appearance, eating habits and exercise behaviour. The authors found that mothers were more involved in controlling their children’s eating behaviour and were more likely to be held responsible for their physical appearance than fathers. Similar results were found by Smetana (1988) who suggested that mothers were seen by both spouses and children as responsible for enforcing family norms regarding physical appearance. Spitzack (1990) commented that both parents exerted some influence over their children’s eating and physical appearance although fathers were more likely to complement and mothers criticise.
Some studies suggest the gender of the child makes a difference to the parental view. Costanzo and Woody (1979) for example found that parents were more likely to restrict access to food for overweight daughters than they were for overweight sons. In the Striegel-Moore and Kearney-Cooke (1994) study some differences in parental attitudes were found consistent with the greater importance of beauty to women. However other data suggested that boys are increasingly included in our cultural directive to pursue physical attractiveness.

Striegel-Moore and Kearney-Cooke (1994) found a strong relationship between parental dieting efforts and encouraging the child to diet. This relationship was not limited to mothers and their daughters but also held for fathers and daughters and fathers and sons. Furthermore, their results suggested that concerns about shape, weight and dieting were being role modelled by mothers to their daughters.

A number of other authors have also found similar results. Pike and Rodin (1991) studied 77 mothers of 16 year-old girls. The mothers were selected on the basis of the extent of their daughters disordered eating. Striking correspondences between mother and daughter eating psychopathology was revealed. The mothers of girls who achieved a high score on a measure of eating disorder symptomatology, themselves scored significantly higher than the mothers of comparison low scorers on three subscales from the Eating Disorder Inventory (Garnder et al, 1983) namely Drive for Thinness, Bulimia and Body Dissatisfaction. The mothers of the high scorers also reported dieting at a younger age and thought that their daughters should lose more weight. Hill and Franklin (1996) examined a group of forty eleven year-olds and their mothers. Twenty of the girls had high Dietary Restraint scores and twenty had low Dietary Restraint scores. The expected differences between the two groups of maternal Dietary Restraint scores were not observed. In fact the majority of the mothers reported feeling overweight and wanting to be thinner. The authors comment that Dietary Restraint is about current behaviour but gives no insight into past dieting concerns or attempts to control eating. They suggest that there were subtle differences between the two groups which may be markers of more intense past dieting. Mothers of the high restraint girls did report more between meal snacking.
and fasting and rated their daughters as less attractive. The authors conclude that their results provide some support for the role that mothers may play in the transmission of cultural values regarding shape, weight and appearance.

Parental encouragement to control weight was also found to be associated with dieting in a study of nine and ten year-olds (Thelen and Cormier, 1995). Hill et al (1990) emphasise the fact that parental attitudes to weight and dieting are conveyed to and accepted by their children at a very young age. They found a strong family link between mothers and their ten year-old daughters concerning their motivation to diet. The authors found a correlation between the Dietary Restraint scores achieved by mothers and their daughters of $R = 0.68$.

Some authors have explored the familial link by studying whether or not the mothers of children with feeding problems show any signs of eating psychopathology themselves. The findings in this area are conflicting. Hall et al (1986) found no differences on measures of weight and dieting history between mothers of anorexic clients and mothers of controls. In fact the mothers of the anorexics scored significantly lower on a measure about weight, shape and eating behaviour which was interpreted by the authors as a denial or minimisation of concern.

McCann et al (1994) investigated the eating attitudes and habits concerning body shape and weight among twenty-six mothers with children with Nonorganic Failure To Thrive (N.F.T.T.) and twenty-six matched controls. The average age of the children with N.F.T.T. was 3.8 years, range 0 - 9 years. Each of the fifty-two participants was interviewed using the Eating Disorder Examination, the E.D.E. (Cooper and Fairburn, 1987). Mothers of the index group had higher levels of Dietary Restraint and, despite their child’s low weight, 50 percent were restricting their child’s intake of sweet foods and 30 percent were restricting food they considered fattening and unhealthy. The authors suggest that the mothers may be restricting these foods for health reasons. Alternatively they suggest that the high level of Dietary Restraint in the mothers led them to restrict their child’s intake as well.
McCan et al (1994) also found that although each of the children with N.F.T.T. was at the third percentile or above, 58 percent of the index mothers felt that their child was of normal weight or slightly under and 38 percent perceived their child’s shape as normal. The authors conclude that their results suggest that maternal eating habits and attitudes may have a causal role in the development of N.F.T.T. in their children.

Stein et al (1995) assessed the parents of thirty children, aged two to twelve years, referred to local child psychiatric clinics with a diagnosis of a feeding disorder. This diagnosis generally involved food refusal and/or extreme faddiness. The thirty children were matched with children referred to the clinics with a behavioural disorder. The mothers of the sixty children were asked to complete the Eating Disorder Examination Questionnaire, the E.D.E.Q. (Fairburn and Beglin, 1994). In addition data were extracted from a study in which the E.D.E.Q. was administered to a community sample of women at child bearing age. The mothers of the children with feeding disorders scored significantly higher than the other mothers on all but one of the five E.D.E.Q. subscales. These results suggest that parental eating problems can be readily seen in the feeding difficulties of their children from a preschool age and beyond.

Clearly these findings do not prove causality but they do suggest that maternal eating attitudes and behaviours play a role in the process of the acquisition of eating psychopathology in children. Linked with this, literature concerning the acquisition of food choices and preferences also identifies the operation of parental influences on children from a very early age (Ray and Klesges, 1993).

The main aim of the following dissertation is to build on the results obtained by Stein et al (1995) by investigating the link between the eating attitudes and habits of parents and the eating behaviour of their children in a general community sample. However, before detailing the specific hypotheses, it is first necessary to briefly examine issues relating to the measures used in this study.

**Measures.**
The Child Questionnaire.

Owing to the sparse literature in this area, a number of difficulties were experienced when selecting a suitable measure for assessing the eating behaviour of four to twelve year-old children. Due to the fact that a large community sample was sought, self report questionnaires were felt to be the most appropriate method of assessment. Assessment via interview was felt to be inappropriate due to the time factor. In addition, owing to the nature of the issues investigated in this study, it was felt that parents and children would find an interview too intrusive.

The majority of self report questionnaires about eating have been developed specifically for adults. Many of these questionnaires, for example the Eating Disorder Inventory, the E.D.I. (Garner et al, 1983) and the Eating Attitudes Test, the E.A.T. (Garner and Garfinkle, 1979) contain questions relating to issues such as self induced vomiting and laxative use. Clearly there are tremendous ethical considerations around asking young children questions related to such factors.

There are a number of self report tools which have been developed specifically for children. For example the Children’s Eating Behaviour Inventory (Archer et al, 1991). However this measure looks at formal parent child relationships rather than eating disorder symptoms. A child version of the E.A.T. has also been developed, namely the C.H.E.A.T. (Maloney et al, 1988), but, according to Smolak and Lavine (1994) who administered the questionnaire to a group of school girls with a mean age of 13.2 years, wording changes would be needed to make the scale accessible to younger children.

Due to the young age of the target sample, it was decided that the most appropriate way of assessing the children’s eating was to ask their parents. Clearly children as young as four would have tremendous difficulties in completing a questionnaire themselves not least because of difficulties with understanding the questions. There is some evidence to suggest that even older children have difficulties with expressing their problems (Fallowfield, 1995). Furthermore, for consistency it was felt
appropriate that all the children should be assessed using the same measure regardless of their age.

The measure chosen to assess the children's eating behaviour was the Eating Behaviour Questionnaire (E.B.Q.) developed by Rebecca Harris (1995) under the supervision of Rachel Waugh at Great Ormond Street Hospital for Children (G.O.S.H.). This measure was devised specifically to assess selective or fussy eating in children i.e. individuals who appear to survive on a narrow range of foods (Bryant-Waugh and Kaminski, 1993).

The items on the E.B.Q. were derived after consultation with the experts in the field of eating disorders at G.O.S.H.; a review of the relevant literature into food habits and preferences; and comprehensive analysis of the past and current selective eater case notes at G.O.S.H. Initially 24 items were selected for the E.B.Q. reflecting a range of reported selective eating attitudes and behaviours. Subsequent research using this measure was conducted assessing selective eating in a normal population of 105 children aged eight to sixteen years. Factor analysis of the results revealed a one factor solution which, according to the authors, could be described as Varied Eating. 6 items which failed to load sufficiently on this factor were dropped from the questionnaire. After the removal of these items the factor was found to account for 33.4% of the variance.

Reliability for the measure was calculated using Chronbach's Alpha which produced a coefficient of =0.87 suggesting that there is a high level of consistency between the items. Due to the lack of knowledge in this field, it was much more difficult to establish the validity of the measure. High face validity was assumed since the questionnaire was designed in conjunction with experts in the field. In addition discriminant validity of the measure is being investigated at G.O.S.H. in that the E.B.Q. is currently being administered to any new children referred with selective eating.

Given the lack of knowledge in this area and the infancy of the E.B.Q., it was also
decided that part of this research would involve exploratory work around identifying additional factors which appear to relate to selective or fussy eating in children.

The Parent Questionnaire.

There are numerous measures available for the assessment of eating disorders in adults. Many of these, for example the E.A.T. (Garner and Garfinkle, 1979) and the E.D.I. (Garner et al, 1983), assess both the general and specific psychopathology of eating disorders. General psychopathology concerns features found in other psychiatric disorders, for example depression and anxiety, whilst the specific psychopathology assesses the specific components of Bulimia Nervosa, Anorexia Nervosa and their variants, for example extreme dieting. There are also questionnaires which are intended to measure specific aspects of the eating disorder psychopathology, for example the Bulimia Investigatory Test, the Bite (Henderson and Freeman 1987).

In this study the aim is to assess the range of specific psychopathology associated with eating disorders and the instrument selected to do this was the Eating Disorders Examination Questionnaire, the E.D.E.Q. (Fairburn and Beglin, 1994). This has the advantage that it aims to measure both behavioural and attitudinal aspects of eating psychopathology. The E.D.E.Q. is a self report version of the Eating Disorder Examination, the E.D.E. (Fairburn and Cooper, 1993). The E.D.E. is an investigator-based interview which provides frequency or severity ratings for key behavioural and attitudinal aspects of eating disorders. It is a measure of present state in that it is concerned with the respondent’s behaviour and attitudes over the previous 28 days. The E.D.E. has been revised over an 8 year period to maximise its reliability and validity and is now in its 12th edition, (Fairburn and Cooper, 1993).

Originally five subscales were derived by grouping together items which represented major areas of psychopathology. The subscales were Dietary Restraint, Eating Concern, Shape Concern, Weight Concern and Bulimia (Cooper et al, 1987). The
fifth scale, Bulimia, has recently been dropped from the E.D.E. as it did not add further descriptive information beyond that which can be derived from the frequencies of the various forms of overeating assessed.

It has been demonstrated that the E.D.E. can be used reliably and tests of its discriminant and concurrent validity support its use (Cooper et al, 1989, Fairburn et al, 1992, Marcus et al, 1992, Striegel-moore et al, 1992, Rosen et al, 1990). Furthermore, Wilson and Smith (1989) claimed that the E.D.E. is a more sensitive measure than many of the self report questionnaires to the central features of Bulimia.

Clearly, given the large number of respondents assessed in this study and the time available to conduct it, it was not appropriate to use the E.D.E. itself. Preliminary training is needed to conduct the interview and it takes on average 30 to 60 minutes to administer. In addition the authors report that clients can find the interview intrusive and embarrassing. Furthermore, the interview is felt to be more sensitive in treatment outcome studies and since this was not the agenda, the E.D.E.Q. was utilised in this study instead.

The adaptations made to the E.D.E. were those needed to make it suitable for administration as a self report measure (Fairburn and Beglin, 1994). It was designed to be simple to complete and of a length so that it could be completed in less than fifteen minutes. Unlike the E.D.E., key terms are not defined and there are no detailed guidelines for making ratings as these would make the questionnaire too long and complex.

Fairburn and Beglin (1994) compared the performance of the E.D.E. and the E.D.E.Q. Two groups of individuals were assessed, namely a community sample and a group of participants with Anorexia Nervosa or Bulimia. Participants completed the self report questionnaire and, within 24 hours, were interviewed using the 11th edition of the E.D.E. For both the community and patient samples the scores on the three subscales Dietary restraint, Shape Concern and Weight Concern were highly correlated. The two methods produced close agreement on the assessment of Dietary
Restraint perhaps because the behaviours and attitudes being assessed were relatively clear cut. There was somewhat more disagreement with the assessment of concern about weight, although the discrepancy did not reach clinical significance. The largest disagreement between the two measures was found with the assessment of Shape Concern. Problems of definition were probably responsible for this discrepancy because this subscale addresses a number of particularly complex features.

In summary, the E.D.E.Q. was felt to be the most appropriate measure to utilise in this investigation. An added advantage of this instrument was that it had been used in studies very similar in nature to this research.

Aims and Hypotheses.

In the following study, parental eating attitudes and behaviours will be assessed using the E.D.E.Q. In addition the eating behaviour of their offspring will be assessed by asking the parents to complete the E.B.Q. on behalf of their child. Background information about each child and his/her family eating patterns will also be collected.

The overall aims of the study are as follows -

1. To examine the relationship between eating attitudes and behaviours of parents and the eating behaviour of their offspring.

2. To explore what variables affect selective eating in children.

3. To compare the results obtained from a community sample and a clinical sample comprising children referred for psychological help regarding a feeding disorder.

The specific hypotheses for this study are as follows -
1. An increase in the parental global score on the E.D.E.Q. will be associated with an increase in the child’s score on the E.B.Q.

2. An increase in parent scores on each of the four subscales of the E.D.E.Q., Dietary Restraint, Eating Concern, Shape Concern and Weight Concern, will be associated with an increase in the child’s score on the E.B.Q.

3. Parental scores on the E.D.E.Q. will explain a high proportion of the child’s score on the E.B.Q.
METHOD.

Participants.

The intention in this study was to obtain two groups of participants.

1. A random community sample consisting of the parent/guardian of 360 children aged 4 - 12 years. The aim was to try to obtain an approximately equal number of participants in each age group. Therefore the parent/guardian of 40 children selected at random from each of the nine ages (4 - 12 years) was contacted.

2. A clinical sample consisting of the parent/guardian of any children aged 4 - 12 years referred to a Child Clinical Psychologist with a feeding disorder. The aim was that this sample should be as large as possible but clearly its size would depend on the number of appropriate referrals made to the service.

Measures.

Three questionnaires and a covering letter were distributed to each of the 360 participants in the community sample and to the participants in the clinical sample.

The Covering Letter.

The batch of questionnaires sent to each parent/guardian was accompanied by an introductory letter which included a brief outline of the research, highlighted the fact that the survey was anonymous and emphasised the nonobligatory nature of the study.

The participants were requested to complete the initial two questionnaires for their ...-year-old child. The actual age of the targeted child was specified on the letter to avoid confusion where more than one child was present in a family. This method also ensured that the respondent did not deliberately choose or avoid completing the
forms about a particular child with significant eating problems. The participants were asked to complete the final questionnaire about their own eating behaviour.

The participants were asked to return the completed forms in the free post envelope provided. If they did not wish to complete the forms, they were requested to return them blank, if possible with a note explaining their reasons for not wishing to take part in the survey.

Finally the number of the Eating Disorders help-line was included on the letter and the participants were encouraged to contact this service if they were at all concerned about their own or their child’s eating behaviour.

The introductory letter sent to the clinical sample was amended slightly to ensure that respondents were aware that this research was totally separate from any treatment that their child might receive. In addition, they were informed that space had been provided on the survey for them to enter both their own and their child’s name. However it was highlighted that they were not obliged to complete this item and could return the questionnaires anonymously if they chose to do so. (A copy of both the covering letters sent to the community and clinical sample can be found in appendix A).

**The Eating Behaviour Questionnaire.**

In order to assess the eating behaviour of each child, respondents were asked to complete the Eating Behaviour Questionnaire (E.B.Q.) for their ...-year-old child. Again the actual age of the targeted child was entered onto the form to avoid confusion.

The E.B.Q. is an 18 item questionnaire designed to assess selective (fussy) eating in children. The questionnaire was devised by an undergraduate Psychologist, Ms. R. Harris (unpublished) under the supervision of Dr. Rachel Waugh at Great Ormond Street Hospital for Children (G.O.S.H.).
The E.B.Q. consists of 18 questions. For each item the parent/guardian is required to mark on a six point Likert forced response scale how typical that behaviour is of his/her child. The Likert scale ranges from not at all typical (1) to very typical (6).

In terms of scoring, nine of the items are scored positively and nine items are scored in the negative direction. The maximum score that may be obtained on the scale is 108 and the minimum score is 18. (A copy of the E.B.Q. may be found in Appendix B).

**Background Information.**

The second questionnaire was designed by the researcher and aimed to obtain background information from each adult respondent about his/her child. This questionnaire consists of sixteen items and is divided into two sections.

The first section, entitled "Personal Details" consists of seven questions aiming to obtain demographic information about each child. These questions were designed to elicit information that was considered important for describing the sample (e.g. gender and ethnicity of the target child) and for obtaining information that might prove significant when interpreting the results (e.g. medical problems experienced by the child).

The second section, entitled "Food Details" consists of nine questions. These items were designed to provide background information on the eating habits of both the child (e.g. if he/she has any allergies or eats a special diet for medical reasons) and the family (e.g. who prepares the meals in the household).

The majority of items in this questionnaire were included in the study for exploratory purposes i.e. to see whether or not these variables had any significant influence over fussy eating in children.

This questionnaire was slightly adapted for the clinical sample so that space was made
for respondents to enter their own and their child’s names. (A copy of this questionnaire may be found in Appendix C).

**The Eating Disorder Examination Questionnaire.**

The third and final questionnaire aimed to assess the eating attitudes and habits of the adult respondents themselves. The measure used to achieve this aim was the Eating Disorder Examination Questionnaire (E.D.E.Q) (Fairburn and Beglin, 1994). This is a self report version of the Eating Disorder Examination (E.D.E.) (Fairburn and Cooper, 1993) which is an investigator-based interview designed to assess the broad range of specific psychopathology associated with eating disorders. The E.D.E.Q. is a measure of the respondents’ present state as it is concerned with the behaviour and attitudes of individuals over the past twenty-eight days. The E.D.E.Q. was designed to be simple to fill in and of a length so that it could be completed in fifteen minutes or less.

The E.D.E.Q. is a 36 item questionnaire which uses the same probe questions as the E.D.E. The majority of items (i.e. questions 1 - 15 and 29 - 36) require the respondents to mark their response on a 7-point forced choice scale. The nature of this 7-point scale varies in different sections of the questionnaire. For questions 1 - 14, the respondents are required to rate the frequency of days over the past month on which the particular forms of behaviour occurred. The scale ranges from 0 days (0) to every day (6). In questions 29 - 36 the respondents are required to rate the severity of certain forms of behaviour on a 7-point scale ranging from not at all (0) to markedly (6). Finally question 15 has its own unique scale ranging from none of the time (0) to every time (6).

Questions 16, 19, 21, 23, 25 and 27 require yes/no responses as to whether certain behaviours, such as self induced vomiting or use of laxatives, occurred over the past twenty-eight days. If the respondent answers "yes" to any of these questions, he/she is then required to enter the number of times this behaviour occurred (over the last month) in the subsequent item.
In general the E.D.E.Q. comprises four main subscales:

A. Dietary Restraint (items 1 - 5).
B. Eating Concern (items 6, 7, 9, 15 and 34).
C. Shape Concern (items 10 - 13, 30, 33, 35 and 36).
D. Weight Concern (items 11, 14, 29, 31 and 32).

Questions 8 and 16 - 28 previously comprised the fifth subscale, Bulimia, but the use of this subscale has recently been dropped and instead the authors suggest considering these items independently.

A score for each of the subscales is obtained by summing the responses for the relevant items and then dividing this result by the number of items that make up the subscale. Three of the subscales contain five items and the fourth subscale, Shape Concern, contains eight items. The maximum score that may be obtained on each subscale is 6 and the minimum score is 0. A subscale score can still be obtained even if the respondent has not rated all the appropriate items. In this case the number of rated items are summed and the result is then divided by the number of items that have been rated. This form of scoring only applies in cases where over half of the items in the subscale have been rated.

Finally an overall global score of eating psychopathology may be obtained by summing the four subscale scores and dividing this result by four. The maximum global score that may be obtained is 6 and the minimum score is 0. (A copy of the E.D.E.Q. may be found in Appendix D).

Procedure.

A copy of the research proposal along with the covering letter and all the questionnaires that would be distributed to participants, was submitted to the University of Surrey ethics committee. Subsequently ethical approval for the research was granted by the committee.
The community sample of parents was contacted via schools in the London Borough of Merton. Initially all of the middle schools and half of the first schools in Merton were contacted by telephone. A brief outline of the research was given to the head teacher or deputy head teacher and he/she was asked if his/her school might be interested in participating in the research. Overall twenty-six schools expressed an interest, sixteen first schools and ten middle schools. Each was sent a copy of the research proposal along with the covering letter and all the questionnaires that would be distributed to participants.

Four schools responded saying that they would be willing for parents/guardians of children attending their school to be contacted. Three of the positive responses were received from first schools and one was from a middle school. All four schools were mixed gender schools and none had any religious affiliation.

Each of the schools was visited by the researcher who took along a batch of envelopes each containing a covering letter and copies of the three questionnaires to be distributed. Each envelope also contained a free post envelope in which the participants were asked to return their completed forms.

Three schools provided the researcher with a list of pupils names and ages and a random sample of children was selected. Each envelope was then addressed "Parent/guardian of .." and the appropriate child’s name was entered. For security reasons, the fourth school chose to address the envelopes themselves. However instructions were given to the administrator to ensure that a random sample of the children was obtained.

The envelopes were then distributed to the appropriate children via class teachers and each child was instructed that he/she should give the envelope to his/her parent/guardian. The Initial intention was to send the questionnaires to participants directly. However all the schools felt that distributing the questionnaires via the children would be most appropriate.

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In order to obtain a clinical sample, a number of Child Clinical Psychologists in the region were contacted and asked if they would be interested in participating in this research.

A positive response was received from one clinician who felt that this work would be useful for her own clinical practice. She therefore suggested that the questionnaires should be adapted for the clinical sample so that space was made for entering both the respondent’s and target child’s names. This would then enable Dr. Wilson to use the information gathered from the questionnaires in her assessment of the child.
RESULTS.

Data Analysis.

Of the 360 questionnaires distributed via the schools, 171 (47.5%) completed forms were returned. In addition 4 questionnaires were returned blank but with no explanation concerning the respondents reasons for not wishing to take part in the survey.

Some of the questionnaires returned were incomplete in that occasional questions had not been answered. In terms of the E.D.E.Q. measure, where there were missing data items, prorated values were calculated in line with the scoring procedure outlined previously. In terms of the E.B.Q., prorated values were calculated and entered where missing data points existed. These prorated scores were obtained by calculating the overall score attained by the respondent on the E.B.Q. and dividing this by the number of items that had been answered.

One of the 171 respondents did not answer any of the questions on the E.D.E.Q. and this case was therefore excluded from any analyses involving results from the E.D.E.Q.

All the data from the three questionnaires were entered on to the Statistical Package for the Social Sciences (S.P.S.S.) for analysis.

In terms of the clinical sample, due to low levels of referrals of children with feeding problems, only two questionnaires were returned. This was considered to be an insufficient data set and so unfortunately no analyses involving a clinical sample could be performed.

General Sample Characteristics.

The vast majority of the questionnaires received (89.5%) were completed by the
child’s mother. Fourteen (8.2%) were completed by fathers and two (1.2%) were completed by grandmothers. Two respondents failed to answer this item.

Seventy-eight (45.6%) of the forms returned concerned a male child and 93 (54.4%) were completed by participants regarding a female child. Questionnaires were returned regarding children at all the ages surveyed i.e. 4 - 12 years. The average age of the child sample was 7.92 years S.D. 2.66 years. For full details concerning the ages of the child sample see Table 1. In terms of ethnicity, the majority of the children surveyed (76.6%) were white British. For full details concerning the ethnic make-up of the child sample see Table 2.

Table 1.

Age distribution of the child sample.

<table>
<thead>
<tr>
<th>Age</th>
<th>Frequency</th>
<th>Percentage of children.</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td>22</td>
<td>12.9%</td>
</tr>
<tr>
<td>5</td>
<td>20</td>
<td>11.7%</td>
</tr>
<tr>
<td>6</td>
<td>19</td>
<td>11.1%</td>
</tr>
<tr>
<td>7</td>
<td>18</td>
<td>10.5%</td>
</tr>
<tr>
<td>8</td>
<td>20</td>
<td>11.7%</td>
</tr>
<tr>
<td>9</td>
<td>12</td>
<td>7%</td>
</tr>
<tr>
<td>10</td>
<td>22</td>
<td>12.9%</td>
</tr>
<tr>
<td>11</td>
<td>20</td>
<td>11.7%</td>
</tr>
<tr>
<td>12</td>
<td>18</td>
<td>10.5%</td>
</tr>
</tbody>
</table>

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Table 2.

Ethnicity of the child sample.

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>Frequency</th>
<th>Percentage of children.</th>
</tr>
</thead>
<tbody>
<tr>
<td>White British</td>
<td>131</td>
<td>76.6%</td>
</tr>
<tr>
<td>Mixed Race</td>
<td>15</td>
<td>8.8%</td>
</tr>
<tr>
<td>African</td>
<td>2</td>
<td>1.2%</td>
</tr>
<tr>
<td>Asian</td>
<td>12</td>
<td>7%</td>
</tr>
<tr>
<td>Caribbean</td>
<td>2</td>
<td>1.2%</td>
</tr>
<tr>
<td>White Other</td>
<td>5</td>
<td>2.9%</td>
</tr>
<tr>
<td>Other</td>
<td>1</td>
<td>0.6%</td>
</tr>
<tr>
<td>Missing Data</td>
<td>3</td>
<td>1.8%</td>
</tr>
</tbody>
</table>

Background Information about the Child sample.

Twenty-two (12.9%) of the children were reported to have a medical complaint. Nineteen of these had asthma, five had eczema and three had hay fever. In addition one child was reported to be partially sighted and to suffer from skin allergies and lumps on his back.

Five children (2.9%) were reported to have experienced serious medical complaints which caused feeding problems. One child was reported to have had loose bowels at nine months and one child was reported to have had a milk allergy since birth. Details of the feeding difficulties experienced by the other three children were not provided.
Ten children (5.8%) were reported to have received counselling or psychological input. One child was reported to have seen an Educational Psychologist and one child was reported to have received help for his dyslexia. No other details were given concerning either the reasons why the children received counselling or the type of counselling they received.

Eleven children (6.4%) were reported to have been significantly overweight or underweight at some time. Two of these were reported to be currently overweight, one of whom was reported to be very concerned about this and is consequently trying to follow a fat reduced diet. The remaining nine children were reported to have been significantly underweight at some time. The majority of these had been underweight as babies and were still small for their age. Table 3 contains further details regarding each of the underweight children.

Seven children (4.1%) were reported to be following a special diet for either religious or medical reasons. Five of these appeared to be on a special diet for religious reasons. One of these ate Kosher food and the other four ate no pig products or extracts. Details regarding the special diet were not supplied for the other two children.

Three children (1.8%) were reported to be vegetarian. In addition four children (2.3%) were reported to be semi or sometimes vegetarian.

Thirteen children (7.6%) were reported to be allergic to certain foods. Table 4 contains a list of the food the children were reported to be allergic to.
### Table 3.

Details of each of the nine children who were reported to have been underweight at some time.

1. Premature baby born 32 weeks gestation weighing 1.2 K.G. and has always been small for age.
2. Sometimes when ill loses weight quickly but gains when well.
3. Underweight before asthma diagnosed but is now steadily gaining.
4. Very small for age but weight is in proportion to height.
5. Has always been small and underweight. At 18 months was referred to a paediatrician who felt it was due to a combination of inheritance and poor appetite.
7. A small for dates baby weighing four pounds six ounces at 37 weeks. Is currently being monitored by the G.P. because has always been below the third percentile. It is felt that there might be a genetic link but the child is also reported to be a very faddy eater.
8. Slightly underweight as baby and is now small for age.
9. Born weighing only five pounds three ounces. Had picked up by seven months and had caught up completely by one year.
Table 4.

Information concerning the food allergies experienced by the thirteen children.

<table>
<thead>
<tr>
<th>Type of Food Allergy</th>
<th>Number of Children Experiencing this Allergy.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strawberries</td>
<td>2</td>
</tr>
<tr>
<td>nuts</td>
<td>2</td>
</tr>
<tr>
<td>eggs</td>
<td>2</td>
</tr>
<tr>
<td>chocolate</td>
<td>2</td>
</tr>
<tr>
<td>dairy products</td>
<td>1</td>
</tr>
<tr>
<td>clotted cream</td>
<td>1</td>
</tr>
<tr>
<td>fish</td>
<td>1</td>
</tr>
<tr>
<td>beef</td>
<td>1</td>
</tr>
<tr>
<td>peppers</td>
<td>1</td>
</tr>
<tr>
<td>tea/coffee and fizzy drinks</td>
<td>1</td>
</tr>
<tr>
<td>cake and crisps</td>
<td>1</td>
</tr>
<tr>
<td>food colouring</td>
<td>1</td>
</tr>
<tr>
<td>food preservatives</td>
<td>1</td>
</tr>
</tbody>
</table>

The majority of the children (53.2%) were reported to eat a packed lunch. In addition 24.6% ate a school meal and 13.5% varied between having school meals and packed lunches. Twelve children (7%) had neither a packed lunch or a school meal as they attended nursery and so went home for lunch. Finally three respondents did not complete this item.
Family Eating Patterns.

The majority of respondents (82.5%) reported that all/most of the time they ate at least one meal per day with their child. The majority of respondents (74.9%) also reported that all/most of the time they ate the same type of food as their child at meal-times. In terms of helping themselves to food, 59.1% of the children were able to do this sometimes. For further details of these three issues see Tables 5 - 7.

Table 5.

Frequency of participants eating at least one meal per day with their child.

<table>
<thead>
<tr>
<th>How often</th>
<th>Frequency</th>
<th>Percentage of respondents.</th>
</tr>
</thead>
<tbody>
<tr>
<td>All of the time</td>
<td>82</td>
<td>48%</td>
</tr>
<tr>
<td>Most of the time</td>
<td>59</td>
<td>34.5%</td>
</tr>
<tr>
<td>Sometimes</td>
<td>30</td>
<td>17.5%</td>
</tr>
<tr>
<td>None of the time</td>
<td>0</td>
<td>0%</td>
</tr>
</tbody>
</table>
Table 6.

Frequency of care giver and child eating the same food at meal-times.

<table>
<thead>
<tr>
<th>How often</th>
<th>Frequency</th>
<th>Percentage of respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>All of the time</td>
<td>42</td>
<td>24.6%</td>
</tr>
<tr>
<td>Most of the time</td>
<td>86</td>
<td>50.3%</td>
</tr>
<tr>
<td>Sometimes</td>
<td>40</td>
<td>23.4%</td>
</tr>
<tr>
<td>None of the time</td>
<td>2</td>
<td>1.2%</td>
</tr>
<tr>
<td>Missing data</td>
<td>1</td>
<td>0.6%</td>
</tr>
</tbody>
</table>

Table 7.

Frequency of children being permitted to help themselves to food they want.

<table>
<thead>
<tr>
<th>How often</th>
<th>Frequency</th>
<th>Percentage of children</th>
</tr>
</thead>
<tbody>
<tr>
<td>All of the time</td>
<td>17</td>
<td>9.9%</td>
</tr>
<tr>
<td>Most of the time</td>
<td>28</td>
<td>16.4%</td>
</tr>
<tr>
<td>Sometimes</td>
<td>101</td>
<td>59.1%</td>
</tr>
<tr>
<td>None of the time</td>
<td>24</td>
<td>14%</td>
</tr>
<tr>
<td>Missing data</td>
<td>1</td>
<td>0.6%</td>
</tr>
</tbody>
</table>
In terms of food preparation, most of the respondents (90.1%) prepared 50% or more of the food in their house themselves. When a respondent prepared 50% or less, the rest of the food tended to be prepared by the child's mother or father i.e. the opposing parent to that completing the questionnaire. For further details of these results see Tables 8 and 9.

**Table 8.**

Frequency of meals prepared in the house by the adult respondents.

<table>
<thead>
<tr>
<th>Meal Percentage</th>
<th>Frequency</th>
<th>Percentage of respondents.</th>
</tr>
</thead>
<tbody>
<tr>
<td>100%</td>
<td>90</td>
<td>52.6%</td>
</tr>
<tr>
<td>75%</td>
<td>49</td>
<td>28.7%</td>
</tr>
<tr>
<td>50%</td>
<td>15</td>
<td>8.8%</td>
</tr>
<tr>
<td>25%</td>
<td>13</td>
<td>7.6%</td>
</tr>
<tr>
<td>0%</td>
<td>1</td>
<td>0.6%</td>
</tr>
<tr>
<td>missing data</td>
<td>3</td>
<td>1.8%</td>
</tr>
</tbody>
</table>
Table 9.

Frequency of preparation of most of the other meals in the household where the respondents prepare 50% or less of the food.

<table>
<thead>
<tr>
<th>Relation to child</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child’s mother</td>
<td>9</td>
</tr>
<tr>
<td>Child’s father</td>
<td>14</td>
</tr>
<tr>
<td>Child minder/nanny</td>
<td>2</td>
</tr>
<tr>
<td>Other e.g. sibling</td>
<td>2</td>
</tr>
<tr>
<td>Missing data</td>
<td>5</td>
</tr>
</tbody>
</table>

N.B. 139 of the participants prepared over 50% of the meals in their household.

Reliability of the Questionnaires.

In order to assess the reliability of the Eating Behaviour Questionnaire and the Eating Disorder Examination Questionnaire Chronbach’s Alpha was calculated to assess the internal consistency of the items used on the measures. In terms of the E.D.E.Q. separate Alpha values were calculated for each of the four subscales.

The Chronbach’s Alpha for the E.B.Q. was 0.90 and the removal of any item from the questionnaire would not improve its reliability. This result suggests that there is a high level of consistency between all the items in the E.B.Q.

Chronbach’s Alpha for the Dietary Restraint scale was 0.80. Two items, if removed from the questionnaire, would improve the reliability of the scale. The removal of item 2 would increase the Alpha value to 0.83 and the removal of item 5 would
increase the Alpha value to 0.84. However even without the removal of these items, the scale shows a high level of consistency between items.

Chronbach’s Alpha for the Eating Concern subscale was 0.83. Removing any item from this scale would reduce reliability. Again this scale shows high internal consistency between items.

Chronbach’s Alpha for the Shape Concern subscale was 0.91. The removal of items 10 or 11 would slightly improve the reliability. However the scale already shows high internal consistency between items.

Finally the Chronbach’s Alpha for Weight Concern was 0.79. The removal of item 11 would increase the Alpha value to 0.82 and the removal of item 31 would increase the Alpha value to 0.80.

Results from the E.B.Q.

The overall mean score on the E.B.Q was 49.61, S.D. =19.03 The scores attained ranged from 18 - 94.

A frequency distribution of the E.B.Q. scores was plotted and was found to have a Kurtosis value of -0.656. A normal distribution curve was superimposed on to the E.B.Q. distribution and a comparison between the two graphs suggested that the results from the E.B.Q. were approximately normally distributed.

A series of one way Analyses of Variance (Anovas) were conducted to study differences between scores on the E.B.Q. An anova was calculated between the E.B.Q. scores and a number of background variables concerning the child, namely age, gender, history of medical complaints, history of feeding problems, previous counselling, history of being significantly overweight or underweight, whether or not the child has a special diet for religious or medical reasons, whether or not the child is vegetarian, whether or not the child has allergies to certain foods, the type of lunch
eaten by the child i.e. packed lunch, school meals, both, or neither, how often the respondents eat with their children, how often the respondents eat the same food as their children at meal-times and finally how often the children are able to help themselves to food they want. The results obtained from these anovas are listed in Table 10. The majority of Anovas yielded nonsignificant results suggesting that variables such as age and gender are not associated with a variation in scores on the E.B.Q. i.e. fussy eating in children.

Two variables yielded highly significant results, namely whether or not the child is vegetarian and how often respondents eat the same food as their children at meal-times (F =6.05 P=0.003 and F =12.01 P<0.0005 respectively). These results suggest that both these variables are linked with variations in the E.B.Q. scores i.e. fussy eating in children.

In order to identify the direction of the variance, the means for the two variables were studied. An examination of the mean scores concerning the vegetarian individuals showed that the mean score on the E.B.Q for vegetarians was 85.65, the mean score for semi vegetarians was 43.25 and for non-vegetarians the mean score was 48.98. These results suggest that vegetarian children tended to achieve a higher score on the measure of fussy eating. However due to the small sample size of vegetarian children, clearly this result must be viewed with caution.

In terms of how often the respondents ate the same food as their children at meal-times, the results suggest that there is a monotonic relationship between the two variables for as frequency of eating the same as the child declines, fussiness assessed by the E.B.Q. increases. For details of the mean scores on this variable see Table 11.
Table 10.

The results obtained in the one way Anovas calculated between the E.B.Q. scores and a number of variables concerning background information about the child sample and his/her family eating patterns.

<table>
<thead>
<tr>
<th>Variable</th>
<th>F</th>
<th>D.F.</th>
<th>Significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td>2.19</td>
<td>1,169</td>
<td>N.S.</td>
</tr>
<tr>
<td>Age</td>
<td>0.52</td>
<td>8,162</td>
<td>N.S.</td>
</tr>
<tr>
<td>Medical Complaints</td>
<td>0</td>
<td>1,169</td>
<td>N.S.</td>
</tr>
<tr>
<td>Feeding complications</td>
<td>0.87</td>
<td>1,169</td>
<td>N.S.</td>
</tr>
<tr>
<td>Previous counselling</td>
<td>0.94</td>
<td>1,169</td>
<td>N.S.</td>
</tr>
<tr>
<td>History of being underweight/overweight</td>
<td>3.51</td>
<td>1,168</td>
<td>P. =0.063</td>
</tr>
<tr>
<td>Special diet</td>
<td>2.53</td>
<td>1,169</td>
<td>N.S.</td>
</tr>
<tr>
<td>Vegetarian</td>
<td>6.05</td>
<td>2,168</td>
<td>P. =0.003</td>
</tr>
<tr>
<td>Allergies</td>
<td>0.16</td>
<td>1,169</td>
<td>N.S.</td>
</tr>
<tr>
<td>Type of lunch</td>
<td>1.38</td>
<td>3,164</td>
<td>N.S.</td>
</tr>
<tr>
<td>Eat with child</td>
<td>1.25</td>
<td>2,168</td>
<td>N.S.</td>
</tr>
<tr>
<td>Eat same food as child</td>
<td>12</td>
<td>3,166</td>
<td>P. &lt;0.0005</td>
</tr>
<tr>
<td>Child helps self to food</td>
<td>0.93</td>
<td>3,166</td>
<td>N.S.</td>
</tr>
</tbody>
</table>
Table 11.

Mean scores on the E.B.Q. for the four groups of respondents by frequency of eating the same food as their children at meal-times.

<table>
<thead>
<tr>
<th>Frequency</th>
<th>Mean Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>All of the time</td>
<td>40.20</td>
</tr>
<tr>
<td>Most of the time</td>
<td>47.87</td>
</tr>
<tr>
<td>Sometimes</td>
<td>61.81</td>
</tr>
<tr>
<td>None of the time</td>
<td>71.82</td>
</tr>
</tbody>
</table>

Finally in this section it should be noted that the Anova between E.B.Q. score and whether or not the child had been overweight or underweight in the past produced an F value 3.51, P =0.063. Although this is a nonsignificant result, if a larger number of individuals with weight problems had been included in the sample, a significant result may have been obtained. The mean scores on the E.B.Q. for children who have had weight problems was 59.91 and for those without weight problems was 48.92.

Results from the E.D.E.Q.

Twenty-six of the 170 respondents (15.2%) achieved a global score of 0 on the E.D.E.Q. The mean scores and standard deviation for each subscale of the E.D.E.Q. are given in Table 12.
Table 12.

Mean scores on each of the 4 subscales and the global score from the E.D.E.Q.

<table>
<thead>
<tr>
<th>Subscale</th>
<th>Range</th>
<th>Mean</th>
<th>Standard deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dietary Restraint.</td>
<td>0 - 5</td>
<td>1.01</td>
<td>1.31</td>
</tr>
<tr>
<td>Eating Concern.</td>
<td>0 - 5</td>
<td>0.48</td>
<td>0.91</td>
</tr>
<tr>
<td>Shape Concern.</td>
<td>0 - 5.63</td>
<td>1.79</td>
<td>1.68</td>
</tr>
<tr>
<td>Weight Concern.</td>
<td>0 - 5</td>
<td>1.31</td>
<td>1.37</td>
</tr>
<tr>
<td>Global Score.</td>
<td>0 - 4.69</td>
<td>1.15</td>
<td>1.17</td>
</tr>
</tbody>
</table>

Given below are details of the other results obtained from the E.D.E.Q. whose values are not included in calculating the subscale totals.

Of the 170 respondents 33 (19.4%) reported that, over the last month, they have at some time eaten what they thought other people would regard as an unusually large amount of food given the circumstances. In terms of frequency, the number of times the 32 people who responded to this item had engaged in this behaviour ranged from 1 - 20 times over the past 28 days, mean =5.12 times and median =4 times. Furthermore 18 individuals reported feeling that they had lost control in the episodes of overeating. The frequency of such behaviour for these 18 participants ranged from 1 - 17 per month, mean =5.66 episodes, median =4 episodes.

Twenty-nine respondents reported experiencing a sense of having lost control over their eating but had not eaten an unusually large amount of food given the circumstances. The frequency of such episodes ranged from 1 - 28 times, mean =4.96 times and median =4 times.

The above results obtained from questions 16 - 20 on the E.D.E.Q. examine objective
binging. However question 8 looks at subjective binging. 24 of the 170 participants (14.11%) reported that they had binged over the last month. Only 2 participants reported binging every day and one of these reported that this was due to the fact that she is pregnant. On a scale of 0 (0 days) - 6 (every day) the mean score for the 14 participants was 2.5 (median =2 mode =1).

None of the respondents had used self induced vomiting to control their shape or weight over the past month. One individual reported having taken laxatives to control his/her shape or weight 22 times over the past 28 days and one person reported using diuretics but did not enter the frequency of this behaviour.

Fifty-two of the 170 respondents (30.58%) reported having exercised hard over the past month as a means of controlling their shape or weight. The frequency of hard exercising for the 48 respondents who answered this question ranged from 2 - 28 times over the past month, Mean =8.97 times, median =6 times.

**Regression Analysis.**

Initially the aim was to regress the E.B.Q. scores on five predictors, namely age and the results from each of the four subscales of the E.D.E.Q. However the Pearson’s correlation coefficients between the five variables yielded a highly significant relationship between Shape Concern and Weight Concern (r =0.91) suggesting colinearity between these two variables. It was therefore necessary to eliminate one of these variables from the regression equation and it was decided to drop Weight Concern as it had the lowest Alpha value of the two.

A direct entry multiple regression was conducted regressing the E.B.Q. scores on 4 predictors - age, Dietary Restraint, Eating Concern and Shape Concern.

The plots of the standardised predicted scores were examined against the regression standardised residuals. The data were normally distributed and the assumptions of linearity, homoscedasticity and residuals were met.
170 cases were used in the regression analysis. A nonsignificant result was obtained with an adjusted R squared value =0.01234, F =1.525 and significance of F =0.197. None of the variables entered significantly predicted the E.B.Q. scores.

A second forced entry multiple regression was calculated regressing scores on the E.B.Q. against two predictors, age and global score on the E.D.E.Q. The plots of the standardised predicted scores were examined against the regression standardised residuals. Again the data were found to be normally distributed and the assumptions of linearity, homoscedasticity and residuals were met. The regression again yielded a nonsignificant result with an adjusted R squared value =0.01237, F =2.052 and significance of F =0.132.

It was noted that 26 of the E.D.E.Q. scores were 0, suggesting that these individuals exhibited no eating disorder psychopathology. A regression was therefore calculated removing these cases. The child score was again regressed on two predictors, age and the global score on the E.D.E.Q. 144 cases were used in the analysis. Again a nonsignificant result was obtained, adjusted R squared =0.009, F =1.635 and significance of F =0.199.
DISCUSSION.

Introduction.

This investigation aimed to assess the eating attitudes and behaviours of parents and the eating behaviour of their offspring. In addition, background information on each child and the data regarding the eating patterns of his/her family were also collected.

The main aim of the study was to assess the relationship between the eating attitudes and behaviours of parents and the eating behaviour of their offspring. It was hypothesised that an increase in the parental score globally on the E.D.E.Q. and on each of the four subscales would be associated with an increase in the child’s score on the E.B.Q. In addition it was predicted that a regression analysis would show that the E.D.E.Q. scores could be used to predict a high proportion of the child’s E.B.Q. score.

Furthermore it was hoped to explore which of the background variables about the child or the eating patterns of his/her family were associated with variation on the measure of the child’s selective eating.

Finally, differences between a community sample of parents and children, which was obtained via schools within the London Borough of Merton, and a clinical sample of children referred to a Child Clinical Psychologist with a feeding problem would be examined.

Overall 171 (47.5%) of the 360 questionnaires distributed to the community sample of parents were returned. Only two questionnaires were received from parents of children with feeding disorders. The small size of this clinical sample was due to the fact that the Child Clinical Psychologist had very few referrals of children with feeding disorders within the time scale of this investigation. Due to the small size of the clinical sample, it was felt that comparisons between the community and clinical groups would not be appropriate.
The vast majority of the questionnaires returned, almost 90%, were completed by the child's mother. Although the majority of literature in this area pertains to the impact of maternal eating attitudes and behaviours on children, the gender of the parent who should complete the questionnaires was deliberately not specified in this study. Instead the forms were addressed to the child's "parent/guardian". This format was used for a number of reasons. Firstly, some children are cared for primarily by their fathers or other relatives. In this study, two grandmothers reported that they were the primary care giver for their child. Secondly some studies have shown that fathers may also model abnormal eating behaviours to their children. For example Striegel-Moore and Kearney-Cooke (1994) reported that they found a strong relationship between parental dieting efforts and encouraging the child to diet and that this link held not only for mothers and daughters but also for fathers and daughters and fathers and sons. The fact that questionnaires were returned completed by fathers, enabled an examination of any differences between the impact of mothers and fathers eating behaviour and attitudes on the eating behaviour of their children, if a significant link for the group as a whole was found.

Methodological Criticisms.

Before discussing the results of this research, a number of methodological criticisms which could be raised will first be considered.

Firstly the E.B.Q. and the E.D.E.Q. are both newly developed tools and have not been used extensively as yet in research. The authors of the E.D.E.Q. (Fairburn and Beglin, 1994) emphasise the point that researchers using this measure should mention that it is an instrument in evolution rather than a final version. However, as outlined by the measures section in the introduction, these were felt to be the most appropriate forms available for assessing the variables under investigation. Furthermore, as discussed below, both measures demonstrated a high level of internal consistency between items.

Secondly, in specifying the psychological content of the research to the respondents
in the covering letter accompanying the questionnaires, a number of problems may have followed in interpretation and subsequent responses to the questionnaire. Individuals concerned about both their own and their child's eating may feel threatened and hence not respond to the survey. Alternatively such individuals may respond but enter responses which they perceive as the norm.

A third criticism may be levelled at the way questionnaires were distributed to parents i.e. via pupil post. With this method of distribution questionnaires may be lost, disregarded or destroyed by the children in their passage to parents. However this method of circulation was specifically chosen by the four schools involved who, from past experience of distributing their own post via pupils, were confident that the questionnaires would reach their destination. Over 45% of the questionnaires were returned which is a high response rate for this type of investigation and suggests that the large majority of questionnaires were dispatched appropriately.

**Reliability of the measures.**

The reliability of the E.B.Q. was assessed using Chronbach's Alpha which ascertains the internal consistency between the items on the measure. The Alpha value obtained, 0.90, suggests that there is a high level of internal consistency. Furthermore, the removal of items from the measure would not improve its reliability. This finding is in line with the result found by R. Harris (unpublished) who obtained an Alpha value for the E.B.Q. of 0.87.

Alpha values for the four E.D.E.Q. subscales also suggest that all four show high internal consistency between items. The highest Alpha value was obtained for the Shape Concern subscale, Alpha =0.91, and the lowest was for the Weight Concern subscale, Alpha =0.79. The removal of either item 11 or 31 from the E.D.E.Q. would increase the Alpha value for Weight Concern to 0.82 and 0.80 respectively.

The Alpha values obtained in this study for the E.D.E.Q. are in fact higher than those previously obtained by Cooper et al (1989) for the E.D.E. on which the E.D.E.Q.
was based. Cooper et al (1989) found values ranging from 0.67 (for Shape Concern) to 0.82 (for Weight Concern).

**Results from the E.B.Q.**

The mean score on the E.B.Q. was 49.61 S.D. = 19/03. The scores achieved ranged from 18 - 94. Therefore although children attained the lowest possible score on the measure, i.e. 18, the highest scores were 14 points below the highest possible score i.e. 108.

These results are much lower than those found by R. Harris (unpublished) who administered the E.B.Q. to a community sample of 105 children aged eight to sixteen. In her study the mean E.B.Q. score obtained by the children was 64.8 S.D. = 18.72.

In order to ascertain which, if any, of the background variables about the child and/or the eating patterns of his/her family were associated with variation in the child’s level of selective eating, a series of one way analyses of variance (anovas) were conducted between these variables and the E.B.Q. scores. The results of these analyses are discussed below.

**Characteristics of the Child Sample.**

A slightly higher proportion of the questionnaires returned were completed by respondents concerning a female child (54.5%) as opposed to a male child (45.6%). The average age of the children sampled was 7.92 years (S.D. = 2.96; range 4 - 12 years). An equal number of questionnaires, 40, were distributed to the parents of children at each of the nine ages surveyed i.e. 4 - 12 years. The questionnaires returned gave a good representation of selective eating across the age range in that approximately equal numbers of questionnaires were returned regarding children at each age (range 18 - 22 children). The only exception was for nine year-olds where only 12 of the 40 questionnaires distributed were returned. The approximately equal distribution of the sample according to age and gender suggested that later analysis
would allow us to determine the impact of these two variables on selective eating in children. In addition, if a positive link was found between parental and child eating behaviour, it would be possible to explore whether or not the gender or age of the child had any impact on the strength of this relationship.

Most of the children surveyed (76.6%) were white British. However questionnaires were also received concerning children who were African, Asian, Caribbean, mixed race and white other.

A one way analysis of variance was conducted between the children’s E.B.Q. scores and age and gender. Neither of these variables caused any significant variation in the E.B.Q. scores. This suggests that selective eating occurs in both male and female children and its presence does not vary according to the age of the child. The results concerning age of the child are in line with those found by R. Harris (unpublished). She found that there was no visible differences regarding age between high and low scorers on the E.B.Q. However, some authors have suggested that selective or picky eating is a relatively frequent problem occurring in particularly young children. It may therefore have been expected that the younger children in the sample would have an increased likelihood of being selective eaters. However the results do not support this notion.

In terms of gender, R. Harris (unpublished) suggested that male children more frequently present with selective eating at the Great Ormund Street Hospital for Children where she conducted her study. However the results from this study do not support this trend.

Twenty-two of the children (12.9%) were reported to have a medical complaint. Of these, 19 had asthma. A one way anova between this variable and the E.B.Q. scores yielded a nonsignificant result suggesting that the presence of a medical problem in the child does not affect his/her eating. R. Harris (unpublished) found similar results. She found a high prevalence of asthmatics among children who achieved both high and low scores on the E.B.Q. and concluded that there is a high prevalence of asthma
among the child population in general but that this appears to have no effect on eating habits.

Five children (2.9%) were reported to have experienced serious medical complaints which caused problems with their feeding. These included one child who had a milk allergy from birth and one child who had loose bowels at nine months. Douglas (1991) reported that two of the etiological factors associated with feeding disorders in young children were past history of medical problems influencing the child’s feeding experience and fear of eating due to early adverse experiences associated with feeding. In terms of this study, Douglas’s (1991) ideas suggest that children with a history of feeding difficulties are more likely to be selective eaters. However this was found not to be the case and a one way anova between the two variables yielded a nonsignificant result. The children sampled in this study were aged four and over. In fact all five children who had experienced medical complaints which had caused problems with their feeding were aged six and over. Therefore, they may well have overcome any resulting feeding difficulties by this age.

Ten children (5.8%) were reported to have received previous counselling or psychological help and thirteen children (7.6%) were reported to be allergic to certain foods. However, again in line with the results found by Harris (unpublished) neither of these variables caused any significant variation in the child’s E.B.Q. score.

Seven children (4.1%) were on a special diet for religious or medical reasons. One of these was on a Kosher diet and four children were reported to eat no pig products or extracts. Details concerning the special diets of the remaining two children were not given. Again this variable was found to cause no significant variation in the child’s E.B.Q. score. This result corresponded to that found by R. Harris (unpublished) who, after dividing her participants into two groups according to their score on the E.B.Q., found that there was one child on a special diet in both the group of high and lower scorers.

Three children (1.8%) were reported to be vegetarian and four children (2.3%) were
reported to be semi-vegetarian. Interestingly all three of the full vegetarians were boys aged eight to eleven years. In terms of the semi-vegetarians, two were girls aged seven and twelve and two were boys aged six and twelve. This variable was associated with significant variation in the child's E.B.Q. score. An examination of the means for the three groups suggested that the three vegetarian children scored significantly higher on the E.B.Q. than both semi-vegetarian and non-vegetarian children. The mean score for the semi-vegetarians was slightly lower than that of the non-vegetarians. These results suggest that vegetarian children are more likely to be selective eaters than are either semi-vegetarian or non-vegetarian children. However these results must be viewed with caution. Firstly it is important to remember that the E.B.Q. assesses the parental view of his/her child's eating habits. Therefore some parents, depending on their own views and eating preferences, may see vegetarians as fussy eaters. In order to clarify the situation, in future research it would be interesting to make some assessment as to whether or not the parents themselves are vegetarian. Secondly it is important to bear the small sample size in mind. Only three of the 171 children were vegetarian and clearly a larger sample would need to be assessed before any definite conclusions regarding this issue could be drawn. Finally this result is in conflict to that obtained by R. Harris (unpublished). Four of her 105 children were vegetarian but she found that this variable had no significant impact on the children's E.B.Q. scores. In order to clarify this situation, further research is needed into this area.

Eleven children (6.4%) were reported to have been significantly underweight or overweight at some time. Two children, both males aged seven and twelve, were reported to be currently overweight and one of these in particular was reported to be very concerned about his weight and so is trying to follow a fat reduced diet. In terms of the nine underweight children, three were girls and six were boys with ages ranging from four to eleven years. Four of these children were small as babies and have been underweight ever since. Additionally two children were born underweight, one of whom had caught up by one year. Two children appear to be underweight due to health problems. One of these was reported to have been underweight prior to the diagnosis of asthma but is now gaining and the other is reported to lose weight when
ill but gains it again when well. The final child is reported to be small for her age but her weight is felt to be in proportion to her height.

This variable was not associated with significant variation in the E.B.Q. score. However the result obtained was approaching significance at the five percent level. Clearly only a small percentage of the overall sample had experienced weight problems and, if a larger proportion of children with previous or current weight problems had been included, a significant result may have been obtained. An examination of the means suggested that individuals who have had weight problems score higher on the measure of selective eating than those who have not had such problems. The reason for this result is unclear. For some children the weight problems may arise as a result of their fussy eating rather than being a cause of it. However four of the eleven children had been underweight since birth. It may be that an underweight baby is at risk of developing selective eating. However much further research is needed before any definite conclusions may be drawn in this area.

Just over half of the children surveyed (53.2%) ate a packed lunch, just under 25% ate a school meal and 13.5% varied between school meals and packed lunches. It was suspected that fussy eaters would be more likely to eat packed lunches since this would give them more control over the content of their meal. However this was not borne out in the analysis and the type of lunch eaten by the children has no significant link with their E.B.Q. score.

**Family Eating Patterns.**

Most of the respondents (82.5%) ate at least one meal per day with their children all or most of the time. Furthermore, no respondents never ate with their children. In terms of helping themselves to food, 59.1% were allowed to do this sometimes and 14% never helped themselves. Given the young age of the sample, these results are perhaps not surprising. In addition, it was felt that the wording of this question may have caused some confusion. From the respondents comments, it seems that some parents interpreted "helping themselves to food" to mean cooking their own meals
whilst others interpreted it as helping themselves to snacks e.g. biscuits. If a similar item is to be used in future studies, further clarification is obviously necessary.

Neither of the above variables were found to cause any significant variation in the child's level of selective eating. R. Harris (unpublished) found in her study that the families of all the children who obtained low scores on the E.B.Q. ate together. However she found that 25% of the families of high scorers on the E.B.Q. did not eat together. The results from this study do not support this trend.

Most of the respondents (74.9%) reported that all or most of the time, they ate the same type of food as their child at meal-times. However two respondents reported that they never ate the same type of food as their child and 40 respondents only ate the same food as their child some of the time. This variable was associated with highly significant variation in the E.B.Q. scores. An assessment of the mean E.B.Q. scores for the four groups divided according to this variable suggests that there is a monotonic relationship between the two variables for as frequency of eating the same food as the child declines, selective eating in the child increases. The mean scores on the E.B.Q. for the children who eat the same food as their parents most or all of the time are below the overall mean score attained on the E.B.Q. In contrast the mean E.B.Q. scores for the children who never or only sometimes eat the same food as their parents, are well above the overall mean score obtained on the E.B.Q.

This relationship is likely to have arisen as a result of selective eating rather than being a cause of it. It is likely that the more fussy the child, the less likely he/she is to eat the same food as his/her parents at meal-times.

In terms of food preparation 90.1% of the respondents prepared 50% or more of the food in their house themselves. Since most of the questionnaires returned were completed by the child's mother, it seems that the female parent is, as might be predicted, largely responsible for meal preparation. This result corresponds with that found by R. Harris (unpublished). Where a respondent prepared 50% or less of the food, the rest of the meals were generally prepared by the child's father or mother.
i.e. the opposing parent to that completing the questionnaire.

**Results from the E.D.E.Q.**

Overall 26 of the 170 respondents (15.29%) achieved a global score of 0 on the E.D.E.Q. which suggests that these individuals show no signs of eating psychopathology. Furthermore, the mean scores achieved by parents in this sample were much lower than those attained by both the community sample and mothers of children with feeding disorders discussed in the investigation conducted by Stein et al (1995).

A regression analysis suggested that neither the age of the child, the parent's global score on the E.D.E.Q. or the parent's scores on the subscales of the E.D.E.Q. significantly predicted the child's E.B.Q. score. Since a high proportion of respondents achieved a score of 0, therefore skewing the overall distribution, the regression analysis was rerun after removing all the cases who showed no signs of eating psychopathology i.e. individuals who obtained a global score of 0 on the E.D.E.Q. However a nonsignificant result was still obtained.

In summary, the results do not provide any support for the three hypotheses outlined at the start of this study. The results from this study suggest that there is no relationship between abnormal eating attitudes and behaviours in parents and selective eating in children. These results conflict with the findings of Stein et al (1995) that parents of children referred to psychiatric clinics with a feeding problem which generally involved food refusal or extreme faddiness, achieved higher scores on the E.D.E.Q. than control respondents. However it is important to note that the children of the parents assessed in this study had feeding disorders of clinical severity where as the sample in this study was drawn from the community. In addition, the child sample in the Stein et al (1995) study contained food refusers as well as fussy eaters.

A possible explanation for these findings may be obtained from a model outlined by G. Harris (in press) in a paper which was obtained after the current study had been
conducted. She comments that there are no generally accepted definitions of food refusal and food fussiness and that the two terms are therefore often used interchangeably. However she suggests that instead of lying along a continuum, they represent two orthogonal dimensions of food related behaviour which she terms Appetite Regulation (food refusal) and Food Acceptance (Food fussiness). Food fussiness is hypothesised to relate to the temperament of the child or may be an age related indication of a phobia because the child has not been exposed to the food before. In terms of temperament, a child who engages in risk taking would not be wary of new food textures and tastes. The author sees food refusal as an over-regulation of appetite or an attempt to maintain self regulation of intake. In this condition, typically insufficient calories are ingested as a result of a cognitive override of hunger. This indiscriminate negative response to food may be a learned response occurring as a result of early negative experience or it may be an attempt by the child to gain parental attention (Iwata et al, 1982). Furthermore, it may be a response to prevailing social norms (Lewis and Blair, 1993).

In order to investigate this model, Whitehouse and Harris (in press) looked at the eating behaviour of nursery school children and the eating attitudes and management styles of their primary care givers which in this study were mothers. The mothers were assessed using the Bite (Henderson and Freeman, 1987) and the E.A.T. (Garner and Garfinkle, 1979). The eating behaviour of children aged 31 - 60 months and the management style of their parents were assessed using a specialist questionnaire developed from the feeding assessment form (Harris and Booth, 1992). Two groups of parent and child pairs were selected for the study on the basis of the parental scores on the Bite and E.A.T. One group contained parents with bulimic and anorectic attitudes and these were matched with parents who scored below the cutoff on the Bite and E.A.T. to make up a control group.

Whitehouse and Harris (in press) found no significant predictors of food fussiness in children. Food refusal in contrast co-varied with the care givers management style. Furthermore, food refusal was higher in the children with parents with disordered eating attitudes although the difference between the two groups was not statistically
significant. Food fussiness in contrast was similar in both groups which, according to the authors, supports the notion that it is a stable factor related to novel foods and the temperament of the child and is impervious to the eating attitudes of the care giver. The authors conclude that their research suggests that there is a connection between food refusal and care givers management style and eating attitudes. However they stress that these results do not imply causality but suggest that much further investigation into this connection is needed.

The application of this model to the current study would explain why no link was found between parental eating attitudes and behaviours and selective, or fussy, eating in children. Furthermore, Whitehouse and Harris’s (in press) findings do suggest that a link may have been found if food refusal instead had been measured in children. Unfortunately it was felt that the items on the E.B.Q. did not easily lend themselves to be split into those relating to food refusal and those relating to food fussiness and therefore a reanalysis of the data with G. Harris’s (in press) hypothesis in mind was not felt to be appropriate.

R. Harris (unpublished) the author of the E.B.Q. highlights the distinction between selective eating and childhood onset Anorexia. She comments that although both are related to a restriction of food intake, for selective eaters the restriction is in terms of range and type of food but for Anorexia restriction is in terms of quantity. However although the E.B.Q. was derived specifically to assess selective eating, the items used on the questionnaire were felt to assess general aspects of eating behaviour in children and hence its use in this study. R. Harris (unpublished) herself states that the E.B.Q. in its current form is unlikely to distinguish between selective eaters and individuals with Anorexia and therefore the latter group would also be expected to achieve a high score on the measure.

**General Conclusions.**

The results from this study suggest that there is no link between abnormal eating attitudes and behaviours in parents and selective eating in their children in a
community sample. This may be interpreted to suggest that shape, weight and dietary concerns of parents do not impinge on the eating behaviour of their children at least in this study. Alternatively the measure used to assess the children’s eating behaviour may not have been an appropriate way of assessing eating concern in children. The results do provide further evidence for the model proposed by G. Harris (in press) and confirm Whitehouse and Harris’s (in press) finding that food fussiness in children is not affected by parental eating behaviour.

The results of many studies cited in the introduction to this report suggest that eating concerns in parents do affect the eating attitudes and behaviour of their children from a very young age. Furthermore, dieting behaviour is now considered normal in adults. Whitehouse and Harris (in press) discovered that at least 40% of the care givers they studied were terrified of being overweight. Such disordered eating attitudes could arguably lead to more eating problems in young children who may then go on to develop eating disorders in adolescence. Clearly therefore this area warrants further investigation. However, in order to achieve this, a measure needs to be devised for assessing eating concerns in children as young as four or five years. The measure used in this study assessed the eating behaviour of children via the perceptions of their parents. This method of assessment was selected because there are many ethical difficulties involved in asking young children about their eating habits. However, it should be borne in mind that the parental perceptions may not always be accurate. Parents who have abnormal eating attitudes themselves may be less likely to notice or view as significant any abnormal eating attitudes in their children. Clearly these are all issues that need to be given careful consideration when devising an assessment measure in this area.

Finally, this study has focused on the influence of parental eating attitudes and behaviours which is only one of many factors which culminate to cause eating problems in children. Other factors which have been highlighted include - wider cultural influences from school, peers and the media, family interactional patterns (Heron and Leheup, 1984) and, more recently, authors have begun suggesting that there may be a genetic factor involved. Therefore the link between parent and child
eating attitudes and behaviours found in previous research may reflect genetic as well as environmental influences (Hill et al, 1990).
CONCLUSIONS.

In conclusion this study suggests that there is not a link between abnormal eating attitudes and behaviours in parents and selective eating in their children. This provides confirmation for the model suggested by G. Harris (in press) who proposes that fussiness in children is a stable factor primarily related to the temperament of the child. Furthermore, her model suggests that a link may have been found if food refusal in children had instead been assessed. The high incidence of disturbed eating attitudes and habits among the adult population emphasises the need for further investigation into this connection.

Selective eating in children aged four - twelve years was more likely to occur if the child was vegetarian. However, due to the small number of vegetarian children studied, this result should be viewed with caution. In addition the frequency of respondents eating the same type of food as their children at meal-times caused significant variation in the children's E.B.Q. scores. In fact a monotonic relationship between the two variables was found for as frequency of eating the same as the child declines, selective eating in the child increases. However, this relationship is likely to have arisen as a result of selective eating rather than being a cause of it. In conclusion the link between selective eating and these two factors warrants further investigation.
REFERENCES.


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Dear Parent,

Eating Attitudes and Behaviours in Children Aged 4 - 12 Years

I appreciate that there are many demands on your time but I would be most grateful for your help. I am conducting research into parent and child eating patterns. Surprisingly, little research has been conducted in this area yet such information would be most useful to understand child eating behaviour.

Your child’s school has given me a list of its pupils in order to assist with this research. This list is simply taken from a list of children at the school; inclusion of your name on the list does not in any way reflect concern about your child’s or your family’s eating patterns. I would be very grateful if you could find the time to complete the enclosed questionnaires and return them to me in the FREEPOST envelope provided. The questionnaires are all anonymous and overall the survey should take around 20 minutes to complete. Please complete the first two forms about your child, who is aged 12 years. The final questionnaire is about your own eating behaviour.

I wish to emphasise that you are not obliged to complete the questionnaires. If you choose not to do so, please return them to me blank, if possible with a brief note explaining your reasons for not wishing to take part.

If you are at all concerned about either your child’s or your own eating behaviour, there is an Eating Disorder help-line on 01603 621414.

Yours sincerely,

Louise Byles BSc
Clinical Psychologist in Training

Research Supervisor: Dr Elizabeth Campbell
Senior Lecturer in Clinical Psychology

University Telephone No: (+44) 01483 300800
Dear Parent,

I appreciate that there are many demands on your time but I would be most grateful for your help. I am currently conducting research into the link between parent and child eating patterns. Surprisingly little research has been conducted in this area yet such information would be most helpful in furthering our understanding of children’s eating patterns.

I am conducting my research in conjunction with Dr Wilson who has allowed me to distribute the enclosed questionnaires to the parents of any children between the ages of 4 and 12 years referred to her with a feeding difficulty.

I would be very grateful if you could find the time to complete the enclosed questionnaires and return them to me in the envelope provided. Overall the survey should take around 20 minutes to complete. Please complete the first two forms for your child who has been referred to Dr Wilson. The final questionnaire is about your own eating behaviour.

I wish to emphasise that you are not obliged to complete the questionnaires and that this research is separate from any therapy that your child might receive. If you choose not to complete the forms, please return them to me blank, if possible with a brief note explaining your reasons for not wishing to take part.

The information gained from these questionnaires may prove very useful to Dr Wilson in her assessment of your son or daughter. For this reason, space is provided on the survey for you to choose not to provide this information and instead return the forms anonymously.

I hope that you are willing to complete this survey and look forward to receiving your completed forms. Thank you in advance for your time and co-operation.

Yours sincerely

Louise Byles
Clinical Psychologist in Training

Research Supervisor: Dr Elizabeth Campbell
Senior Lecturer in Clinical Psychology

University Telephone No: (+44) 01483 300800
Please complete the following questionnaire for your year old child. Please rate each statement according to how typical it is of your child by ticking the appropriate point on the six point scale provided.

<table>
<thead>
<tr>
<th>My child:</th>
<th>1 Not at all Typical</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6 Very Typical</th>
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<tbody>
<tr>
<td>1 Eats a wide variety of different foods</td>
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<td>2 Eats green vegetables</td>
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<td>3 Eats food with lumps/bits in it</td>
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<td>4 Absolutely refuses to eat food he/she dislikes</td>
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<td>5 Can not stand the smell of certain foods</td>
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<td>6 Eats what he/she is given</td>
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<td>7 Has a good appetite</td>
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<td>8 Can be made to eat what he/she does not like</td>
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<td>9 Is a very fussy eater</td>
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<td>10 Often has temper tantrums about food</td>
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<td>11 Regularly tries new foods</td>
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<td>12 Dislikes many types of food</td>
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<td>13 Is adamant about what he/she will not eat</td>
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<td>14 Always chooses the same food for supper at night</td>
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<td>15 Regularly eats three proper meals a day</td>
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<td>16 Argues about what he/she will eat</td>
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<td>17 Would rather not eat anything at all than eat something he/she dislikes</td>
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<td>18 Enjoys different foods</td>
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</table>
Personal Details About Your ___ Year Old Child

Child’s Name:........................................................................................................

Parent’s Name:......................................................................................................

Please tick the boxes that apply to your child:

1. Gender
   Male □ Female □

2. Ethnicity
   White British □ Asian □
   White Other □ African □
   Caribbean □ Other □
   Please specify □

3. What is your relationship to the child?
   Mother □ Father □
   Stepmother □ Stepfather □
   Other □
   Please specify □

4. Does your child have any medical conditions eg diabetes, asthma?
   Yes □ No □
   If yes, please give details □

5. Has your child ever experienced any serious medical complaints which caused feeding problems eg lactose intolerance?
   Yes □ No □
   If yes, please give details □

6. Has your child ever received counselling or seen anyone such as an educational psychologist?
   Yes □ No □

7. Has your child ever been significantly overweight or underweight?
   Yes □ No □
   If yes, please give details.

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Food Details

8. Does your child follow a particular diet for religious or medical reasons?
   Yes □  No □
   If yes, please give details

9. Is your child vegetarian?
   Yes □  No □

10. Is your child allergic to any particular foods?
   Yes □  No □
   If yes, which?

11. Does your child eat:
    School Meals □  Packed Lunch □
    Other □
    Please specify

12. How often do you eat at least one meal per day with your child?
    All of the time □  Most of the time □
    Sometimes □  Never □

13. Do you and your child eat the same type of food at meal-times?
    All of the time □  Most of the time □
    Sometimes □  Never □

14. How often does your child help himself/herself to food he/she wants?
    All of the time □  Most of the time □
    Sometimes □  Never □

15. How many meals do you prepare in your house?
    100% □  75% □
    50% □  25% □
    0% □

16. If you prepare 50% or less of the meals in your house, who prepares most of the other meals
    Child’s mother □
    Child’s father □
    Child’s sibling □
    Other □
    Please specify who

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### Instructions
The following questions are concerned with the **PAST FOUR WEEKS (28 days)**. Please read each question carefully and tick the appropriate box on the right. Please answer all the questions.

<table>
<thead>
<tr>
<th>Question</th>
<th>0 days</th>
<th>1-5 days</th>
<th>6-12 days</th>
<th>13-15 days</th>
<th>16-22 days</th>
<th>23-27 days</th>
<th>Every day</th>
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<tbody>
<tr>
<td>1. Have you been deliberately trying to limit the amount of food you eat to influence your shape or weight?</td>
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<td>2. Have you gone for long periods of time (8 hours or more) without eating anything in order to influence your shape or weight?</td>
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<td>3. Have you tried to avoid eating foods which you like in order to influence your shape or weight?</td>
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<td>4. Have you tried to follow definite rules regarding your eating in order to influence your shape or weight; for example a calorie limit, a set amount of food, or rules about what or when you should eat?</td>
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<td>5. Have you wanted your stomach to be empty?</td>
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<td>6. Has thinking about food or its calorie content made it much more difficult to concentrate on things you are interested in; for example, read, watch TV or follow a conversation?</td>
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<td>7. Have you been afraid of losing control over eating?</td>
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<td>8. Have you had episodes of binge eating?</td>
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<td>9. Have you eaten in secret? (Do not count binges)</td>
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<td>10. Have you definitely wanted your stomach to be flat?</td>
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<td>11. Has thinking about shape or weight made it more difficult to concentrate on things you are interested in; for example watch TV or follow a conversation?</td>
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<td>12. Have you had a definite fear that you might gain weight or become fat?</td>
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<td>13. Have you felt fat?</td>
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<td>14. Have you had a strong desire to lose weight?</td>
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</tbody>
</table>
### OVER THE PAST FOUR WEEKS (28 DAYS)

On what proportion of times that you have eaten have you felt guilty because of the effect on your shape or weight? (Circle the number which applies.)

- 0 - None of the times
- 1 - A few of the times
- 2 - Less than half the times
- 3 - Half the times
- 4 - More than half the times
- 5 - Most of the time
- 6 - Every time

<table>
<thead>
<tr>
<th></th>
<th>Question</th>
<th>Yes</th>
<th>No</th>
<th>How many?</th>
</tr>
</thead>
<tbody>
<tr>
<td>16</td>
<td>Over the past four weeks (28 days), have there been any times when you have felt that you have eaten what other people would regard as an unusually large amount of food given the circumstances?</td>
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<tr>
<td>17</td>
<td>How many such episodes have you had over the past four weeks?</td>
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<td>18</td>
<td>During how many of these episodes of overeating did you have a sense of having lost control over your eating?</td>
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<td>19</td>
<td>Have you had other episodes of eating in which you have had a sense of having lost control and eaten too much, but have not eaten an unusually large amount of food given the circumstances?</td>
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<tr>
<td>20</td>
<td>How many such episodes have you had over the past four weeks?</td>
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<tr>
<td>21</td>
<td>Over the past four weeks have you made yourself sick (vomit) as a means of controlling your shape or weight?</td>
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<tr>
<td>22</td>
<td>How many times have you done this over the past four weeks?</td>
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<tr>
<td>23</td>
<td>Have you taken laxatives as a means of controlling your shape or weight?</td>
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<td>24</td>
<td>How many times have you done this over the past four weeks?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>25</td>
<td>Have you taken diuretics (water tablets) as a means of controlling your shape or weight?</td>
<td></td>
<td></td>
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<tr>
<td>26</td>
<td>How many times have you done this over the past four weeks?</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>27</td>
<td>Have you exercised hard as a means of controlling your shape or weight?</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>28</td>
<td>How many times have you done this over the past four weeks?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Question</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
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<td>-------------------------------------------------------------------------</td>
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<td>Has your weight influenced how you think about (judge) yourself as a person?</td>
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<td></td>
<td></td>
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</tr>
<tr>
<td>Has your shape influenced how you think about (judge) yourself as a person?</td>
<td></td>
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</tr>
<tr>
<td>How much would it upset you if you had to weigh yourself once a week for the next four weeks?</td>
<td></td>
<td></td>
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<tr>
<td>How dissatisfied have you felt about your weight?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>How dissatisfied have you felt about your shape?</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>How concerned have you been about other people seeing you eat?</td>
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<td>How uncomfortable have you felt seeing your body: for example, in the mirror, in shop window reflections, while undressing or taking a bath or shower?</td>
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</tr>
<tr>
<td>How uncomfortable have you felt about others seeing your body: for example, in communal changing rooms, when swimming or wearing tight clothes?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
CLINICAL APPENDIX.

The following appendix contains all the clinical logbooks and evaluation forms for the six placements I attended. It should be noted that the evaluation of my core adult placement was lost in its transmission from my clinical supervisor to the clinical tutor and therefore does not appear in this document.
APPENDIX 7
Log Book

UNIVERSITY OF SURREY /S W T R H A
M Sc in Clinical Psychology

Ainee's name. LOUISE BLYES. Placement Type. ADULT.

Date: 22/4/94. Supervisors Name. MRS. RHODA TROTTER.

Placement District. KINGSBURY AND ESHER.

Summary of Clinical Activity

Please indicate at the end of your placement what you have covered under the following seven categories:

1) Clinical activity with individual clients, couples & families (use attached sheet C)
2) Group work - use attached sheet B
3) Teaching/Skills transmission/Presentations
   Outline each experience of teaching, indicating what, to whom, how organised, the extent of your role and its degree of success.
   A Stress Management workshop open to C.U.H.T professionals. The teaching was conducted by the Head of Adult Psychiatry. My role was teaching assistant.

4) Organisational Work (eg: developing IPP system, staff support, assessing case recording system). Outline each piece of work, indicating the extent of your role and outcome.
5. **RESEARCH**

Outline any projects which you initiated or with which you were involved and indicate the extent of your involvement.

6. **MEETINGS, VISITS, OBSERVATIONS**

Outline briefly each experience and the extent of your involvement.

Meetings: As an active member of the adult specialty, I participated in departmental meetings held weekly. Every two weeks I attended specialty and allocation meetings, and from the latter I accepted a number of referrals.

I attended 7 ward rounds on the acute psychiatric ward, during which I participated in case discussions, and accepted a number of referrals.

I represented my year on the committee established to discuss trainee support.

I was an observer during two primary care meetings and a quality meeting.

Visits: I visited Roselands Resource Centre where I discussed with the manager its running and the activities offered. I also had the chance to explore the centre.

I spent 1 day observing the work of individuals in Elmbridge C.U.H.T. During a visit I attended their weekly allocation meeting, a discussion on community programmes and talked with various professionals, including an occupational therapist, ward nurse, and social worker about their roles in the C.U.H.T. I was also able to talk with a mental health worker (as the C.U.H.T. is based in a day centre).

I visited the unstaffed group home of three individuals with schizophrenia, discussed with them the day-to-day running of their home.

Seminars:

On four occasions I observed the work of my supervisor in a G.P. Surgery.

Saw clients with a wide range of problems, including a lady with Post-Viral Indigestion.
7. COURSES AND TRAINING EVENTS ATTENDED AS PART OF PLACEMENT

Please list and outline each one.

I attended a 1 day Workshop on Anorexia Nervosa run by Professor Crisp at the Atkinson Morley's Hospital.

8. OTHER

Please outline any other experience on placement.

I met with a psychologist working with people with Physical Disabilities. We had a general discussion about the work she does and the type of clients she sees.

I attended weekly departmental seminars presented by various members from all the specialties within the department. Topics covered included case presentations, working in the acute care, and the work of the Kingdon Bereavement Counselling Service.

Signed: Trainee: Date: 22/4/94.

Signed: Supervisor: Date: 22/4/94.
<table>
<thead>
<tr>
<th>Sex</th>
<th>Age</th>
<th>Assessment</th>
<th>Intervention</th>
<th>Type of Contact</th>
<th>Presenting Need</th>
<th>Model of Therapy</th>
<th>No of Hours</th>
<th>Outcome/ Evaluation</th>
<th>Additional Info/Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>F</td>
<td>45</td>
<td>Assessment for treatment.</td>
<td>FI</td>
<td>S</td>
<td>Feelings of Depression and Guilt.</td>
<td>C.B.T.</td>
<td>9</td>
<td>Significant Improvement</td>
<td>felt very positive about the dose</td>
</tr>
<tr>
<td>M</td>
<td>47</td>
<td>Subtests from the W.H.S - Cognitive Estimates test. - Botten and Thurstone's word fluency tests.</td>
<td>FI</td>
<td>S</td>
<td>Memory problems? Frontal lobe problems?</td>
<td>assessment only</td>
<td>2½</td>
<td>Scored highly on majority of tests. GP to closely observe.</td>
<td></td>
</tr>
<tr>
<td>F</td>
<td>46</td>
<td>Subtests from the W.H.S which had to be repeated due to anxiety levels. Vocab test from WAIS-R and B.D.T.</td>
<td>FI</td>
<td>S</td>
<td>Memory problems and depression.</td>
<td>assessment only</td>
<td>3</td>
<td>Low scores - GP referred for C.A.T. Scan.</td>
<td></td>
</tr>
<tr>
<td>M</td>
<td>31</td>
<td>Assessment for treatment.</td>
<td>FI</td>
<td>S</td>
<td>Needle Phobia.</td>
<td>C.B.T.</td>
<td>4</td>
<td>Unknown - due to not yet having had an injection.</td>
<td>Client felt improvement had taken place</td>
</tr>
</tbody>
</table>
## Clinical Activity with Individual Clients, Couples, and Families - Placement Summary

<table>
<thead>
<tr>
<th>Sex</th>
<th>Age</th>
<th>Assessment</th>
<th>Intervention</th>
<th>Type of Contact</th>
<th>Presenting Need</th>
<th>Model of Therapy</th>
<th>No of Hours</th>
<th>Outcome/Evaluation</th>
<th>Additional Info/Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>F</td>
<td>27</td>
<td>Assessment for treatment</td>
<td>FI</td>
<td>S</td>
<td>low self esteem/confidence</td>
<td>non-directive therapy, C.B.T.</td>
<td>3</td>
<td>Slight improvement. Client terminated treatment as felt she now had necessary skills to work alone.</td>
<td>Change of job. Anxious about taking time off for therapy?</td>
</tr>
<tr>
<td>F</td>
<td>22</td>
<td>Assessment for treatment</td>
<td>FI</td>
<td>S</td>
<td>Difficulty eating in public</td>
<td>C.B.T.</td>
<td>1</td>
<td>Improved. Found the session and material very helpful. No further sessions needed.</td>
<td>Long wait between receiving referral and offering appointment. Allergic to setting. A hypnotherapist.</td>
</tr>
<tr>
<td>M</td>
<td>50</td>
<td>Assessment for treatment</td>
<td>FI</td>
<td>S</td>
<td>Divorce/hand of family access causing depression</td>
<td>C.B.T.</td>
<td>2</td>
<td>D.N.A. twice I felt his was not currently committed to attending therapy.</td>
<td>Terminated treatment with hypnotherapist last year after a couple of sessions. Nationality: Hawaiian.</td>
</tr>
<tr>
<td>F</td>
<td>32</td>
<td>Assessment for treatment</td>
<td>FI</td>
<td>S</td>
<td>Depression and toxic abuse</td>
<td>Assessment only</td>
<td>1</td>
<td>Treatment terminated by client.</td>
<td>? Husband did not want her to attend sessions.</td>
</tr>
<tr>
<td>M</td>
<td>34</td>
<td>-</td>
<td>FI</td>
<td>S</td>
<td>Depression following mental breakdown</td>
<td>Non-directive therapy</td>
<td>1</td>
<td>Supervisor chewed (I saw her for a last emergency session).</td>
<td></td>
</tr>
<tr>
<td>Sex</td>
<td>Age</td>
<td>Assessment</td>
<td>Intervention</td>
<td>Type of Contact</td>
<td>Presenting Need</td>
<td>Model of Therapy</td>
<td>No of Hours</td>
<td>Outcome/Evaluation</td>
<td>Additional Info/Comment</td>
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</tr>
<tr>
<td>F</td>
<td>49</td>
<td>Assessment for Treatment</td>
<td>FI IT</td>
<td>S</td>
<td>Depression / attempted suicide</td>
<td>C.B.T.</td>
<td>3½</td>
<td>Moved to Rose Lodge (Residential home) then referred to C.M.H.T. Psychologist</td>
<td>An inpatient on Kenley Ward, nationality: Indigenous</td>
</tr>
<tr>
<td>F</td>
<td>27</td>
<td>Assessment for Treatment</td>
<td>FI IT</td>
<td>S</td>
<td>Anger problems</td>
<td>C.B.T.</td>
<td>1</td>
<td>Organized to meet client jointly with Supervisor but client D.N.A.D.</td>
<td>Nationality: Sri-Lankan</td>
</tr>
<tr>
<td>F</td>
<td>27</td>
<td>Assessment for Treatment</td>
<td>FI IT</td>
<td>S</td>
<td>Bulimia / Alcohol Abuse</td>
<td>C.B.T. non-directive therapy</td>
<td>8</td>
<td>I saw the client concurrently with my Supervisor. Sessions with Supervisor are ongoing.</td>
<td>For a number of sessions client was an inpatient on the Psychiatric ward.</td>
</tr>
<tr>
<td>M</td>
<td>17</td>
<td>Assessment for Treatment</td>
<td>FI IT</td>
<td>S</td>
<td>Drug-induced psychosis</td>
<td>Assess only</td>
<td>2½</td>
<td>Psychiatric and I currently face Psychology not suitable.</td>
<td>Inpatient on Psychiatric ward</td>
</tr>
<tr>
<td>F</td>
<td>26</td>
<td>Assessment for Treatment</td>
<td>FI DS</td>
<td>S</td>
<td>Hostile Impulsive Behaviour</td>
<td>non-directive therapy</td>
<td>2½</td>
<td>Saw as a &quot;one off&quot; while Supervisor on holiday. Supervisor's client</td>
<td>Suggested as a &quot;one off&quot; while Supervisor on holiday. Supervisor's client.</td>
</tr>
<tr>
<td>Sex</td>
<td>Age</td>
<td>Assessment</td>
<td>Intervention</td>
<td>Type of Contact</td>
<td>Presenting Need</td>
<td>Model of Therapy</td>
<td>No of Hours</td>
<td>Outcome/Evaluation</td>
<td>Additional Info/Comments</td>
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<tr>
<td>F</td>
<td>28</td>
<td>Assessment for treatment</td>
<td>FI</td>
<td>S (P), DS</td>
<td>Depression, low self esteem and marital problems</td>
<td>Cognitive Behavioral and non-directive therapy</td>
<td>9</td>
<td>Much improved</td>
<td></td>
</tr>
<tr>
<td>F</td>
<td>57</td>
<td>Assessment for treatment</td>
<td>FI</td>
<td>S (P), DS</td>
<td>Depression and Social Phobia</td>
<td>CBT</td>
<td>8</td>
<td>Still being seen by Supervisor</td>
<td>I worked individually on the mood program and observed my Supervisor training for her depression</td>
</tr>
<tr>
<td>F</td>
<td>36</td>
<td>Assessment for treatment</td>
<td>FI</td>
<td>S (P), DS</td>
<td>Depression/low self esteem and parenting</td>
<td>CBT, non-directive therapy</td>
<td>2</td>
<td>Ongoing care of Supervisor</td>
<td>I saw her more while Supervisor was on holidays</td>
</tr>
<tr>
<td>F</td>
<td>46</td>
<td>Assessment for treatment</td>
<td>FI</td>
<td>S (P)</td>
<td>Physical trauma to help with divorce and depression</td>
<td>CBT</td>
<td>4</td>
<td>Some improvement</td>
<td>Often fell on an even keel, and that no funds: Sessi were necessary</td>
</tr>
<tr>
<td>F</td>
<td>61</td>
<td>Assessment for treatment</td>
<td>FI</td>
<td>S (P)</td>
<td>Low self esteem, Ambivalence about forming relationships</td>
<td>CBT</td>
<td>4</td>
<td>Improved</td>
<td></td>
</tr>
<tr>
<td>Sex</td>
<td>Age</td>
<td>Assessment for Treatment</td>
<td>Type of Contact</td>
<td>Presenting Need</td>
<td>Model of Therapy</td>
<td>No of Hours</td>
<td>Outcome/ Evaluation</td>
<td>Additional Info/ Comments</td>
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<tr>
<td>F</td>
<td>30</td>
<td>Assessment for treatment</td>
<td>FI</td>
<td>Relationship difficulties, Anorexic tendencies</td>
<td>C.B.T.</td>
<td>3</td>
<td>Referred on to supervisor</td>
<td></td>
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</tr>
<tr>
<td>F</td>
<td>34</td>
<td>Assessment for treatment</td>
<td>FI</td>
<td>Sleeping difficulties, Difficulty dealing with anorexic daughter</td>
<td>C.B.T.</td>
<td>2</td>
<td>Much improved</td>
<td>I worked voluntarily with the client on her sleeping difficulty.</td>
<td></td>
</tr>
<tr>
<td>F</td>
<td>29</td>
<td>Assessment for treatment</td>
<td>FI</td>
<td>Adult survivor of sexual abuse; relationship difficulties</td>
<td>Assessment only</td>
<td>2</td>
<td>Referred on to another member of the specialty for long term intervention (Psychotherapy)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>F</td>
<td>27</td>
<td>Assessment for treatment</td>
<td>FI</td>
<td>Stress/Anxiety following drug experience</td>
<td>Cog. Beh. Therapy</td>
<td>3</td>
<td>Referred onto another member of the specialty</td>
<td>An emergency referral</td>
<td></td>
</tr>
<tr>
<td>N</td>
<td>21</td>
<td>Assessment for treatment</td>
<td>FI</td>
<td>O.C.D., Low self esteem</td>
<td>C.B.T.</td>
<td>4</td>
<td>Some improvement Referred on to another member of the specialty</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sex</td>
<td>Age</td>
<td>Assessment</td>
<td>Intervention</td>
<td>Type of Contact</td>
<td>Presenting Need</td>
<td>Model of Therapy</td>
<td>No of Hours</td>
<td>Outcome/Evaluation</td>
<td>Additional Info/Comments</td>
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<tr>
<td>F</td>
<td>26</td>
<td>Assessment for treatment</td>
<td>FT</td>
<td>S</td>
<td>previous anorexic, now anxious about having a baby.</td>
<td>non-directive</td>
<td>3</td>
<td>referred on to supervisor who will provide support throughout pregnancy of the conceives</td>
<td></td>
</tr>
<tr>
<td>M</td>
<td>21</td>
<td>Assessment for treatment</td>
<td>FT</td>
<td>DS S (P)</td>
<td>Anxious following bad drug experience.</td>
<td>non-directive</td>
<td>3</td>
<td>Ongoing client of supervisor.</td>
<td></td>
</tr>
<tr>
<td>F</td>
<td>42</td>
<td>Assessment for treatment</td>
<td>FC</td>
<td>DS</td>
<td>Relationship difficulties</td>
<td>Systemic</td>
<td>3</td>
<td>Ongoing client of supervisors.</td>
<td>Wife has rheumatoid arthritis</td>
</tr>
<tr>
<td>F</td>
<td>43</td>
<td>-</td>
<td>FT</td>
<td>DS</td>
<td>Post traumatic stress following road traffic accident.</td>
<td>eclectic</td>
<td>2</td>
<td>Ongoing client of supervisor</td>
<td></td>
</tr>
<tr>
<td>F</td>
<td>-</td>
<td>-</td>
<td>FT</td>
<td>DS</td>
<td>Bereavement.</td>
<td>eclectic</td>
<td>1</td>
<td>Ongoing client of supervisors</td>
<td></td>
</tr>
<tr>
<td>Sex</td>
<td>Age</td>
<td>Assessment</td>
<td>Intervention</td>
<td>Type of Contact</td>
<td>Presenting Need</td>
<td>Model of Therapy</td>
<td>No of Hours</td>
<td>Outcome/Evaluation</td>
<td>Additional Info/Comments</td>
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<td>--------------------------</td>
</tr>
<tr>
<td>F</td>
<td>28</td>
<td>-</td>
<td>FI</td>
<td>DS</td>
<td>Low self esteem/confidence 1 Mental problems.</td>
<td>eclectic</td>
<td>2</td>
<td>Ongoing client of Supervisors</td>
<td></td>
</tr>
<tr>
<td>F</td>
<td></td>
<td>-</td>
<td>FI</td>
<td>DS</td>
<td>Adult survivor of physical, emotional and sexual abuse</td>
<td>eclectic</td>
<td>2</td>
<td>Ongoing client of Supervisors</td>
<td></td>
</tr>
<tr>
<td>F</td>
<td>45</td>
<td>-</td>
<td>FI</td>
<td>DS</td>
<td>Gaining to terms with not being able to work and feeling depressed.</td>
<td>eclectic</td>
<td>2</td>
<td>Ongoing client of Supervisors</td>
<td>Nationality: Czechoslovakian. Also an Asthmatic</td>
</tr>
<tr>
<td>F</td>
<td>44</td>
<td>-</td>
<td>FI</td>
<td>DS</td>
<td>Depression/mental problems/ inability to cope with family.</td>
<td>eclectic</td>
<td>2</td>
<td>Ongoing client of Supervisors</td>
<td></td>
</tr>
<tr>
<td>M</td>
<td>21</td>
<td>-</td>
<td>FI</td>
<td>DS</td>
<td>Panic attacks.</td>
<td>eclectic</td>
<td>2</td>
<td>Ongoing client of supervisor.</td>
<td></td>
</tr>
<tr>
<td>Sex</td>
<td>Age</td>
<td>Assessment</td>
<td>Intervention</td>
<td>Type of Contact</td>
<td>Presenting Need</td>
<td>Model of Therapy</td>
<td>No of Hours</td>
<td>Outcome/ Evaluation</td>
<td>Additional Info/Comments</td>
</tr>
<tr>
<td>-----</td>
<td>-----</td>
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<td>--------------------------</td>
</tr>
<tr>
<td>F</td>
<td>—</td>
<td>—</td>
<td>FI</td>
<td>DS</td>
<td>Mental Problems</td>
<td>eclectic</td>
<td>1</td>
<td>ongoing client of Supervisor</td>
<td></td>
</tr>
<tr>
<td>F</td>
<td>47</td>
<td>—</td>
<td>FI</td>
<td>DS</td>
<td>Panic Attacks</td>
<td>eclectic</td>
<td>2</td>
<td>&quot;</td>
<td></td>
</tr>
<tr>
<td>F</td>
<td>48</td>
<td>—</td>
<td>FI</td>
<td>DS</td>
<td>Coming to terms with husband's affair 6 years ago</td>
<td>eclectic</td>
<td>1</td>
<td>&quot;</td>
<td></td>
</tr>
<tr>
<td>M</td>
<td>Assessment for treatment</td>
<td>FI</td>
<td>DS</td>
<td>O.C.D.</td>
<td>eclectic</td>
<td>1</td>
<td>&quot;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>M</td>
<td>57</td>
<td>—</td>
<td>FI</td>
<td>DS</td>
<td>Anxiety / Panic attacks / Speech difficulties</td>
<td>eclectic</td>
<td>2</td>
<td>&quot;</td>
<td></td>
</tr>
</tbody>
</table>
## Clinical Activity with Individual Clients, Couples, and Families - Placement Summary

<table>
<thead>
<tr>
<th>Sex</th>
<th>Age</th>
<th>Assessment</th>
<th>Intervention</th>
<th>Type of Contact</th>
<th>Presenting Need</th>
<th>Model of Therapy</th>
<th>No of Hours</th>
<th>Outcome/Evaluation</th>
<th>Additional Info/Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>M</td>
<td>20</td>
<td>-</td>
<td>IF</td>
<td>DO</td>
<td>Problems coming to terms with presenting homosexuality</td>
<td>Milan Systemic</td>
<td>1 1/2</td>
<td>Ongoing client of Psychologists</td>
<td></td>
</tr>
<tr>
<td>F</td>
<td></td>
<td>-</td>
<td>IF</td>
<td>DO</td>
<td>Relationship difficulties</td>
<td>Milan Systemic</td>
<td>1 1/2</td>
<td>Much improved</td>
<td></td>
</tr>
<tr>
<td>F</td>
<td>24</td>
<td>Assessment for treatment</td>
<td>IF</td>
<td>DO (Psychologist)</td>
<td>Family living to client illness; client experiencing difficulties obtaining independence</td>
<td>Milan Systemic</td>
<td>3</td>
<td>Client to be seen on an individual basis</td>
<td></td>
</tr>
<tr>
<td>M</td>
<td>24</td>
<td>Assessment for treatment</td>
<td>IF</td>
<td>DO (Psychologist)</td>
<td>Family having difficulty coping with son's anxiety</td>
<td>Milan Systemic</td>
<td>3</td>
<td>Some improvement</td>
<td></td>
</tr>
</tbody>
</table>
## Appendix C3

**Clinical Activity with Individual Clients, Couples, and Families - Placement Summary**

<table>
<thead>
<tr>
<th>Sex</th>
<th>Age</th>
<th>Assessment for Treatment</th>
<th>Intervention</th>
<th>Type of Contact</th>
<th>Presenting Need</th>
<th>Model of Therapy</th>
<th>No of Hours</th>
<th>Outcome/Evaluation</th>
<th>Additional Info/Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>M</td>
<td>19</td>
<td>Assessment for Treatment</td>
<td>IF</td>
<td>DO (Psychologist)</td>
<td>Family having difficulty coping with Son's obsessional thoughts</td>
<td>Human Systemic</td>
<td>3</td>
<td>ongoing client of Psychologist</td>
<td>Son has mood</td>
</tr>
<tr>
<td>M</td>
<td>21</td>
<td>Assessment for Treatment</td>
<td>IF</td>
<td>DO (Psychologist)</td>
<td>Stressed family relationships due to Suicidal Son</td>
<td>Human Systemic</td>
<td>112</td>
<td>ongoing client of Psychologist</td>
<td></td>
</tr>
</tbody>
</table>
LOGBOOK INSTRUCTIONS

The placement logbook's purpose is to chart the range of clinical experience over each clinical placement. In addition to the core experiences required by the BPS, there is also additional experiences - such as in neuropsychology and rehabilitation and overlap areas (such as children with developmental delay or disorder) which it is important to cover. Other pertinent issues are - the range of models of therapy, the amount of couple, group and family work and teaching experience.

You are asked at the end of the placement to summarise your clinical activity under the different headings. The following gives guidance but you are expected to use your own judgement in interpreting ambiguous situations. Later on there may be more 'given' categories; at present many are open ended.

Sex & Age
If you are seeing the family then the age and sex of the person referred should be used. If a couple, both.

Assessment
Please list all formal or structured assessment procedures used. If there was an assessment for treatment interview just state that.

Intervention can be either face to face or indirect with various subheadings; you may use more than one.

Type of Contact
This covers the amount of independent work you do in addition to observation and joint work with others. If you want to use more than one category please indicate which was prime.

Presenting Needs
This should be described in your own words and should cover the main presenting needs dealt with in the intervention.

Model of Therapy used - Again this is left open for you to use your own words.

Number of Hours
of direct or indirect client contact - not covering client administration activities.

Outcome/Evaluation
Please give some notion of the outcome of the intervention using your own words.

Any other additional information or comments.

This is really to add in particularly useful information - eg. if there were major professional issues (confidentiality), particular types of supervision used or particular issues of the setting you wish to bear in mind.
LOG BOOK CATEGORIES
(for clinical activities, with individual couples and families)

Sex M/F
Age in years
Assessment
Please state all psychometric tests/formal assessment procedures used (eg WAIS, Merrill Palmer, HALO, Beck) or structured assessments - eg eating habits, interview or assessment for treatment interview.

Intervention
F - Face to Face
FI - individual
FC - couple
FF - family
FO - other - please describe.
I - Indirect
IC - with carer (not family) - residential day or community support staff.
IT - with therapist/other 'professional' staff (eg. OT, psychiatrist, SW, Ed psychologist, Teacher, CPN, HV)

(T) - family member
(TO) - other - please describe.

NB: You may use more than one category.

Type of Therapist Contact
S - Solo work
J - Joint - please state co-worker.
DS - Direct observation supervisor (eg sitting in)
(DO) - Direct observation of other - please say whom.
IS - Indirect observation of supervisor (eg audio/video)
(IO) - Indirection observation of other - please describe.

NB: If you wish to use more than one category, please indicate which was prime by putting (P) against it.

Presenting Need
Please use your own words.

Model of Therapy Used
Please use your own words.

No of hours - Of direct or indirect client contact.

Outcome/Evaluation

Any additional information or comments
Please mention here anything extra which helped give a full picture of your clinical activity.
# UNIVERSITY OF SURREY/SWTRHA

**Psych D/MSc IN CLINICAL PSYCHOLOGY**

**EVALUATION OF THE TRAINEE ON PLACEMENT LEARNING DISABILITIES**

<table>
<thead>
<tr>
<th>TRAINEE NAME</th>
<th>LOUISE BYLES</th>
</tr>
</thead>
<tbody>
<tr>
<td>PLACEMENT TITLE</td>
<td>PEOPLE &amp; LEARNING DIFFICULTIES</td>
</tr>
<tr>
<td>PLACEMENT DATES</td>
<td>APRIL TO OCTOBER 1994</td>
</tr>
<tr>
<td>SUPERVISOR NAME</td>
<td>Tony Overell</td>
</tr>
<tr>
<td>PLACEMENT ADDRESS</td>
<td>NORMANSFIELD</td>
</tr>
<tr>
<td></td>
<td>KINGSTON RD</td>
</tr>
<tr>
<td></td>
<td>TEDDINGTON</td>
</tr>
<tr>
<td></td>
<td>MIDDLESEX</td>
</tr>
</tbody>
</table>

## OVERALL RATING FOR THE PLACEMENT

In the supervisor’s opinion, has the trainee reached the standard expected to pass the placement?

<table>
<thead>
<tr>
<th>COMMENT</th>
<th>TICK</th>
</tr>
</thead>
<tbody>
<tr>
<td>PASS</td>
<td>✓</td>
</tr>
<tr>
<td>PASS: The trainee has gaps in experience that need to be addressed later in training</td>
<td></td>
</tr>
<tr>
<td>PASS: The trainee needs to focus on specified areas of clinical skills in subsequent placements</td>
<td></td>
</tr>
<tr>
<td>FAIL: The trainee has not reached the standard expected</td>
<td></td>
</tr>
</tbody>
</table>

**General Comments from Supervisor:**

LOUISE HAS PERFORMED WELL IN THIS PLACEMENT. SHE IS ABLE TO FUNCTION AT OR ABOVE THE LEVEL TO BE EXPECTED AT THIS STAGE. I HAVE IDENTIFIED A NUMBER OF AREAS FOR FUTURE DEVELOPMENT, BUT REGARD THESE AS APPROPRIATE AT THIS POINT IN LOUISE'S TRAINING.

Signed [Signature] (Supervisor) Date: 28/10/94

**Comments from the trainee:**

This seems a fair evaluation.

Signed [Signature] (Trainee) Date: 7/12/95
Procedure
- refer generally to the items on the evaluation form and standards set for the speciality area:
- take into account the stage of training, but also identify areas of skill development or gaps in experience which do need further attention:
- do not make allowances for any particular difficulty in the placement or that the trainee has had.

WHERE THERE IS A RATING OF 0 THE REVIEW PROCEDURE IS INSTIGATED BY COURSE OFFICERS.

WHERE THERE IS A RATING OF 2 OR 1 THIS IS INCLUDED IN THE TRAINEE'S CLINICAL TRAINING PLAN AND MONITORED CLOSELY ON SUBSEQUENT PLACEMENTS.

EVALUATION OF THE TRAINEE'S PERFORMANCE ON EACH ITEM

For each item, the Supervisor decides whether, in their opinion, the trainee reaches the standard expected:

<table>
<thead>
<tr>
<th>RATING</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>3</td>
<td>YES - Above expected level</td>
</tr>
<tr>
<td>2</td>
<td>YES - At expected level</td>
</tr>
<tr>
<td>1</td>
<td>NO - Borderline</td>
</tr>
<tr>
<td>0</td>
<td>NO</td>
</tr>
</tbody>
</table>

The Supervisor may then give an explanation, expansion of the rating, or other comments.

Procedure:
- refer to the criterion level and any standards set for the speciality area:
- take into account the stage of training where it is clearly relevant to the development of the particular area.
- do not make allowances for any particular difficulty in the placement or that the trainee has had.
  - put this into the explanation below so that it can be included in later training.

Please attach:
  i) Contract
  ii) Log Book
  iii) Trainee feedback form
  iv) Placement visit feedback form
### SUPERVISOR - TRAINEE RELATIONSHIP

<table>
<thead>
<tr>
<th>The supervisor may raise questions or present options for the trainee to consider, but usually the trainee can present plans and make decisions on how to proceed which they have devised independently.</th>
<th>2</th>
<th>House is able to think through issues and plan actions with advice of support appropriate to an end of first year trainee.</th>
</tr>
</thead>
<tbody>
<tr>
<td>The trainee does not usually require observation, monitoring or detailed questioning to maintain the standard of work, but this is used to ‘fine tune’ skills. The trainee self monitors and identifies the need for assistance in normal circumstances.</td>
<td>3</td>
<td>I have felt confident that house will work appropriately and seek help if necessary.</td>
</tr>
<tr>
<td>The trainee shows a balance between autonomy and the use of support and advice which is appropriate to their level of skills, the client and the service setting.</td>
<td>2</td>
<td>House is able to seek support as needed - including support needed as a consequence of her disability.</td>
</tr>
</tbody>
</table>

In your opinion, does the trainee reach the standard expected:

- 3  YES - Above expected level - please expand
- 2  YES - At expected level - please expand
- 1  NO - Borderline - please expand
- 0  NO - Please explain
- N/A Not applicable
SUPERVISOR NOTES ON CORE COMPETENCIES FOR TRAINEES

It is likely that trainees will work with less independence and autonomy in this speciality because of:
- the complexity of client presentation and needs
- the range of interprofessional and interagency work required
- the need for continuity for clients with long term needs.

1. The development of competency in the use of scientific method

1.1 Will be able to identify questions that can be answered by psychological assessment for people with learning difficulties.

1.2 Will be able to select an appropriate norm referenced and criterion referenced test for a given client from the range available to clinical psychologists.

1.3 Will be able to apply the WAIS-R, Leiter and BPVS.

1.4 Will be able to apply at least two of the following criterion referenced tests: HALO, Bereeweke, Scale for Assessing Coping Skills, Vineland, Functional Performance Record, Star Profile.

1.5 Will be able to undertake a functional analysis with guidance and structure from the supervisor.

1.6 Will be able to undertake other types of assessment which may be appropriate for a given client: e.g. cognitive-behavioural family systemic interpersonal disability counselling advocacy

For a given client will be able to assess the personal and social impact of chronic disability.

1.7 Will be able to interpret the WAIS-R, Leiter, BPVS and will be able to interpret at least two of the following criteria referenced tests: HALO, Bereeweke, Scale for Assessing Coping Skills, Vineland, Functional Performance Record, Star Profile.

1.8 Will be able to select an appropriate therapeutic model for a given client from the range available to the clinical psychologist.

In your opinion does the trainee reach the standard expected:

3 YES - Above expected level - please expand
2 YES - At expected level - please expand
1 NO - Borderline - please explain
0 NO - Please explain
N/A Not applicable
<table>
<thead>
<tr>
<th>THE DEVELOPMENT OF COMPETENCY IN THE USE OF SCIENTIFIC METHOD</th>
<th>RATING</th>
<th>Explanation/Expansion of Rating/Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.1 The trainee can convert presenting problems into questions that can be delineated within a psychological perspective and with measurable solutions.</td>
<td>2</td>
<td>Louise has made a good start in grasping, or using psychological models.</td>
</tr>
<tr>
<td>1.2 The trainee has good knowledge of the range of assessment procedures available and is able to choose the appropriate one to use in straightforward situations.</td>
<td>3</td>
<td>Louise is well able to use or select tools.</td>
</tr>
<tr>
<td>1.3 to 1.6 The trainee carries out procedures and collects information in an objective way, yet retains a sensitive stance with clients and is able to recognize factors that limit the reliability and validity of assessment.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.3 Psychometric measurement</td>
<td>2</td>
<td>Louise has made a good start in grasping testing practice. She needs to continue.</td>
</tr>
<tr>
<td>1.4 Other formal psychological assessments</td>
<td>2</td>
<td>Louise understands the principles of and is able to devise strategies for achieving observational assessments.</td>
</tr>
<tr>
<td>1.5 Behavioural/observational assessments &amp; functional analysis</td>
<td>2</td>
<td>Louise has made a good start or needs to continue to develop.</td>
</tr>
<tr>
<td>1.6 Other assessments</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>1.7 The trainee separates fact from interpretation, can integrate information from a variety of perspectives, compares and contrasts models; devises a formulation independently that encompasses multifactorial elements.</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>1.8 The trainee can devise a realistic and appropriate intervention plan based on an appropriate therapeutic model.</td>
<td>3</td>
<td>Louise is well able to identify useful or innovative strategies.</td>
</tr>
</tbody>
</table>
SUPERVISOR NOTES

1.8, 1.9, 1.10
Will be able to design and evaluate behavioural programmes to (i) increase skills and (ii) decrease challenging behaviours.

2. Therapy and intervention Skills

2.1 It is likely that trainees will work with less independence and autonomy in this speciality because of:
- the complexity of client presentation and needs
- the range of interprofessional and interagency work required
- the need for continuity for clients with long term needs

2.2

2.3 Will be able to modify their use of language to hold a conversation with a person with moderate learning disabilities, and will be able to initiate and maintain an interaction with a person with profound learning disabilities or multiple handicap. Will also be able to produce and understand signs from Makaton stages I and II.

2.4 Will be able to feedback the outcome of psychological assessment/intervention in an appropriate manner to:-
   i) a person with mild learning disabilities
   ii) the parent or relative
   iii) the staff member caring for the person
   iv) other professionals

2.5 Will be able to take an initial assessment interview with:-
   i) a person with mild learning disabilities
   ii) the parent or relative
   iii) the staff member caring for the person
   iv) other professionals

In your opinion does the trainee reach the standard expected:

3 YES - Above expected level - please expand
2 YES - At expected level - please expand
1 NO - Borderline - please explain
0 NO - Please explain
N/A Not applicable
1.9 The trainee can plan an overall intervention strategy, evaluate progress, re-formulate and modify the intervention plan.

1.10 Evaluation of clinical interventions: the trainee understands the importance of evaluation in clinical work; chooses and uses appropriately common methods and can modify measures for a new situation.

<table>
<thead>
<tr>
<th>THERAPY AND INTERVENTION SKILLS</th>
<th>RATING</th>
<th>Explanation/Expansion of Rating/Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.1 The trainee takes overall responsibility for action in relation to routine client matters such as making appointments, setting up meetings with colleagues etc.</td>
<td>3</td>
<td>LOUSE PRESENTS HERSELF FORMAL, BUT NEEDS TO CONTINUE TO BUILD CONFIDENCE. SHE IS ABLE TO DETECT A RANGE OF CURS FROM CLIENTS OR NEEDS TO BUILD ON OR ENHANCE THIS ABILITY.</td>
</tr>
<tr>
<td>2.2 The trainee can handle unplanned and unexpected events in a therapy session in an effective and controlled way to the benefit of the client, referring back to the supervisor subsequently.</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>2.3 The trainee engages the client, communicates appropriately to them, demonstrates awareness of what is clinically relevant and is sensitive and flexible in applying techniques. This particularly applies to clients from different cultural or ethnic backgrounds, or at different levels of intellectual ability.</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>2.4 Communication of psychological information or opinion. The trainee can present psychological information or opinion to clients, relatives and/or carers and staff effectively, modifying language appropriately, using the appropriate style and addressing concerns raised in a facilitative manner.</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>2.5 Interviewing: The trainee interviews clients effectively and appropriately, keeps control of the session, keeps to a structure yet allows the client to express their own issues.</td>
<td>2</td>
<td></td>
</tr>
</tbody>
</table>
SUPERVISOR NOTES

2.6 Will be able to implement behavioural programmes to (i) increase skills and (ii) decrease challenging behaviours.

2.6 - 2.10
Will be able to apply one of the following approaches to an individual/group with mild/moderate learning disabilities:-
- social skills
- advocacy
- interpersonal relationships
- self awareness
- loss and bereavement
- anger management
- assertiveness

2.11 Will be able to design and evaluate behavioural programmes to (i) increase skills and (ii) decrease challenging behaviours. Will also be able to explain and negotiate the implementation of a behavioural programme with residential/day care staff.

2.12 Will be able to perform the generic keyworking role for a given client within a multidisciplinary team, and will be able to chair such a team.

Will be able to give a clear presentation of a psychological assessment/intervention within a multidisciplinary meeting.

3. The development of professionalism.

3.1 Will be able to explain the role of the Regional Special Interest Group.

3.2 Will demonstrate an understanding of relevant philosophies of care through their work i.e.
- interactions with clients
- attitudes and work with carers/professionals
- report writing.

Will know the main elements of the normalisation philosophy.
Will reflect relevant philosophies of care in their work.

3.3 Will be able to use skills in time and case load management.

In your opinion does the trainee reach the standard expected:

3 YES - Above expected level - please expand
2 YES - At expected level - please expand
1 NO - Borderline - please explain
0 NO - Please explain
N/A Not applicable
2.6 to 2.10 The trainee demonstrates effective therapy skills both at a general level and in the use of particular models; the supervisor gives feedback primarily to 'fine tune' their skills.

| 2.6 Individual therapy work: | 3 |
| 2.7 Therapy work with couples: | 2.A |
| 2.8 Therapy work with families | 2.A |
| 2.9 Directive/behavioural groups: | LOUISE TO DEVELOP HER GROUP WORK ABILITIES, BUT HAS MADE A GOOD START IN AN ECLECTIC SOCIAL SKILLS/ADVOCACY GROUP. |
| 2.10 Non-directive/psychotherapeutic groups: | |

2.11 Indirect client work: The trainee demonstrates effective skills both at a general level and in relation to the particular requirements of the setting; the supervisor gives feedback primarily to 'fine tune' their skills.

2.12 Client work within a formal system (such as IPP): The trainee demonstrates effective skills both at a general level and in relation to the particular requirements of the system; the supervisor gives feedback primarily to 'fine tune' their skills.

| 2.11 Indirect client work: | 2 |
| 2.12 Client work within a formal system (such as IPP): | 2 |

### Table: THE DEVELOPMENT OF PROFESSIONALISM

<table>
<thead>
<tr>
<th>THE DEVELOPMENT OF PROFESSIONALISM</th>
<th>RATING</th>
<th>Explanation/Expansion of Rating/Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.1 The trainee knows the background, structure and future trends of the profession that underlie the work of clinical psychologists sufficient to relate it appropriately to the placement.</td>
<td>3</td>
<td>LOUISE IS FAMILIAR WITH NORMALISATION OF SOCIAL MODELS OF DISABILITY.</td>
</tr>
<tr>
<td>3.2 The trainee understands the history, philosophy, structure, working rules and procedures that relate to the particular placement.</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>3.3 The trainee demonstrates effective work management skills (time management, record keeping, reliability and administrative independence).</td>
<td>2</td>
<td></td>
</tr>
</tbody>
</table>
SUPERVISOR NOTES

3.4  -

3.5, 3.6  
Will recognise the significance of issues of discrimination, labelling, prejudice and stereotyping.

3.7  -

3.8  Will be able to give a clear presentation of a psychological assessment/intervention within a multidisciplinary meeting.

Will be able to communicate the method, outcome and interpretation of a psychological assessment in writing.

Will be able to communicate the formulation, method and outcome of an intervention in writing.

3.9  -

3.10  -

In your opinion does the trainee reach the standard expected:

3  YES - Above expected level - please expand
2  YES - At expected level - please expand
1  NO - Borderline - please explain
0  NO - Please explain
N/A Not applicable
<table>
<thead>
<tr>
<th>3.4 The trainee demonstrates self management skills (awareness of skill limitations when overworked, stressed or needing personal support).</th>
<th>2</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.5 The trainee presents in a professional way to the client and maintains a proper and effective therapeutic relationship, maintaining an over-riding concern for the client’s interests, an awareness of the boundaries of competence and of ethical and procedural guidelines that apply.</td>
<td>2</td>
</tr>
<tr>
<td>3.6 Equal opportunities/equality of access: The trainee understands the importance of these factors in service provision within the health and social services and addresses them within their work, particularly in relation to attitudes and skills in client work.</td>
<td>2</td>
</tr>
<tr>
<td>3.7 The trainee presents well and relates effectively to colleagues both in psychology and elsewhere within the NHS and other agencies.</td>
<td>2</td>
</tr>
<tr>
<td>3.8 The trainee makes a positive contribution in verbal communication, presents material clearly, concisely and well structured, can separate fact from interpretation, incorporate information and opinions from others, can argue effectively and negotiate to a satisfactory outcome in normal circumstances within the placement.</td>
<td>2</td>
</tr>
<tr>
<td>3.9 The trainee presents material clearly and concisely in written communication, and makes good use of structure; separates fact from interpretation and relevant from irrelevant material; has a flexible style depending on the needs of the recipient.</td>
<td>2</td>
</tr>
<tr>
<td>3.10 The trainee demonstrates an understanding of the range of roles that psychologists might undertake, such as teaching, supervision, consultancy, research project work and service development.</td>
<td>3</td>
</tr>
</tbody>
</table>
**SUPERVISOR NOTES**

4. Development of awareness and competence in service organisational issues.

4.1 Will recognize the institutional responses to human need and methods of ameliorating their impact.

4.2 Will demonstrate the ability to work within service networks.

4.3 Will be able to perform the generic keyworking role for a given client within a multidisciplinary team and will be able to chair a multidisciplinary meeting.

4.4 Will be able to identify the network of specialist and generic services and access these according to the needs of a given client e.g.
- residential placement
- respite care
- day placement
- social work
- community nursing
- psychiatry
- general practitioners
- occupational therapy
- physiotherapy
- speech therapy
- disablement resettlement office
- careers
- voluntary agencies
- education

4.5 Will be able to assess the psychological and social impact of institutional processes occurring in
a) large residential settings and community services on individual clients.

4.6 Will be able to explain the main elements of the normalisation philosophy to other professionals/carers.

4.7 Will be able to prepare, deliver and evaluate a presentation on a specific psychological topic to a group of staff.

4.8 -

In your opinion does the trainee reach the standard expected:

3   YES - Above expected level - please expand
2   YES - At expected level - please expand
1   NO - Borderline - please explain
0   NO - Please explain
N/A Not applicable
<table>
<thead>
<tr>
<th>THE DEVELOPMENT OF AWARENESS AND COMPETENCE IN SERVICE AND ORGANISATIONAL ISSUES</th>
<th>RATING</th>
<th>Explanation/Expansion of Rating/Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>4.1 The trainee demonstrates a balanced and realistic awareness of how organisational factors impinge on client work both directly and through staff practices.</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>4.2 The trainee works appropriately and effectively within the boundaries and constraints of organisations and settings.</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>4.3 The trainee works appropriately and effectively within the boundaries and constraints of a multi-disciplinary team.</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>4.4 The trainee understands, and is knowledgeable, in relation to the skills and work practices of other professions and other staff groups.</td>
<td>3</td>
<td><strong>Has a good grasp of services available to people &amp; learning difficulties.</strong></td>
</tr>
<tr>
<td>4.5 The trainee is able to analyse and describe, with some independence, some psychological processes active within groups, settings or organisations.</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>4.6 The trainee is able to describe, with some level of independence, the psychological skills and methods required to produce change within groups, settings or organisations.</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>4.7 <strong>Presentation:</strong> The trainee prepares the material in terms of structure and content, relevant to the needs of the audience; displays effective verbal and non-verbal skills; shows effective use of time; chooses appropriate style (didactic or facilitative) relevant to the audience.</td>
<td>2</td>
<td><strong>Has begun to acquire skills in this area, but needs further opportunities for presentations &amp; teaching. Would benefit from further exploration of evaluation in training teaching.</strong></td>
</tr>
<tr>
<td>4.8 <strong>Teaching:</strong> The trainee prepares the material in terms of structure and content, relevant to the needs of the audience; displays effective verbal and non-verbal skills; shows effective use of time; chooses appropriate style (didactic or facilitative) relevant to the audience. The trainee chooses assessment and evaluation materials.</td>
<td>2</td>
<td></td>
</tr>
</tbody>
</table>
5. The shift to work being grounded in psychological principles from being orientated in relation to specific techniques.

5.1 Trainees should be able to take the following competencies from a placement working with people with learning disabilities forward to other placements.

Ability (Skill and Confidence) to work with people who have learning disabilities in other settings e.g. Mental Health, Children, Elderly, Neuro, Forensic. This will include:
- people who learn slowly
- people who have limited or abnormal communication
- people who have attentional deficits
- people who have concrete thought processes
- people who have social impairment.

Recognise the effects of chronic disability.

5.2 Will demonstrate knowledge of the existence of mental illness, social impairment and specific genetic syndromes in some people with learning disabilities.

5.3 Will be able to apply an appropriate therapeutic model for a given client from the range available to the clinical psychologist.

Competencies trainees are expected to get elsewhere to back up learning disabilities experience:

Behavioral Interventions
Working in teams
Residential/Day care facilities
Children with learning difficulties
Psychometric tests and other assessments
Teaching/Seminars

In your opinion does the trainee reach the standard expected:

3 YES - Above expected level - please expand
2 YES - At expected level - please expand
1 NO - Borderline - please explain
0 NO - Please explain
N/A Not applicable
4.9 If the trainee has undertaken work in any of the following areas, please tick and briefly describe the work, and comment on the skills used and level of expertise displayed:

- consultancy

- supervision

- project work

- service development work

5. THE SHIFT TO WORK BEING GROUNDED IN PSYCHOLOGICAL PRINCIPLES FROM BEING ORIENTATED IN RELATION TO SPECIFIC TECHNIQUES

<table>
<thead>
<tr>
<th>RATING</th>
<th>Explanation/Expansion of Rating/Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>5.1</td>
<td>The trainee is able to perceive issues from different perspectives; draws information from a variety of sources and develops it into an individualised framework; can see how facts can be conceptualised in different ways - using supervisor primarily as a sounding board for own thinking processes.</td>
</tr>
<tr>
<td>2</td>
<td></td>
</tr>
<tr>
<td>5.2</td>
<td>The trainee approaches work from a theoretical stance with a broad vision of the general applicability of principles of practice, integrating theories from general psychology and those specific to settings or client groups.</td>
</tr>
<tr>
<td>2</td>
<td></td>
</tr>
<tr>
<td>5.3</td>
<td><strong>Generic skills:</strong> The trainee draws on therapeutic skills techniques and methods from the range of client groups, and uses them with appropriate modifications for the individual client.</td>
</tr>
<tr>
<td>2</td>
<td></td>
</tr>
</tbody>
</table>
Summary of Clinical Activity

Please indicate at the end of your placement what you have covered under the following seven categories:

1) Clinical activity with individual clients, couples & families (use attached sheet C)

2) Group work - use attached sheet B

3) Teaching/Skills transmission/Presentations

Outline each experience of teaching, indicating what, to whom how organised, the extent of your role and its degree of success.

Jointly with another psychologist, I was involved in the preparation and presentation of a two-day workshop on 'Sexuality & Relationships for People with Learning Difficulties'. This was attended by 10 care staff working in group homes in the community.

Methods used in the workshop included: completion of questionnaires, discussion of case scenarios & role play.

The workshop appeared to be successful. The feedback obtained suggested that the members found it particularly useful to discuss case scenarios.

4) Organisational Work (eg: developing IPP system, staff support, assessing case recording system). Outline each piece of work, indicating the extent of your role and outcome.
RESEARCH

Outline any projects which you initiated or with which you were involved and indicate the extent of your involvement.

In conjunction with another psychologist, I conducted a service evaluation of crisis management by members of the Community Team. Together we designed a questionnaire which was circulated to all the team members. On the basis of the responses obtained, I wrote a report including recommendations for future service planning.

MEETINGS, VISITS, OBSERVATIONS

Outline briefly each experience and the extent of your involvement.

Meetings I attended the following:
- Weekly CTPR/MD meetings at which I represented the Psychology Speciality
- Speciality meetings at which I took my turn at chairing and noting
- Monthly department meetings
- The Regional Special Interest Group
- Three multi-disciplinary team meetings (held at the hospital, at which I represented the Psychology speciality)
- Two joint team meetings to discuss the future of Community Teams in the district
- Two Pre-IPP meetings where I was involved in drawing up strengths/needs lists for clients
- Four main IPP meetings where I was involved in setting goals
- A Strategy Meeting regarding Abuse
- Two case co-ordinating meetings re abuse
- A challenging needs steering group meeting
- A Resettlement Planning meeting.
In each of the meetings I actively participated in the discussions. A variety of issues were discussed, including individual client, the PhD service, and quality.

Visits
I visited two day centres where I observed a number of groups including Art, Discussion and Poetry. Through my client work, I visited both MENCAP, and Social Services Group Home Establishments and a client supported by a Group Home Training Scheme.
COURSES AND TRAINING EVENTS ATTENDED AS PART OF PLACEMENT

Please list and outline each one.

I attended a One Day Workshop on Supported Living run by a Psychologist in the Department.

OTHER

Please outline any other experience on placement.

I attended a Psychology Specialty Away Day at which we reviewed the current work of the Specialty and set goals for the future.

[Signature]
Trainee

[Signature]
Supervisor

[Date]
<table>
<thead>
<tr>
<th>Therapists (Active/Observer)</th>
<th>Your Role (Active/Observer)</th>
<th>Membership (Ages &amp; Sexes)</th>
<th>Selection of Members</th>
<th>Nature of Group Work</th>
<th>Number of Sessions</th>
<th>Outcome Evaluation</th>
</tr>
</thead>
<tbody>
<tr>
<td>House Byles (plus support from a member of the house staff)</td>
<td>Active</td>
<td>F 49 years</td>
<td>All residents of a group home</td>
<td>Interpersonal skills development and discussion of group living skills</td>
<td>10</td>
<td>Some improvement of the level of communication between group members.</td>
</tr>
</tbody>
</table>
## CLINICAL ACTIVITY WITH INDIVIDUAL CLIENTS, COUPLES, and FAMILIES - PLACEMENT SUMMARY

<table>
<thead>
<tr>
<th>ex</th>
<th>Age</th>
<th>Assessment</th>
<th>Intervention</th>
<th>Type of Contact</th>
<th>Presenting Need</th>
<th>Model of Therapy</th>
<th>No of Hours</th>
<th>Outcome/ Evaluation</th>
<th>Additional Info/Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>F</td>
<td>31</td>
<td>Observation, Interview, Inventory (RI)</td>
<td>IC, FL</td>
<td>S</td>
<td>Phobia of Travelling</td>
<td>Behavioural</td>
<td>5</td>
<td>Desensitisation Programme designed</td>
<td>Nationality Greek</td>
</tr>
<tr>
<td>F</td>
<td>53</td>
<td>ABC Charts, RI</td>
<td>IC</td>
<td>S(P), J</td>
<td>Verbal/Physical Aggression</td>
<td>Behavioural</td>
<td>7</td>
<td>Some improvement</td>
<td>Management Plan</td>
</tr>
<tr>
<td>F</td>
<td>23</td>
<td>Assessment for Treatment</td>
<td>FI</td>
<td>S</td>
<td>Low Self Esteem/Abused</td>
<td>Eclectic</td>
<td>11</td>
<td>Some improvement</td>
<td>CSW to help her find employment</td>
</tr>
<tr>
<td>F</td>
<td>23</td>
<td>WAIS(R), McHaleman Reading Analysis, Basic Money Skills</td>
<td>FL</td>
<td>S</td>
<td>Wish to gain employment</td>
<td>Assessment only</td>
<td>5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>F</td>
<td>38</td>
<td>HALO</td>
<td>FL</td>
<td>S</td>
<td>Request to move house</td>
<td>Eclectic</td>
<td>10</td>
<td>Some improvement</td>
<td>Referred to S/W</td>
</tr>
<tr>
<td>F</td>
<td>22</td>
<td>WAIS(R)</td>
<td>FL</td>
<td>S</td>
<td>Intellectual ability unknown</td>
<td>Assessment only</td>
<td>3½</td>
<td></td>
<td></td>
</tr>
<tr>
<td>F</td>
<td>49</td>
<td>Assessment for Treatment</td>
<td>IC</td>
<td>J</td>
<td>Verbal/Physical aggression</td>
<td>Behavioural</td>
<td>3½</td>
<td>Management Plan Revised</td>
<td></td>
</tr>
<tr>
<td>F</td>
<td>44</td>
<td>ABC Charts, RI</td>
<td>IC, IT</td>
<td>S(P), J</td>
<td>Continuous screaming, chewing hands</td>
<td>Behavioural</td>
<td>4</td>
<td>Management Plan Revised</td>
<td></td>
</tr>
<tr>
<td>F</td>
<td>—</td>
<td>Charts of incontinence RI</td>
<td>IC</td>
<td>S</td>
<td>Control of incontinence Day &amp; Night</td>
<td>Behavioural</td>
<td>2½</td>
<td>Report Written</td>
<td></td>
</tr>
<tr>
<td>F</td>
<td>—</td>
<td>Charts of incontinence RI</td>
<td>IC</td>
<td>S</td>
<td>Control of incontinence Day &amp; Night</td>
<td>Behavioural</td>
<td>2½</td>
<td>Report Written</td>
<td></td>
</tr>
<tr>
<td>F</td>
<td>25</td>
<td>—</td>
<td>IC</td>
<td>DS</td>
<td>Mental health Problems query Abuse?</td>
<td>Eclectic</td>
<td>3</td>
<td>Ongoing</td>
<td></td>
</tr>
</tbody>
</table>
SOUTH WEST THAMES REGIONAL HEALTH AUTHORITY

CLINICAL PSYCHOLOGY CONTINUING PROFESSIONAL DEVELOPMENT COMMITTEE

THIS IS TO CERTIFY THAT

Louise Byles

attended a one day workshop on the subject of

CHILD PROTECTION: A FRAMEWORK FOR PRACTICE

on

FRIDAY, 28 APRIL 1995

Signed: 

Position: Committee Member of CPCPDC
**EVALUATION OF THE TRAINEE ON PLACEMENT**

<table>
<thead>
<tr>
<th>TRAINEE NAME</th>
<th>Louise Byles</th>
</tr>
</thead>
<tbody>
<tr>
<td>PLACEMENT TITLE</td>
<td>Child and Adolescent</td>
</tr>
<tr>
<td>PLACEMENT DATES</td>
<td>1/1/95 - 12/1995</td>
</tr>
<tr>
<td>No. of DAYS-YR 1</td>
<td>4mths</td>
</tr>
<tr>
<td>No. of DAYS-YR 2</td>
<td></td>
</tr>
<tr>
<td>SUPERVISOR NAME</td>
<td>B. O'Brien</td>
</tr>
<tr>
<td>PLACEMENT ADDRESS</td>
<td>Child Development Centre</td>
</tr>
<tr>
<td></td>
<td>Children's Unit, RBC, Chichester</td>
</tr>
<tr>
<td></td>
<td>Dept. of Child Development</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**OVERALL RATING FOR THE PLACEMENT**

In the supervisor’s opinion, has the trainee reached the standard expected to pass the placement?

<table>
<thead>
<tr>
<th>COMMENT</th>
<th>TICK</th>
</tr>
</thead>
<tbody>
<tr>
<td>PASS</td>
<td>✔</td>
</tr>
<tr>
<td>PASS: The trainee has gaps in experience that need to be addressed later in training</td>
<td></td>
</tr>
<tr>
<td>PASS: The trainee needs to focus on specified areas of clinical skills in subsequent placements</td>
<td></td>
</tr>
<tr>
<td>FAIL: The trainee has not reached the standard expected</td>
<td></td>
</tr>
</tbody>
</table>

**General Comments from Supervisor:**

Louise coped amazingly well. She picked up principles quickly and used her excellent memory to full effect. She needed an assistant with very young children. She performed assessments but wrote them reports intelligently.

Signed: B. O'Brien (Supervisor) Date 17/1/95

**Comments from the trainee:**

Signed: Louise Byles (Trainee) Date 17/7/95
<table>
<thead>
<tr>
<th>SUPERVISOR - TRAINEE RELATIONSHIP</th>
<th>RATING</th>
<th>Explanation/Expansion of Rating/Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>The supervisor may raise questions or present options for the trainee to consider, but usually the trainee can present plans and make decisions on how to proceed which they have devised independently.</td>
<td>2</td>
<td>Have prepared procedures very conscientiously and used his amazing money raising for independent work.</td>
</tr>
<tr>
<td>The trainee does not usually require observation, monitoring or detailed questioning to maintain the standard of work, but this is used to ‘fine tune’ skills. The trainee self monitors and identifies the need for assistance in normal circumstances.</td>
<td>2</td>
<td>Have observed closely at the beginning of the assessment and was extremely able to work independently thereafter.</td>
</tr>
<tr>
<td>The trainee shows a balance between autonomy and the use of support and advice which is appropriate to their level of skills, the client and the service setting.</td>
<td>2</td>
<td>Have counselled 8-year-olds + on their own (but benefited from Senior Practitioner’s help with assessments and very young children. Otherwise she did not need social work input).</td>
</tr>
</tbody>
</table>

In your opinion, does the trainee reach the standard expected:

- 3 YES - Above expected level - please expand
- 2 YES - At expected level - please expand
- 1 NO - Borderline - please expand
- 0 NO - Please explain
- N/A Not applicable
<table>
<thead>
<tr>
<th>ASSESSMENT, FORMULATION, CLINICAL EVALUATION</th>
<th>RATING</th>
<th>Explanation/Expansion of Rating/Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.1 The trainee can convert presenting problems into questions that can be delineated within a psychological perspective and with measurable solutions.</td>
<td>2</td>
<td>Louise grasped basic principles quickly. She played it &quot;safe&quot; initially but demonstrated gradual progress.</td>
</tr>
<tr>
<td>1.2 The trainee has good knowledge of the range of assessment procedures available and is able to choose the appropriate one to use in straightforward situations.</td>
<td>2</td>
<td>Course gained considerable experience of tests using James's LPA.</td>
</tr>
<tr>
<td>1.3 to 1.6 The trainee carries out procedures and collects information in an objective way, yet retains a sensitive stance with clients and is able to recognize factors that limit the reliability and validity of assessment.</td>
<td></td>
<td>Course reports reflected thoughtful analysis and recommendations.</td>
</tr>
<tr>
<td>1.3 Psychometric measurement</td>
<td>2</td>
<td>Course demonstrated appreciation of statistics used in psychological assessments.</td>
</tr>
<tr>
<td>1.4 Other formal psychological assessments</td>
<td>2</td>
<td>Course carried out development assessment and met procedures.</td>
</tr>
<tr>
<td>1.5 Behavioural/observational assessments &amp; functional analysis</td>
<td>2</td>
<td>Behavioural &quot;observation&quot; was remarkable. Louise could build on Sarah's comfort and produce clean and intelligent reports.</td>
</tr>
<tr>
<td>1.6 Other assessments</td>
<td>(2)</td>
<td>(Family Therapy Conference at Kingston)</td>
</tr>
<tr>
<td>1.7 The trainee separates fact from interpretation, can integrate information from a variety of perspectives, compares and contrasts models; devises a formulation independently that encompasses multifactorial elements.</td>
<td>2</td>
<td>Course memorises these experiences and can formulate similarly more confidently/fluently with time.</td>
</tr>
<tr>
<td>1.8 The trainee can devise a realistic and appropriate intervention plan based on an appropriate therapeutic model.</td>
<td>2</td>
<td>Course devised appropriate intervention plans. Based on the models she came across on placement.</td>
</tr>
</tbody>
</table>
1.10 **Evaluation of clinical interventions:**
the trainee understands the importance of evaluation in clinical work; chooses and uses appropriately common methods and can modify measures for a new situation.

<table>
<thead>
<tr>
<th>THERAPY AND INTERVENTION SKILLS</th>
<th>RATING</th>
<th>Explanation/Expansion of Rating/Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.1 The trainee takes overall responsibility for action in relation to routine client matters such as making appointments, setting up meetings with colleagues etc.</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>2.2 The trainee can handle unplanned and unexpected events in a therapy session in an effective and controlled way to the benefit of the client, referring back to the supervisor.</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>2.3 The trainee engages the client, communicates appropriately to them, demonstrates awareness of what is clinically relevant and is sensitive and flexible in applying techniques. This particularly applies to clients from different cultural or ethnic backgrounds, or at different levels of intellectual and linguistic ability.</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>2.4 Communication of psychological information or opinion. The trainee can present psychological information or opinion to clients, relatives and/or carers and staff effectively, modifying language appropriately, using the appropriate style and addressing concerns raised in a facilitative manner.</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>2.5 Interviewing: The trainee interviews clients effectively and appropriately, keeps control of the session, keeps to a structure yet allows the client to express their own issues.</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>2.6 to 2.10 The trainee demonstrates effective therapy skills both at a general level and in the use of particular models; the supervisor gives feedback primarily to 'fine tune' their skills.</td>
<td>2.6 Individual therapy work:</td>
<td>2</td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td></td>
<td>2.7 Therapy work with couples:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2.8 Therapy work with families</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2.9 Directive/behavioural groups:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2.10 Non-directive/psychotherapeutic groups:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2.11 Indirect client work: The trainee demonstrates effective skills both at a general level and in relation to the particular requirements of the setting; the supervisor gives feedback primarily to 'fine tune' their skills.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2.12 Client work within a formal system (such as IPP): The trainee demonstrates effective skills both at a general level and in relation to the particular requirements of the system; the supervisor gives feedback primarily to 'fine tune' their skills.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2.13 Trainee handles termination of client contract effectively (either end of treatment or end of placement), dealing with both practical issues and the emotional aspect.</td>
<td></td>
</tr>
</tbody>
</table>

### The Development of Professionalism

<table>
<thead>
<tr>
<th>THE DEVELOPMENT OF PROFESSIONALISM</th>
<th>RATING</th>
<th>Explanation/ Expansion of Rating/Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.1 The trainee knows the background, structure and future trends of the profession that underlie the work of clinical psychologists sufficient to relate it appropriately to the placement.</td>
<td>2</td>
<td>She's picking up the ideas quite quickly</td>
</tr>
<tr>
<td>3.2 The trainee understands the history, philosophy, structure, working rules and procedures that relate to the particular placement.</td>
<td>2</td>
<td>Louise is sensitive to the issues involved</td>
</tr>
<tr>
<td>3.3 The trainee demonstrates effective work management skills (time management, record keeping, reliability and administrative independence).</td>
<td>3</td>
<td>Lorraine is very conscious about record keeping.</td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>3.4 The trainee demonstrates self management skills (awareness of skill limitations when overworked, stressed or needing personal support).</td>
<td>2</td>
<td>Lorraine understood her limitations but she also sought independence as far as she was able.</td>
</tr>
<tr>
<td>3.5 The trainee presents in a professional way to the client and maintains a proper and effective therapeutic relationship, maintaining an over-riding concern for the client’s interests, an awareness of the boundaries of competence and of ethical and procedural guidelines that apply.</td>
<td>2</td>
<td>The client responded extremely well to her sensitive approach.</td>
</tr>
<tr>
<td>3.6 Equal opportunities/equality of access: The trainee understands the importance of these factors in service provision within the health and social services and addresses them within their work, particularly in relation to attitudes and skills in client work.</td>
<td>2</td>
<td>I was happy with Lorraine’s understanding of these factors.</td>
</tr>
<tr>
<td>3.7 The trainee presents well and relates effectively to colleagues both in psychology and elsewhere within the NHS and other agencies.</td>
<td>2</td>
<td>Lorraine related really well to staff. She was a popular member of the team.</td>
</tr>
<tr>
<td>3.8 The trainee makes a positive contribution in verbal communication, presents material clearly, concisely and well structured, can separate fact from interpretation, incorporate information and opinions from others, can argue effectively and negotiate to a satisfactory outcome in normal circumstances within the placement.</td>
<td>2</td>
<td>Excellent verbal reports. Sensitivity present. Clear presentation of social skills to team meeting.</td>
</tr>
<tr>
<td>3.9 The trainee presents material clearly and concisely in written communication, and makes good use of structure; separates fact from interpretation and relevant from irrelevant material; has a flexible style depending on the needs of the recipient.</td>
<td>2</td>
<td>Very clear concise written reports. Amazing sensitive to subtleties. Very direct and indirect information.</td>
</tr>
</tbody>
</table>

Maximum potential Assistant observations incorporated intelligently.
3.10 The trainee demonstrates an understanding of the range of roles that psychologists might undertake, such as teaching, supervision, consultancy, research project work and service development.

<table>
<thead>
<tr>
<th>THE DEVELOPMENT OF AWARENESS AND COMPETENCE IN SERVICE AND ORGANISATIONAL ISSUES</th>
<th>RATING</th>
<th>Explanation/Expansion of Rating/Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>4.1 The trainee demonstrates a balanced and realistic awareness of how organisational factors impinge on client work both directly and through staff practices.</td>
<td>2</td>
<td>Complex issues as Child work but Louise picked up on these quickly</td>
</tr>
<tr>
<td>4.2 The trainee works appropriately and effectively within the boundaries and constraints of organisations and settings.</td>
<td>2</td>
<td>Kept to the &quot;rules&quot; very consciously</td>
</tr>
<tr>
<td>4.3 The trainee works appropriately and effectively within the boundaries and constraints of a multi-disciplinary team.</td>
<td>2</td>
<td>LOUISE very sensitive to team's needs</td>
</tr>
<tr>
<td>4.4 The trainee understands, and is knowledgeable, in relation to the skills and work practices of other professions and other staff groups.</td>
<td>2</td>
<td>Louise able to observe several different professions at once</td>
</tr>
<tr>
<td>4.5 The trainee is able to analyse and describe, with some independence, some psychological processes active within groups, settings or organisations.</td>
<td>2</td>
<td>Louise is remarkably observant of underlying processes</td>
</tr>
<tr>
<td>4.6 The trainee is able to describe, with some level of independence, the psychological skills and methods required to produce change within groups, settings or organisations.</td>
<td>2</td>
<td>Louise is quite astute and with more experience would soon master these complex skills</td>
</tr>
<tr>
<td>4.7 Presentation: The trainee prepares the material in terms of structure and content, relevant to the needs of the audience; displays effective verbal and non-verbal skills; shows effective use of time; chooses appropriate style (didactic or facilitative) relevant to the audience.</td>
<td>2</td>
<td>Although visually disabled Louise is able to respond to other non-verbal cues normally missed by the sighted person. The presentations were well prepared and presented including social skills group and...</td>
</tr>
</tbody>
</table>
### 4.8 Teaching
The trainee prepares the material in terms of structure and content, relevant to the needs of the audience; displays effective verbal and non-verbal skills; shows effective use of time; chooses appropriate style (didactic or facilitative) relevant to the audience. The trainee chooses assessment and evaluation materials.

<table>
<thead>
<tr>
<th>RATING</th>
<th>Explanation/Expansion of Rating/Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>Low in each confidence here but is quite competent and gave good presentation</td>
</tr>
</tbody>
</table>

### 4.9 If the trainee has undertaken work in any of the following areas, please tick and briefly describe the work, and comment on the skills used and level of expertise displayed:

- consultancy
- supervision
- project work
- service development work

<table>
<thead>
<tr>
<th>RATING</th>
<th>Rating/Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>Low in some advice to teachers, parents, and community nurses</td>
</tr>
<tr>
<td>2</td>
<td>Low in supporting the role of the psychology assistant</td>
</tr>
<tr>
<td>2</td>
<td>Low in designed and carried out and reported on a six-week project efficiently</td>
</tr>
<tr>
<td>2</td>
<td>Low in discussed current issues helpfully</td>
</tr>
</tbody>
</table>

### 5. The Shift to Work Being Grounded in Psychological Principles from Being Orientated in Relation to Specific Techniques

<table>
<thead>
<tr>
<th>THE SHIFT TO WORK BEING GROUNDED IN PSYCHOLOGICAL PRINCIPLES FROM BEING ORIENTATED IN RELATION TO SPECIFIC TECHNIQUES</th>
<th>RATING</th>
<th>Explanation/Expansion of Rating/Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>5.1 The trainee is able to perceive issues from different perspectives; draws information from a variety of sources and develops it into an individualised framework; can see how facts can be conceptualised in different ways - using supervisor primarily as a sounding board for own thinking processes.</td>
<td>2</td>
<td>Low but grasped the basic concepts in verbal and conceptualisation clearly</td>
</tr>
<tr>
<td>5.2 The trainee approaches work from a theoretical stance with a broad vision of the general applicability of principles of practice, integrating theories from general psychology and those specific to settings or client groups.</td>
<td>2</td>
<td>A very complex task in child works but Low in terms of integration well</td>
</tr>
<tr>
<td>5.3 <strong>Generic skills</strong>: The trainee draws on therapeutic skills techniques and methods from the range of client groups, and uses them with appropriate modifications for the individual client.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>---</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td><strong>Revise refers to</strong> he provides placement and combines information with current client work effectively.</td>
<td></td>
</tr>
</tbody>
</table>
APPENDIX 7

Log Book

UNIVERSITY OF SURREY /S W T R H A

M Sc in Clinical Psychology

nee's name. LOUISE BYLES............ Placement Type. CHILD & ADOLESCENT

18 - 6 - 95 Supervisors Name. DR. WILSON

Summary of Clinical Activity

Use indicate at the end of your placement what you have covered under following seven categories:

Clinical activity with individual clients, couples & families (use attached sheet C)

Group work - use attached sheet B

Teaching/Skills transmission/Presentations

Outline each experience of teaching, indicating what, to whom how organised, the extent of your role and its degree of success.

1) A joint presentation to paediatric nurses, entitled "Behaviour approaches to Child Psychotherapy". My role included present, oral and visual information and facilitating group discussion and exercises. Positive feedback.

2) A joint presentation to the Child and Family team, on the social skills group that I conducted. Positive feedback was given.

Organisational Work (eg: developing IPP system, staff support, assessing case recording system). Outline each piece of work, indicating the extent of your role and outcome.
5. **RESEARCH**

Outline any projects which you initiated or with which you were involved and indicate the extent of your involvement.

---

5. **MEETINGS, VISITS, OBSERVATIONS**

Outline briefly each experience and the extent of your involvement.

**Observations.**

For 11 sessions, I observed the Family Therapy Team at Kingston Hospital. The model of therapy used by the Team was the Milan Systemic approach. Issues covered included: deliberate self-harm, reconstituted families, alleged physical and sexual abuse, conflict over parenting and antisocial behaviour at school and home. In addition, one of the families seen was Iranian.

Part of each of the Family Team's sessions involved a seminar discussion. During these seminars, we discussed in detail the various family therapy models.

I observed my supervisor providing a number of consult sessions to health visitors, where problems discussed included: bereavement, encopresis, sibling rivalry and night terrors. I also observed my supervisor providing supervision to community nurses regarding Portage.

On two occasions, I attended the Baby Play Therapy Group. All babies attending the group had some form of developmental delay. During the group, I observed my supervisor giving advice to parents on the most suitable toys for their babies, according to their current developmental stage.

**Visits**

During the placement, I made the following visits:

1) A visit to a school for children with severe learning difficulties during which I discussed a case with a teacher...
2) A visit to a school for children with Autistic Spectrum Characteristics.
3) A visit to a respite care home, during which clients were reviewed by the care staff and my supervisor.
4) A visit to a nursery and primary school, during which I conducted behavioural observations.
5) I made a Portage home visit with a community nurse.
6) On a number of occasions, I visited the opportunity playgroup based in the Children's Unit. All children attending the group had developmental delay. Here I assessed and played with the children. I also accompanied the playgroup on a visit to an adventure playground, where facilities included soft play.

MEETINGS.

I attended the following meetings:
1) A regional Special Interest Group meeting.
2) A multidisciplinary team meeting at the Child and Family Clinic.
COURSES AND TRAINING EVENTS ATTENDED AS PART OF PLACEMENT

Please list and outline each one.

1. A seminar given by my Supervisor to the Specialty on administering Psychological Assessments.
2. An update on the Children's Act, presented at the Child S
3. A presentation on child abuse. This included talks by a social worker, a member of the police force and an art therapist.
4. A talk on the value of, and new developments in, the area of Psychological testing.
5. A talk on Asberger's Syndrome, given by Lorna Wing.
6. A talk on genograms.

OTHER

Please outline any other experience on placement.

I attended the following talks given by my Supervisor:

i) A talk to primary school teachers on: Separation anxiety, immature self help skills, comfort habits, language and communication problems.
ii) A talk to secondary school teachers on: School refusal, anxiety and phobias.
iii) A talk to health visitors on: Bereavement, sleep problems, aggression, and enuresis.
iv) A talk to S.H.O.S on eating problems.
v) A talk to parents with children with learning difficulties, on managing behavioural problems.

Signed: Trainee: Louise Byles. Date: 18-6-95

Signed: Supervisor. Date:
<table>
<thead>
<tr>
<th>Therapist</th>
<th>Your Role (Active/Observer)</th>
<th>Membership (Ages &amp; Sexes)</th>
<th>Selection of Members</th>
<th>Nature of Group Work</th>
<th>Number of Sessions Each Lasting</th>
<th>Outcome Evaluation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rainee Psychologist, Assistant Psychologist</td>
<td><strong>Main Facilitator</strong></td>
<td>F-10, F-12, M-11, M-13, M-13, M-14</td>
<td><strong>Referrals from Team. All members were experiencing difficulties interacting with peers and adults.</strong></td>
<td><strong>Social skills group, based on a model of social learning, which involved: instruction, modelling, role play, feedback.</strong> <strong>The group aim to:</strong> 1) Increase awareness of basic communication skills. 2) Introduce members to alternative ways of responding in certain social situations.</td>
<td>6 sessions each lasting 90 mins.</td>
<td>All children experienced an increase in perceptual confidence in dealing with certain social situations, e.g. being teased/bullied, making friends or dealing with adult criticisms.</td>
</tr>
</tbody>
</table>
APPENDICES

APPENDIX 1

CHECKLIST - ENGAGING AND WORKING WITH A CHILD

By mid-placement the trainee would be expected:

- To use skills to keep a child in the room
- To use language appropriate to the child’s developmental level
- To have a reasonable knowledge of child development
- To be comfortable with silence
- To select the use of toys appropriately
- To explain to a child about levels of confidentiality
- To establish the child’s preconceptions
- To achieve a balance between eliciting information and making therapeutic suggestions
- To maintain an appropriate level of identification with the child
- To be able to set limits of what is acceptable within a session
- To engage a child/parent enough that they come back
- To be aware of separation anxiety in negotiating the length of the session
- To maintain a balance between structure and play
- To plan the session
- To plan endings

The trainee would not be expected to work independently with:

- Bereavement
- Suicidal thoughts
- Long term problems
- Sexual abuse/disclosure
- Work with legal implications

APPENDIX 2

CHECKLIST - WORKING WITH A FAMILY

By mid-placement the trainee would be expected:

- To say something to each family member in the first session
- To understand and use appropriate equipment
- To elicit information and draw a family tree
- To use appropriate language
- To have a model for interviewing
- To have an awareness of issues relating to race, sex and class differences
- To observe relationships accurately
- To respect family hierarchy and points of view
- To be in charge of sessions
- To engage them enough to bring them back
- To remain impartial between family members
- To have strategies for dealing with heavy criticism of the child by the family

The trainee would not be expected:

- To reframe and hypothesise within the session but should be gathering information and have ideas about it between sessions.
- To challenge families
- To understand different models of family therapy
APPENDIX 3

CHECKLIST - HANDLING A CASE WITH RISK FACTORS

By approximately the middle of the placement, the trainee would be expected:

To have some knowledge of literature - one model
To have some knowledge of guidelines of local social services department
To have knowledge of the relevant professionals and their roles
To understand the role and responsibilities of a Psychologist
To recognize signs of risk in an interview
To have skills to be open with family discussing risk as it emerges
To be aware of the importance of recording details of the interview accurately and to record appropriately
To be able to interview from a neutral position but be able to switch mode as appropriate

Throughout the placement the trainee would not be expected to:

To hold network meeting or attend them alone
To carry out therapy alone
To assess degree of risk alone
To have a detailed knowledge of the literature
To write court reports
## CLINICAL ACTIVITY WITH INDIVIDUAL CLIENTS, COUPLES, AND FAMILIES - PLACEMENT SUMMARY

<table>
<thead>
<tr>
<th>Sex</th>
<th>Age</th>
<th>Assessment</th>
<th>Intervention</th>
<th>Type of Contact</th>
<th>Presenting Need</th>
<th>Model of Therapy</th>
<th>No of Hours</th>
<th>Outcome/Evaluation</th>
<th>Additional Info/Comments</th>
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</thead>
<tbody>
<tr>
<td>M</td>
<td>11</td>
<td>—</td>
<td>FF</td>
<td>DS</td>
<td>ABUSED AT SCHOOL.</td>
<td></td>
<td>1 1/2</td>
<td>ON GOING</td>
<td>DEVELOPMENTAL DELAY, GENUS CORPUS COLOSUM WITH EPILEPSY</td>
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<tr>
<td>F</td>
<td>1 1/2</td>
<td>—</td>
<td>FF</td>
<td>DS</td>
<td>SLEEPING PROBLEMS</td>
<td></td>
<td>1 1/2</td>
<td>ON GOING</td>
<td>—</td>
</tr>
<tr>
<td>M</td>
<td>6</td>
<td>—</td>
<td>IF/IF</td>
<td>DS</td>
<td>ANXIETY</td>
<td></td>
<td>1 1/2</td>
<td>ON GOING</td>
<td>—</td>
</tr>
<tr>
<td>M</td>
<td>8</td>
<td>—</td>
<td>IF/IF</td>
<td>DS</td>
<td>BEHAVIOUR PROBLEMS</td>
<td></td>
<td>1 1/2</td>
<td>ON GOING</td>
<td>TOURETTES SYNDROME, QUERY ASBERGER SYNDROME</td>
</tr>
<tr>
<td>F</td>
<td>5</td>
<td>—</td>
<td>IF/IF</td>
<td>DS</td>
<td>ENURESIS</td>
<td></td>
<td>1 1/2</td>
<td>ON GOING</td>
<td>—</td>
</tr>
<tr>
<td>Sex</td>
<td>Age</td>
<td>Assessment</td>
<td>Intervention</td>
<td>Type of Contact</td>
<td>Presenting Need</td>
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<tr>
<td>M</td>
<td>4</td>
<td>MyRIL Palmer</td>
<td>FI.</td>
<td>S</td>
<td></td>
<td>Assessment</td>
<td>2</td>
<td></td>
<td>CHILD WITH LANGUAGE DELAY</td>
</tr>
<tr>
<td>F</td>
<td>2 1/2</td>
<td>A. Locke Developmental Scale</td>
<td>FI.</td>
<td>S</td>
<td></td>
<td>Assessment</td>
<td>3</td>
<td></td>
<td>CHILD WITH LANGUAGE MOTOR DELAY</td>
</tr>
<tr>
<td>F</td>
<td>10</td>
<td>School Observation</td>
<td>FI.</td>
<td>S</td>
<td>Agressive behaviour towards peers.</td>
<td>Assessment</td>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>M</td>
<td>4</td>
<td>School Observation</td>
<td>FI.</td>
<td>S</td>
<td>Aggression towards peers and teachers.</td>
<td>Assessment</td>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>F</td>
<td>12</td>
<td></td>
<td>FI.</td>
<td>DS</td>
<td>Client bereaved of mother. Reconstituted family.</td>
<td></td>
<td>2 1/2</td>
<td>ONGOING</td>
<td></td>
</tr>
<tr>
<td>Sex</td>
<td>Age</td>
<td>Assessment</td>
<td>Intervention</td>
<td>Type of Contact</td>
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<td>No of Hours</td>
<td>Outcome/ Evaluation</td>
<td>Additional Info/Comment</td>
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<td>------------------------</td>
</tr>
<tr>
<td>M</td>
<td>2½</td>
<td>ASSESSMENT FOR TREATMENT</td>
<td>FF</td>
<td>J, CMO, S</td>
<td>TEMPER TANTRUMS, NON-COMPLIANCE, SLEEP PROBLEMS.</td>
<td>CBST</td>
<td>7</td>
<td>MUCH IMPROVED</td>
<td></td>
</tr>
<tr>
<td>M</td>
<td>4</td>
<td>SUBTEST FROM THE BAS AND MCCARTHY.</td>
<td>FI</td>
<td>S</td>
<td></td>
<td>ASSESSMENT</td>
<td>2</td>
<td></td>
<td>CHILD WITH AUTISTIC SPECTRUM DISORDER</td>
</tr>
<tr>
<td>M</td>
<td>2</td>
<td>RUTH GRIFFITHS DEVELOPMENTAL SCALE</td>
<td>FF</td>
<td>S</td>
<td></td>
<td>ASSESSMENT</td>
<td>2</td>
<td></td>
<td>CHILD WITH L.D.</td>
</tr>
<tr>
<td>M</td>
<td>7</td>
<td>WISC III - WORD - BENTON VISUAL GESTALT ALT. TEST.</td>
<td>FI</td>
<td>S</td>
<td>SOCIAL SKILLS DIFFICULTIES, DIFFICULTY WRITING.</td>
<td>ASSESSMENT</td>
<td>5</td>
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<td>M</td>
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<td>A. LOCKE DEVELOPMENTAL SCALE - MYRIL - PALMER, OBSERVATION.</td>
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<td>S</td>
<td>CHOOSING NURSERY FOR CHILD.</td>
<td>ASSESSMENT</td>
<td>8</td>
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<td>CHILD WITH LANGUAGE &amp; MOTOR DELAY</td>
</tr>
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</table>
## CLINICAL ACTIVITY WITH INDIVIDUAL CLIENTS, COUPLES, AND FAMILIES - PLACEMENT SUMMARY

<table>
<thead>
<tr>
<th>Sex</th>
<th>Age</th>
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<th>Outcome/ Evaluation</th>
<th>Additional Info/Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>F</td>
<td>9</td>
<td>ASSESSMENT FOR TREATMENT.</td>
<td>FI</td>
<td>S</td>
<td>PHOBIA - dogs, dark, needles, spiders, becoming ill again, somatic symptoms.</td>
<td>CBT.</td>
<td>6</td>
<td>MUCH IMPROVED</td>
<td></td>
</tr>
<tr>
<td>M</td>
<td>3</td>
<td>ASSESSMENT FOR TREATMENT.</td>
<td>FF</td>
<td>S</td>
<td>ATTENTION DEFICIT, HYPERACTIVITY.</td>
<td>ASSESSMENT INTERVIEW</td>
<td>1.5</td>
<td>CHILD'S DIET CHANGED, NO INTERVENTION REQUIRED</td>
<td></td>
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<tr>
<td>F</td>
<td>13</td>
<td>ASSESSMENT FOR TREATMENT.</td>
<td>FI, FF.</td>
<td>S</td>
<td>DAY AND NOCTURNAL ENURESIS, RELATIONSHIP DIFFICULTIES WITH MOTHER.</td>
<td>CBT, FAMILY WORK</td>
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<td>SOME IMPROVEMENT.</td>
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<td>M</td>
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<td>FF</td>
<td>S</td>
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<td>BEHAVIOUR THERAPY</td>
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<tr>
<td>M</td>
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<td>ASSESSMENT FOR TREATMENT.</td>
<td>FI, FF</td>
<td>S</td>
<td>DEPRESSION, SUICIDAL IDEATION, ANGER PROBLEMS.</td>
<td>CBT.</td>
<td>3.5</td>
<td>SOME IMPROVEMENT.</td>
<td>REFFERRED ON FOR FAMILY THERAPY</td>
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</table>
### Clinical Activity with Individual Clients, Couples, and Families - Placement Summary

<table>
<thead>
<tr>
<th>Sex</th>
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<th>No of Hours</th>
<th>Outcome/ Evaluation</th>
<th>Additional Info/Comment</th>
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<tbody>
<tr>
<td>F</td>
<td>16</td>
<td>ASSESSMENT FOR TREATMENT</td>
<td>FI</td>
<td>J</td>
<td>OVEREATING, PROBLEMS CONTROLLING EPILEPSY</td>
<td>ASSESSMENT INTERVIEW</td>
<td>1 1/2</td>
<td>TO BE SEEN BY SUPERVISOR FOR TREATMENT</td>
<td>ADOLESCENT WITH MILD LEARNING DIFFICULTIES</td>
</tr>
<tr>
<td>F</td>
<td>8</td>
<td>ASSESSMENT FOR TREATMENT</td>
<td>FF</td>
<td>S</td>
<td>OVEREATING, ANXIETY STRESS</td>
<td>CBT</td>
<td>2 1/2</td>
<td>CLIENT WITHDRAWN FROM TREATMENT</td>
<td>-</td>
</tr>
<tr>
<td>TWINS</td>
<td></td>
<td>ASSESSMENT FOR TREATMENT</td>
<td>FF IF</td>
<td>S</td>
<td>SIBLING RIVALRY; FIGHTING &amp; ARGUING, COMPETITIVE BEHAVIOUR</td>
<td>CBT</td>
<td>6</td>
<td>MUCH IMPROVED</td>
<td>-</td>
</tr>
<tr>
<td>M</td>
<td>11</td>
<td>ASSESSMENT FOR TREATMENT</td>
<td>FI, FF</td>
<td>S</td>
<td>O.C.D, CONDUCT DISORDER</td>
<td>CBT, FAMILY WORK</td>
<td>15</td>
<td>SOME IMPROVEMENT</td>
<td>-</td>
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<td>S</td>
<td>SCHOOL REFUSER, CONDUCT DISORDER, BEING BULLIED</td>
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<td>4 1/2</td>
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<td>CHILD WITH DYSGUEIA</td>
</tr>
<tr>
<td>Sex</td>
<td>Age</td>
<td>Assessment</td>
<td>Intervention</td>
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</tr>
<tr>
<td>M</td>
<td>11</td>
<td></td>
<td>IF FI</td>
<td>DS</td>
<td>ANXIETY, RUMINATION</td>
<td></td>
<td>1½</td>
<td>ONGOING</td>
<td></td>
</tr>
<tr>
<td>M</td>
<td>6</td>
<td></td>
<td>IF FI</td>
<td>DS</td>
<td>TRYING TO FIND SCHOOL</td>
<td></td>
<td>1½</td>
<td>ONGOING</td>
<td>CHILD WITH SEMANTIC PRAGMATIC DISORDER</td>
</tr>
<tr>
<td>M</td>
<td>2</td>
<td></td>
<td>IF</td>
<td>DO</td>
<td>REVIEW</td>
<td></td>
<td>1</td>
<td></td>
<td>CHILD WITH DOWN SYNDROME</td>
</tr>
<tr>
<td>F</td>
<td>4</td>
<td></td>
<td>FI</td>
<td>DO</td>
<td>BEHAVIOUR PROBLEMS - DIFFICULTIES WITH FINE MOTOR SKILLS</td>
<td></td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>M</td>
<td>13</td>
<td></td>
<td>IF IF</td>
<td>DO</td>
<td>EXPOSURE OF GENITALS TO PEERS</td>
<td></td>
<td>1</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Clinical Activity with Individual Clients, Couples, and Families - Placement Summary

<table>
<thead>
<tr>
<th>Sex</th>
<th>Age</th>
<th>Assessment</th>
<th>Intervention</th>
<th>Type of Contact</th>
<th>Presenting Need</th>
<th>Model of Therapy</th>
<th>No of Hours</th>
<th>Outcome/Evaluation</th>
<th>Additional Info/Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>M</td>
<td>10</td>
<td>-</td>
<td>IF</td>
<td>DS</td>
<td>SYBLING RIVALRY.</td>
<td>1</td>
<td>ON GOING</td>
<td></td>
<td>CHILD WITH ASBERGER'S SYNDROME</td>
</tr>
<tr>
<td>F</td>
<td>4</td>
<td>-</td>
<td>IF</td>
<td>DS</td>
<td>ENURETIC AND ENCOPRETIC.</td>
<td>1/2</td>
<td>ON GOING</td>
<td></td>
<td></td>
</tr>
<tr>
<td>F</td>
<td>5</td>
<td>-</td>
<td>IF</td>
<td>DS</td>
<td>PROBLEMS WITH: - SLEEPING. - FEEDING. - BEHAVIOUR. - WEARING TIGHT CLOTHES</td>
<td>1/2</td>
<td>ON GOING</td>
<td></td>
<td></td>
</tr>
<tr>
<td>M</td>
<td>8</td>
<td>-</td>
<td>IF</td>
<td>FI</td>
<td>QUERY HYPERACTIVE. - RECENTLY MOVED FROM AMERICA. - PARENTS WANTED ADVICE ON HOW TO TELL HIM OF HIS ABDUCTION</td>
<td>1/2</td>
<td>ON GOING</td>
<td></td>
<td></td>
</tr>
<tr>
<td>F</td>
<td>6</td>
<td>-</td>
<td>FF</td>
<td>DS</td>
<td>RECONSTITUTED FAMILY. MOTHER JUST HAD NEW BABY.</td>
<td>1/2</td>
<td>ON GOING</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Main Supervisor: Farzad Shamsavari  
Department: Older Adults

Trainee: Louise Green  
Department Address: Buxted House, Twickenham

Start Date: 18 May 1995  
Finishing Date: 30 November 1995

Holiday Arrangements: 25 Aug to 29 Aug, 21 Oct to 3 Nov

Supervision Day and Time: Monday, Thursday, 9:30-10:30 a.m.

Clinical Study Time: Tuesday, 9 a.m.

Source(s) of secretarial support: Buxted House, C.M.H.E. Secretary

Date for Placement Review:
Internal: 24 September 1995
External: 24 September 1995
PLACEMENT GUIDELINES

Responsibilities of the Supervisor

1. To provide appropriate facilities, such as secretarial facilities, client and office rooms to at least the minimum standard required by the course.

2. To devise a contract in consultation with the trainee at the start of the placement.

3. To plan an induction to discuss the structure of the week prior to the start of the placement.

4. To provide regular supervision and ensure additional supervision in specialty areas to at least the minimum standard (2 hours). To ensure there is an assigned person to take over supervision.

5. To assist the trainee to structure their time appropriately and to ensure that there is allocated adequate study time. To ensure work demands can be met within normal working hours.

6. To ensure that the trainee is aware of relevant policies and procedures and familiar with local professional practice in terms of letter and report writing.

7. To inform the trainee of relevant meetings, activities and structures.

8. To aim to ensure that the trainee is provided with a suitable range of clients to meet the placement criteria.

9. To address relevant models of therapy within the placement.

Role of the Trainee

1. To be active in using opportunities provided on placement so as to meet the requirements of the relevant placement guidelines.

2. To read and adhere to the B.P.S. guidelines for professional practice, departmental polices and procedures, and trust policies and procedures.

3. To attend relevant department meetings, special interest group meetings and other relevant group meetings.

4. To carry out routine administrative duties connected with the provision of a Clinical Psychology service in line with departmental and trust policies and procedures - for example, note keeping, completing relevant information for data systems such as Korner, writing up diaries etc.

5. To carry out professional tasks and responsibilities with an expected level of professional conduct (eg. timekeeping and attitude).

6. To bring up with supervisor concerns and worries which may relate to clinical practice.

Signed: Supervisor

Trainee

Date
INTRODUCTION

The client group

The term 'Older Adults' is taken to refer to people over the age of 60. It is hoped that a high proportion will work with clients over 70 years of age; it is anticipated that work with people over the age of 85 will tend to be largely through indirect contact.

The age of 60 is taken as the cut off since this marks the beginning of retirement for many people and also because after that age their is an increased incidence of organic and physical disorders. People who are younger but who display similar clinical features - such as people with Downs Syndrome who are dementing and people with pre-senile dementia are excluded.

This client group should include;

- Elderly people who are not in contact with services; e.g. people attending day centres and luncheon clubs, parents and grandparents of clients.
- People with functional problems, both short term (e.g. anxiety, depression, bereavement) and long term (individuals with chronic mental health problems and older people with learning disabilities).
- Those with an organic condition - stroke, dementia or specific neurological impairment.
- Those suffering from physical ill health.

It needs to be emphasised that a major feature of the work in the specialty is through contact with carers - both paid and unpaid- and entails clinical work with families, networks and staff groups.

Principles

It is felt important to make clear that psychologists working with older adults tend to work to particular principles and values and that these underlie the experiences and competencies described later in this document.

Some of the principles and values held by psychologists might include;

- That older people experience the same psychological processes as younger people and therefore have the right to the same psychological treatments.
- That older people should be understood in the context of life span development as having similar intentions, goals and values as younger people but that there may be factors of special significance for an older person.
- That it is important to apply the principles of normalisation to work with older adults, in particular that of maintaining and strengthening social role.

- That there needs to be explicit principles underlying services such as those from the King’s Fund document.

- That most older people have a history of competency and independence and come into first contact with helping services when old.

**Functions of the older adult placement;**

- To gain a realistic picture of older adulthood and the range of experiences of ageing and adulthood based on research.

- To clarify and challenge assumptions and prejudices about ageing and how these interact with other prejudices.

- To consider the models and strategies for enabling constructive therapeutic work to take place with this client group and also to determine appropriate therapeutic goals.

- To be aware of the personal impact of working with the elderly client with the aim of facilitating constructive self protection for depression and pain.

- To consider the similarities and differences between older adults and other client groups, and the implications of this for therapy.

- To consider the issues of mortality, dependency, disability, gender and ethnicity and their relevance for older people.

- To become familiar with services provided for elderly people and to become able to differentiate between those that enhance psychological well being from those that work against it.

- To be able to work as part of a team in order to effectively meet the complex and diverse needs of the client group.

**Required experience with the client group**

**Age**

The trainee will see clients across the age span, covering individuals from 60 to 85 years of age.

**Sex**

The trainee where possible 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 substantially more) from a different cultural and or ethnic background. 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;

- Assessment wards
- Continuing care wards - (e.g. acute, long stay and rehabilitation)
- Day Hospitals
- Social Service settings
- Clients home
- Primary health care settings
- Day centres

**Client work**

The trainee will have direct experience with the problem areas described below.

- Depression in old age.
- Cognitive change with age.
- Dementia.
- Adjustment and adaption difficulties as a result of dependency and or disability.
- The relevance of gender and ethnicity for older adults.
- Mortality.
- Strokes
- Challenging Behaviour.

**Specialities**

Older Adult Disability

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

**Number of clients**

The trainee will see a number of clients during observation of the supervisor and will also undertake a number of assessments that may not lead to treatment. The aim should be that the trainee takes on approximately 10 independent treatment cases. In addition it is hoped that the trainee will be involved in a group.

The following outlines what is seen to be good quality, minimum experience for trainees during their course. Experience is either categorised as essential or desirable depending on its level of importance. When a skill is described it is assumed that the level will be reached by the end of the placement.
UNIVERSITY OF SURREY/SWTRHA
Psych D/MSc IN CLINICAL PSYCHOLOGY
EVALUATION OF THE TRAINEE ON PLACEMENT

<table>
<thead>
<tr>
<th>TRAINEE NAME</th>
<th>Louise Byles</th>
</tr>
</thead>
<tbody>
<tr>
<td>PLACEMENT TITLE</td>
<td>Older Adults</td>
</tr>
<tr>
<td>PLACEMENT DATES</td>
<td>18th May to 30th Nov. 95</td>
</tr>
<tr>
<td>SUPERVISOR NAME</td>
<td>Fayyad Shammasani</td>
</tr>
<tr>
<td>PLACEMENT ADDRESS</td>
<td>Amyand House</td>
</tr>
</tbody>
</table>

OVERALL RATING FOR THE PLACEMENT

In the supervisor's opinion, has the trainee reached the standard expected to pass the placement?

<table>
<thead>
<tr>
<th>COMMENT</th>
<th>TICK</th>
</tr>
</thead>
<tbody>
<tr>
<td>PASS</td>
<td>✗</td>
</tr>
<tr>
<td>PASS: The trainee has gaps in experience that need to be addressed later in training</td>
<td></td>
</tr>
<tr>
<td>PASS: The trainee needs to focus on specified areas of clinical skills in subsequent placements</td>
<td></td>
</tr>
<tr>
<td>FAIL: The trainee has not reached the standard expected</td>
<td></td>
</tr>
</tbody>
</table>

General Comments from Supervisor:

Louise has worked with interest and confidence and in my opinion, her work with older people has reached a high level of effectiveness and competence.

Signed Fayyad Shammasani (Supervisor) Date 29.11.95

Comments from the trainee:

Signed ____________________________ (Trainee) Date ____________
The supervisor may raise questions or present options for the trainee to consider, but usually the trainee can present plans and make decisions on how to proceed which they have devised independently.

<table>
<thead>
<tr>
<th>SUPERVISOR - TRAINEE RELATIONSHIP</th>
<th>RATING</th>
<th>Explanation/Expansion of Rating/Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>The supervisor may raise questions or present options for the trainee to consider, but usually the trainee can present plans and make decisions on how to proceed which they have devised independently.</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>The trainee does not usually require observation, monitoring or detailed questioning to maintain the standard of work, but this is used to “fine tune” skills. The trainee self monitors and identifies the need for assistance in normal circumstances.</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>The trainee shows a balance between autonomy and the use of support and advice which is appropriate to their level of skills, the client and the service setting.</td>
<td>2</td>
<td></td>
</tr>
</tbody>
</table>

In your opinion, does the trainee reach the standard expected:

- 3 YES - Above expected level - please expand
- 2 YES - At expected level - please expand
- 1 NO - Borderline - please expand
- 0 NO - Please explain
- N/A Not applicable
<table>
<thead>
<tr>
<th><strong>THE DEVELOPMENT OF COMPETENCY IN THE USE OF SCIENTIFIC METHOD</strong></th>
<th><strong>RATING</strong></th>
<th><strong>Explanation/Expansion of Rating/Comments</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>1.1 The trainee can convert presenting problems into questions that can be delineated within a psychological perspective and with measurable solutions.</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>1.2 The trainee has good knowledge of the range of assessment procedures available and is able to choose the appropriate one to use in straightforward situations.</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>1.3 to 1.6 The trainee carries out procedures and collects information in an objective way, yet retains a sensitive stance with clients and is able to recognize factors that limit the reliability and validity of assessment.</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>1.3 Psychometric measurement</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>1.4 Other formal psychological assessments</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>1.5 Behavioural/observational assessments &amp; functional analysis</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>1.6 Other assessments</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>1.7 The trainee separates fact from interpretation, can integrate information from a variety of perspectives, compares and contrasts models; devises a formulation independently that encompasses multifactorial elements.</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>1.8 The trainee can devise a realistic and appropriate intervention plan based on an appropriate therapeutic model.</td>
<td>2</td>
<td></td>
</tr>
</tbody>
</table>
1.9 The trainee can plan an overall intervention strategy, evaluate progress, reformulate and modify the intervention plan.

<table>
<thead>
<tr>
<th>RATING</th>
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<tbody>
<tr>
<td>3</td>
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</tbody>
</table>

1.10 Evaluation of clinical interventions: the trainee understands the importance of evaluation in clinical work; chooses and uses appropriately common methods and can modify measures for a new situation.

<table>
<thead>
<tr>
<th>RATING</th>
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</thead>
<tbody>
<tr>
<td>3</td>
</tr>
</tbody>
</table>

In your opinion does the trainee reach the standard expected:

- 3 YES - Above expected level - please expand
- 2 YES - At expected level - please expand
- 1 NO - Borderline - please explain
- 0 NO - Please explain
- N/A Not applicable

<table>
<thead>
<tr>
<th>THERAPY AND INTERVENTION SKILLS</th>
<th>RATING</th>
<th>Explanation/Expansion of Rating/Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.1 The trainee takes overall responsibility for action in relation to routine client matters such as making appointments, setting up meetings with colleagues etc.</td>
<td>3</td>
<td>Very efficient and independent.</td>
</tr>
<tr>
<td>2.2 The trainee can handle unplanned and unexpected events in a therapy session in an effective and controlled way to the benefit of the client, referring back to the supervisor (subsequently).</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>2.3 The trainee engages the client, communicates appropriately to them, demonstrates awareness of what is clinically relevant and is sensitive and flexible in applying techniques. This particularly applies to clients from different cultural or ethnic backgrounds, or at different levels of intellectual ability.</td>
<td>3</td>
<td>Louise has been very sensitive and prepared to learn about other people and adjust her way of relating to the special needs of this age group.</td>
</tr>
<tr>
<td>2.4 Communication of psychological information or opinion. The trainee can present psychological information or opinion to clients, relatives and/or carers and staff effectively, modifying language appropriately, using the appropriate style and addressing concerns raised in a facilitative manner.</td>
<td>3</td>
<td></td>
</tr>
</tbody>
</table>
2.5 Interviewing: The trainee interviews clients effectively and appropriately, keeps control of the session, keeps to a structure yet allows the client to express their own issues.

2.6 to 2.10 The trainee demonstrates effective therapy skills both at a general level and in the use of particular models; the supervisor gives feedback primarily to ‘fine tune’ their skills.

2.6 Individual therapy work:

2.7 Therapy work with couples:

2.8 Therapy work with families:

2.9 Directive/behavioural groups:

2.10 Non-directive/psychotherapeutic groups:

2.11 Indirect client work: The trainee demonstrates effective skills both at a general level and in relation to the particular requirements of the setting; the supervisor gives feedback primarily to ‘fine tune’ their skills.

2.12 Client work within a formal system (such as ipp): The trainee demonstrates effective skills both at a general level and in relation to the particular requirements of the system; the supervisor gives feedback primarily to ‘fine tune’ their skills.

<table>
<thead>
<tr>
<th>In your opinion does the trainee reach the standard expected:</th>
</tr>
</thead>
<tbody>
<tr>
<td>3 YES - Above expected level - please expand</td>
</tr>
<tr>
<td>2 YES - At expected level - please expand</td>
</tr>
<tr>
<td>1 NO - Borderline - please explain</td>
</tr>
<tr>
<td>0 NO - Please explain</td>
</tr>
<tr>
<td>N/A Not applicable</td>
</tr>
<tr>
<td><strong>THE DEVELOPMENT OF PROFESSIONALISM</strong></td>
</tr>
<tr>
<td>----------------------------------------</td>
</tr>
<tr>
<td>3.1 The trainee knows the background, structure and future trends of the profession that underlie the work of clinical psychologists sufficient to relate it appropriately to the placement.</td>
</tr>
<tr>
<td>3.2 The trainee understands the history, philosophy, structure, working rules and procedures that relate to the particular placement.</td>
</tr>
<tr>
<td>3.3 The trainee demonstrates effective work management skills (time management, record keeping, reliability and administrative independence).</td>
</tr>
<tr>
<td>3.4 The trainee demonstrates self management skills (awareness of skill limitations when overworked, stressed or needing personal support).</td>
</tr>
<tr>
<td>3.5 The trainee presents in a professional way to the client and maintains a proper and effective therapeutic relationship, maintaining an over-riding concern for the client's interests, an awareness of the boundaries of competence and of ethical and procedural guidelines that apply.</td>
</tr>
<tr>
<td>3.6 Equal opportunities/equality of access: The trainee understands the importance of these factors in service provision within the health and social services and addresses them within their work, particularly in relation to attitudes and skills in client work.</td>
</tr>
<tr>
<td>3.7 The trainee presents well and relates effectively to colleagues both in psychology and elsewhere within the NHS and other agencies.</td>
</tr>
<tr>
<td>3.8 The trainee makes a positive contribution in verbal communication, presents material clearly, concisely and well structured, can separate fact from interpretation, incorporate information and opinions from others, can argue effectively and negotiate to a satisfactory outcome in normal circumstances within the placement.</td>
</tr>
</tbody>
</table>
3.9 The trainee presents material clearly and concisely in written communication, and makes good use of structure; separates fact from interpretation and relevant from irrelevant material; has a flexible style depending on the needs of the recipient.

<table>
<thead>
<tr>
<th>RATING</th>
<th>Explanation/Expansion of Rating/Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td></td>
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</tbody>
</table>

3.10 The trainee demonstrates an understanding of the range of roles that psychologists might undertake, such as teaching, supervision, consultancy, research project work and service development.

<table>
<thead>
<tr>
<th>RATING</th>
<th>Explanation/Expansion of Rating/Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>3</td>
<td></td>
</tr>
</tbody>
</table>

In your opinion does the trainee reach the standard expected:

- 3 YES - Above expected level - please expand
- 2 YES - At expected level - please expand
- 1 NO - Borderline - please explain
- 0 NO - Please explain
- N/A Not applicable

### 4. THE DEVELOPMENT OF AWARENESS AND COMPETENCE IN SERVICE AND ORGANISATIONAL ISSUES

<table>
<thead>
<tr>
<th>4.1 The trainee demonstrates a balanced and realistic awareness of how organisational factors impinge on client work both directly and through staff practices.</th>
<th>3</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>4.2 The trainee works appropriately and effectively within the boundaries and constraints of organisations and settings.</th>
<th>3</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>4.3 The trainee works appropriately and effectively within the boundaries and constraints of a multi-disciplinary team.</th>
<th>3</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>4.4 The trainee understands, and is knowledgeable, in relation to the skills and work practices of other professions and other staff groups.</th>
<th>3</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>4.5 The trainee is able to analyse and describe, with some independence, some psychological processes active within groups, settings or organisations.</th>
<th>3</th>
</tr>
</thead>
<tbody>
<tr>
<td>4.6 The trainee is able to describe, with some level of independence, the psychological skills and methods required to produce change within groups, settings or organisations.</td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>4.7 Presentation: The trainee prepares the material in terms of structure and content, relevant to the needs of the audience; displays effective verbal and non-verbal skills; shows effective use of time; chooses appropriate style (didactic or facilitative) relevant to the audience.</td>
<td>3</td>
</tr>
<tr>
<td>4.8 Teaching: The trainee prepares the material in terms of structure and content, relevant to the needs of the audience; displays effective verbal and non-verbal skills; shows effective use of time; chooses appropriate style (didactic or facilitative) relevant to the audience. The trainee chooses assessment and evaluation materials.</td>
<td>3</td>
</tr>
<tr>
<td>4.9 If the trainee has undertaken work in any of the following areas, please tick and briefly describe the work, and comment on the skills used and level of expertise displayed:</td>
<td></td>
</tr>
<tr>
<td>- consultancy</td>
<td></td>
</tr>
<tr>
<td>- supervision</td>
<td></td>
</tr>
<tr>
<td>- project work ✓</td>
<td>Louis collaborated in developing Questionnaire for quality monitoring and displayed a good level of ability &amp; skill.</td>
</tr>
<tr>
<td>- service development work</td>
<td></td>
</tr>
</tbody>
</table>

In your opinion does the trainee reach the standard expected:

3 YES - Above expected level - please expand
2 YES - At expected level - please expand
1 NO - Borderline - please explain
0 NO - Please explain
N/A Not applicable
<table>
<thead>
<tr>
<th>THE SHIFT TO WORK-BEING GROUNDED IN PSYCHOLOGICAL PRINCIPLES FROM BEING ORIENTATED IN RELATION TO SPECIFIC TECHNIQUES</th>
<th>RATING</th>
<th>Explanation/Expansion of Rating/Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>5.1 The trainee is able to perceive issues from different perspectives; draws information from a variety of sources and develops it into an individualised framework; can see how facts can be conceptualised in different ways - using supervisor primarily as a sounding board for own thinking processes.</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>5.2 The trainee approaches work from a theoretical stance with a broad vision of the general applicability of principles of practice, integrating theories from general psychology and those specific to settings or client groups.</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>5.3 Generic skills: The trainee draws on therapeutic skills techniques and methods from the range of client groups, and uses them with appropriate modifications for the individual client.</td>
<td>3</td>
<td></td>
</tr>
</tbody>
</table>

In your opinion does the trainee reach the standard expected:

- 3 YES - Above expected level - please expand
- 2 YES - At expected level - please expand
- 1 NO - Borderline - please explain
- 0 NO - Please explain
- N/A Not applicable
M Sc in Clinical Psychology

Trainee's name: Louise Bylde ........ Placement Type: Older Adults.
Date: 28th November 1995. Supervisors Name: Fazal Shamsavari ....
Placement District: RTK ..................................................

Summary of Clinical Activity

Please indicate at the end of your placement what you have covered under the following seven categories:

1) Clinical activity with individual clients, couples & families (use attached sheet C)

2) Group work - use attached sheet B

3) Teaching/Skills transmission/Presentations

   Outline each experience of teaching, indicating what, to whom how organised, the extent of your role and its degree of success.

   a) A talk to Care Staff in a Residential Home on managing difficult behaviour. This involved a verbal presentation, followed by a discussion of difficult cases. Informal positive feedback was given.

   b) Presentation of a complex case to the members of the Older Adults Specialty.

4) Organisational Work (e.g., developing IPP system, staff support, assessing case recording system). Outline each piece of work, indicating the extent of your role and outcome.
5. **RESEARCH**

Outline any projects which you initiated or with which you were involved and indicate the extent of your involvement.

Design of a Pre and Post Treatment questionnaire for Carers / Staff / Referring Agents

---

5. **MEETINGS, VISITS, OBSERVATIONS**

Outline briefly each experience and the extent of your involvement.

**Meetings** I participated in the following meetings:

Specially, departmental, weekly community team clinical meetings

I also attended ward rounds on the EMI assessment and respite care ward.

**Visits** I made the following induction visits:

1. A day observation in the Day Hospital for clients with dementia
2. A day observation in the D.H. for clients with dementi
3. ½ day observation in the D.H. for care of the elderly
4. ½ day observation at a Social Day Centre

My client work involved making visits to a number of additional settings including inpatient long stay wards, residential and nursing homes and home visits.
7. COURSES AND TRAINING EVENTS ATTENDED AS PART OF PLACEMENT

Please list and outline each one.

A video presentation on Depression in the Elderly
A video presentation on the use of Prozac with older adults

3. OTHER

Please outline any other experience on placement.

Signed: ................. Trainee: ................. Date: .................

 Signed: F. Shamsarah. Supervisor: Fazaq Shamsarah. Date: 29/11/95
**Appendix B - Work with Groups**

<table>
<thead>
<tr>
<th>Therapists</th>
<th>Your Role (Active/Observer)</th>
<th>Membership (Ages &amp; Sexes)</th>
<th>Selection of Members</th>
<th>Nature of Group Work</th>
<th>Number of Sessions</th>
<th>Outcome Evaluation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cruise Byles Gela-Totunon</td>
<td>Presentation of information and facilitation of group discussion</td>
<td>5 Females 70 - 80 years</td>
<td>Members were referred by the Day Hospital Staff</td>
<td>Problem solving group, where members were encouraged to share experiences and think through strategies for solving difficulties</td>
<td>4</td>
<td>Topiss listening skills, memory, time management, preparation for learning. Members found the group enjoyable and beneficial.</td>
</tr>
<tr>
<td>B. Psychologist</td>
<td>Presentation of information and facilitation of group exercises (e.g. Role Play)</td>
<td>1 Male 4 Females 70 - 85 years</td>
<td>Ditto</td>
<td>Social Skills Training. Topics - non verbal, verbal, communication skills, making friends &amp; assertiveness training.</td>
<td>6</td>
<td>Informal Positive Feedback</td>
</tr>
<tr>
<td>B. Psychologist Supervisor</td>
<td>Facilitation of group discussion &amp; presentation of information</td>
<td>6 Females 70 - 85 years</td>
<td>Ditto</td>
<td>Support Group for Members about to leave the D.H</td>
<td>5</td>
<td>Ditto</td>
</tr>
<tr>
<td>Ditto</td>
<td>Ditto</td>
<td>Ditto</td>
<td>Ditto</td>
<td>Support Group for Day Hospital clients</td>
<td>4</td>
<td>Ditto</td>
</tr>
<tr>
<td>B. Psychologist T, CPIN</td>
<td>Ditto</td>
<td>Various</td>
<td>—</td>
<td>Support Group for Individuals coping for relatives with dementia</td>
<td>6</td>
<td>Ongoing</td>
</tr>
<tr>
<td>B. Psychologist Supervisor</td>
<td>Observation Only</td>
<td>Ditto</td>
<td>—</td>
<td>Support Group for Nursing Staff on the EMI Assessment Ward</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Age</td>
<td>Assessment</td>
<td>Intervention</td>
<td>Type of Contact</td>
<td>Presenting Need</td>
<td>Model of Therapy</td>
<td>No of Hours</td>
</tr>
<tr>
<td>-----</td>
<td>--------------------------------</td>
<td>--------------</td>
<td>-----------------</td>
<td>-------------------------------------------------</td>
<td>------------------</td>
<td>-------------</td>
</tr>
<tr>
<td>79</td>
<td>Interview with client and MEAMS</td>
<td>FI</td>
<td>S</td>
<td>Bereavement leading to psychotic episodes</td>
<td>Bereavement</td>
<td>7</td>
</tr>
<tr>
<td>20</td>
<td>Assessment for Treatment</td>
<td>IC, IF</td>
<td>J Supervisor</td>
<td>Behaviour Problems</td>
<td>Behaviour</td>
<td>2</td>
</tr>
<tr>
<td>40</td>
<td>Assessment for Treatment</td>
<td>IC</td>
<td>J Supervisor</td>
<td>Behaviour Problems</td>
<td>D/To</td>
<td>15</td>
</tr>
<tr>
<td>85</td>
<td>Jitto</td>
<td>IC</td>
<td>J Supervisor</td>
<td>Refusal to eat or drink</td>
<td>Jitto</td>
<td>3</td>
</tr>
<tr>
<td>79</td>
<td>Jitto</td>
<td>FI, FC</td>
<td>PS, J Supervisor</td>
<td>Frontal lobe damage, disinhibited behaviour,</td>
<td>Eclectic</td>
<td>7</td>
</tr>
<tr>
<td>83</td>
<td></td>
<td>FI, IT</td>
<td>D, J</td>
<td>Anxious, depressed</td>
<td>Non Destructive</td>
<td>3</td>
</tr>
<tr>
<td>Age</td>
<td>Assessment</td>
<td>Intervention</td>
<td>Type of Contact</td>
<td>Presenting Need</td>
<td>Model of Therapy</td>
<td>No of Hours</td>
</tr>
<tr>
<td>-----</td>
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<td>----------------</td>
<td>-----------------</td>
<td>-------------</td>
</tr>
<tr>
<td>87</td>
<td>—</td>
<td>FI, IF</td>
<td>PS, J / Supervisor</td>
<td>Anxious, depressed Marital Problems Daughter having difficulty setting boundaries with Parents</td>
<td>Eclectic</td>
<td>9</td>
</tr>
<tr>
<td>82</td>
<td>Assessment</td>
<td>FI, IC, IT</td>
<td>S</td>
<td>Difficulty adjusting to disability and aging, lack of assertiveness</td>
<td>Eclectic</td>
<td>11</td>
</tr>
<tr>
<td>77</td>
<td>Assessment</td>
<td>FI</td>
<td>S</td>
<td>Anxious Hypochondriasis Social skills difficulty</td>
<td>CBT, limit setting</td>
<td>20</td>
</tr>
<tr>
<td>81</td>
<td>Assessment</td>
<td>FI, PS, J-CPN</td>
<td>S</td>
<td>Delayed Bereavement, depressed, anxious and socially isolated</td>
<td>Non Directive CBT</td>
<td>4</td>
</tr>
<tr>
<td>87</td>
<td>Assessment</td>
<td>FI</td>
<td>S</td>
<td>Anxious, depressed Sleeping difficulties Low self-confidence Among Multi-factor Dementia</td>
<td>CBT</td>
<td>7</td>
</tr>
<tr>
<td>Phased</td>
<td>Ongoing</td>
<td>2</td>
<td>5</td>
<td>Depressed and</td>
<td>FC</td>
<td>85</td>
</tr>
<tr>
<td>--------</td>
<td>---------</td>
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<td>-------------</td>
<td>----</td>
<td>----</td>
</tr>
<tr>
<td>Ongoing</td>
<td>1½</td>
<td></td>
<td></td>
<td>Squint /</td>
<td>FC</td>
<td>85</td>
</tr>
<tr>
<td>Ongoing</td>
<td>2½</td>
<td></td>
<td></td>
<td>Non-ethnic</td>
<td>FC</td>
<td>85</td>
</tr>
<tr>
<td>Ongoing</td>
<td></td>
<td></td>
<td></td>
<td>Non-disease</td>
<td>FC</td>
<td>85</td>
</tr>
<tr>
<td>Ongoing</td>
<td></td>
<td></td>
<td></td>
<td>Recent /</td>
<td>FC</td>
<td>85</td>
</tr>
<tr>
<td>Ongoing</td>
<td></td>
<td></td>
<td></td>
<td>Community</td>
<td>FC</td>
<td>85</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Additional</th>
<th>Information/Outcome</th>
<th>Evaluation</th>
<th>Therapy Needs</th>
<th>Pre-Existing</th>
<th>Contact</th>
<th>Type of</th>
<th>Intervention</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Clinical Activities with Individual Clients, Couples, and Families - Placement Summary**
Main Supervisor: BENNA WATTS
Department: RTR

Trainee: ROSE BYLES

Departmental Address: Royal
Trainee Base: Royal
(see 2 pages ahead)

Start Date: 4th December
Finishing Date: 18th July

Holiday Arrangements (for supervisor and trainee)

Supervision Day and Time: Thursdays 2 pm

Clinical Study Time: as required

Additional Supervisors:

Areas Responsible for:

Supervision Time and Day:

Source(s) of secretarial support: CMHT

Date for Placement Review:
Internal: 4th July
External: 11th July
# UNIVERSITY OF SURREY/SWTRHA

**PsychD in Clinical Psychology**

**Evaluation of the Trainee on Placement**

<table>
<thead>
<tr>
<th>Trainee Name</th>
<th>Louise Byles</th>
</tr>
</thead>
<tbody>
<tr>
<td>Placement Title</td>
<td>Specialist - Bulimia</td>
</tr>
<tr>
<td>Placement Dates</td>
<td>Dec '95 - July '96</td>
</tr>
<tr>
<td>No. of Days YR 1</td>
<td></td>
</tr>
<tr>
<td>No. of Days YR 2</td>
<td></td>
</tr>
<tr>
<td>Supervisor Name</td>
<td>Bena Waite</td>
</tr>
<tr>
<td>Placement Address</td>
<td>Richmond Royal</td>
</tr>
<tr>
<td></td>
<td>Kent Foot Rd</td>
</tr>
<tr>
<td></td>
<td>Richmond</td>
</tr>
<tr>
<td></td>
<td>Surrey TW9 2TE</td>
</tr>
</tbody>
</table>

**Overall Rating for the Placement**

In the supervisor's opinion, has the trainee reached the standard expected to pass the placement?

<table>
<thead>
<tr>
<th>Comment</th>
<th>Tick</th>
</tr>
</thead>
<tbody>
<tr>
<td>PASS: The trainee has gaps in experience that need to be addressed later in training</td>
<td>✔</td>
</tr>
<tr>
<td>PASS: The trainee needs to focus on specified areas of clinical skills in subsequent placements</td>
<td></td>
</tr>
<tr>
<td>FAIL: The trainee has not reached the standard expected</td>
<td></td>
</tr>
</tbody>
</table>

**General Comments from Supervisor:**

Signed _________________________ (Supervisor) Date ________________

**Comments from the trainee:**

Signed _________________________ (Trainee) Date ________________
<table>
<thead>
<tr>
<th>SUPERVISOR - TRAINEE RELATIONSHIP</th>
<th>RATING</th>
<th>Explanation/Expansion of Rating/Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>The supervisor may raise questions or present options for the trainee to consider, but usually the trainee can present plans and make decisions on how to proceed which they have devised independently.</td>
<td>3</td>
<td>Louise was a joy to supervise. She took an appropriate level of autonomy and was able to ask for help when needed. She was able to formulate difficulties clearly and was very responsive to feedback.</td>
</tr>
<tr>
<td>The trainee does not usually require observation, monitoring or detailed questioning to maintain the standard of work, but this is used to 'fine tune' skills. The trainee self monitors and identifies the need for assistance in normal circumstances.</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>The trainee shows a balance between autonomy and the use of support and advice which is appropriate to their level of skills, the client and the service setting.</td>
<td>3</td>
<td></td>
</tr>
</tbody>
</table>

In your opinion, does the trainee reach the standard expected:

- 3 YES - Above expected level - please expand
- 2 YES - At expected level - please expand
- 1 NO - Borderline - please expand
- 0 NO - Please explain
- N/A Not applicable
<table>
<thead>
<tr>
<th>ASSESSMENT, FORMULATION, CLINICAL EVALUATION</th>
<th>RATING</th>
<th>Explanation/Expansion of Rating/Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.1 The trainee can convert presenting problems into questions that can be delineated within a psychological perspective and with measurable solutions.</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>1.2 The trainee has good knowledge of the range of assessment procedures available and is able to choose the appropriate one to use in straightforward situations.</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>1.3 to 1.6 The trainee carries out procedures and collects information in an objective way, yet retains a sensitive stance with clients and is able to recognize factors that limit the reliability and validity of assessment.</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>1.3 Psychometric measurement</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>1.4 Other formal psychological assessments</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>1.5 Behavioural/observational assessments &amp; functional analysis</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>1.6 Other assessments</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>1.7 The trainee separates fact from interpretation, can integrate information from a variety of perspectives, compares and contrasts models; devises a formulation independently that encompasses multifactorial elements.</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>1.8 The trainee can devise a realistic and appropriate intervention plan based on an appropriate therapeutic model.</td>
<td>3</td>
<td>devise several realistic, tailored treatment plans to clients' needs.</td>
</tr>
</tbody>
</table>
1.9 The trainee can plan an overall intervention strategy, evaluate progress, reformulate and modify the intervention plan.

1.10 Evaluation of clinical interventions: the trainee understands the importance of evaluation in clinical work; chooses and uses appropriately common methods and can modify measures for a new situation.

<table>
<thead>
<tr>
<th>THERAPY AND INTERVENTION SKILLS</th>
<th>RATING</th>
<th>Explanation/Expansion of Rating/Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.1 The trainee takes overall responsibility for action in relation to routine client matters such as making appointments, setting up meetings with colleagues etc.</td>
<td>3</td>
<td>Despite only being on placement for one day a week, Louise's organisational ability was faultless.</td>
</tr>
<tr>
<td>2.2 The trainee can handle unplanned and unexpected events in a therapy session in an effective and controlled way to the benefit of the client, referring back to the supervisor.</td>
<td>2</td>
<td>Louise was able to respond empathically to unexpected events, development in this area will come as her experience increases.</td>
</tr>
<tr>
<td>2.3 The trainee engages the client, communicates appropriately to them, demonstrates awareness of what is clinically relevant and is sensitive and flexible in applying techniques. This particularly applies to clients from different cultural or ethnic backgrounds, or at different levels of intellectual and linguistic ability.</td>
<td>2</td>
<td>Not a great deal of experience of different cultural or ethnic backgrounds on this placement. However, generally her ability to engage clients was excellent.</td>
</tr>
<tr>
<td>2.4 Communication of psychological information or opinion. The trainee can present psychological information or opinion to clients, relatives and/or carers and staff effectively, modifying language appropriately, using the appropriate style and addressing concerns raised in a facilitative manner.</td>
<td>3</td>
<td>Very clear + comprehensive provision of information.</td>
</tr>
<tr>
<td>2.5 Interviewing: The trainee interviews clients effectively and appropriately, keeps control of the session, keeps to a structure yet allows the client to express their own issues.</td>
<td>3</td>
<td></td>
</tr>
</tbody>
</table>
2.6 to 2.10 The trainee demonstrates effective therapy skills both at a general level and in the use of particular models; the supervisor gives feedback primarily to 'fine tune' their skills.

| 2.6 Individual therapy work: | 3 |
| 2.7 Therapy work with couples: | 2 |
| 2.8 Therapy work with families | N/A |
| 2.9 Directive/behavioural groups: | N/A |
| 2.10 Non-directive/psychotherapeutic groups: | 2 |

2.11 Indirect client work: The trainee demonstrates effective skills both at a general level and in relation to the particular requirements of the setting; the supervisor gives feedback primarily to 'fine tune' their skills.

| 2.11 Indirect client work: | 2 |

2.12 Client work within a formal system (such as IPP): The trainee demonstrates effective skills both at a general level and in relation to the particular requirements of the system; the supervisor gives feedback primarily to 'fine tune' their skills.

| 2.12 Client work within a formal system | 2 |

2.13 Trainee handles termination of client contract effectively (either end of treatment or end of placement), dealing with both practical issues and the emotional aspect.

| 2.13 Trainee handles termination of client contract effectively | 3 |

3. THE DEVELOPMENT OF PROFESSIONALISM

<table>
<thead>
<tr>
<th>RATING</th>
<th>Explanation/ Expansion of Rating/Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>Louise is already developing an ability to communicate well with staff.</td>
</tr>
<tr>
<td></td>
<td>Handled endings both sensibly and practically.</td>
</tr>
</tbody>
</table>

<p>| 3.1 The trainee knows the background, structure and future trends of the profession that underlie the work of clinical psychologists sufficient to relate it appropriately to the placement. | 2 |
| 3.2 The trainee understands the history, philosophy, structure, working rules and procedures that relate to the particular placement. | 2 |</p>
<table>
<thead>
<tr>
<th>3.3</th>
<th>The trainee demonstrates effective work management skills (time management, record keeping, reliability and administrative independence).</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>3</td>
</tr>
<tr>
<td>3.4</td>
<td>The trainee demonstrates self management skills (awareness of skill limitations when overworked, stressed or needing personal support).</td>
</tr>
<tr>
<td></td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>aware of limitations over needs to learn to look after herself better when unwell!</td>
</tr>
<tr>
<td>3.5</td>
<td>The trainee presents in a professional way to the client and maintains a proper and effective therapeutic relationship, maintaining an over-riding concern for the client's interests, an awareness of the boundaries of competence and of ethical and procedural guidelines that apply.</td>
</tr>
<tr>
<td></td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Very professional in all these areas.</td>
</tr>
<tr>
<td>3.6</td>
<td>Equal opportunities/equality of access: The trainee understands the importance of these factors in service provision within the health and social services and addresses them within their work, particularly in relation to attitudes and skills in client work.</td>
</tr>
<tr>
<td></td>
<td>2</td>
</tr>
<tr>
<td>3.7</td>
<td>The trainee presents well and relates effectively to colleagues both in psychology and elsewhere within the NHS and other agencies.</td>
</tr>
<tr>
<td></td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Louise made good relationships with work colleagues.</td>
</tr>
<tr>
<td>3.8</td>
<td>The trainee makes a positive contribution in verbal communication, presents material clearly, concisely and well structured, can separate fact from interpretation, incorporate information and opinions from others, can argue effectively and negotiate to a satisfactory outcome in normal circumstances within the placement.</td>
</tr>
<tr>
<td></td>
<td>2</td>
</tr>
<tr>
<td>3.9</td>
<td>The trainee presents material clearly and concisely in written communication, and makes good use of structure; separates fact from interpretation and relevant from irrelevant material; has a flexible style depending on the needs of the recipient.</td>
</tr>
<tr>
<td></td>
<td>2</td>
</tr>
</tbody>
</table>
3.10 The trainee demonstrates an understanding of the range of roles that psychologists might undertake, such as teaching, supervision, consultancy, research project work and service development.

<table>
<thead>
<tr>
<th>THE DEVELOPMENT OF AWARENESS AND COMPETENCE IN SERVICE AND ORGANISATIONAL ISSUES</th>
<th>RATING</th>
<th>Explanation/Expansion of Rating/Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>4.1 The trainee demonstrates a balanced and realistic awareness of how organisational factors impinge on client work both directly and through staff practices.</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>4.2 The trainee works appropriately and effectively within the boundaries and constraints of organisations and settings.</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>4.3 The trainee works appropriately and effectively within the boundaries and constraints of a multi-disciplinary team.</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>4.4 The trainee understands, and is knowledgeable, in relation to the skills and work practices of other professions and other staff groups.</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>4.5 The trainee is able to analyse and describe, with some independence, some psychological processes active within groups, settings or organisations.</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>4.6 The trainee is able to describe, with some level of independence, the psychological skills and methods required to produce change within groups, settings or organisations.</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>4.7 Presentation: The trainee prepares the material in terms of structure and content, relevant to the needs of the audience; displays effective verbal and non-verbal skills; shows effective use of time; chooses appropriate style (didactic or facilitative) relevant to the audience.</td>
<td>N/A</td>
<td></td>
</tr>
</tbody>
</table>
4.8 Teaching: The trainee prepares the material in terms of structure and content, relevant to the needs of the audience; displays effective verbal and non-verbal skills; shows effective use of time; chooses appropriate style (didactic or facilitative) relevant to the audience. The trainee chooses assessment and evaluation materials.

4.9 If the trainee has undertaken work in any of the following areas, please tick and briefly describe the work, and comment on the skills used and level of expertise displayed:
- consultancy
- supervision
- project work
- service development work

5.

<table>
<thead>
<tr>
<th>THE SHIFT TO WORK BEING GROUNDED IN PSYCHOLOGICAL PRINCIPLES FROM BEING ORIENTATED IN RELATION TO SPECIFIC TECHNIQUES</th>
<th>RATING</th>
<th>Explanation/Expansion of Rating/Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>5.1 The trainee is able to perceive issues from different perspectives; draws information from a variety of sources and develops it into an individualised framework; can see how facts can be conceptualised in different ways - using supervisor primarily as a sounding board for own thinking processes.</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>5.2 The trainee approaches work from a theoretical stance with a broad vision of the general applicability of principles of practice, integrating theories from general psychology and those specific to settings or client groups.</td>
<td>2</td>
<td></td>
</tr>
</tbody>
</table>
5.3 Generic skills: The trainee draws on therapeutic skills techniques and methods from the range of client groups, and uses them with appropriate modifications for the individual client.

| 3. |
Trainee's Name: Louise Byles
Placement Type: Specialist (Bulimia)
Supervisor's Name: Bewna Wates
Date: 31 July 1996
Placement District: Richmond

Summary of Clinical Activity

Please indicate at the end of your placement what you have covered under the following seven categories:

1) Clinical activity with individual clients, couples and families - use attached sheet C
2) Group work - use attached sheet B
3) Teaching/Skills transmission/presentations
   Outline each experience of teaching, indicating what, to whom, how organised, the extent of your role and its degree of success:
4) Organisational Work (e.g. developing IPP system, staff support, assessing case recording system). Outline each piece of work, indicating the extent of your role and outcome:
5) RESEARCH

Outline any projects which you initiated or with which you were involved and indicate the extent of your involvement:

6) MEETINGS, VISITS, OBSERVATIONS

Outline briefly each experience and the extent of your involvement:

- 1. Quality meetings
- 2. Client reviews which included a discussion about a woman weighing 50 stone and a teenager with anorexia.
- 3. I also observed my supervisor providing supervision to CMHT and Day Centre Staff.
7) COURSES AND TRAINING EVENTS ATTENDED AS PART OF PLACEMENT

Please list and outline each one:

8) OTHER

Please outline any other experience on placement:

Signed .................................... Trainee .................................. Date ........................................

Signed .................................... Supervisor .............................. Date ........................................
## WORK WITH GROUPS

<table>
<thead>
<tr>
<th>Therapists</th>
<th>Your Role (Active/Observer)</th>
<th>Membership (Ages and Sexes)</th>
<th>Selection of Members</th>
<th>Nature of Group work</th>
<th>Number of Sessions</th>
<th>Outcome Evaluation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical Psychologist and Clinical Psychologist in Training</td>
<td>Mainly observation but I ran the group when my supervisor was away</td>
<td>4 females aged 22 - 36 years</td>
<td>Each member was assessed individually by my supervisor</td>
<td>Psychotherapy group for people with Bulimia</td>
<td>12</td>
<td>Ongoing</td>
</tr>
<tr>
<td>Sex</td>
<td>Age</td>
<td>Assessment</td>
<td>Intervention</td>
<td>Type of Contact</td>
<td>Presenting Needs</td>
<td>Model of Therapy</td>
</tr>
<tr>
<td>-----</td>
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<td>----------------</td>
<td>-----------------</td>
<td>------------------</td>
</tr>
<tr>
<td>F</td>
<td>49</td>
<td>Assessment for Treatment</td>
<td>FI</td>
<td>S</td>
<td>Obsession with eating &amp; depression</td>
<td>CBT</td>
</tr>
<tr>
<td>F</td>
<td>22</td>
<td>ditto</td>
<td>FI</td>
<td>S</td>
<td>Bulimia</td>
<td>Eclectic</td>
</tr>
<tr>
<td>F</td>
<td>22</td>
<td>ditto</td>
<td>FI</td>
<td>S</td>
<td>Bulimia</td>
<td>Assessment only</td>
</tr>
<tr>
<td>F</td>
<td>23</td>
<td>ditto</td>
<td>FI</td>
<td>S</td>
<td>Bulimia &amp; relationship difficulties</td>
<td>Eclectic</td>
</tr>
<tr>
<td>F</td>
<td>22</td>
<td>ditto</td>
<td>FI</td>
<td>S</td>
<td>Bulimia &amp; relationship difficulties</td>
<td>Eclectic</td>
</tr>
<tr>
<td>F</td>
<td>26</td>
<td>ditto</td>
<td>FI</td>
<td>S</td>
<td>Bulimia I concern re feeding child</td>
<td>CBT</td>
</tr>
<tr>
<td>Sex</td>
<td>Age</td>
<td>Assessment</td>
<td>Intervention</td>
<td>Type of Contact</td>
<td>Presenting Needs</td>
<td>Model of Therapy</td>
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<td>-----</td>
<td>-----</td>
<td>------------</td>
<td>--------------</td>
<td>-----------------</td>
<td>-----------------</td>
<td>------------------</td>
</tr>
<tr>
<td>F</td>
<td>28</td>
<td>Assessment for treatment</td>
<td>FI</td>
<td>S</td>
<td>Bulimia</td>
<td>Assessment only</td>
</tr>
<tr>
<td>F</td>
<td>36</td>
<td>Ditto</td>
<td>FI</td>
<td>S</td>
<td>Bulimia, history of sexual abuse</td>
<td>Non-directive CBT</td>
</tr>
<tr>
<td>F</td>
<td>40</td>
<td>Ditto</td>
<td>FI</td>
<td>S</td>
<td>history of physical, sexual, emotional abuse</td>
<td>Eclectic</td>
</tr>
<tr>
<td>F</td>
<td>40</td>
<td>—</td>
<td>FI</td>
<td>DS</td>
<td>Feeling of inadequacy as a parent</td>
<td>-</td>
</tr>
<tr>
<td>M</td>
<td>18</td>
<td>Ditto</td>
<td>FI</td>
<td>DS</td>
<td>Bulimia</td>
<td>-</td>
</tr>
<tr>
<td>F</td>
<td>35</td>
<td>Ditto</td>
<td>FI</td>
<td>DS</td>
<td>Bulimia, perfectionist ideas</td>
<td>-</td>
</tr>
</tbody>
</table>
UNIVERSITY OF SURREY/STRHA(W)
Psych D/MSc IN CLINICAL PSYCHOLOGY

PLACEMENT FRONT SHEET

Main Supervisor: [Name]

Department: K.2 District

Trainee: [Name]

Community NTS Teams

Departmental Address: [Address]

Trainee Base: [Address]

Start Date: Dec 1996

Finishing Date: [End Date]

Holiday Arrangements (for supervisor and trainee): [Description]

Supervision Day and Time: Wed 4.00

Clinical Study Time: Adv fixed

Additional Supervisors: [Names]

Areas Responsible for: [Details]

Supervision Time and Day: As required

Source(s) of secretarial support: [Details]

Date for Placement Review:

Internal: Wed 27th 3.30 - 5.00

External: 11/5/96
# UNIVERSITY OF SURREY/SWTRHA

PsychD IN CLINICAL PSYCHOLOGY

## EVALUATION OF THE TRAINEE ON PLACEMENT

<table>
<thead>
<tr>
<th>TRAINEE NAME</th>
<th>LOUISE BYLAE</th>
</tr>
</thead>
<tbody>
<tr>
<td>PLACEMENT TITLE</td>
<td>HEALTH PSYCHOLOGY</td>
</tr>
<tr>
<td>PLACEMENT DATES</td>
<td>Dec 96 - end July 96</td>
</tr>
<tr>
<td>No. of DAYS-YR 1</td>
<td></td>
</tr>
<tr>
<td>No. of DAYS-YR 2</td>
<td></td>
</tr>
<tr>
<td>SUPERVISOR NAME</td>
<td>CATHALINE DUBIN</td>
</tr>
<tr>
<td>PLACEMENT ADDRESS</td>
<td></td>
</tr>
</tbody>
</table>

### OVERALL RATING FOR THE PLACEMENT

In the supervisor's opinion, has the trainee reached the standard expected to pass the placement?

<table>
<thead>
<tr>
<th>COMMENT</th>
<th>TICK</th>
</tr>
</thead>
<tbody>
<tr>
<td>PASS</td>
<td>✓</td>
</tr>
<tr>
<td>PASS: The trainee has gaps in experience that need to be addressed later in training</td>
<td></td>
</tr>
<tr>
<td>PASS: The trainee needs to focus on specified areas of clinical skills in subsequent placements</td>
<td></td>
</tr>
<tr>
<td>FAIL: The trainee has not reached the standard expected</td>
<td></td>
</tr>
</tbody>
</table>

**General Comments from Supervisor:** This was a challenging placement in which Louise clearly developed a broad range of skills. Confidence in her clinical style.

Signed: [Signature] (Supervisor) Date: 29/12/96

**Comments from the trainee:**

Signed: [Signature] (Trainee) Date: [Blank]

---

Note: The document contains a handwritten comment under the general comments section: "This was a challenging placement in which Louise clearly developed a broad range of skills. Confidence in her clinical style."
<table>
<thead>
<tr>
<th>SUPERVISOR - TRAINEE RELATIONSHIP</th>
<th>RATING</th>
<th>Explanation/Expansion of Rating/Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>The supervisor may raise questions or present options for the trainee to consider, but usually the trainee can present plans and make decisions on how to proceed which they have devised independently.</td>
<td>2</td>
<td>At a good level, particularly given the client complexity, need to make decisions about referred on.</td>
</tr>
<tr>
<td>The trainee does not usually require observation, monitoring or detailed questioning to maintain the standard of work, but this is used to 'fine tune' skills. The trainee self monitors and identifies the need for assistance in normal circumstances.</td>
<td>2</td>
<td>See comments later</td>
</tr>
<tr>
<td>The trainee shows a balance between autonomy and the use of support and advice which is appropriate to their level of skills, the client and the service setting.</td>
<td>3</td>
<td>A good balance at times; entirely appropriate</td>
</tr>
</tbody>
</table>

In your opinion, does the trainee reach the standard expected:

- 3 YES - Above expected level - please expand
- 2 YES - At expected level - please expand
- 1 NO - Borderline - please expand
- 0 NO - Please explain
- N/A Not applicable
<table>
<thead>
<tr>
<th>ASSESSMENT, FORMULATION, CLINICAL EVALUATION</th>
<th>RATING</th>
<th>Explanation/Expansion of Rating/Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.1 The trainee can convert presenting problems into questions that can be delineated within a psychological perspective and with measurable solutions.</td>
<td>2</td>
<td>This was a particularly pertinent aspect of the placement.</td>
</tr>
<tr>
<td>1.2 The trainee has good knowledge of the range of assessment procedures available and is able to choose the appropriate one to use in straightforward situations.</td>
<td>(2)</td>
<td>Hard to know in advance, part of placement.</td>
</tr>
<tr>
<td>1.3 to 1.6 The trainee carries out procedures and collects information in an objective way, yet retains a sensitive stance with clients and is able to recognize factors that limit the reliability and validity of assessment.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.3 Psychometric measurement</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>1.4 Other formal psychological assessments</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>1.5 Behavioural/observational assessments &amp; functional analysis</td>
<td>3</td>
<td>Well demonstrated</td>
</tr>
<tr>
<td>1.6 Other assessments</td>
<td>2</td>
<td>Some aspects quite hard work, part of placement.</td>
</tr>
<tr>
<td>1.7 The trainee separates fact from interpretation, can integrate information from a variety of perspectives, compares and contrasts models; devises a formulation independently that encompasses multifactorial elements.</td>
<td>(2)</td>
<td>Some difficulty in separating from client's perspective, primarily in client's office. Otherwise good.</td>
</tr>
<tr>
<td>1.8 The trainee can devise a realistic and appropriate intervention plan based on an appropriate therapeutic model.</td>
<td>2 - 3</td>
<td>Very good as planning a pragmatic, stepped approach for complex client issues.</td>
</tr>
</tbody>
</table>
1.9 The trainee can plan an overall intervention strategy, evaluate progress, re-formulate and modify the intervention plan.

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>2-3</td>
<td>mostly big task but where needed could do them.</td>
</tr>
</tbody>
</table>

1.10 Evaluation of clinical interventions: the trainee understands the importance of evaluation in clinical work; chooses and uses appropriately common methods and can modify measures for a new situation.

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>yes - limited chance to demonstrate</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>THERAPY AND INTERVENTION SKILLS</th>
<th>RATING</th>
<th>Explanation/Expansion of Rating/Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.1 The trainee takes overall responsibility for action in relation to routine client matters such as making appointments, setting up meetings with colleagues etc.</td>
<td>3</td>
<td>excellent, particularly given previous terms of client work.</td>
</tr>
<tr>
<td>2.2 The trainee can handle unplanned and unexpected events in a therapy session in an effective and controlled way to the benefit of the client, referring back to the supervisor.</td>
<td>3</td>
<td>some quite difficult issues handled well.</td>
</tr>
<tr>
<td>2.3 The trainee engages the client, communicates appropriately to them, demonstrates awareness of what is clinically relevant and is sensitive and flexible in applying techniques. This particularly applies to clients from different cultural or ethnic backgrounds, or at different levels of intellectual and linguistic ability.</td>
<td>3</td>
<td>Indeed evidence would be that was a strength for home.</td>
</tr>
<tr>
<td>2.4 Communication of psychological information or opinion. The trainee can present psychological information or opinion to clients, relatives and/or carers and staff effectively, modifying language appropriately, using the appropriate style and addressing concerns raised in a facilitative manner.</td>
<td>3</td>
<td>Home had to present a fair profile claim - seemed to work well.</td>
</tr>
<tr>
<td>2.5 Interviewing: The trainee interviews clients effectively and appropriately, keeps control of the session, keeps to a structure yet allows the client to express their own issues.</td>
<td>2</td>
<td>Initially perhaps not enthusiastic, formed later on - seemed excellent.</td>
</tr>
<tr>
<td>2.6 to 2.10 The trainee demonstrates effective therapy skills both at a general level and in the use of particular models; the supervisor gives feedback primarily to 'fine tune' their skills.</td>
<td>2.6 Individual therapy work:</td>
<td>3</td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>2.7 Therapy work with couples:</td>
<td></td>
<td>2</td>
</tr>
<tr>
<td>2.8 Therapy work with families</td>
<td></td>
<td>N/A</td>
</tr>
<tr>
<td>2.9 Directive/behavioural groups:</td>
<td></td>
<td>2</td>
</tr>
<tr>
<td>2.10 Non-directive/psychotherapeutic groups:</td>
<td></td>
<td>2</td>
</tr>
</tbody>
</table>

| 2.11 Indirect client work: The trainee demonstrates effective skills both at a general level and in relation to the particular requirements of the setting; the supervisor gives feedback primarily to 'fine tune' their skills. | 2.11 Indirect client work: | 2 | limited in this placement |

| 2.12 Client work within a formal system (such as IPP): The trainee demonstrates effective skills both at a general level and in relation to the particular requirements of the system; the supervisor gives feedback primarily to 'fine tune' their skills. | 2.12 Client work within a formal system (such as IPP): | N/A | |

| 2.13 Trainee handles termination of client contract effectively (either end of treatment or end of placement), dealing with both practical issues and the emotional aspect. | 2.13 Trainee handles termination of client contract effectively (either end of treatment or end of placement), dealing with both practical issues and the emotional aspect. | 3 | Handle this well for both brief & longer term issues |

### THE DEVELOPMENT OF PROFESSIONALISM

<table>
<thead>
<tr>
<th>THE DEVELOPMENT OF PROFESSIONALISM</th>
<th>RATING</th>
<th>Explanation/ Expansion of Rating/Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.1 The trainee knows the background, structure and future trends of the profession that underlie the work of clinical psychologists sufficient to relate it appropriately to the placement.</td>
<td>(2 - limited knowledge)</td>
<td></td>
</tr>
<tr>
<td>3.2 The trainee understands the history, philosophy, structure, working rules and procedures that relate to the particular placement.</td>
<td>(2 - weak within medical model)</td>
<td>(3 - adapted to this well)</td>
</tr>
<tr>
<td>3.3</td>
<td>The trainee demonstrates effective work management skills (time management, record keeping, reliability and administrative independence).</td>
<td>3</td>
</tr>
<tr>
<td>3.4</td>
<td>The trainee demonstrates self management skills (awareness of skill limitations when overworked, stressed or needing personal support).</td>
<td>2</td>
</tr>
<tr>
<td>3.5</td>
<td>The trainee presents in a professional way to the client and maintains a proper and effective therapeutic relationship, maintaining an over-riding concern for the client's interests, an awareness of the boundaries of competence and of ethical and procedural guidelines that apply.</td>
<td>2</td>
</tr>
<tr>
<td>3.6</td>
<td>Equal opportunities/equality of access: The trainee understands the importance of these factors in service provision within the health and social services and addresses them within their work, particularly in relation to attitudes and skills in client work.</td>
<td></td>
</tr>
<tr>
<td>3.7</td>
<td>The trainee presents well and relates effectively to colleagues both in psychology and elsewhere within the NHS and other agencies.</td>
<td>3</td>
</tr>
<tr>
<td>3.8</td>
<td>The trainee makes a positive contribution in verbal communication, presents material clearly, concisely and well structured, can separate fact from interpretation, incorporate information and opinions from others, can argue effectively and negotiate to a satisfactory outcome in normal circumstances within the placement.</td>
<td></td>
</tr>
<tr>
<td>3.9</td>
<td>The trainee presents material clearly and concisely in written communication, and makes good use of structure; separates fact from interpretation and relevant from irrelevant material; has a flexible style depending on the needs of the recipient.</td>
<td>2</td>
</tr>
</tbody>
</table>
3.10 The trainee demonstrates an understanding of the range of roles that psychologists might undertake, such as teaching, supervision, consultancy, research project work and service development.

## THE DEVELOPMENT OF AWARENESS AND COMPETENCE IN SERVICE AND ORGANISATIONAL ISSUES

<table>
<thead>
<tr>
<th>RATING</th>
<th>Explanation/Expansion of Rating/Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| 4.1 The trainee demonstrates a balanced and realistic awareness of how organisational factors impinge on client work both directly and through staff practices. | 3 | Y6 Y6 Y6 !
| 4.2 The trainee works appropriately and effectively within the boundaries and constraints of organisations and settings. | 3 | Y6 Y6 Y6 |
| 4.3 The trainee works appropriately and effectively within the boundaries and constraints of a multi-disciplinary team. | N/A |  |
| 4.4 The trainee understands, and is knowledgeable, in relation to the skills and work practices of other professions and other staff groups. | 2 | Many specific minor.
| 4.5 The trainee is able to analyse and describe, with some independence, some psychological processes active within groups, settings or organisations. | ? 2 | Not covered in depth |
| 4.6 The trainee is able to describe, with some level of independence, the psychological skills and methods required to produce change within groups, settings or organisations. | ? 2 | Not covered formally |
| 4.7 Presentation: The trainee prepares the material in terms of structure and content, relevant to the needs of the audience; displays effective verbal and non-verbal skills; shows effective use of time; chooses appropriate style (didactic or facilitative) relevant to the audience. | N/A |  |
4.8 **Teaching:** The trainee prepares the material in terms of structure and content, relevant to the needs of the audience; displays effective verbal and non-verbal skills; shows effective use of time; chooses appropriate style (didactic or facilitative) relevant to the audience. The trainee chooses assessment and evaluation materials.

4.9 If the trainee has undertaken work in any of the following areas, please tick and briefly describe the work, and comment on the skills used and level of expertise displayed:
- consultancy
- supervision
- project work
- service development work

5. **THE SHIFT TO WORK BEING GROUNDED IN PSYCHOLOGICAL PRINCIPLES FROM BEING ORIENTATED IN RELATION TO SPECIFIC TECHNIQUES**

<table>
<thead>
<tr>
<th>THE SHIFT TO WORK BEING GROUNDED IN PSYCHOLOGICAL PRINCIPLES FROM BEING ORIENTATED IN RELATION TO SPECIFIC TECHNIQUES</th>
<th>RATING</th>
<th>Explanation/Expansion of Rating/Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>5.1 The trainee is able to perceive issues from different perspectives; draws information from a variety of sources and develops it into an individualised framework; can see how facts can be conceptualised in different ways - using supervisor primarily as a sounding board for own thinking processes.</td>
<td>2</td>
<td>part of the placement</td>
</tr>
<tr>
<td>5.2 The trainee approaches work from a theoretical stance with a broad vision of the general applicability of principles of practice, integrating theories from general psychology and those specific to settings or client groups.</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>5.3 Generic skills: The trainee draws on therapeutic skills techniques and methods from the range of client groups, and uses them with appropriate modifications for the individual client.</td>
<td>3</td>
<td>demonstrated use</td>
</tr>
</tbody>
</table>
LOG BOOK
UNIVERSITY OF SURREY / S T R H A
PsychD in Clinical Psychology

Trainee's Name...LOUISE BILES... Placement Type...SPECIALIST (HEALTH)
Supervisor's Name...CATHERINE RAGLAN

Date.............................................. Placement District...KINGSTON..............

Summary of Clinical Activity

Please indicate at the end of your placement what you have covered under the following seven categories:

1) Clinical activity with individual clients, couples and families - use attached sheet C

2) Group work - use attached sheet B

3) Teaching/Skills transmission/presentations

Outline each experience of teaching, indicating what, to whom, how organised, the extent of your role and its degree of success:

I observed my supervisor presenting a seminar to nurses on the Obstetrics and Gynaecology ward on bereavement and loss. Informal feedback suggested that the nurses found this very useful.

4) Organisational Work (e.g. developing IPP system, staff support, assessing case recording system). Outline each piece of work, indicating the extent of your role and outcome:
5) RESEARCH

Outline any projects which you initiated or with which you were involved and indicate the extent of your involvement:

6) MEETINGS, VISITS, OBSERVATIONS

Outline briefly each experience and the extent of your involvement:

**Meetings**

I attended two specialty meetings.

Along with my supervisor, I met with a counsellor from the cancer ward to discuss her work and role.

**Observations**

I sat in on clinics with the respiratory nurse, consultant and senior registrar in the chest clinic. During this time, I supplied psychological help to clients as and when required.
7) COURSES AND TRAINING EVENTS ATTENDED AS PART OF PLACEMENT

Please list and outline each one:

8) OTHER

Please outline any other experience on placement:

Signed .................................. Trainee ........................... Date ........................................

Signed .................................. Supervisor ....................... Date ........................................
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<thead>
<tr>
<th>Therapists</th>
<th>Your Role (Active/Observer)</th>
<th>Membership (Ages and Sexes)</th>
<th>Selection of Members</th>
<th>Nature of Group work</th>
<th>Number of Sessions</th>
<th>Outcome Evaluation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Specialist diabetes nurse, specialist diabetes dietitian, and clinical psychologist in training</td>
<td>I was an active therapist which involved presentation of information and facilitation of group discussion</td>
<td>4 females: Approximate age range 32 - 67 yrs</td>
<td>Selection criteria: 1) Score on General Health Questionnaire 2) 16 years + 3) experience either insulin dependent or non insulin dependent diabetes 4) be overweight (BMI score) 5) verbally express motivation to lose weight and improve control of diabetes 6) comfortable in group environment 7) willing to do homework</td>
<td>A group aiming to enable overweight clients with diabetes to adopt a healthier lifestyle. The primary model used in the group was Prochaska and DiClemente's Process Model of Change.</td>
<td>8</td>
<td>Prior to the group, the following 2 questionnaires were administered: The Well Being Questionnaire and The Treatment Experience of Treatment - Benefits and Barriers, both by Clare Bailey In addition, physical measures were taken eg of overweight and blood sugar level. All these measures will be readministered after the group for comparison.</td>
</tr>
<tr>
<td>Sex</td>
<td>Age</td>
<td>Assessment</td>
<td>Intervention</td>
<td>Type of Contact</td>
<td>Presenting Needs</td>
<td>Model of Therapy</td>
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<tr>
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<td>------------</td>
<td>--------------</td>
<td>----------------</td>
<td>-----------------</td>
<td>-----------------</td>
</tr>
</tbody>
</table>
| M   | 60  | assessment for treatment | F1 | S | long history of anxiety and depression related to daughter's adoption | only | 2 | referred on for counselling
<p>| M   | 70  | assessment for treatment | F1 | S | depression of anxiety difficulties adjusting to physical health problems | CBT | 3 | client deceased |
| F   | 65  | assessment for treatment | F1 | S | long history of depression difficulties adjusting to health problems particular asthma | eclectic | 3 | referred to Older Adult service |
| F   | 49  | as above | F1 | S | depression, difficulties adjusting to physical disability | non-directive counselling | 5 | much improved |
| F   | 48  | as above | F1 | S | health breakdown fell in part to be due to psychological stress | CBT | 12 | much improved |
| F   | 54  | as above | F1 | S | anxiety triggering asthma | CBT | 3 | much improved |</p>
<table>
<thead>
<tr>
<th>Sex</th>
<th>Age</th>
<th>Assessment</th>
<th>Intervention</th>
<th>Type of Contact</th>
<th>Presenting Needs</th>
<th>Model of Therapy</th>
<th>No. of Hours</th>
<th>Outcome/ Evaluation</th>
<th>Additional Info/Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>M</td>
<td>24</td>
<td>as above</td>
<td>F1</td>
<td>S</td>
<td>anxiety, depression, OCD, lack of social skills</td>
<td>CBT/ nondirect.</td>
<td>6</td>
<td>referred to CBT/MT</td>
<td>Problems were to be more appropriately addressed in a medical, rather than health, setting.</td>
</tr>
<tr>
<td>F</td>
<td>46</td>
<td>as above</td>
<td>F1</td>
<td>S</td>
<td>overweight, since 13 yrs.</td>
<td>Exploratory work</td>
<td>10</td>
<td>much improved</td>
<td></td>
</tr>
<tr>
<td>F</td>
<td>74</td>
<td>assessment only</td>
<td>FC</td>
<td>S</td>
<td>long history of anxiety, depression, multiple physical health problems.</td>
<td>Assessment only</td>
<td>2</td>
<td>—</td>
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</tr>
<tr>
<td>F</td>
<td>45</td>
<td>assessment for treatment</td>
<td>F1</td>
<td>S</td>
<td>depression</td>
<td>Assessment only</td>
<td>2</td>
<td>referred on for counselling</td>
<td>not appropriate for health psychology setting.</td>
</tr>
<tr>
<td>F</td>
<td>48</td>
<td></td>
<td>F1</td>
<td>S</td>
<td>bereavement, difficulties adjusting to chronic obstructive airways disease (COPD)</td>
<td>Non directive counselling</td>
<td>6</td>
<td>much improved</td>
<td></td>
</tr>
<tr>
<td>F</td>
<td>49</td>
<td></td>
<td>F1</td>
<td>S</td>
<td>recurrent cough, anxiety related to hospital diagnosis, difficulty communicating with medical staff</td>
<td>Eclectic</td>
<td>6</td>
<td>some improvement</td>
<td>referred on to general adult service.</td>
</tr>
<tr>
<td>Sex</td>
<td>Age</td>
<td>Assessment</td>
<td>Intervention</td>
<td>Type of Contact</td>
<td>Presenting Needs</td>
<td>Model of Therapy</td>
<td>No. of Hours</td>
<td>Outcome/Evaluation</td>
<td>Additional Info/Comments</td>
</tr>
<tr>
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</tr>
<tr>
<td>M</td>
<td>68</td>
<td>as above</td>
<td>F1</td>
<td>S</td>
<td>difficulties adjusting to life</td>
<td>assessment only</td>
<td>1</td>
<td></td>
<td>Client did not want psychological help at this time.</td>
</tr>
<tr>
<td>F</td>
<td>69</td>
<td>as above</td>
<td>F1 e FC</td>
<td>S</td>
<td>adjusting to changes in health (after recent heart attack)</td>
<td>eclectic</td>
<td>9</td>
<td>much improved</td>
<td></td>
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<tr>
<td>F</td>
<td>39</td>
<td>as above</td>
<td>F1</td>
<td>S</td>
<td>overweight</td>
<td>personal consent (reporting grid)</td>
<td>5</td>
<td>some improvement</td>
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</tr>
<tr>
<td>M</td>
<td>45</td>
<td>as above</td>
<td>F1</td>
<td>S</td>
<td>PTSD following car accident</td>
<td>CBT &amp; non-directed</td>
<td>5</td>
<td>referred on for neuro-psychological assessment</td>
<td></td>
</tr>
<tr>
<td>F</td>
<td>40</td>
<td>—</td>
<td>F1 T R Nurse</td>
<td>T</td>
<td>post-natal depression and breathing difficulties</td>
<td>—</td>
<td>1</td>
<td></td>
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<tr>
<td>F</td>
<td>32</td>
<td>—</td>
<td>F1 T R Nurse</td>
<td>T</td>
<td>asthma, difficulties adjusting</td>
<td>—</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sex</td>
<td>Age</td>
<td>Assessment</td>
<td>Intervention</td>
<td>Type of Contact</td>
<td>Presenting Needs</td>
<td>Model of Therapy</td>
<td>No. of Hours</td>
<td>Outcome/Evaluation</td>
<td>Additional Info/Comments</td>
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</tr>
<tr>
<td>F</td>
<td>59</td>
<td>assessment for treatment</td>
<td>F1</td>
<td>S</td>
<td>anxiety related to asthma</td>
<td>CBT</td>
<td>3</td>
<td>much improved</td>
<td></td>
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<tr>
<td>F</td>
<td>40</td>
<td>-</td>
<td>F1</td>
<td>DS</td>
<td>anxiety with unusual symptoms, grief NE</td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>M</td>
<td>55</td>
<td>-</td>
<td>F1</td>
<td>DS</td>
<td>respiratory and heart condition, working on curbing down activity</td>
<td></td>
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</tbody>
</table>