Research Title:
Coping, perceived control, parenting stress and psychological symptomatology in mothers and fathers of children with Autistic Spectrum Disorder

Imogen Clarke 2003
Volume I.
Acknowledgements

Many thanks to my researcher supervisor Dr. Linda Dowdney and to my research tutor Dr. Mick Finlay for their supervision and support. I would also like to thank my field supervisor Dr. María Callias for her expertise, the services that helped in recruiting participants for my major research project, and the mothers and fathers who participated in this study.

Finally, to Justin and to my parents.
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I. Adult mental health essay

Compare and contrast cognitive behavioural and psychoanalytic concepts of depression in adults, and the evidence underlying each of these models

December 2000

Year 1
Introduction

The high prevalence of depression has led this disorder to be labeled the “common cold of psychiatry” (Seligman, 1975; cited in Fennel, 1989). Indeed 12% of adults experience depression sufficiently severe to require treatment at some point in their lives (Fennel, 1989). Symptoms include sadness, feelings of guilt and irritability, anxiety and tension, inability to react emotionally, low motivation, poor concentration and disturbed sleep and appetite (Fennel, 1989). Depression is seen as being of a clinical nature when it seriously interferes with an individual’s functioning. The first psychological theory of depression was provided by Freud’s psychoanalytic notion of depression as a pathological form of mourning. Here, the depressed individual is seen as responding to the loss of something or someone who was intensely loved and hated, resulting in him/her unconsciously identifying with the lost object (Smith, 1999). The psychoanalytic theories of depression to be discussed here are Klein’s (1935; cited in Hinshelwood, 1994) object relational concept of depression, and Bowlby’s (1980; cited in Gomez, 1997) attachment theory notion of this disorder. Cognitive behavioural therapy was developed in the 1960’s as a result of dissatisfaction with behavioural and psychoanalytic approaches to psychopathology and it was at this time that cognitive behavioural models of depression began to appear. The cognitive behavioural theories of depression to be discussed here are Beck et al.’s model of depression (Beck, Rush, Shaw & Emery, 1979) and Teasdale and Barnard’s (1993; cited in Teasdale, 1997) Interacting Cognitive Subsystems framework, which incorporates within it a theory of depression. The present discussion will not include an in-depth comparison of the treatment processes and outcomes resulting from these theories.

Cognitive behavioural theories of depression

Beck’s cognitive model

Beck’s cognitive behavioural model of depression is derived largely from clinical observation, but has also been contributed to by the extensive empirical investigation of
hypotheses raised by this model. It was developed as an explanatory heuristic and a basis for treatment of reactive depression. Beck et al. propose that our experience leads to the creation of “schemata” which are subsequently used to organise, predict and make sense of the world. These are defined as “relatively stable cognitive pattern(s) which form the basis for the regularity of interpretations of a particular set of situations” (Beck et al., 1979; pg.12). In people with depression, Beck et al. argue that early experiences have provided the basis for the formation of negative schemata. These remain latent without influencing mood or cognition until they are activated by a critical incident occurring in the individual’s life, and once activated, form the basis for him/her to interpret his/her experiences. In 1983, Beck (cited in Haaga, Dyck & Ernst, 1991) elaborated his theory of the activation of negative schemata through his notions of “sociotropic” and “autonomous” modes of personality. It is suggested that sociotropic individuals place greater emphasis on the value of positive exchanges with others, and those with an autonomous personality attach greater importance to choice and independent functioning. Beck proposes that if an individual experiences a stressor that is congruent with his/her personality, negative schemata relating to the meaning of the stressful event may be activated and a depressive episode precipitated.

Beck et al. (1979) assert that once activated, negative schemata produce systematic errors in thinking (later termed “cognitive distortions” Beck, 1987; cited in McDermut, Haaga & Bilek, 1997) and help to maintain the depressed individual’s belief in his negative concepts despite his/her being presented with disconfirmatory evidence. A further result of the activation of negative schemata is an increase in negative automatic thoughts that come into the mind of the depressed individual in an undeliberated manner. These represent negative views of the self, the world and ongoing experience (termed the “cognitive triad” Beck, 1987; cited in Haaga et al., 1991). It is suggested that these lead to the behavioural, emotional, motivational and cognitive symptoms of depression. A vicious cycle forms between an increasing number of negative automatic thoughts and other depressive symptoms which maintain the depressive episode.

From the above it may therefore be seen that although Beck's cognitive behavioural model acknowledges the potential roles of personality and early experience, he sees the
primary psychopathology, both in the aetiology and the maintenance of depression, as being cognitive. The emphasis of the model is firmly in the present and pays little attention to notions of the unconscious. The idea that errors may occur in the thinking of the depressed individual suggest that an absolute reality exists for the client to aspire to, thus revealing the roots of the model in cognitive psychology and it's positivist tradition. In saying this, it is important to note that Beck's theory is also influenced by Freudian structural theory and it's concept of hierarchical arrangements of cognition.

**Evidence underlying Beck's cognitive model**

An enormous amount of research has been carried out investigating hypotheses raised by Beck et al.'s (1979) model of depression and has produced considerable evidence of the cognitive triad of negative thinking, and some support for the notion of negative automatic thoughts. As yet, little research has been conducted examining personality vulnerabilities to depression (Haaga et al.1991).

Due to constraints of space, it is not possible to consider research relating to each causal and maintaining factor proposed. Therefore, in order to draw out the principal features of evidence underlying the Beckian model, the present discussion will be limited to studies typical of those examining negative schemata and cognitive distortion. Haaga et al. (1991) state that in order to consider negative schemata to be causal factors in depression, these must predate the depressive episode. However, because these are suggested to be latent before activation by a precipitating event, they may not be available to awareness before the beginning of a depressive episode. This renders measurement of negative schemata problematic. Barnett and Gotlib (1990; cited in Haaga et al., 1991) attempted such a measurement in their prospective longitudinal study examining negative schemata and depressive symptomatology before and after an event potentially precipatory of a depressive episode. Results indicated that the presence of negative schemata prior to such an event were not predictive of depressive symptomatology following the event. Similarly, O'Hara, Rehm and Campbell (1982; cited
in Haaga et al., 1991) report that negative schemata in women during their second trimester of pregnancy were not predictive of depressive symptoms postpartum if symptoms of depression during the second trimester were controlled for. The lack of significant findings in the above authors' attempts to gather empirical evidence of the causal nature of negative schemata may be due to the difficulties in measurement mentioned above, methodological flaws in the studies described, or indeed may suggest that negative schemata do not play a part in the precipitation of a depressive episode.

Empirical evidence for the presence of cognitive distortions in the thinking of depressed individuals is seen in McDermut et al.'s (1997) study testing the hypothesis that depression is positively associated with endorsement of irrational beliefs. Results indicated that depressed participants were more biased in justifying attributions made for the cause of a negative event and were less biased in their justifications of attributions made for a positive event. Support for these results was found in Cook and Peterson's (1986; cited in McDermut et al., 1997) study which indicated that depressed participants offer fewer rational justifications for their negative event attributions than non-depressed participants. As such, both of these studies appear to support Beck's claim that the thinking of depressed individuals is characterised by cognitive distortions. However, the role of such distortions in maintaining a depressive episode is not clear from the research discussed here.

The importance attached to cognitive factors in the aetiology and maintenance of depression is reflected in the aims of Beckian cognitive behavioural therapy to effect an improvement in the symptoms of depression through changing the thinking of the depressed client. This change includes the correction of cognitive biases and enabling the client to question his/her negative thinking, and in so doing break the vicious cycle described above.

**Teasdale and Barnard's Interacting Cognitive Subsystems framework (ICS)**

The ICS (Teasdale & Barnard 1993; cited in Teasdale, 1997) is an information processing model theoretically conceived, in part from research investigating hypotheses.
derived from Beck et al.'s (1979) model of depression. However, in contrast to Beck’s model which is specific to depression in its’ explanatory scope, the ICS framework was designed to facilitate the development of accounts of a number of phenomena with depression representing one of this number.

The ICS framework proposes that different sorts of information or mental codes represent aspects of our experience. At the lowest level are codes representing information gleaned from raw sensory experience. Second level codes represent regularities extracted from patterns in the sensory codes, which are created as these regularities are repeated during an individual’s experience. At the third level, recurring patterns identified in second level codes are represented by codes containing information related to meaning. These can be specific low-level meanings such as internal speech in the form of a negative automatic thought; or generic high-level meaning containing, for example, a pattern typical of previous rejection-related situations. As such, high-level meanings may include contributions from a number of low-level meanings including sensorily derived input. Teasdale and Barnard suggest that schematic mental models related to depression are created through the extraction of recurring themes and patterns from situations that elicit depression, which encode relevant high-level meanings. A depressive response is produced when high-level meanings related to these themes are synthesised into a depression-related schematic model. Thus the ICS framework suggests that no single factor is causal in precipitating depression. Rather, synthesis in cognitive structure of a combination of meanings derived from an individual’s internal and external experience produce depression. This emphasis on individual experience and the meaning attached to it in the aetiology of depression, may be paralleled with Beck et al.’s (1979) indication that difficult life experience does not lead to depression unless an individual is sensitive to such an experience due to the presence of dysfunctional schemas originating in early experience. However in contrast to Beck, Teasdale and Barnard do not explicitly discuss early experience in relation to the aetiology of depression. Rather, the ICS framework allows for the influence of past experience in general in its proposal that experience encoded in high-level meaning may be stored and subsequently accessed via retrieval cues. Once retrieved from memory, this can be synthesised with other high-level meaning in the formation of depressogenic schematic models.
Once a depressive response has been produced through the synthesis of a depressogenic schematic mental model, depression is maintained through the repeated production of these models. Although meanings derived from the environment such as loss or rejection, may contribute to the maintenance of the depression, like Beck, Teasdale and Barnard (1993; cited in Teasdale, 1997) suggest that the depressive state can be maintained internally. More specifically, Teasdale (1997) suggests that depressogenic schematic models produce negative specific meanings such as negative predictions regarding the future, and these are recycled into the synthesis of new depressogenic schematic models. This may be likened to Beck et al.'s (1979) proposal that negative schemata lead to the production of negative automatic thoughts. Secondly, as mentioned above, bodily feedback from the physiological effects of depression can also contribute to the synthesis of depressogenic schematic models. This process may be likened to the vicious circle described by Beck et al. (1979), in which the behavioural, motivational, affective, cognitive and somatic symptoms of depression lead to a greater frequency of negative automatic thoughts. According to Teasdale and Barnard's ICS framework, feedback from somatic depressive symptomatology enters straight into the formation of new depressogenic schematic models comprised of higher-level meanings. This is distinct from Beck et al.'s (1979) proposal that feedback from somatic depressive symptomatology enters directly into the specific meaning level or negative automatic thought level. Finally, the ICS framework states that "cognitive imperialism" (Teasdale, 1997), or the tendency of the information processing system to give preferential treatment to information likely to maintain depression, represents an additional maintaining factor. Again a parallel may be drawn between this proposal and Beck's (1979) notion of the distorting of disconfirmatory information to fit with cognitive distortions contributing to the maintenance of depression. Therefore, although the ICS framework points to the importance of cognitive factors in the aetiology of depression, the maintenance of depression is seen as being significantly contributed to by other components of the information processing system, including mood state or depressive affect (Teasdale, 1997).
Evidence underlying Teasdale and Barnard's ICS framework

Empirical evidence cited by Teasdale (1997) in support of the ICS framework falls into two categories: The first comprises research undertaken prior to the development of the ICS framework, results from which have been reinterpreted retrospectively. One such study conducted by Clark and Teasdale (1982) examined the effect of natural diurnal mood variation on the likelihood that depressed patients would rate recalled real life experiences positively and negatively. Findings indicated that memories of unhappy experiences were more likely to be retrieved by patients when feeling more depressed, and that the more depressed a patient was, the more likely it was that the current hedonic tone of a recalled experience would be recalled more negatively than the original hedonic tone. These findings seem to support Teasdale’s (1997, pg. 74) assertion that in line with ICS framework predictions, depressive cognitive biases can be conceptualised as “transient effects of mood state on information processing rather than as enduring characteristics of individuals prone to depression”. However, since this study was not designed to investigate the latter hypothesis, attempts to extrapolate findings to fit in with ICS framework predictions should be treated with caution. Teasdale, Taylor, Cooper, Hayhurst and Paykel’s (1995) study provides more persuasive evidence for the validity of I.C.S framework predictions. Here, the assertion that depression is associated with a shift to dysfunctional depressogenic schematic models representing the interrelationships and dependencies between patterns of constructs was investigated (Teasdale et al. 1995). Depressed and non-depressed participants completed a sentence stem constructed in such a way that dysfunctional schematic mental models indicating that personal worth is dependent on approval, would lead to positive completions of the sentence. Results suggested that depressed participants were significantly more likely to make more positive completions, and at three-month follow-up patients whose mood had improved showed a significant decrease in positive completions.

Therefore, it seems that whilst some limited evidence exists for the ICS framework, more enquiry into hypotheses raised by this model is required. Like Beck et al.’s (1979) model of depression, Teasdale and Barnard’s (1993) conception of mood disorder is based in the positivist tradition of cognitive psychology and therefore lends itself well to the sort of
empirical investigations outlined above. In sum, the ICS framework emphasises the role of events in cognitive structure and individual experience and meaning in the aetiology of depression. This model also emphasises the importance of other aspects of the information processing system, particularly affect, in the maintenance of a depressive episode. In addition it is proposed that depression can be maintained internally. Furthermore, this model does not refer to personality in relation to depression and does not address explicitly the part played by early experience. Teasdale et al. (2000) have developed a psychological intervention aimed at preventing relapse in depression that is theoretically based in the ICS framework. “Mindfulness-based cognitive therapy” (MBCT) aims to prevent depressive recurrence through the redeployment of information-processing resources required for the maintenance of depression, thus overriding the cognitive imperialism of the system (Teasdale, et al., 1995), and through creating alternative schematic mental models that are related to depression but are not depressogenic (Teasdale, 1997). MBCT integrates features of cognitive behavioural therapy for depression (Beck et al., 1979) with the mindfulness based stress reduction program (MBSR) (Kabat-Zinn, 1990; cited in Teasdale et al., 2000) and in practice terms, emphasises changing the depressed individuals’ awareness of and relationship to his/her thoughts (Teasdale et al. 2000).

Psychoanalytic theories of depression

Klein's theory of depression

In contrast to cognitive behavioural models, psychoanalytic theory originating in the work of Sigmund Freud, conceives of psychopathology as deriving from distortions and disruptions of normal psychological development (Blatt, 1998). Melanie Klein's (1935; cited in Hinshelwood, 1994) formulation of the "depressive position" is directly descended from Freud and Abraham's work, and like Freud, Klein emphasises the role of the unconscious in normal development, and consequently also in depression. An additional feature of development described by Klein is that of "introjection" in which the ego internalises what it experiences of the object (something or someone of importance to the child, often the mother) (Smith,1999). Given that during development what is
perceived of external objects is internalised, a threat to an external object denotes threat to its' internal counterpart.

A "position" in the Kleinian sense may be understood as "a constellation of anxieties, feelings object relations and defenses" (Hinshelwood, 1994 pg. 95). Klein stated that a child enters the depressive position after having negotiated the "paranoid-schizoid" position during the first three months of life. At this age the child begins to form whole object relations and to recognise and interact with his/her mother as a whole being, rather than as a number of good and bad part-objects (Segal, 1988). With this recognition comes the realisation that the hated object that has been attacked and destroyed in phantasy, is the same as that which was loved and idealised (Smith, 1999). This realisation results in "depressive anxiety" (Smith, 1999) in which the child develops fear and concern for the loved objects (internal and external) that have been under attack. However, because the internal loved objects are perceived to be damaged, these no longer seem able to provide protection (Hinshelwood, 1994). Klein suggests that the depressive position is resolved through "reparation", in which concern for the damaged objects brings remorse and the desire to repair the damage.

Klein (1935; cited in Hinshelwood, 1994) argues that the resolution of the depressive position through the transformation of guilt into reparation is dependent on the child having an external good object that may be internalised. This allows the secure establishment of an internal good object and a sufficiently good sense of self. If the child is bereft of an external good object, the feelings of guilt may become too powerful. In such circumstances, the child must employ defense mechanisms which ensure that he/she is not forced to endure these feelings consciously. Klein (1935; cited in Hinshelwood, 1994) proposes that clinical depression is experienced when the paranoid defense converts guilty concern for the damaged object into a persecutory fear for the self. In some respects, the depressive position is never entirely worked through, as losses in later life re-awaken anxieties about losing the good internal object, and alongside these, all of the anxieties associated with the original depressive position. However, if the original depressive position has been successfully resolved, subsequent situations of depressive anxiety in which the depressive position is re-entered will not result in mental illness.
The focus of this theory on the importance of early childhood experiences and relationships may be contrasted with Beck et al.'s (1979) and Teasdale (1997), both of whom pay greater attention to cognitive events and events in the depressed individuals' present and recent past. Within this, Beck et al. do explicitly acknowledge the role of early experience in providing occasion for the formation of negative schemata which are later activated by a precipitating event. This notion that the origins of depression lie in the very earliest of experience and that depressive disorder may be activated later in life is closer to Klein's concept of depression than it would first seem. Some similarity may also be seen in the acceptance of all three theorists that personal meaning attached to an individual's experience is important in the genesis of depression. However of the three, Klein pays least attention to this factor, and merely acknowledges this implicitly in her suggestion that the process of introjection involves internalisation of an external object as the individual perceives it. A further parallel may be drawn between Teasdale and Klein in their lack of account for the potential role of personality in the aetiology of depression, and none of these three theorists appear to account for biological factors in depression. Finally Klein does not appear to address the question of how depression is maintained.

In defining clinical depression in terms of the paranoid defense it seems that Klein is describing a general psychopathology rather than depressive disorder in particular. Unfortunately this inclusive approach presents difficulty when attempting to test hypotheses raised by the theory, and it is perhaps partly for this reason that it is difficult to find research providing empirical evidence for Klein's concept of depression. However, support for Klein's more general notion of psychopathology may be seen in a study examining pathological object relations in suicide attempters (Kaslow et al., 1998). Results indicated that suicide attempters were more likely to have a history of childhood loss combined with adult loss, and had more impaired object relations than non-attempters. Although this finding seems to support the Kleinian prediction (Kaslow et al., 1998) that object loss is important in aetiology of suicidal behaviour, it is interesting to note that 49% of the sample was clinically depressed. Thus it may that this study indicates that impaired object relations are associated with depression in general, not suicide attempts in particular.
Evidence underlying Klein's theory of depression

Support cited by Klein for the depressive position takes the form of case examples from her psychoanalytic work (Klein, 1935; cited in Hinshelwood, 1994 pg. 85). The following description of a patient's dream is given in support of her notions of concern for damaged objects and the reparative urge:

"The patient felt that he was 'managing the whole thing', taking care of the parents, who were much older and more in need of his care than in reality. The parents were lying in bed, not side by side, as they usually did, but with the ends of the beds joined together. The patient found it difficult to keep them warm".

Klein interpreted the patient's parents being older than they were in reality in terms of his concern for them, and the ends of their beds being joined together as the damage that he felt he had inflicted upon them. The patient's attempts to keep his parents warm are seen as reflecting his reparative urges. Difficulties associated with reliance on such case examples to support this theory of depression include their dependence on interpretations imposed upon them. This opens the possibility of bias on the part of the author in the interpretation process to make material fit into the predetermined theoretical framework. As such we are at the mercy of the authors' integrity. Further criticisms may be made of Klein's lack of evidence for her claim that depression originates in the early experience of an unresolved depressive position. However, it is noteworthy that as yet little empirical evidence exists for Beck's (1979) proposal that negative schemata formed in early experience are causal in the aetiology of depression despite the fact that unlike Klein, Beck's theory has its' roots in positivism. This raises the question of whether it is possible to demonstrate empirically that the origins of depression lie in early experience.

All forms of psychoanalytic psychotherapy see depression as being associated with neurotic difficulties and therefore does not treat depression as such, but aims to strengthen an individual's adaptive abilities (Smith, 1999). Thus, like Beck et al.'s (1979) cognitive behavioural therapy and Teasdale et al.'s (2000) mindfulness-based cognitive therapy, Kleinian psychoanalysis aims to effect a structural modification within the client,
with Beck attempting a cognitive restructuring, Teasdale a restructuring in information processing and Klein a restructuring of personality.

**Bowlby's Attachment Theory of depression**

Like Kleinian object relations, John Bowlby's Attachment Theory (1980; cited in Gomez, 1997) points to the importance of healthy relationships in normal development. Although Bowlby trained with Klein, he became critical of psychoanalysis claiming that psychoanalytic theories of child development place too great an emphasis on the influence of internal conflict, and too little on that of the environment. Thus, attachment theory represented a departure from traditional object relations and drew on scientific developments in ethology and systems theory to conceive of human development as a process of maintaining attachments towards primary attachment figures. More specifically, Bowlby asserts that we are born with biologically hard-wired behavioural patterns designed to promote and maintain relationships. As such we move through stages of development in an orderly sequence, during which these behavioural patterns unfold in interaction with the environment.

Bowlby (1988, pg. 62; cited in Gomez, 1997) states that “All of us from the cradle to the grave are happiest when life is organized as a series of excursions, long or short, from the secure base provided by our attachment figures”. He argues that our experiences of relationships and explorations of the world are encoded in an internal working model, which in normal development is consistent yet open to change. (Here a parallel may be seen with Klein’s concept of introjection [see above]). If however, we experience difficult relationships or insecure attachments, this internal model becomes distorted. This may happen in a number of ways. Firstly, Bowlby (1980; cited in Gomez, 1997) suggests that particularly between the ages of six months and three years, prolonged separation and the concomitant disruption in attachment bonds can result in permanent damage to the child’s capacity to relate to others. Other circumstances under which attachment bonds may become disrupted include the death of an attachment figure (Bowlby, 1980; cited in Gomez, 1997) and emotional deprivation during childhood (Bowlby, 1988; cited in
Gomez, 1997). Bowlby argues that vulnerability to depression is likely when attachment bonds are disrupted.

So, like other psychoanalytic theories, attachment theory suggests that depression is the result of disruption to normal development. Particular similarities may also be seen between Bowlby and Klein, both of whom suggest that vulnerability to depression originates in early childhood experience, with relational aspects of this experience representing the critical factor for both theorists. Thus the psychoanalytic theories discussed here may be contrasted with the cognitive behavioural models in terms of their differing emphasis on past and current experience in the aetiology of the depression. In addition, neither Beck nor Teasdale propose vulnerability models of depression, rather the concern of these authors rests with the precipitation and maintenance of depression. Attachment theory does not explore issues of individual difference. Furthermore, possible roles of personal significance attached to experience and of personality in depression, are not given any weight. It is interesting given Bowlby's psychoanalytic training, that he does not acknowledge the role of the unconscious in attachment theory, and in this respect his work may be contrasted with that of Klein. Finally it should be noted that Bowlby attaches far greater importance to environmental influences than any of the other theorists discussed here.

**Evidence underlying Bowlby's Attachment Theory of depression**

Empirical evidence for Bowlby's notions of attachment and an internal model of relationships can be seen in the "strange situation" experiments (Ainsworth, Blehar, Waters & Wall, 1978; Bowlby, 1988; cited in Gomez, 1997). Here observations of the behaviour of one year old children when left with a stranger and alone, and upon the return of their mother were used to indicate the nature of the child's internal working model of relationship. It was found that the children who were able to cope with the separation had mothers who were more responsive and attuned to their children, thus suggesting that they were more securely attached. Although these results are based upon the authors' interpretations of the observations made, the findings have been
replicated and have been accepted as providing a good indication of the nature of the child's attachment to his/her mother.

Difficulties encountered in gathering empirical evidence for the notion that the origin of depression lies in the disruption of attachment are similar to those seen in finding support for Beck et al.'s (1979) idea that negative schemata formed in early experience are important in the aetiology of depression. Within this, Parker (1979; cited in Klerman, 1984) found that a group of depressed patients were more likely to report low maternal care and/or over protection in comparison with a control group. These reports were confirmed by patients' mothers' descriptions of their interactions with their offspring during childhood. Similar findings are reported by Orvaschel, Weissman and Kidd (1980; cited in Klerman, 1984), who state that adult depressives are more likely to have experienced family discord, parental neglect, rejection and abuse during childhood than a control group. However, the reports of adults suffering from depression must be treated with caution due to the likelihood that they will recall past experience more negatively than non-depressed individuals (see above). Thus it seems that difficulties are associated with finding convincing evidence for theories that locate the origin of depression in childhood.

The focus of psychotherapy according to Bowlby (1977; cited in Klerman et al., 1984) is on helping the client to examine his/her current interpersonal relationships, to explore how these have developed from experience of attachment figures in both childhood and adulthood, and to modify self-defeating patterns in attachments. This emphasis on the importance of addressing issues surrounding our relationships with others, can be contrasted with the emphasis on personality of Kleinian psychoanalysis and on cognitive factors and on the information-processing system advocated by Beck and Teasdale respectively.

Conclusion

In conclusion, the principal distinction between cognitive behavioural and psychoanalytic concepts of depression lies in the fact that psychoanalytic theories conceive of
psychopathology as a disruption in normal development, with depression representing one such disruption. In contrast, cognitive behavioural theories address themselves more specifically to the provision of an explanatory account of the phenomenon of depression, without substantial reference to how this relates to other aspects of the individual. Due to the way in which both cognitive behavioural and psychoanalytic theories discussed here draw in some respect on the work of Freud, similarities may be found between them. However broadly speaking, the cognitive behavioural theories emphasise cognitive events and the psychoanalytic theories emphasise events in development and in early relationships in explaining depression. In contrast to Beck and Bowlby, there appears to be little empirical evidence underlying theories proposed by Klein and Teasale. Within this, cognitive behavioural and psychoanalytic theories proposing that depression originates in part in early experience, as yet have little convincing evidence to support this assertion. Although Beck and Bowlby have made attempts to find such support with varying degrees of success, Klein relies much more on anecdotal evidence in the form of case examples.
References


II. People with learning disabilities essay
Sexually abused and/or sexually abusing: What is the role of the clinical psychologist in working with people with learning disabilities who have been abused or who abuse others?

July 2001
Year 1
Introduction

Sexual abuse of is an issue which is increasingly recognised as a prevalent problem for the learning disabled population, and as such is a problem that clinical psychologists must be equipped to work with. Attempts to define sexual abuse as it effects people with learning disabilities have been confused by lack of clarity regarding whether to focus on the sexual act, the legal definition of sexual abuse, the outcome for the victim or the intentions of the perpetrator (Brown & Turk, 1992a). This has meant that a variety of definitions are in current use. However in the present context, Brown and Turk's (1992a, pg. 46) definition that “sexual abuse occurs where sexual acts are performed on, or with, someone who is unwilling or unable to consent to those acts”, will be employed. These authors differentiate between contact and non-contact sexual abuse. Non-contact abuse is proposed to include looking, photography, indecent exposure, harassment, serious teasing and innuendo. Contact abuse includes various forms of touch, masturbation of either or both persons, and penetration or attempted penetration. Consent is a pivotal issue in determining whether an act, situation or relationship is abusive. Abuse may be understood as occurring when a person withholds consent, is unable to give consent due to the nature and severity of their learning disability, or another barrier to consent exists such as the presence of differential power in favour of the perpetrator (Brown & Turk, 1992a). A similar multiplicity of definitions exists of learning disability, particularly with regard to categorisation of mild, moderate, severe and profound learning disability. As with definitions of sexual abuse, this has meant that research findings can be difficult to compare since like is not always compared with like. For the purposes of the present context the American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders (fourth edition; DSM-IV, 1994) definition of learning disability will be used. This defines learning disability as “a. Significantly sub-average intellectual functioning: an IQ of approximately 70 or below...b. concurrent deficits or impairments in present adaptive functioning ...in at least two of the following areas: communication, self-care, home-living, social/interpersonal skills, use of resources, self-direction, functional academic skills, work, leisure, health and safety; c. onset before age 18 years”. DSM-IV also distinguishes between mild leaning disability, which describes people with an IQ of 50-55 to approximately 70; moderate learning disability for people with an IQ level of 35-
40 to 50-55; severe learning disability for people with an IQ level of 20-25 to 35-40, and profound learning disability for people with an IQ level below 20 or 25.

The problems with the definitions outlined above have also made it difficult to establish the prevalence of sexual abuse in people with learning disabilities. This has been compounded by difficulties in determining when abuse has occurred due to the often partial, uncorroborated and conflicting nature of information surrounding allegations of sexual abuse (Sobsey & Varnhagen, 1989; cited in Brown and Turk, 1992a). Perhaps partly due to these difficulties, estimates of prevalence vary considerably, with figures varying from 25% (Chamberlain, Rauh, Passer, McGrath & Burket, 1984; cited in Turk & Brown, 1993) to 58% (Hard and Plumb, 1987; cited in Turk & Brown, 1993). But whatever the "true" figure, the latter findings suggest that this phenomenon is all too common.

In addressing the question set out above, the present discussion will be confined to the role of the clinical psychologist in working with people with learning disabilities who have been sexually abused in order to allow a more in depth examination of the issues. More specifically the discussion will centre upon work with adults who have been sexually abused at some time during their lives, with no particular distinction being drawn between sexual abuse as it occurs during childhood or adulthood. In order to determine the nature of the role of the clinical psychologist in working with people with learning disabilities who have been sexually abused, it will be necessary to examine potential aspects of the clinical psychologist's role in abuse prevention. These will include sex education and self-protection training for people with learning disabilities, staff training to facilitate the detection and reporting of abuse and the role of the clinical psychologist in addressing cultural beliefs regarding people with learning disabilities. An examination will also be conducted of the potential role of the clinical psychologist in providing treatment for victims of abuse, including individual and group therapy and work to interrupt the cycle of abuse.
The role of the clinical psychologist in the prevention of sexual abuse

Findings from Sobsey’s (1994a) survey of reports of sexual abuse of people with learning disabilities over a two year period indicate that in only one fifth of cases was an incidence of abuse an isolated occurrence for the victim. This finding suggests that an important role potentially exists for the clinical psychologist not only in the prevention of sexual abuse occurring in the first instance, but also in preventing victims of sexual abuse from being revictimised. However, in order to be able to provide appropriate preventive interventions, it is necessary to understand why people with learning disabilities are vulnerable to sexual abuse.

Sobsey (1994a) describes an ecological model of child abuse developed by Belsky (1980) and Garbarino and Stocking (1980) which can be applied to the understanding of the increased vulnerability of people with learning disabilities. This model gives equal weight to the role of three groups of factors contributing to vulnerability. The macrosystem or broader cultural setting, the exosystem or environmental context and the microsystem or abusive interaction between offender and victim. It is proposed that the interactional nature of these factors mean that it is not possible to attribute causality to a single domain. Victim related microsystem factors include physical defencelessness, lack of knowledge regarding sex and sexuality, poor communication skills, over-compliance and learned helplessness. Exosystem factors contributing to vulnerability include the fact that people with learning disabilities are more likely to be cared for outside their natural families, in institutions and by a large number of care givers. Indeed, Sobsey’s (1994a) survey indicated that in 43.78% of cases, abusers had a relationship with the victim specifically related to his/her learning disability. Rindfleisch and Rabb (1984; cited in Sobsey, 1994a) found that the risk of abuse occurring in institutions is two and a half times higher than in community settings. Macrosystem factors might include views of people with learning disabilities as worthless and thus incapable of suffering damage from further abuse, or unworthy of the protection that might be offered to others. Although Sobsey’s model is useful in aiding comprehension of vulnerability to sexual abuse, it is noteworthy that he does not present evidence of the contribution to vulnerability of all of the factors identified in the model. Thus this model might best be regarded as theoretical until relevant research evidence to support it is
collated or collected. The collation or collection of such research evidence regarding why sexual abuse occurs so prevalently in people with learning disabilities might also represent an aspect of the role of the clinical psychologist.

Education regarding sex and relationships for people with learning disabilities represents a preventative intervention that might form part of the role of the clinical psychologist. This addresses microsystem vulnerability factors including lack of knowledge regarding sex and sexuality. More specifically, the provision of education and a forum for discussion regarding sex and sexuality should provide people with learning disabilities with a conceptual and linguistic framework within which they are able to understand and describe (potential) abusive experiences, thus increasing the likelihood of disclosure of abuse. Evidence of people with learning disabilities' lack of knowledge regarding sexuality, is seen in Timmers, Du Charme and Jacob's (1981; cited in McCabe & Cummins, 1996) finding that learning disabled adults living in the community had lower levels of sexual knowledge and more negative attitudes to sex than the general population. Similarly, McCabe and Cummins (1996) found that in comparison to university students, people with a mild learning disability had less knowledge of sexual abuse and how to prevent this from occurring, were more likely to think that it is alright to have sex with everyone and to have positive feelings in relation to abuse experiences.

Although a need evidently exists for education and discussion regarding sex and relationships, the delivery of this is not without its' difficulties. In the case of people with mild and moderate learning disabilities, traditional means of delivering sex education that rely on verbal communication are appropriate. However, as Downs and Craft (1996) point out, the content and delivery of sex education for people with more severe and profound learning disabilities is not so straightforward. More specifically, the greater level of cognitive impairment in these individuals often means that their expressive and receptive verbal communication skills are poor. This issue is particularly pointed given Brown and Turk's (1992b) findings that the majority of victims of sexual abuse they surveyed had a severe or profound learning disability. As such it seems that an additional aspect of the role of the clinical psychologist in abuse prevention might involve the development of sex education programmes for people with severe and profound
learning disabilities, who are no less at risk from sexual abuse than those with mild and moderate disabilities.

Another intervention aimed at preventing people with learning disabilities from becoming (re)victimised that might form part of the role of the clinical psychologist, also addresses microsystem vulnerability factors including defencelessness, over compliance and lack of knowledge regarding sexuality including sexual abuse. Self-protection training has been delivered via behavioural skills training and through cognitive and motivationally based decision making training. Raymond et al. (1999) evaluated a 10 week behavioural sexual abuse prevention skills training program, including in situ training for people with mild and moderate learning disability. Results indicated that although participants acquired sexual abuse prevention skills through the skills training program, these did not generalise to naturalistic contexts until they had undergone in situ training. Skills were maintained one month after training. The authors propose that such in situ training allows stimulus control to be exerted over the behaviour in a naturalistic context. In other words, a sexual abuse lure in a naturalistic setting becomes the trigger for abuse prevention behaviours. Similar findings are reported by Collins, Schuster and Nelson (1992; cited in Raymond et al., 1999) in their evaluation of the teaching of a generalised response to the lures of strangers to people with severe learning disabilities. Therefore it seems that a behavioural approach to self-protection training represents an effective preventative intervention. Within this it is important to note that very often such training does not include in situ work to aid generalisation of skills learnt, and results of these programmes are very much less impressive (Singer, 1996). Thus it would appear that although costly and time consuming, this part of the intervention is pivotal in ensuring effectiveness.

Findings from a number of studies have suggested that people with learning disabilities experience difficulties in interpersonal decision-making (Hickson & Khemka, 1999 and Hickson, Golden, Khemka, Urv & Yamusah, 1998; cited in Khemka, 2000). Such skills are important in the successful handling of a situation of sexual abuse (Lumley and Miltenerber, 1997; cited in Khemka, 2000). As such, training in decision making skills should support people with learning disabilities in preventing sexual abuse from occurring through improving their chances of successfully managing abusive situations.
Wehmeyer (1992; cited in Khemka, 2000) found that perceptions of control and influence over the environment are crucial to self-determined decision making. However people with learning disabilities have been found to be more likely to have external perceptions of control (Wehmeyer, 1997; cited in Khemka, 2000) and lower self confidence in their ability to effect change in their environment (Swain, 1989; cited in Khemka, 2000). Thus, Khemka (2000) argues that decision-making training should involve cognitive elements in order to provide a framework for decision making and motivational elements to facilitate the use of these. Khemka (2000) compared a decision making training programme providing instruction in the use of a cognitive decision making strategy with a programme incorporating self-directed decision making and cognitive decision making strategies. Results indicated that whilst decision making skills improved in both programmes, this was more pronounced in the self-directed decision making programme. In addition, participants in the latter programme developed greater self-confidence and motivation to exert control over their environment. Additional support for these findings are seen in Wehmeyer and Kelchner’s (1994; cited in Khemka, 2000) study of interpersonal problem solving in people with learning disabilities which has produced similar results.

Evidently, decision-making skills are very much more flexible in their applicability to a variety of potentially abusive situations than pre-prescribed behavioural responses that have been learnt by rote. Therefore it is likely that cognitively and motivationally based decision making training represents the intervention of choice if self-protection training is to be conducted with people with learning disabilities. Within this it is also important to note that more pronounced levels of learning disability might prevent some individuals from engaging in the cognitively more demanding decision making training approaches. As such, it seems that a place also exists for behavioural skills training. To date, there does not appear to be evidence for the effectiveness of either form of training in actual abuse situations. Obviously such data is difficult to gather, however given the proposed interaction of a number of factors in producing vulnerability to abuse (Sobsey, 1994a) it is important for data to be gathered regarding the real life circumstances under which skills taught are employed by an individual in an abusive situation. Again, what of those with severe and profound learning disabilities who might be unable to engage in either of the approaches outlined above? Downs and Craft (1996) suggest that differentiating and
communicating preferred and non-preferred touch might form part of sexual abuse prevention training for this group. However, given the ease with which non-verbal communications can be missed or ignored (Brown and Lehr, 1989; cited in Downs and Craft, 1996), these authors also wonder whether such teaching would really increase participants' safety. Thus, as above it seems that a role exists for the clinical psychologist in abuse prevention in the development of self-protection training for people with severe and profound learning disabilities. Finally, it is likely that in order to understand the issues addressed in self-protection training, it is necessary for participants to have received more general education regarding sex and sexuality beforehand.

Exosystem factors identified by Sobsey (1994a) as contributing to the vulnerability of people with learning disabilities to sexual abuse include their being cared for in institutions and outside of their natural family, with risk of abuse being elevated in both of these settings. Thus a potential further aspect of the role of the clinical psychologist in working to prevent people with learning disabilities from being (re)abused is in providing training for carers in general and paid carers in particular, regarding sexual abuse, it's detection and reporting. Such educational work should help to reduce the contribution of the exosystem factors outlined above to the vulnerability of people with learning disabilities. Evidence of the need for such training may be seen in Brown, Hunt and Stein's (1994) study examining attitudes, knowledge, support, expectations and experience of sexual abuse of paid carers. Results indicated that although carers were aware that people with learning disabilities are at risk from abuse, they predominantly identified behavioural changes and physical signs as potential indicators of abuse. Whilst it is encouraging that these carers could identify some potential indicators, they appeared to lack awareness of mood changes as a sign of abuse, and that physical evidence is present only in a minority of cases (Turk & Brown, 1993). Carers were also confused regarding appropriate roles, were abuse to be discovered. Obviously it is difficult to generalise from findings of one study, however indications from this study of the existence of gaps in paid carers knowledge regarding detection and reporting of sexual abuse suggests that these might also exist in other staff groups. Brown and Turk's (1992a) finding that in two thirds of cases victims themselves reported sexual abuse suggests that the issue of staff awareness of indicators of abuse detection may be
particularly important for those caring for people with communication difficulties. More specifically, for those people who have communication difficulties, the onus is on carers to "hear" their non-verbal communication that they are experiencing sexual abuse and to be clear how to act appropriately upon these communications. Sobsey and Mansell (1990) point out that such non-verbal communications can easily be attributed to the disability and ignored. Hames (1996) evaluated training in sexual abuse, its detection and reporting conducted for staff working with people with learning disabilities in three day centres. As a result of training, awareness was increased of the vulnerability of people with mild disabilities and of men as well as women to sexual abuse. However, despite the presentation of research evidence, awareness regarding the risk posed by familiar people did not increase. The author concludes that training alone is not adequate to address this issue. As such it seems that an additional role for the clinical psychologist may exist in the development of alternative strategies for the effective delivery of training to carers regarding sexual abuse.

The final factor identified by Sobsey (1994a) as contributing to vulnerability to sexual abuse that might be addressed as part of the role of the clinical psychologist, is the prevailing cultural attitude towards people with learning disabilities. In the psychoanalytic literature Sinason (1999, pg. 195) refers to a death wish of mothers of learning disabled individuals and of society towards that individual which is internalised by him/her and which forms a "secondary handicap" that compounds the original organic deficit. This author also discusses a widespread unconscious fantasy that people with learning disabilities have destructive powers. Although these postulates are based on clinical observation and psychoanalytic theory rather than research evidence, Sinason is not the only author to have noted such facets of cultural views towards people with learning disabilities. Sobsey and Mansell (1990, pg. 61) describe myths that people with learning disabilities are less human than the rest of the population, that they are "damaged merchandise", that they do not experience pain or suffering, that they are dangerous and that they are helpless. Sobsey and Mansell (1990) propose that these myths may contribute to an offender's rationale for offending, as well as to inertia in the successful tackling of sexual abuse in people with learning disabilities. As Moss (1998, pg. 180) suggests "to the extent that people with intellectual disabilities are considered not fully human, abuse may be seen as less damaging and less reprehensible". Moss goes on to
propose that part of the role of the clinical psychologist working with people with learning disabilities who have been sexually abused lies in addressing beliefs about people with learning disabilities through their own behaviour, support of advocacy work and through publishing work. An example of how the behaviour of clinical psychologists might influence cultural beliefs cited by Moss, is the way in which clinical psychologists decide to share confidential information pertaining to someone with a learning disability. If this is shared too openly, this may collude with the notion that people with learning disabilities do not have the right to a private life. At present only limited evidence exists for the effectiveness of more direct strategies aimed at promoting positive attitudes amongst professionals towards people with learning disabilities including educational programmes and disability simulation (Westwood, Vargo and Vargo, 1981; cited in Sobsey & Mansell, 1990). Therefore it seems that again, a role exists for the clinical psychologist in developing proactive strategies aimed at engendering more positive cultural attitudes towards people with learning disabilities. In addition, given the apparent lack of research evidence investigating cultural views of people with learning disabilities, this may also represent an appropriate part of the clinical psychologist's role.

Role of the clinical psychologist in providing treatment for victims of sexual abuse

In providing treatment for victims of sexual abuse, the role of the clinical psychologist involves working with clients to manage the impact of abuse. To date, little research has been conducted investigating the experiences of people with learning disabilities who have been sexually abused. Fenwick (1994) suggests that the effects of sexual abuse seen in the general population may be exacerbated in people with learning disabilities due to their existing poor self-image and self-esteem and feelings of powerlessness. Some effects which seem to be similar to those experienced by the non-learning disabled population are seen in Cruz, Price-Williams and Andron’s (1988; cited in Mansell, Sobsey & Calder, 1992) observation that learning disabled women who were sexually abused during childhood experienced difficulties relating to guilt, need for intimacy, low self-esteem, feelings of isolation and anger. In addition, as a result of his survey, Sobsey (1994a) found that psychological sequelae of sexual abuse included withdrawal, aggression, sexually inappropriate behaviour and emotional distress.
Evidently more research examining the sequelae of sexual abuse is required. Such work is crucial to the development of appropriate treatment strategies (Mansell et al., 1992) and represents an important potential aspect of the role of the clinical psychologist in working with people with learning disabilities who have been sexually abused.

Historically, talking therapies have not been used with people with learning disabilities due to communication difficulties and difficulties with insight and metacognition (Mansell et al., 1992). This, along with a long-standing lack of acknowledgement of the problem of sexual abuse in this population has meant that interventions for people with learning disabilities who have been abused are in their infancy, with little systematic evidence existing for the effectiveness of a particular approach (Moss, 1998). Within this, some authors have made suggestions regarding appropriate foci for treatment of survivors of abuse. Moss (1998) suggests that helping a client to understand the process of recovery and attempting to overcome feelings of powerlessness through ensuring that the he/she has control over the therapeutic process, are important aspects of therapy. More formal individual approaches to the treatment of the impact of sexual abuse involve the adaptation of conventional therapeutic techniques. For instance, Moss (1998) proposes a range of cognitive and behavioural techniques for working with abuse issues. These include recalling and describing the abuse using guided visualisation (through movement and drawing if the client does not use verbal communication); expressing emotion; monitoring of moods, thoughts and behaviour; relaxation; distraction techniques; anger management; graded desensitisation; coping with flashbacks and nightmares, and recording the abuse. In addition, Sinason (1999) describes the use of psychotherapy for people with learning disabilities who have been sexually abused. One of the consequences of treatment observed by this author is a large increase in verbal vocabulary of clients, including the increased use of language that describes their abusive experiences. Facilitating the development of such a vocabulary could be an important part of any intervention for learning disabled individuals who have been the victims of sexual abuse. Evidently the clinical psychologist is faced with considerable practice issues in attempting to deliver individual treatment for sexually abused learning disabled clients. The careful use of a therapeutic contract is particularly important when abuse is an issue because of the possibility of disclosures that the alleged abuser is continuing to abuse. Ensuring that such a contract is established in an understandable
manner is difficult when working with people with learning disabilities. Similarly, the communication difficulties of many people with learning disabilities mean that the psychologist must be aware of, and adept, at using non-verbal communication in delivering interventions. Despite these difficulties, providing such interventions for learning disabled abuse survivors represents a significant part of the role of the clinical psychologist in their work with this population.

Barber, Jenkins and Jones (2000) suggest that group therapy for victims of sexual abuse may be particularly suitable as this provides a normalising environment. Certainly a precedent for the use of group work for victims of sexual abuse exists in the general population, and it seems that group approaches are being employed with some success in the treatment of sexually abused learning disabled individuals. Clare and Grant (1994) describe a group using narrative therapy for four women with moderate to borderline learning disabilities who had been sexually abused. This examined issues of safety, trust, group process, identifying feelings, listening skills, "secret busting" in telling stories, learning to cope with memories, body image, touch and confrontation. The authors report that participants developed greater awareness of feelings that were congruent with their observed behaviour and body language and greater awareness of and willingness to share thoughts and feelings. In addition, frequency counts of dissociative and self-mutilating behaviour decreased towards the end of therapy. Similarly, Cruz, Price-Williams and Andron (1988; cited in Mansell et al., 1992) adapted group therapy techniques including role play and group discussions for learning disabled women who had been sexually abused in childhood. Again, the employment of such therapeutic interventions may contribute to the clinical psychologist's role in working with people with learning disabilities who have been sexually abused.

A final aspect of therapeutic work potentially undertaken by the clinical psychologist with learning disabled sexual abuse survivors, may involve work to prevent these individuals from becoming abusers themselves. In their review of prospective studies of boys who have been sexually abused, Watkins and Bentovim (1992; cited in Browne & Herbert, 1997) found that one in five sexually abused other children later in life. Additional support for this apparent cycle of abuse is seen in Faller's (1989; cited in Browne & Herbert, 1997) finding that 27% of incestuous fathers and stepfathers were themselves
victims of childhood sexual abuse. The social learning theory of rape may be useful in understanding these results. This conceives of rape as part of aggressive behaviour that has been learnt through imitation of sexual aggression, associating sex and violence, and desensitising the observer to the pain, fear and humiliation of sexual aggression (Ellis, 1989). Thus it is possible that victims of sexual abuse come to abuse others through a similar social learning process. However, social learning theory cannot provide a complete explanatory account of the cycle of abuse, as it would seem to predict that all perpetrators of abuse were abused themselves, which is clearly not the case. An alternative theory proposed by Howells (1981; cited in Finkelhor, 1986) is the emotional congruence theory. This proposes that sexual abusers themselves victimise children in order to overcome their own childhood trauma, through reversing the victimisation roles that they experienced and identifying with the aggressor. In contrast to social learning theory, the latter theory seems to account for a proportion of abuse victims not becoming abusers themselves, since presumably these may overcome their victimisation through alternative means. It is important to bear in mind that the research and theory discussed above pertains to the general population, and little or no relevant research currently exists examining how or if these issues relate to people with learning disabilities. However, there does not appear to be any reason to presume that people with learning disabilities somehow escape such issues. Therefore, an aspect of intervention for abuse victims conducted by clinical psychologist might involve work to help prevent these individuals from abusing others. The author is not aware of specialised approaches to this sort of treatment, however in the development of such approaches, existing therapeutic techniques outlined above and treatments of sex offenders with learning disabilities (e.g. Lindsay, Neilson, Morrison & Smith 1998) might usefully be drawn upon. Research investigating how the cycle of abuse effects people with learning disabilities, and development of treatment approaches to interrupt this proposed cycle might represent appropriate aspects of the role of the clinical psychologist working with people with learning disabilities who have been sexually abused.

Other aspects of the role of the clinical psychologist in providing treatment for learning disabled victims of sexual abuse include improving access to appropriate treatment. Sobsey (1994b) found that only 10% of victims of sexual abuse with a learning disability
surveyed were able to access appropriate treatment services without difficulties. Although this survey was conducted in Canada and North America, and the extent to which findings may be extrapolated to UK services is limited, it may be that access to treatment is equally difficult in this country. Obviously a factor contributing to the difficulty in accessing appropriate treatment, is the lack of intervention strategies available for people with cognitive and communication difficulties for whom traditional talking therapies are not suitable. Thus a further aspect of the role of the clinical psychologist entails the development and evaluation of effective interventions for this population. Finally, it is important that when treatment is provided for an individual who has been sexually abused, training regarding the process of recovery is provided for carers so that they are better able to support the victim (Moss, 1998).

Conclusion

Therefore in summary, it may be stated that the role of the clinical psychologist in working with people with learning disabilities who have been sexually abused might include work to prevent individuals from being (re)victimised, including research examining why people with learning disabilities are vulnerable to sexual abuse; the delivery of education regarding sex and relationships and the development of sex education programmes for people with severe and profound learning disabilities; the delivery of self-protection training and the development of such training for people with severe and profound learning disabilities; providing training for carers regarding sexual abuse, its detection and reporting and developing alternative strategies for the effective delivery of such training; addressing cultural attitudes towards people with learning disabilities, developing proactive strategies aimed at engendering more positive cultural attitudes and conducting research investigating these attitudes and how they might be changed. The clinical psychologist's role might also involve providing treatment for victims of sexual abuse, including delivering individual and group interventions to address the impact of abuse; conducting research investigating the experiences of learning disabled victims of abuse; conducting research investigating how the cycle of abuse might effect people with learning disabilities and development of treatment approaches to interrupt this cycle; ensuring that people with learning disabilities who
have been abused can access treatment; developing and evaluating treatment of the impact of abuse, and ensuring that care staff are adequately well informed to support their client.

It is possible that the role of the clinical psychologist working with an individual from this population might involve any one or all of the facets outlined above, and indeed may involve additional aspects that have not been discussed. As such the potential role of the clinical psychologist working in this area is enormously wide ranging and multi-faceted. However, given the current national shortage of clinical psychologists and the particular difficulties in recruiting psychologists to work with people with learning disabilities, it is likely that practitioners will be faced with the question of which of these potential aspects should be undertaken. Given such a decision, two factors are worthy of consideration. Firstly, it has been recommended by the Manpower Planning Advisory Group (MPAG, 1990) that clinical psychologists develop a consultancy model. In this context, this might entail clinical psychologists supervising others in the delivery of interventions, training and education and in carrying out research. In addition, it may also be appropriate for other services to carry out certain aspects of the work outlined, for example sex education, staff training and therapeutic interventions. This aside, the aspect of the role discussed here that perhaps should not be dispensed with is the responsibility of the professions to try to engender more positive cultural attitudes towards people with learning disabilities.
References


III. Child and family essay

Anxiety disorders in childhood are fundamentally different from anxiety disorders in adulthood. Discuss with reference to the theory and treatment of two anxiety disorders.

December 2001
Year 2
Introduction

Fears and anxieties are an adaptive part of normal child development and are necessary to preserve children's safety and survival (Lodge & Tripp, 1995). The number and nature of fears experienced by children change in parallel with their development (Carr, 1999). A distinction may be drawn between adaptive fears and those based on an inaccurate assessment of the threat posed by a situation or stimulus (Carr, 1999). Such maladaptive fears are often described as anxieties. Anxiety disorders are reported to be the most common psychiatric condition in children and adolescents, with estimates of prevalence ranging from 5 to 18% (Liberate, Ginsburg, Walkup & Riddle, 1999).

The anxiety disorders to be examined here are panic disorder and obsessive compulsive disorder (OCD). In addressing the above question, a definition of each disorder and a presentation of phenomenology in adulthood will be undertaken. Cognitive behavioural theories of the disorders in adulthood and evidence for some predictions raised by these will be examined. From this, a number of characteristics of panic and OCD in adulthood will be identified. It will then be possible to compare these characteristics with each disorder as it occurs in childhood, and to discuss reasons underlying similarities and differences found. Finally, the rationale, process and research regarding effectiveness of cognitive behavioural therapy for these disorders in adulthood will be presented. These aspects of treatment in childhood and adulthood will then be discussed. Cognitive behavioural models and therapy have been selected for discussion due to their current prominence in the explanation and treatment of panic disorder and OCD in adults. For the purposes of this discussion childhood will be defined as spanning birth to eighteen years. Due to developmental changes that occur during childhood, differences may exist in how anxiety disorders occur over this period. As such, wherever possible reference will be made to ages of children participating in research summarised and distinctions made between anxiety in children and adolescents.
Panic Disorder

Phenomenology of panic disorder in adulthood

DSM-IV (American Psychiatric Association, 1994) defines a panic attack as an abrupt onset period of intense fear or discomfort which reaches its peak within ten minutes, and is accompanied by at least four of thirteen symptoms. Symptoms described are breathlessness, accelerated heart rate, chest pain, a feeling of choking, dizziness, nausea, hot or cold flushes, tingling or numbing sensations, sweating, trembling, fear of dying, fear of losing control and fear of going mad. Panic attacks defined in this way are a feature of many anxiety disorders. However, a diagnosis of panic disorder is reserved for those experiencing recurrent panic attacks, some of which are unexpected and which are followed by persistent concern regarding the possibility of having another attack, or significant related behaviour change. The six month prevalence of adults diagnosed with panic disorder is estimated at 0.6 to 1% (Hoen-Saric & Mcleod, 1988; cited in Acierno, Hersen & Van Hasselt, 1993). Onset in adults is typically in the late twenties to early thirties (Rapee, 1985; cited in Acierno et al., 1993).

Cognitive behavioural theory of panic disorder in adulthood

There are a number of cognitive models of panic disorder in adults, however Clark’s (1986, cited in Clark, 1996) model has become one of the most widely employed and will be discussed here. This model differentiates between panic attacks preceded by elevated anxiety and those that appear unexpectedly. In attacks preceded by heightened anxiety, external stimuli are perceived as threatening, producing bodily sensations associated with anxiety which are catastrophically misinterpreted, leading to a vicious circle of escalating panic. In unexpected attacks, stressful life-events, hormonal changes, illness and other events produce bodily sensations that are catastrophically misinterpreted. Thus the vicious cycle of panic is produced outside of the individual’s awareness of the origin of the panic. Once an individual has experienced a panic attack, three factors contribute to their maintenance. Firstly, the individual may attend selectively to bodily sensations leading to a greater likelihood that sensations will be
perceived and catastrophically misinterpreted. Secondly, an individual may engage in safety behaviours which aim to prevent the occurrence of the feared catastrophe, and which can intensify physiological symptoms and prevent the belief in the catastrophe from being disconfirmed. Finally, the individual may avoid anxiety-provoking situations preventing disconfirmation of their belief in the catastrophe (Wells, 1997). As such, Clark’s theory incorporates the physiological and cognitive symptoms of panic identified in DSM-IV, and provides a plausible theoretical account of the development and maintenance of panic disorder in adults.

Several predictions derived from Clark’s theory of panic have been tested empirically. The most central is his proposition that adults with panic disorder have an enduring tendency to catastrophically misinterpret bodily sensations. Support for this proposition is seen in McNally and Foa’s (1987; cited in Clark, 1996) finding that adults with panic disorder are more likely than non-patients to interpret bodily sensations and potentially threatening external events negatively. Similarly, Clark et al. (1996; cited in Clark, 1996) found that individuals with panic disorder were more likely to interpret ambiguous physiological sensations catastrophically and were more likely to believe these interpretations than those with social phobia and generalised anxiety disorder. Taken together, these findings provide support for Clark’s proposition that catastrophic misinterpretation of bodily sensations play a central role in panic disorder.

From the above, a number of characteristics of panic disorder in adulthood may be identified. Firstly, the DSM-IV definition suggests that sufferers experience a range of physiological and cognitive symptoms, that attacks occur repeatedly in an expected and unexpected manner and that the prospect of further attacks causes the sufferer concern, or to change their behaviour. In addition, Clark’s cognitive model indicates that individuals with panic disorder catastrophically misinterpret and selectively attend to bodily sensations, engage in safety behaviours and avoid anxiety provoking situations. In order to address the question of whether panic disorder is fundamentally different in adulthood from panic disorder in childhood, it is necessary to determine whether these characteristics are present in adolescents and children.
Panic disorder in childhood

Prevalence and age of onset of panic disorder in childhood has been the subject of debate, and data pertaining to these are not available. This situation has been contributed to by methodological difficulties, which have hampered investigation of panic in children and adolescents. In particular, small sample sizes, the use of numerous criteria for the occurrence of panic attacks and panic disorder, reliance upon self-reporting, and poorly described and unreliable assessment procedures make it difficult to draw conclusions regarding the occurrence of panic disorder in these populations (Kearney & Silverman, 1992).

Panic disorder in adolescents

Persuasive evidence indicates that substantial numbers of adolescents experience physiological and cognitive symptoms of panic such as those seen in adulthood. In their study of a normative sample of adolescents aged twelve to seventeen, King, Ollendick, Mattis, Yang, and Tonge (1997; cited in Ollendick, 1998) found that 16% of participants reported having experienced at least one panic attack. Symptoms included trembling, dizziness, faintness, accelerated heart rate and sweating. Thirty nine percent of this sample reported fear of dying and 57% reported fear of going mad or losing control. Similar findings are reported in a clinical sample of “post-pubertal children” by Last and Strauss (1989; cited in Ollendick, Mattis & King, 1994), 59% of whom reported fear of dying and 65% reported fear of going mad. Despite the fact that many investigations have not differentiated between expected and unexpected panic attacks, some evidence exists suggesting that both are found in adolescents as well as in adults. Twenty one percent of adolescents participating in King et al.'s (1997; cited in Ollendick, 1998) study experienced unexpected panic attacks as did 28% of a normative sample aged thirteen to eighteen described by Macaulay and Kleinknecht (1989; cited in Ollendick et al., 1994). It also seems that like adults, adolescents may feel concerned at the prospect of experiencing further panic attacks, and Warren and Zgourides (1988; cited in Ollendick et al., 1994) found that 24% of a normative sample of twelve to nineteen year olds were
worried about this eventuality. Similarly, limited evidence has been found of adolescent avoidance of situations in which a further panic attack is feared (Ollendick, 1995).

Therefore, it seems that adolescents experience physiological and cognitive symptoms of panic as they occur in adulthood, that they experience expected and unexpected panic attacks, that they fear the occurrence of these and engage in behaviour to avoid them. As such, it seems that panic disorder as defined by DSM-IV probably does occur in adolescents. However, given methodological difficulties described above, further research is required before this may be stated definitively. What remains entirely unclear is whether panic experienced by adolescents is consistent with that predicted by Clark's cognitive model. More specifically, although evidence exists of the cognitive symptoms of panic in adolescents, it is not clear whether, as in adults, these symptoms are a consequence of the catastrophic misinterpretation of bodily sensations. In addition, no research has been conducted to date investigating selective attention to bodily sensations or engagement in safety behaviours in adolescents. Thus, further research is required in order to answer the question of whether panic disorder in adolescence is consistent with Clark's model of the disorder in adulthood.

Panic disorder in children

Very little work investigating panic in prepubescent children has been reported. In their exploration of panic disorder in hospitalised children aged seven to twelve, Alessi and Magen (1988; cited in Ollendick et al., 1994) found that 5% of their sample were experiencing panic attacks. Of these, 50% evidenced physiological symptoms of panic and 50% evidenced cognitive symptoms, specifically a fear of dying. Similarly, Vitiello, Behar, Wolfson and McLeer (1990; cited in Ollendick et al., 1994) and Ballenger, Carek, Steele and Cornish-McTighe (1989; cited in Ollendick et al., 1994) also describe small samples of prepubescent children experiencing physical and cognitive symptoms of panic. In addition, Biederman (1987; cited in Ollendick et al., 1994) describes three children aged eight to eleven years experiencing unexpected panic attacks and Vitiello et al. report that children in their sample also experienced panic out of the blue.
Whilst it is difficult to draw conclusions in light of such limited literature and in the absence of data pertaining to prevalence and normative samples, it seems that a small number of children may experience the physiological and cognitive symptoms of panic which characterise panic disorder in adults. However, given such a dearth of literature, it seems likely that their occurrence is less frequent than in adolescents. Similarly, although some evidence exists indicating that children experience unexpected panic attacks, again it seems unlikely that these occur as frequently as they do in adults or in adolescents. In addition, due to a lack of research it is not clear whether cognitive symptoms are a consequence of catastrophic misinterpretation of bodily sensations, whether panic in children is maintained by selective attention to bodily sensations and engagement in safety behaviours, whether children feel worried at the prospect of having another attack, or whether they avoid situations associated with panic. Thus more research is required in order to clarify these issues and to ascertain whether panic disorder in adults as defined in DSM-IV and described by Clark's cognitive model also exists in children.

Why then do children only rarely experience unexpected panic attacks accompanied by the full range of cognitive and physical symptoms seen in adults and adolescents? Following Clark's model, Nelles and Barlow (1988) propose that the ability to catastrophically misinterpret bodily sensations is required in order to experience unexpected panic attacks. They go on to suggest that cognitive symptoms of panic and unexpected panic attacks are rare in children because they lack this ability. These authors base this proposal on Bibace and Walsh's (1981; cited in Nelles and Barlow, 1988) work defining a developmental progression of children's conception of illness tied to Piaget's stages of cognitive development. Bibace and Walsh propose that during Piaget's preoperational stage, which is characterised by an inability to differentiate between self and world (usually seen in children aged two to seven), children attribute illness to an external cause. During the concrete operational stage, which is characterised by an ability to differentiate between self and world (usually reached by children aged seven), children are able to link external causes of illness to internal consequences. During the formal operational stage, in which children are able to think hypothetically (usually reached in children aged eleven or twelve), children are able to conceptualise illness in terms of functions, structures and processes which are not
visible, and to perceive psychological factors as causes of illness. Nelles and Barlow suggest that children are not able to make the necessary internal catastrophic misinterpretations of bodily sensations associated with panic disorder until they reach the formal operational stage in adolescence. Despite a lack of empirical support, this theory provides a useful framework within which to begin thinking about the sorts of cognitive developmental issues which may have some influence on the manifestation of panic in children. In particular, this theory provides a viable explanation of the seemingly rare occurrence of cognitive symptoms of panic as seen in adults and adolescents, and of unexpected panic attacks in children.

In sum, it seems that panic disorder in adolescents as defined in DSM-IV is similar to that seen in adulthood. However, further research is necessary before conclusions may be drawn regarding similarities between adolescent and adult panic disorder as described by Clark's cognitive model. With respect to panic disorder in children, it seems that panic as defined by DSM-IV may be present in a small number of children. But it is likely that cognitive developmental stage reached influences manifestation of panic disorder in children.

**Cognitive behavioural treatment of panic disorder in adulthood**

A number of cognitive behavioural packages have been developed to treat panic disorder in adulthood. The one to be considered here is the Oxford based Cognitive Therapy Package developed by Salkovskis and Clark (1991; cited in Clark, 1996). Following Clark's cognitive model, the rationale underlying this approach to treating panic is two fold. Firstly, it aims to help patients to change their catastrophic misinterpretation of bodily sensations. Secondly, it aims to help patients to drop safety and avoidance behaviours. Cognitive strategies employed to achieve the first objective include reviewing recent panic attacks in order to derive the vicious circle model and to socialise into the cognitive model, identifying and challenging patients' evidence of catastrophic misinterpretations of bodily sensations and replacing these with more realistic interpretations, and restructuring catastrophic images. Behavioural techniques are used to induce feared bodily sensations in order to demonstrate origins of bodily
sensations, and consequently to challenge catastrophic misinterpretations. The second part of rationale for treatment is addressed through behavioural strategies including dropping safety behaviours and entering avoided situations in order to provide opportunities for patients' catastrophic predictions to be disconfirmed. As a result of their review of research investigating effectiveness of various treatments of panic disorder in adults, Roth and Fonagy (1996, pg. 143) state that "panic disorder ...respond(s) best to a combination of cognitive techniques ...and exposure treatment". Thus it is reasonable to conclude that cognitive behavioural treatment of adult panic disorder represents treatment of choice.

_Treatment of panic disorder in childhood_

_Treatment of panic disorder in adolescents_

As discussed above, it seems that adolescents experience cognitive symptoms of panic also seen in adults. To date, no direct evidence indicates that these thoughts are a consequence of catastrophic misinterpretation of bodily sensations. However, if we are to presume that they are indeed linked to bodily sensations in adolescents, it is possible to tentatively suggest that the modification of these represents a reasonable treatment rationale. In addition, some evidence exists indicating that adolescents engage in avoidance behaviour seen in adults. As such, helping them to drop such behaviour also represents a good rationale for treatment. As yet no research has been conducted investigating the presence of safety behaviours in adolescents. Consequently, the targeting of these in treatment would appear to be premature. Thus it seems that some aspects of the rationale for CBT of panic in adults are similar to those for adolescents. However, further research is required in order to establish whether the rationale for CBT of these populations should be entirely analogous.

Attempts to apply CBT techniques to the treatment of adolescent panic disorder are in their infancy. Ollendick (1995) reports one attempt. Techniques employed by this author in the treatment of four adolescents aged thirteen to seventeen with panic disorder and
agoraphobia, included socialisation into the cognitive model; progressive muscle relaxation training; applied relaxation training; cognitive restructuring; self-instructional training; problem solving training; interoceptive cue exposure; in vivo exposure; participant modelling, and involvement in treatment of family members. Some of these treatment strategies are also included in the CBT for adults outlined above, but there are also important differences. These include Ollendick's use of relaxation training, self-instructional training, participant modelling and involvement of family members. The presence of these differences suggests that if CBT for panic disorder in adults is to be applied to the treatment of adolescents, developmentally sensitive modifications should be made. Although Ollendick reports that the treatment described was effective, no other research examining the effectiveness of such treatment has been undertaken. Therefore further research is required before conclusions may be drawn regarding the effectiveness of CBT for panic disorder in adolescents.

In light of the questions outlined above surrounding the number of prepubescent children who experience cognitive symptoms of panic, at present it would seem inappropriate to target these as part of a rationale for treating panic in children. Furthermore, given Piaget's (1952, cited in Gleitman, 1991) proposal that children below the age of eleven or twelve are not capable of hypothetical thinking, it may be that children below this age would not be able to engage with cognitive treatment techniques which often involve metacognitive skills. In contrast, it may be that if evidence were found of avoidance and safety behaviours in children, that these aspects of panic disorder might be addressed with behavioural strategies similar to those employed for adults. In this respect, Carr (1999) suggests that exposure techniques may be suitable for treating childhood panic disorder, but should be preceded by relaxation training. In addition, as is the case for adolescents, developmentally sensitive modification of adult treatment techniques would be required in order to make these appropriate for use with children. Similarly, enlisting support of family members would be important in maintaining treatment integrity. Unfortunately, the dearth of research investigating psychological treatments of panic disorder in children prevents a discussion of the effectiveness of these proposed treatments.
In summary, it seems that CBT of adolescents with panic disorder may be similar to that employed for adults, although developmentally sensitive modifications may be required. In contrast, it appears that whilst behavioural strategies developed to treat panic disorder in adults may be suitable for use with prepubescent children, cognitive strategies may not be.

**Obsessive compulsive disorder**

OCD is described by DSM-IV as involving either obsessions or compulsions. Obsessions are recurrent or persistent thoughts, impulses or images that are experienced as intrusive or inappropriate and cause significant anxiety or distress. An individual may attempts to ignore or suppress these or to neutralise them with another action or thought. Compulsions are defined as repetitive behaviour or mental acts that an individual feels compelled to perform in response to an obsession and which are aimed at preventing or reducing distress. Twenty per cent of adults with OCD have developed the disorder during childhood, 29% in adolescence and 74% before the age of 30 (Karno & Golding, 1991; cited in Roth & Fonagy, 1996). As such, in contrast to panic disorder, there is no question that OCD occurs in childhood. The lifetime prevalence rate of OCD in adulthood is 3% (Karno, Golding, Sorenson & Burnham, 1988; cited in Roth & Fonagy, 1996). Common obsessions seen in adulthood concern thoughts about contamination, doubting, violence, aggression and sexual imagery. Frequently seen adult compulsions include hand washing, checking and ordering (Wells, 1997).

**Cognitive behavioural theory of obsessive compulsive disorder in adulthood**

As with panic disorder, there are a number of cognitive behavioural theories of OCD in adulthood. The theory to be considered here was developed by Salkovskis (1999). This author cites evidence that the occurrence of intrusive cognitions is a normal phenomenon (Rachman & de Silva, 1978; cited in Salkovskis, 1999), but states that what differentiates this phenomenon in those with and without OCD is the way in which they are interpreted. Salkovskis suggests that individuals with OCD interpret the occurrence
of intrusive cognitions as indicating that they may be responsible for harm to themselves or others. Such an appraisal results in negative affect and the motivation to engage in neutralising behaviours. Negative affect and neutralising behaviours in turn increase the attention focussed on intrusions and stimuli linked to them and consequently to an increased likelihood of further intrusions. This attention may involve closer scrutiny of mental processes including attempts to suppress intrusions. They are also proposed to increase perceptions of threat of responsibility. Thus a cycle of negative thinking and neutralising is created. Assumptions proposed to characterise responsibility appraisals include “failing to prevent (or failing to try to prevent) harm to self or others is the same as having caused it in the first place” and “having a thought about an action is like performing the action” (Salkovskis, 1996, pg. 63). The latter assumption has been termed thought action fusion, or the equating of thoughts with actions (Rachman, 1993; cited in Wells, 1997). Thus Salkovskis’ model incorporates phenomenological aspects of OCD noted in the DSM-IV definition in providing a theoretical account of the disorder in adulthood.

Various predictions made through the cognitive behavioural model of OCD have been tested empirically. However, the most central of these is the assertion that individuals with OCD have inflated appraisals regarding their responsibility for harm to others. Support for this proposition may be seen in Freeston, Ladoucer, Gagnon and Thibodeau’s (1993; cited in Salkovskis et al., 2000) finding that patients with OCD endorse more beliefs related to responsibility on a self report questionnaire than a group of matched controls. Similar findings are reported by Freeston and Ladouceur (1993; cited in Salkovskis et al., 2000). In addition, Salkovskis et al. (2000) demonstrated not only that individuals with obsessive compulsive disorder are more likely to endorse general responsibility beliefs and assumptions than non-obsessionals, but also that they are more likely to appraise intrusive thoughts about possible harm in terms of responsibility. These findings provide persuasive support for Salkovskis’ proposition that responsibility beliefs and assumptions are important in the development and maintenance of OCD.
Obsessive compulsive disorder in childhood

In discussing OCD as it occurs in childhood, it will not be possible to separate children from adolescents, as authors in this field have not distinguished between these populations in their reporting. The average age of onset for childhood OCD ranges from 7.5 to 12.5 years (Geller et al., 1998), and approximately 2% of children and adolescents are estimated to suffer from OCD (Thomsen, 1999; cited in Shafran, 2001). In childhood, obsessions most frequently concern contamination, death, violence, aggression, potential harm and danger or moral and religious violations. Common childhood compulsions involve ritualistic cleaning, repetition, ordering, arranging and counting rituals (Henin & Kendall, 1997). Therefore it seems that OCD as defined by DSM-IV occurs in childhood with the same frequency with which it occurs in adulthood, and that content of obsessions and compulsions in children are largely the same as those in adults.

It is now necessary to consider whether characteristics of OCD in adulthood proposed by Salkovskis' cognitive model are present in children. Salkovskis' model indicates that adults with OCD make appraisals of cognitive intrusions in terms of responsibility which are characterised by assumptions such as thought-action fusion. In addition, the model suggests that adults with OCD pay close attention to and attempt to control their mental processes. Unfortunately no research has been conducted to date investigating the presence of the cognitive aspects of OCD described above in children. Therefore at present, it is impossible to draw definitive conclusions with regard to whether characteristics of OCD described by Salkovskis' model of the disorder in adulthood also occur in children. This aside, similarities between responsibility appraisals and assumptions of thought action fusion in adulthood, and magical thinking in childhood, suggest that thinking similar to that described by Salkovskis may indeed be present in children. Superstition and ritual are prevalent in childhood, and are characterised by a belief that thoughts and apparently irrelevant actions can influence reality (Bolton, 1996). In this respect, these may be understood as types of magical thinking. Such childhood beliefs regarding the influence of thoughts and apparently irrelevant actions upon events may be likened to the responsibility appraisals and assumptions of thought action fusion seen in adults with OCD (Bolton, 1996). However, magical thinking represents a normal
part of child cognitive development. Indeed, distinguishing between mental events and events that occur in reality has been suggested to be a major developmental task in childhood (Piaget, 1937; cited in Bolton, 1996). More recent findings have indicated that a rational grasp of everyday causal principles is evident from early infancy, but that children appeal to magical thinking in order to explain apparent transgressions of these principles (Harris, 1994; cited in Bolton, 1996). As such, rather than reaching an age at which rational thought is achieved, children have a capacity for rational thought from a young age, but appeal to magical thought to explain the seemingly unexplainable. Although these findings do not provide direct evidence that children experience the cognitive aspects of OCD Salkovskis describes in adults, they do suggest that children engage in similar sorts of thinking as part of normal cognitive development. It is noteworthy that blurring of mental and physical events seen in magical thought and in the thinking of adults with OCD is developmentally appropriate in children but not in adults. This may represent a difference between the disorder as seen in childhood and adulthood that has implications for its conceptualisation and treatment.

Therefore, given that children are developmentally capable of thought such as that seen in adults with OCD, and that the phenomenology of OCD is similar in children and adults, it may be that the disorder is not fundamentally different in these populations. However, further research is required in order to clarify this issue.

Cognitive behavioural treatment of obsessive compulsive disorder in adulthood

Numerous cognitive behavioural approaches to treatment of OCD in adults have been developed based upon various cognitive behavioural theories of the disorder. Given that Salkovskis' model has been considered here, the treatment package based upon this will also be examined. The rationale underlying this approach is to reduce the perceived threat of obsessions by modifying responsibility beliefs and appraisals (Salkovskis, Forrester, Richards & Morrison, 1998). Cognitive strategies employed to this end include normalisation of the occurrence of intrusive thoughts, identifying and monitoring of obsessional thoughts whilst socialising into the cognitive model, and cognitive challenges of responsibility beliefs and appraisals. Behavioural experiments including exposure and
response prevention are also used in order to challenge responsibility beliefs and appraisals. Exposure and response prevention comprises exposing the patient to situations that will trigger obsessions and preventing him/her from carrying out compulsions or other neutralising actions. Behavioural experiments are also conducted in order to illustrate the counter productive effects of close scrutiny of mental events including thought suppression, and to demonstrate the way in which neutralising maintains anxiety and preoccupation (Salkovskis et al., 1998).

Theory driven research investigating the cognitive basis of OCD in adults is currently more advanced than research examining treatment effectiveness, and to date little systematic evaluation of the effectiveness of CBT for OCD has been conducted (Clark, 2000). In addition, methodological difficulties with published studies make it difficult to draw conclusions regarding the relative importance of cognitive and behavioural elements of treatment packages (James & Blackburn, 1995; cited in Roth & Fonagy, 1996). However, Roth and Fonagy (1996, pg. 156) suggest that “Cognitive therapy appears to be an effective adjunct to exposure treatment in the treatment of intrusive thoughts, ruminations and the prevention of relapse”.

Treatment of obsessive compulsive disorder in childhood

In contrast to panic disorder, considerable work has been undertaken developing CBT for children with OCD. Some of these have been based upon treatments used in adults, however the most widely employed approach was developed by March, Mulle, and Herbel (1994). This has its' roots in the neurobehavioural model of OCD which, alongside some neurobiological theories, currently dominates conceptualisations of the disorder in children (Shafran, 2001). Although in some respects the theoretical framework underlying this intervention is rather different to that underlying CBT for OCD in adulthood, similarities also exist. The neurobehavioural theory is based on the proposition that OCD is a result of the paring of non-threatening stimuli with anxiety provoking stimuli by a process of classical conditioning (Carr, 1999). This results in the elicitation of cognitive intrusions, which in turn are neutralised with compulsive rituals. These rituals bring relief from anxiety and so are reinforced. In addition, genetically
determined hyperarousability, socialisation experiences that have led to the development of high moral standards, and a belief system involving assumptions of thought action fusion and of responsibility for controlling unacceptable thoughts, are seen as vulnerability factors for the development of OCD (Rachman & Hodgson, 1987; cited in Carr, 1999). Similarities between the latter theoretical framework and Salkovskis' conceptualisation of OCD in adults relate to the proposition of both theories that assumptions regarding responsibility and thought action fusion are important in the development of OCD. However, the emphasis of the neurobehavioural model upon genetic predispositions, socialisation experiences and classical conditioning in explaining OCD may be contrasted with the more cognitive emphasis of Salkovskis' model.

The rationale for CBT for childhood OCD originating in the neurobehavioural model, is to reduce anxiety associated with the feared stimulus (the obsession). Behavioural strategies of exposure and response prevention are employed for the child to confront the feared stimulus until anxiety decreases without engaging in compulsions. Repeated exposure aims to decrease anxiety across exposure trials. Cognitive techniques are used in order to facilitate the child's compliance with the behavioural strategies of exposure and response prevention. These include constructive self-talk, cognitive restructuring and avoiding the maintaining effects of thought suppression. The need for family involvement and tailoring treatment packages to the needs of individual children is emphasised. (March, Franklin, Nelson & Foa, 2001). In addition it is noteworthy that, as with panic disorder, cognitive techniques may be unsuitable for children under the age of eleven or twelve due to their difficulty in thinking hypothetically. Therefore it seems that although cognitive and behavioural strategies employed in March et al.'s intervention for OCD in children are similar to those employed in Salkovskis' approach to treating adults, the rationale underlying these strategies are somewhat different. In particular, Salkovskis' approach emphasises the reappraisal of cognitions implicated in OCD, whereas March et al. highlight the need to address conditioned anxiety associated with OCD.

A robust randomised controlled trial of cognitive behavioural therapy for OCD in children has not yet been conducted, with the majority of reports in the literature having been case reports. Despite this, in concluding upon his review of the literature, March (1995;
pg. 7) states that "Although empirical support remains weak, CBT also may be the psychotherapeutic treatment of choice for children and adolescents with OCD (as for adults)". An example of findings supporting March's conclusions may be seen in a study conducted by March et al. (1994). Here, the effectiveness of the cognitive behavioural treatment package described above was evaluated in the treatment of fifteen children and adolescents. Although the interpretation of results are compromised by the fact that all but one of the group were also receiving medication, the combination of cognitive behavioural therapy and medication was more effective than medication alone (Roth & Fonagy, 1996). As such we may tentatively concur with March's above conclusion.

In summary, it appears that whilst cognitive behavioural strategies for treating OCD in adults and children are similar, the theoretical basis and rationale underlying these treatments are somewhat different. In addition the involvement of family members and the developmentally sensitive tailoring of treatment packages distinguishes the applications of these strategies to children and to adults. Finally, it seems that the quality and quantity of research evaluating CBT for OCD is somewhat limited in relation both to children and to adults.

Conclusion

Panic disorder in adolescents is phenomenologically similar to that in adults, although due to lack of evidence it is not possible to conclude whether similarities exist between adolescent and adult panic as described in Clark's cognitive model. In addition it seems that cognitive behavioural treatment of panic disorder in adolescents and adults is also largely the same. As such it seems that panic disorder in adolescents is not fundamentally different from panic disorder in adults. With respect to panic disorder in children, it seems that this disorder as it appears in adults may also appear in some children. However it may be that cognitive developmental stage reached influences manifestation of panic disorder in children. Similarly not all aspects of cognitive behavioural approaches to treating panic disorder in adults may be suitable for use with children. Thus, panic disorder in children does indeed appear to be fundamentally different from the disorder in adults.
In contrast OCD in adulthood and childhood appear to be essentially the same disorder. Further research investigating the presence of aspects of OCD described in Salkovskis' model in children is required, however it seems that children are capable of the same sort of thinking that is present in adults with OCD. Finally, although the rationale and theoretical framework underlying cognitive behavioural treatments of children and adults are different, techniques employed are the same. Thus, it would seem reasonable to conclude that OCD in childhood is not fundamentally different from the disorder in adulthood.

In conclusion it may therefore be stated that OCD appears not to be fundamentally different in childhood and in adulthood, whereas panic disorder in children seems fundamentally different from panic disorder in adults and adolescents. The latter conclusions suggest that some anxiety disorders are fundamentally different in childhood and in adulthood, and others are not. In addition it is noteworthy that cognitive developmental issues may influence manifestations of anxiety disorders in childhood other than those discussed here.
References


IV. Specialist essay

Compare and contrast narrative and solution focused brief approaches to eating disorders in adolescents with reference to the evidence underlying these approaches

July 2002
Year 2
Introduction

Eating disorders are characterised by low self-esteem, perfectionism and depressed affect (Carr, 1999). They have been classified by DSM-IV (American Psychiatric Association, 1994) as falling into categories of anorexia nervosa and bulimia nervosa. The peak age of onset for anorexia and bulimia is mid-adolescence and in this group the female to male ratio is 9:1 (Szmuk Jer & Patton, 1995; cited in Carr, 1999). Adolescence is the period of childhood occurring between the ages of 12 and 18 years. Although adolescents are referred to as a single group, large differences in emotional and cognitive developmental level are present within this. The prevalence of anorexia in teenage girls is 1% (Szmukler & Patton, 1995; cited in Carr, 1999). DSM-IV criteria for anorexia are a refusal to maintain body weight at or above the minimum normal weight for the individual's age and height; intense fear of gaining weight; distorted body image; excessive influence of body weight or shape on self evaluation, or denial of the seriousness of low body weight, and amenorrhea. Some individuals with anorexia restrict food intake and/or binge eat (eating to excess and experiencing a lack of control over their eating) and then purge (self-induced vomiting, misusing laxatives, diuretics or enemas, fasting or exercising excessively in order to prevent weight gain). The mortality rate for anorexia is 20% at 20 year follow up (Szmukler, Dare & Treasure, 1995; cited in Carr, 1999). The prevalence of bulimia in teenage girls is 1-3% (Szmukler & Patton, 1995; cited in Carr, 1999). DSM IV diagnostic criteria include recurrent binge eating and purging which occurs on average at least twice a week for three months. In bulimia, body weight or shape influences self-evaluation excessively, and substance abuse and self-harm are also common (Carr, 1999). This disorder is also associated with serious physical health problems including electrolyte imbalances which can be life threatening.

Here, narrative therapy (NT) and solution focused brief therapy (SFBT) for anorexia and bulimia in adolescents will be discussed. Since much of the NT and SFBT literature is generic in nature, throughout this discussion it will be necessary to consider how this applies to adolescents with anorexia and bulimia. In general, because of the lack of distinction between the application of NT and SFBT to these disorders, anorexia and bulimia will be discussed together. Firstly, a comparison of NT and SFBT conceptualisations of anorexia and bulimia will be undertaken. Next a comparison of NT
and SFBT for treating these disorders will be undertaken. Finally, the evidence underlying NT and SFBT for these disorders will be considered.

**Narrative and solution focused brief theoretical conceptualisations of anorexia and bulimia in adolescents**

**Narrative theoretical conceptualisations of anorexia and bulimia in adolescents**

NT has been developed by Michael White and David Epston, and was influenced by the work of the biologist and anthropologist Gregory Bateson. The philosophical roots of this approach lie in constructivism and social constructionism. Constructivism is the notion that "reality" is a product of our own mental processes rather than representing something which actually exists. Social constructionism is the idea that meaning and reality are socially constructed. Narrative theorists suggest that we construct our realities through our "storying" (creating of a story) of our lived experience. This storying process occurs within discourses shaped through socio-political and cultural contexts. Consequently, it is the individual's storied discourse that determines the meaning that they give to their experience (Epston, 1989; cited in Madigan & Goldner, 1998)

NT has not attempted to provide models of specific disorders in the tradition of cognitive behavioural theory (CBT), but provides theoretical assumptions which are applied in conceptualising any disorder. NT assumes that numerous versions of an individual's past, present and future exist and therefore the objectification and labelling of people and their problems is irrelevant. This has resulted in a reluctance to subscribe to diagnostic classificatory systems and to a lack of provision of models pertaining to particular disorders (Madigan & Goldner, 1998). Because each individual is seen as creating their own reality, it is assumed that the client is the expert regarding their difficulties and that everyone has the capability to construct new realities for themselves. In addition to emphasising human resourcefulness, NT assumes that the individual is not the problem. Rather, "the problem is the problem" (Madigan & Goldner, 1998). These assumptions regarding human resourcefulness have been suggested to instil hope in the therapist (O'Hanlon, 1999). This aspect of NT is of importance in treating severe and enduring
difficulties such as anorexia and bulimia, where the intractability of these can result in
client and therapist hopelessness. However, congruence between therapist beliefs and
these assumptions represents an issue in maintaining treatment integrity.

NT does not make statements regarding predisposing, precipitating and maintaining
factors for psychological difficulties in the traditional sense. White and Epston (1990)
suggest that problems develop in social, cultural and political contexts. Difficulties are
understood as being maintained by dominant narratives regarding the problem and the
person which emanate from the problem and their cultural contexts. Thus, the person
and problem are mutually influenced within a particular discourse. In the case of
anorexia an individual might be struggling alongside culturally embedded knowledge
regarding, for example, the ideal female body shape (Madigan & Goldner, 1998).
Through these processes, the problem comes to dominate the stories that people tell
about themselves (Eron & Lund, 1996). In writing on the maintenance of anorexia,
Madigan and Goldner (1998) also suggest that fears and beliefs associated with
anorexia entrap the individual. Once the disorder is a controlling influence, this obscures
the individual's own thoughts feelings and behaviour. This cognitive emphasis may be
likened to that of CBT models of anorexia which focus on cognitive distortions.

Although these ideas are not specific to the conceptualisation of anorexia and bulimia
they might be appropriately applied to both of these disorders. In addition, the emphasis
of this approach upon cultural influences may be of particular use in understanding
difficulties in adolescents for whom the influences of popular culture and peer groups are
strong.

Solution focused brief theoretical conceptualisations of eating disorders in
adolescents

SFBT was developed by Steve de Shazer (de Shazer, 1985) and draws from strategic
models of family therapy and Erickson's use of hypnosis and belief that our limitations
are mental constructs. Like NT, SFBT draws on the ideas of Bateson, is philosophically
rooted in constructivism, views the individual as the expert on their difficulties
(O'Halloran, 1999), and assumes that individuals have the resources necessary to change (Selekman, 1993). Again, like NT, SFBT's constructivist roots have led to a mistrust of the use of diagnostic labels. A further parallel with NT is seen in claims that SFBT can help clinicians to see clients' strengths and resources rather than just their problems (Wheeler, 2001). Again, this is of importance in the treatment of problems such as anorexia and bulimia. However, as with NT, it would seem important that the therapist believes these assumptions (Wheeler, 1995).

In common with NT, the framework for conceptualising psychological difficulties provided by SFBT is generic, and does not pertain specifically to anorexia and/or bulimia or to adolescents. In contrast to NT, SFBT does not attach importance to the development of psychological difficulties, and has not provided any means of conceptualising this process (Stalker, Levene & Coady, 1999). SFBT notions of the maintenance of psychological difficulties relate principally to the role of expectations. De Shazer proposes that our expectations of situations are of great significance in determining their outcome, saying that "Since expectations help to determine the nature of subsequent events, it seems clear that the behavior will change when the expectation changes" (de Shazer, 1985, pg. 94). Another important element of SFBT conceptualisations of psychological difficulties is the emphasis upon fluctuation in problem severity which means that exceptions to problems always exist (Wheeler, 2001). These ideas regarding problems, their development, and their maintenance are less sophisticated in their elaboration than those of NT. In particular, the emphasis of NT upon contextual factors and upon the influence of dominant narratives is not present in SFBT explanations of psychological difficulty.
Narrative and brief solution focused approaches to treating anorexia and bulimia in adolescents

Narrative approaches to treating anorexia and bulimia in adolescents

Aims of therapy

The broad aim of NT is to help individuals and/or families to challenge the influence of restraints in their lives and to see problem situations differently outside of these restraints and separate from themselves (White, 1986; cited in Selekman, 1993). Narrative therapy is interested in our stories regarding our relationships with our difficulties rather than the difficulties themselves. This meta view is also seen in the position taken by the individual in relation to their cognitions in CBT, and represents a move on from other family therapy approaches. NT aims to help clients to re-author problem saturated dominant narratives maintaining their difficulties (Madigan & Goldner, 1998). The client is the first author and agent of change in this process and the therapist assumes primary responsibility for this (Eron & Lund, 1996). This re-authoring process requires a redefinition of the client’s self-perception involving him/her juxtaposing their old problem saturated story with an alternative story created through therapy. This requires the client to hold two abstract ideas in mind at once, which Kegan’s theory of developmental constructivism suggests is a demanding task in cognitive developmental terms (1982, 1994; cited in Strand, 1997). This theory proposes that meaning making is a developmental or maturational process involving the transformation of subjective experience into experience that may be observed objectively. Since the ability to consider two stories about oneself in an objective fashion is dependent upon an individual’s developmental/maturational stage it is possible that younger adolescents are not capable of this. Unfortunately this theory does not indicate when an individual might reach the developmental/maturational level required to consider two stories objectively, or provide any evidence for these assertions. Anecdotal evidence of the successful practice of NT in children as young as eight suggests either that children are able to manage the cognitive demands of NT, or that NT can be delivered in a less cognitively demanding manner than Strand suggests. These issues aside, it seems that Kegan may be correct in asserting that some of the requirements of NT are cognitively quite
demanding, and throws into question the NT assumption that we all have an equal ability to construct new realities for ourselves (Strand, 1997).

Aims of NT, which are particularly relevant to eating disorders, include increasing political and social awareness through exploring the impact of culture in the creation and maintenance of problems (White & Epston, 1990). Although this might also represent a cognitively demanding task, this is of pertinence to adolescents with anorexia or bulimia, for whom it has been suggested that cultural contexts play a particular role in problem development and/or maintenance (Carr, 1999). In writing about how narrative therapy may be adapted for anorexia and bulimia, Madigan and Goldner (1998) propose a further aim of therapy as involving the client’s reintegration into their social context and thereby countering the “dis-membering” effects of anorexia in separating sufferers from their social groups.

Process of therapy

The reauthoring process of NT is principally achieved through questioning, and has been written about generically and in relation to anorexia and bulimia. Descriptions in the literature of NT are anecdotal rather than treatment manual, and the therapeutic processes described here do not take place in a set order. Relative influence questioning explores the effect of the problem on the person and the person on the problem. This focus upon the effect of the problem on the person allows for the identification of the cognitive, affective, interpersonal and behavioural components of the problem’s impact. This mapping of the detrimental impact of the problem is of importance in aiding motivation to change in individuals with anorexia or bulimia where the presence of cognitive distortions may prevent clients from recognising their difficulties. A parallel may be drawn with a similar process that takes place in motivational interviewing (Miller & Rollnick, 1991). The collection of this type of information fits with the assessment requirements of child and adolescent mental health services. However, NT does not emphasise detailed assessment, and this raises ethical considerations for practitioners using this approach with eating disorders. In particular, the co-morbidity of depressive affect in bulimia and anorexia and substance misuse and self-harm in bulimia, indicates the importance of detailed assessment and history taking when treating individuals with
these disorders in order to minimise risk of parasuicidal and suicidal behaviour. Questions regarding the effect of the person on the problem aim to develop an alternative story of the individual as a "coper" through the identification of "unique outcomes" and the highlighting and supporting of anti anorexic/bulimic thoughts, feelings and actions (Madigan & Goldner, 1998).

Once unique outcomes have been identified, a "unique account" or alternative story is elaborated with "landscape of action" questions regarding how the individual achieved these outcomes and the implications of these for their fight against anorexia/bulimia (Epston, Morris & Maisel, 1998). "Landscape of consciousness" questions identify the qualities associated with their anti-anorexic/bulimic actions. The history of these qualities is established in order to thicken the plot of the alternative story (Epston, Morris & Maisel, 1998). Questions requiring the individual to speculate on the sort of future that might be expected from someone with these qualities further embed the alternative story (O'Hanlon, 1999).

Epston, Morris and Maisel (1998) point to the importance of systematically defying the cognitive, behavioural and interpersonal aspects of anorexia in order to allow the individual to reconnect with the feelings that have been hidden by the problem. This process might also be useful in the treatment of bulimia. This facilitates the creation of a story about the person as a person, and their management of difficult thoughts and feelings that emerge once the anaesthetic of the eating disorder wears off. The use of audiences to root an alternative story in an individual's social context has also been employed in relation to eating disorders. In particular, the Anti-Anorexia and Anti-Bulimia leagues first established by David Epston and now present all over the western world, have been a forum for individuals to elaborate publicly on their struggle with anorexia/bulimia (Madigan & Goldner, 1998). Questions to deconstruct cultural discourses that are supporting anorexia are also used in NT for anorexia, and could be applied to the treatment of bulimia (Madigan & Goldner, 1998).

Use of language is important throughout NT. This is non-deterministic in order to highlight individual choice (O'Hanlon, 1999). Metaphorical descriptions help individuals to unmask the intentions of the problem (Epston, Morris & Maisel, 1998; pg. 152) and a
purposefully political anti-language is developed which aims to subvert discourses on anorexia/bulimia. Embedded suggestion is used as a therapeutic technique and questions are grammatically designed to predict possible future victories against anorexia/bulimia (Madigan & Goldner, 1998). An aspect of this language manipulation is externalisation, which uses client’s language and beliefs about the problem to create a linguistic separation between the person and the problem and to redefine the problem as an objectified external oppressing influence on the family and client (White & Epston, 1990). Externalisation undermines guilt and self-blame and replaces these with “anorexia blame” (Epston, Morris & Maisel, 1998). In light of Szmuker and Dave’s (1991; cited in Carr, 1999) findings that parental criticism of anorexic teenagers is associated with drop out from therapy, the release of blame associated with externalising techniques are of importance in optimising engagement in therapy for this population. Given the potentially life threatening nature of bulimia and particularly anorexia, engagement represents an important issue, and the ability of NT to engage individuals in treatment must be considered a strength. Throughout therapy an indirect approach is taken and goals of altering pattern of food intake are not imposed on the client (Madigan & Goldner, 1998).

In sum, the cognitive demands of some aspects of NT might be too great for younger adolescents. In addition, the lack of emphasis upon detailed assessment raises ethical difficulties in the application of this approach to adolescents with eating disorders. This aside, the mapping of the effects of problem on person, the emphasis on reconnecting with hidden feelings and on the impact of contextual factors upon problems, the Anti-Anorexia and Anti-Bulimia leagues and the use of externalisation, mean that NT may be of particular use in the treatment of adolescents with eating disorders.

Solution focused brief approaches to treating anorexia and bulimia in adolescents

Aims of therapy

In contrast to NT’s emphasis on redefinition of self, SFBT aims to redefine problems and potential solutions in order to construct problems in ways which lead to solutions (de
Shazer, 1985). This process of redefinition does not necessarily require the client to transport their experience of the difficulty from the subjective to the objective, and is a less cognitively demanding task than the juxtaposing and manipulating of two abstract ideas required in NT (Strand, 1997). Following Kegan’s (1982, 1994; cited in Strand, 1997) suggestion that meaning making through the transformation of subjective experience into the objective is a developmental or maturational process, it is possible that younger adolescents might be capable of meeting the cognitive demands of SFBT, but not those of NT. Like NT, SFBT is carried out within the client’s frame of reference. Clients define goals for treatment (Selekman, 1993) and are supported to develop their own solutions (O’Halloran, 1999). The client is responsible for change during the therapeutic process, with the clinician taking responsibility for facilitating this process (Wheeler, 2001). Thus, the therapist assumes less responsibility for change in SFBT than in NT. A further distinction between NT and SFBT in the latter approach’s lack of concern with the impact of culture and context on problems.

The SFBT aim of accepting the client’s problem focused descriptions, but concentrating on solution focused discussions is controversial. This aim is based on the assumption that you do not need to know much about a problem in order to solve it (Selekman, 1993). Whilst both NT and SFBT are competency based (O’Hanlon, 1999), NT involves mapping the effect of the problem on the person and is more problem focused than SFBT. The exclusive solution focus of SFBT has led to criticisms that SFBT does not provide opportunities for clients stories to be heard and neglects the development and history of the problem and broader assessment issues (Stalker, Levene & Coady, 1999). This is a concern in the treatment of clients with severe problems such as anorexia and bulimia, who can be difficult to engage in therapy and for whom feeling understood is of particular importance. This issue is of further significance when adolescents with eating disorders are considered, as adolescence is often a period during which individuals do not feel heard and understood. The fact that NT allows for some collection of problem focused information suggests that NT might fit better within child and adolescent mental health services than SFBT, which fails to provide the opportunity for the collection of assessment information (Wheeler, 1995). This failure raises ethical concerns for practitioners treating adolescents with anorexia and bulimia where co-morbid difficulties are common and it is imperative for these to be picked up if risk is to be managed.
successfully. However, the solution focus of SFBT has the advantage of establishing a constructive and collaborative context in which cycles of blame may be interrupted. As discussed above, this is an issue in eating disorders where the life threatening nature of the disorders mean that sufferers and family members experience feelings of guilt and blame. Externalisation techniques employed in NT achieve this end through a different process.

Process of therapy

As with NT, descriptions in the literature of SFBT are anecdotal in style and the principal therapeutic mechanism of SFBT is questioning. Descriptions of SFBT for eating disorders are few, and treatment tends to be idiosyncratic to the client's definition of the problem and possible solutions. The essential process of SFBT is that of solution building which involves three steps. Goal setting is an important aspect of SFBT and is more greatly emphasised than in NT. This accepts clients' descriptions of problems and helps them to determine what they want from therapy in relation to the problem. Solution setting helps the client to determine what they want from therapy independent of the problem and involves inquiring how their life will be different once the problem is no longer a concern, and from this, constructing future plans (de Shazer, 1994). The miracle question is one of the better known SFBT techniques and is based on the assumption that when an alternative future is envisaged, expectations change thus allowing changes to occur in the present. During the goal and solution setting processes, SFBT may be contrasted with NT in its' interest in determining who the "customer" is and engaging the right individual with setting goals for therapy that are of concern to them. This interest might be useful in engaging difficult to engage clients such as those with anorexia and bulimia. The third stage in solution building involves identifying exceptions to the problem to demonstrate past coping to the client (O'Halloran, 1999). A parallel may be seen here with NT unique outcome questions. However in contrast with NT, SFBT does not inquire regarding the meanings that individuals attach to these successes (Eron & Lund, 1996). In addition, whilst SFBT moves directly from inquiry regarding exceptions to how these might inform future solutions, upon identifying a unique outcome, NT first moves to the past in order to root
the quality used to achieve this outcome, and then to a future focus to further elaborate the alternative story (O'Hanlon, 1999). Thus, an important difference between NT and SFBT is that the former orients itself between past, present and future, whereas the latter is entirely present and future oriented.

Use of language is an important therapeutic tool in SFBT as well as in NT. Like NT, SFBT uses embedded suggestion to indicate that change is inevitable. In contrast with NT, SFBT employs deterministic terms highlighting the inevitability of change rather than individual choice. This reflects the SFBT assumption that change is inevitable and that only a small change is necessary to initiate a more substantial change within the system as a whole (Stalker, Levene & Coady, 1999). SFBT's assumption that changes need only be small differs from the NT assumption that a redefinition of self is required in order to achieve change. One is led to wonder whether small changes would be sufficient to successfully treat severe cases of anorexia and bulimia.

Other SFBT techniques include scaling questions which monitor client's progress towards goals (de Shazer, 1994). These highlight progress and instil a sense of hope in the client/family, which is important in anorexia and bulimia. Clients also receive positive reinforcement for attempts to solve problems through "cheer leading" and therapeutic compliments. SFBT emphasises the therapeutic utility of these techniques in their own right, whilst NT suggests that these successes should form the basis for landscape of action and landscape of consciousness questioning. SFBT shares with NT an indirect approach to the treatment of eating disorders (O'Halloran, 1999). The indirect approach of NT and SFBT may be contrasted with those of traditional cognitive, behavioural and family based approaches which take direct steps towards client weight gain (Carr, 1999). Whilst this indirect approach is controversial due to the physical threat of anorexia and bulimia, this avoids a common difficulty in treating eating disorders of pitting the client and their problem against the world (Madigan & Goldner, 1998).

In sum, the application of SFBT to the treatment of adolescents with eating disorders presents us with a mixed bag. Questions surrounding how understood an adolescent feels, the applicability of this approach to a child and adolescent mental health setting, ethical issues of risk raised in the application of SFBT to this population, and the
assumption that only a small change is necessary, all suggest that this approach is not suitable for treating this client group. However, the indirect approach taken by SFBT, its realistic cognitive demands, use of scaling questions, emphasis on identifying the “customer” and interrupting of cycles of blame, and consequent emphasis on engagement all argue in favour of the use of this approach with adolescents with eating disorders.

**Evidence underlying narrative and solution focused brief approaches to anorexia in adolescents**

In light of the lack of evidence for NT and SFBT conceptualisations of eating disorders in adolescents and constraints of space, this section is limited to a discussion of evidence of the effectiveness of these treatments.

**Evidence underlying narrative approaches to anorexia and bulimia in adolescents**

To date, only one study has examined the effectiveness of NT for anorexia or bulimia. This found that ten women attending a NT anti-anorexic group were more likely to attend and remain connected to treatment, reported more hopefulness about recovery, defined themselves as more separate from anorexia and reported less shame about the problem than ten women attending a support group (Goldner & Madigan, 1997; cited in Madigan and Goldner, 1998). A description of methodology employed in this study was not provided, and this coupled with the small sample size make it difficult to draw conclusions. Few studies have examined the use of NT with other disorders, and fewer have included adolescents within their sample. One such study employed a single case design with six families with children aged between eight and seventeen years experiencing parent-child conflict (Besa, 1994). Difficult child behaviour was targeted to measure outcome, and parents took frequency measurements of this at baseline and during family based NT. Five of the six families showed significant improvements following therapy. Whilst this study provides tentative indications of the effectiveness of
NT to treat parent-child conflict, it is not possible to conclude whether this approach is effective specifically for adolescents due to the wide age range of children participating.

NT's constructivist philosophical background and consequent rejection of the possibility of objectivity mean that this approach is not consistent with the positivist requirements of quantitative empirical research (Neimeyer, 1993; cited in Etchison & Kleist, 2000). This has in part led to the dearth in research examining treatment effectiveness. Qualitative research methods are, however, more compatible with the philosophy of NT, yet still very little research has been conducted to date using this methodology (Etchison & Kleist, 2000). Therefore at present no meaningful statement may be made regarding the effectiveness of NT in the treatment of adolescents with anorexia and bulimia.

Evidence underlying solution focused brief approaches to anorexia and bulimia in adolescents

To date, no research has investigated the effectiveness of SFBT for eating disorders. Despite this, more research has investigated treatment outcome for SFBT than for NT. Two such studies have focused upon adolescent populations. Seagram (1997; cited in Gingerich & Eisengart, 2000) evaluated the efficacy of SFBT in reducing antisocial thinking and behaviour and improving attitudes in 40 psychotic antisocial adolescent offenders. Standardised outcome measures were employed and findings indicated that in comparison to standard (non-counseling) care, individuals who had received ten weekly SFBT sessions made more progress with problem solving, had more optimism for the future and fewer antisocial tendencies. As such, this study appears to provide evidence for the effectiveness of SFBT in comparison with no treatment, but does not demonstrate a specific effect of SFBT. A further study investigated the effects of three types of single session brief therapy in alleviating academic and personal concerns and increasing goal achievements in sixty-one high school students (Littrell, Malia & Vanderwood, 1995; cited in Gingerich & Eisengart, 2000). Outcome was measured during two follow-up sessions using likert scales. Significant change was seen in all conditions, but no significant between-condition effects were found. The lack of pre-treatment and standardised measures makes it difficult to extrapolate from these
findings. Whilst these studies provide preliminary support for the effectiveness of SFBT with adolescents, more research is required to substantiate this, and at present no conclusions can be drawn regarding the usefulness of SFBT for any particular disorder.

SFBT appears to face similar difficulties to those of NT regarding empirical support for treatment efficacy. As we have seen with NT, the constructivist philosophy underlying SFBT has meant practitioners and theorists are reluctant to conduct quantitative research examining treatment outcomes. NT maintains its problem focus and consequently also maintains the opportunity to gather enough problem related information in order to determine which difficulties might be treated effectively using this approach. In contrast SFBT's exclusive solution focus may mean that there is little hope of determining which difficulties this approach is effective for using quantitative methodology. However it may be that evidence will be collected for the effectiveness of SFBT and NT using qualitative research methods.

Conclusion

The common philosophical roots of narrative and SFBT have meant that these approaches both emphasise the individual's construction of their own reality in the conceptualisation and treatment of psychological difficulties. However, the influence of social constructionism has also led NT to a greater emphasis upon the influence of cultural contexts on problems and to a greater elaboration of the development and maintenance of psychological difficulties. The principal distinction between the practice of these approaches is that NT attempts to create a new reality with the client, whilst SFBT aims to remain closer to the client's construction of reality (Strand, 1997). Practitioners must question the ethics of applying these approaches to the treatment of adolescents with eating disorders given the risks associated with these disorders, but must balance these questions with a consideration of their benefits in terms of engagement and motivation. Their shared philosophy has meant that NT and SFBT also share a dearth of data demonstrating their effectiveness, and in a climate of increasing demands for evidence based practice, these approaches may become marginalised if they do not address this issue. This warning, must be tempered by Roth and Fonagy's
(1996, pg. 376 – 377) acknowledgement that "On the whole, research has only limited impact on services....Clinicians are experts in their field, and on many issues may be ahead of empirically generated research findings".
References


V. Adult mental health case report summary
Assessment and intervention for a 60 year old woman presenting with dysthymic disorder and health problems using a cognitive behavioural model.
Confidentiality

Some details presented below have been changed in order to protect the anonymity of the client discussed in this report.

Presenting problem

Jean was a 60 year old woman referred by her G.P. due to depression. Several years previously, she had contracted a lung infection which had left her with an involuntary gasping sound. Although this had improved considerably, the gasp continued to occur, particularly when she was stressed and causing her social embarrassment and distress.

History of presenting problem

Jean reported having felt depressed for the first time during early adulthood, and felt that negativity and low mood had been a difficulty for a substantial part of her adult life. She described the onset of her most recent period of low mood as having coincided with her illness. Until six months prior to assessment Jean had been seeing a speech and language therapist for support in finding strategies to manage her gasp. Consequently her gasp had reduced considerably in frequency. She had not previously received psychological intervention in relation to this or her depression, and was seeking help with her difficulties at this point because she felt no longer able to cope on her own.

Assessment

Assessment information gathered through interviews with Jean related to the nature and course of her symptoms including her current thoughts and beliefs, her employment, family and psychiatric history, and her current psychosocial circumstances. Jean complained of exhaustion, difficulty in concentrating and feelings of inadequacy, fear and anxiety. She was distressed and cried frequently, and her inability to control this and her
gasp caused further distress. Jean’s score on the Beck Anxiety Inventory (BAI) placed her at the lower end of the mild to moderate range of anxiety symptoms. Her score on the Beck Depression Inventory (BDI) placed her at the higher end of the minimal range of depression. Jean had experienced suicidal ideation in the past but not at the time of assessment. Jean’s parents had been emotionally distant and she experienced difficulties in making friends at school. She had two children one of whom was a surviving twin, and her ex-husband had divorced her when the children were young. Jean had friends with whom she enjoyed pursuing a number of interests, however she felt unable to discuss her difficulties with them or with her children. She found that keeping active, regular exercise and plentiful sleep helped her to manage her low mood. She reported a number of thoughts and beliefs in relation to her low mood, including a belief that “I am alone”, a rule for herself that “I must cope on my own”, and a negative automatic thought that “I am inadequate”.

Formulation

Jean met diagnostic criteria for dysthymic disorder. This was formulated using Beck’s cognitive model of depression. Young’s notion of early maladaptive schemas and Winnicott’s notion of containment also informed formulation. Predisposing factors included Jean’s early and ongoing emotional isolation leading to the formation of early maladaptive schemas relating to emotional deprivation. A lack of containment of her negative emotions as a child were hypothesised to have resulted in her current difficulties in containing her distress. The onset of her gasp precipitated her current episode of dysthymia, as this led her to violate her rule that “I must cope alone”. This resulted in the activation of her early maladaptive schema that “I am alone” and to the production of negative automatic thoughts including “I am inadequate”. Factors maintaining Jeans’ difficulties included her adherence to the rule that “I must cope on my own” and her consequent avoidance of discussing her difficulties with friends and family. Her inability to contain this distress violated her rule that “I must cope on my own”, leading to further distress. Her gasp and dysthymic symptomatology contributed directly to her low mood, resulting in negative automatic thoughts relating to her chronic depressive symptoms. Protective factors included the presence of Jean’s friends and
children and her recognition that remaining active would help to prevent her from feeling low in mood.

**Intervention**

Intervention took place over 12 sessions. This aimed to break into the vicious cycle of depression and reduce dysthymic symptomatology, to prevent future relapse and to contain Jean’s negative feelings until she was more able to do this herself. Socialisation into the cognitive behavioural model was undertaken. Dysthymic symptoms were tackled through the cognitive behavioural approach of eliciting, testing and countering the negative automatic thoughts associated with her low mood. In order to prevent relapse, work on identifying Jean's early maladaptive schemas and replacing these with more functional schemas was begun. However Jean found this process painful and difficult and was unable to complete this.

**Outcome**

Jean continued to experience strong negative emotions, but reported that this felt less disastrous. She was able to use the cognitive and behavioural strategies identified during therapy independently and had begun to experiment with sharing her feelings with others. She reported a reduction in distress associated with her gasp and in dysthmic symptomatology. At termination of therapy, Jean’s score on the BDI-II dropped to the lower end of the minimal range of depression. Her score on the BAI reflected a normal level of anxiety.

**Prognosis**

Although a reduction had occurred in Jean’s dysthymic symptomatology, limitations to the schema focused stage of therapy and the long standing nature of her difficulties led the author to be concerned that Jean might relapse in the future.
Reformulation

The original formulation was effective in explaining Jean's difficulties and in intervening to address these. During the course of therapy it also became apparent that past unprocessed traumatic past experiences may have contributed to the surges of negative emotion she continued to experience.
VI. People with learning disabilities case report summary

Functional assessment and behavioural intervention of challenging behaviour in a 24 year old man with Smith-Magenis syndrome and moderate learning disability
Confidentiality

Some details presented below have been changed in order to protect the anonymity of the client discussed in this report.

Presenting problem

Peter was a 24 year old man with moderate learning disabilities and Smith-Magenis syndrome, a recently identified syndrome associated with chromosomal deletions. He exhibited a number of challenging behaviours often found in individuals with this syndrome. His physical aggression had led to his being Sectioned under the 1983 Mental Health Act, and he was living in a secure unit for men with mild and moderate learning disabilities.

History of presenting problems and previous intervention

Peter had experienced behavioural difficulties from 18 months of age. Two sets of behaviour management guidelines had been implemented in his previous residential setting, neither of which were successful in achieving their aims. A previous attempt to undertake individual psychotherapeutic work with Peter was also been undertaken, however his social avoidance had prevented him from engaging with this.

Assessment

Peter had lived at home with his parents and attended a day school until he was six. Between the ages of 6 and 23 he attended four boarding schools and four residential homes. He had moved into the assessment and treatment unit nine months previously. He had a difficult relationship with his mother. Peter was often extremely shy and avoided the company of others. During interviews some staff admitted to feeling physically intimidated by Peter and feeling unclear about how to respond to Peter's
challenging behaviour. Peter had good expressive and receptive language skills and communicated using full sentences, and he enjoyed receiving praise.

A functional assessment of Peter’s challenging behaviour was undertaken. Information was gathered using an informant-based structured interview adapted from La Vigna’s Behavior Assessment Guide conducted with Peter’s key worker and from interviews with staff. Training in completion of antecedent, behaviour, consequence (ABC) recording charts was provided for staff, who completed these allowing a baseline frequency of Peter’s challenging behaviour to be taken. Topography of target behaviours identified were lack of co-operation with requests; self-injurious behaviour; verbal and physical aggression to others, and physical aggression to property. Antecedents and consequences to challenging behaviour were identified.

Formulation

Peter’s challenging behaviour was formulated using Skinner’s model of operant conditioning. Reiss and Havercamp’s sensitivity theory also informed formulation. Factors predisposing Peter’s challenging behaviour included his Smith-Magenis syndrome and his moderate learning disability which resulted in his difficulties in expressing emotions verbally and his seeking alternative means of communicating emotion through behaviour. The difficult relationship with his mother and past disruption to attachment relationships represented a setting factor which increased the likelihood that Peter would experience strong emotions. Peter had an aberrant motivation to avoid social contact and demands, which led him to engage in challenging behaviour in order to secure an optimum level of reinforcement in this regard. Factors precipitating challenging behaviour included directive support from staff members, unpredictability in his routine and (repeated) demands being placed on him. Peter’s challenging behaviour was maintained through negative reinforcement including removal of unwanted demands, and positive reinforcement including concern from staff. His self-injury and verbal and physical aggression to others were also maintained through release of negative emotions. Perseverating factors were important in understanding relationships between target behaviours, which were hierarchical in structure, with Peter progressing from more low level forms of challenging behaviour to more severe forms within a given
episode. Protective factors included Peter's good language expression and comprehension and his enjoyment of praise.

**Intervention**

Intervention took place over six sessions. Aims of this were to manage risks, reduce target behaviour and combat feelings of staff helplessness. Intervention involved production of a behavioural assessment report describing findings of the functional assessment in order to improve staff members' understanding of Peter's behaviour and reduce ambivalence towards him. A support plan for staff was developed including reactive strategies for the management of episodes of challenging behaviour incorporating functionally based constructional strategies and de-escalation strategies. This support plan also included proactive strategies and strategies for building on Peter's existing skills for staff to employ to reduce the likelihood of his engaging in challenging behaviour.

**Outcome**

A comparison of baseline and post intervention frequencies of target behaviours indicated that frequency of ignoring requests and demands marginally increased following intervention. Frequency of self-injury, verbal aggression and physical aggression to others marginally decreased. No change was seen in frequency of physical aggression to property. Staff comments regarding their hopes for achieving consistency in their responses to Peter's challenging behaviour suggested that they felt more sure of how to respond and less helpless in the face of this. In addition, staff members' understanding of Peter's behaviour was improved as a result of the shared understanding of this which was reached.
Reformulation

The initial formulation was useful in explaining Peter's behaviour, but not in producing an intervention that significantly reduced the frequency of this. It is likely that the impact of his social avoidance and disrupted attachments were exerting a negative impact on his mood that was not adequately accounted for in the initial formulation.
VII. Children, adolescents and families case report summary
Assessment and intervention for a mother experiencing difficulty in coping with her three year old child's crying using a cognitive and behavioural model
Confidentiality

Some details presented below have been changed in order to protect the anonymity of the client discussed in this report.

Presenting problem

Susan was a young mother living with her partner Louis, three and a half year old daughter, Nicole, and five month old son, Sam. Her Health Visitor referred the family to the Sure Start Child and Family Psychology Service due to Susan’s difficulty in coping with Nicole’s “constant crying and attention seeking”. The author and her supervisor undertook assessment and intervention jointly, with the author taking the lead in this.

History of presenting problem

When Nicole was born Susan’s mother stayed with the family for the first six months of Nicole’s life and Susan reported that Nicole “bonded more to my mum than she did to me”. Susan first started to experience difficulties in managing Nicole’s crying when she returned to work following her maternity leave when Nicole was 11 months old.

Assessment

Assessment information was gathered through assessment interviews attended by Susan, Nicole and Sam; a telephone conversation with Susan’s health visitor; an observation of Nicole by the author at nursery and an interview with the nursery manager. Susan was a Black woman born in Grenada. She reported a history of disrupted attachments and of physical abuse from her mother, about which she currently felt upset and angry. She also reported a difficult relationship with Louis. The assessment identified antecedents, consequences and frequency of Nicole’s crying. Susan reported feeling angry, upset and guilty when Nicole cried, and negative
automatic thoughts accompanying these feelings were identified. Susan interpreted her angry feelings and thoughts of harming Nicole as indicating that she might lose control and harm her. A risk assessment indicated that Susan had not harmed Nicole in the past and had strategies in place to manage her anger and to prevent this occurring in the future and that Nicole was not currently at risk. Susan’s goals for therapy were to understand better why Nicole was crying, to feel less angry when she cried, and that she knew how to respond when Nicole cried.

Formulation

In light of Susan’s goals for therapy and assessment findings that Nicole’s crying fell within normal limits, the focus of formulation and intervention was Susan’s anger in relation to Nicole’s crying. This was formulated within Deffenbecher’s cognitive behavioural model of anger, and cognitive factors were seen as being most important in this case. Conceptualisation of Nicole’s crying behaviour was informed by Skinner’s model of operant conditioning. Susan’s attachment history and Susan and Nicole’s attachment relationship were conceptualised using John Bowlby’s attachment theory.

Intervention

Cognitive behavioural therapy aiming to reduce Susan’s angry and distressed thoughts and feelings in response to Nicole’s crying represented the focus for intervention, and this took place over five sessions. Susan’s negative automatic thoughts and dysfunctional assumptions associated with her anger and distress were elicited, tested and countered. The occurrence and frequency of Nicole’s crying was normalised, and strategies for managing Susan’s anger were strengthened. Parent management training with Susan was also undertaken in relation to Nicole’s crying. This aimed to further explore factors maintaining this behaviour, help Susan to develop systematic strategies for managing this and reduce crying frequency.
Outcome

Susan and Louis reported a decrease in the frequency of Nicole's crying, and Susan reported feeling less angry and frustrated when this did occur. Her responses to Nicole were more consistent, and she had a better understanding of her. Previously, Susan had appraised Nicole's crying as unreasonable, but was able to adjust this. She had also begun to address her appraisals of her own anger. She had successfully implemented cognitive and behavioural strategies discussed for tackling her angry and distressed thoughts and feelings, and for managing Nicole's crying. She was keen to continue working with the author's supervisor on maintaining treatment gains and relapse prevention once the author had completed her placement. Supportive play was also to be introduced as a means of further strengthening Susan and Nicole's attachment relationship.

Prognosis

It was anticipated that the family would maintain treatment gains but that Susan's expectations of parenting would at times continue not to match with realities, necessitating further future input to address difficulties arising from this mismatch and from her tendencies to self-doubt. Despite invitations from Susan, Louis did not attend sessions and was not engaged in intervention. If the author had been successful in tackling this issue, the prognosis for the family might have been improved.
VIII. Specialist case report summary
Assessment and intervention for a nine year old boy with generalised anxiety disorder using a narrative approach
Confidentiality

Some details presented below have been changed in order to protect the anonymity of the client discussed in this report.

Presenting problem

Connor was a 9 year-old boy referred for psychological input at the request of his School Nurse. Connor experienced Worries (his term for his Generalised Anxiety Disorder (GAD)) regarding a variety of things including school, friends, being teased, electricity, water and insects. These Worries were leading him to avoid activities, made it difficult for him to relax, and made him feel sad and tearful. Connor and his mother Marianne could not identify the onset of Worries, and felt that Connor had always been a worrier. Connor also experienced verbal and physical victimisation at school and suffered from nocturnal enuresis, which was worse during term time.

Assessment

The approach to assessment and intervention was one of narrative therapy (NT). Assessment information was gathered during sessions with Connor and Marianne, and from telephone conversations with his school nurse and Head of Year. Family beliefs that Connor was a "worrier" and was like his father (who was suffering from long-standing depression) were discovered. Marianne was quick to reassure him when anxious. Connor's teachers were not aware of his being bullied and thought that he might be exaggerating his accounts of this. They saw him as a "natural victim". Connor's scores on the Spence Children's Anxiety Scale (SCAS) and the Fear Survey Schedule for Children - revised (FSSC-R) indicated that he was experiencing considerably more fears and anxiety than those of boys his age in the non-clinical population. His score on the Life in School Checklist – Junior School Version, indicated that he was a victim of bullying and physical victimisation. As such, risk to Connor's physical safety at school was a particular issue and was addressed in intervention.
Connor's goal for therapy was to be able to live with his anxiety, and he expressed a wish to focus on this and not on his enuresis, which he had difficulty in discussing.

Formulation

Connor met DSM-IV diagnostic criteria for GAD. His depressed feelings were seen as being secondary to this. His GAD was formulated within a NT theoretical framework which understands problems as being maintained by dominant narratives (problem stories) regarding the problem and the person. Stories that had developed within the family of their being “sensitive” and quiet, about Connor as “the most sensitive person in the family” and about Connor as a “worrier” who couldn’t cope, were understood as maintaining Connor’s difficulties. Marianne’s quickness to reassure Connor further strengthened the story about him as a “worrier” by denying him the opportunity to manage Worries alone. Those around Connor had subscribed to these stories about him as “sensitive” and a “worrier”, which contributed to the maintenance of these stories and of Worries through establishing in Connor and those around him an expectation that he could not manage Worries. These stories and the expectations that they established also led Connor to avoid anxiety provoking situations when Worries were around, again denying him opportunities to become a coper. The bullying that he experienced at school further reinforced the stories about Connor as a “worrier” and “sensitive” by feeding into his anxiety. Children at school had subscribed to these stories, and were even more likely to bully Connor. These problems were exacerbated by being located a western social discourse which states that it is unattractive to be overweight and that being overweight is the fault of the individual, which influenced.

Intervention

Assessment and intervention took place over six sessions. Due to concerns regarding Connor’s safety at school a meeting was held which aimed to raise awareness of his victimisation, help the school to take ownership of this, facilitate development of management strategies, and begin to develop an alternative story about Connor as a
coper at school. The author's concerns regarding the impact of Connor's enuresis led her to suggest a joint session attended by Connor, Marianne and his school nurse to address this. However, Connor did not consent to this and it did not take place. Instead, he and Marianne decided to implement a reward system for staying dry that they had found helpful in reducing Connor's past encopresis. NT was undertaken during sessions attended by Connor and Marianne in relation to Connor's GAD. Aims of intervention were to help Connor to re-author the problem stories about him as a "worrier" and "sensitive" which were maintaining his difficulties, through the creation of an alternative story about Connor as a coper who could overcome Worries. Throughout this process, use was made of Connor's language and definition of the problem, and the therapeutic tool was that of language and questioning. The role of Marianne's reassurance in maintaining Worries was addressed, however neither she nor Connor responded to this. Therefore this issue was tackled indirectly.

Outcome

Connor terminated therapy earlier than expected, and the author was concerned that further work would be required before he was able to maintain treatment gains. However, by this time an alternative story about Connor as a coper had been constructed. Connor had developed a repertoire of strategies for overcoming the Worries and had been able to tackle a number of these. Marianne reported that he was playing outside with other children more, was more outgoing and confident. Because he was on school holidays, it was not clear whether his victimisation at school had improved. There had been no change in his enuresis. Connor's score on the SCAS had reduced considerably but was still higher than that seen in the normative population. A significant reduction in the spread and severity of Connor's fears as measured by the FSSC-R had also occurred.
IX. Older adult case report summary

Neuropsychological assessment of an 86 year old man complaining of word finding difficulties
Confidentiality

Some details presented below have been changed in order to protect the anonymity of the client discussed in this report.

Reason for referral

John was an 86 year old man referred by a Consultant Psychiatrist to the Psychology Service for assessment of his cognitive functioning. The Psychiatrist suspected that John had mild cognitive deficits potentially indicative of an early dementing illness. He also requested an assessment of potential bereavement problems following the death of John's wife two years previously.

History of presenting problem

John reported experiencing difficulties with word finding during conversation and in recalling what had gone before whilst reading a book. He found it difficult to identify a point of onset for these problems, but thought that he had first noticed them about a year previously, and that they were gradually becoming worse.

Assessment

Assessment took place over five sessions. An interview was conducted with John in order to gather information regarding his personal, medical and psychiatric history, and his current social situation and leisure interests. John was reluctant to discuss his difficulties with anyone, and therefore it was not possible to gain a third party view of these. CT scan results indicated that John had suffered a small lacunar infarction adjacent to the corpus striatum. "Symmetrical enlargement of the cerebral sulci and ventricles implying a degree of age-related involution or cerebral atrophy" was also noted. On the basis of interview information, CT scan results and the Psychiatrist's assessment reports, five hypotheses were postulated regarding John's difficulties. John
would have a neuropsychological profile consistent with focal difficulties resulting from lacunar infarction adjacent to the corpus striatum; that he would have a neuropsychological profile consistent with Alzheimer's Disease; that he would have a neuropsychological profile consistent with Vascular Dementia; that John's difficulties were arising from depression related to his bereavement, and that his difficulties were age related. Several neuropsychological tests were selected to test these hypotheses. The National Adult Reading Test – Second Edition (NART-II) was selected in order to provide an estimate of John's pre-morbid intellectual functioning. The Wechsler Adult Intelligence Scale – third edition (WAIS-III) was chosen to establish John's current level of general intellectual functioning, to gain a profile of his strengths and weaknesses, and to determine whether he had experienced a decline from his estimated pre-morbid intellectual functioning. The Wechsler Memory Scale–Third Edition (WMS-III) was selected in order to assess for potential memory impairment. The Controlled Oral Word Association test (COWA) was selected to provide an assessment of John's a fluent anomic aphasia and to assess the possibility that he had executive function deficits. The Brixton Spatial Anticipation test was selected to provide additional assessment of possible executive function deficits. The 15 item Geriatric Depression Scale was used to formally assess for possible depression associated with John's bereavement.

Formulation

Findings of neuropsychological testing suggested that a significant decline had occurred in John's overall cognitive functioning, which confirmed the Psychiatrist's view that he had mild cognitive deficits. On the basis of the assessment the most parsimonious explanation of John's deficits was focal memory dysfunction associated with the lacunar infarction he had suffered adjacent to the corpus striatum. It was not possible to determine whether this was an isolated deficit or part of a progressive dementing process. John's low level of depression and/or brain changes associated with normal ageing may also have been contributing to his difficulties, but did not explain these in themselves.
Recommendations and outcome

The author undertook a joint feedback session with the Psychiatrist in order to provide John with information regarding the CT scan findings. An individual session was also held with John to provide detailed assessment feedback and to discuss strategies for managing his memory dysfunction. A written summary of assessment findings was provided. The possibility of professional support in relation to John's low mood and bereavement were discussed, but he did not wish to pursue this. It was recommended that John receive a further neuropsychological assessment in a year in order to determine whether his cognitive decline represented a progressive illness.
X. Clinical experience summary
Adult mental health placement

This was with the East Elmbridge Community Mental Health Team. During this placement I carried out individual work with seven clients (five female and two male) with ages ranging from 18 to 59 years of age. These clients presented with dysthymic disorder; health problems; anxiety; panic; agoraphobia; obsessive compulsive disorder; paranoid psychosis; bulimia; schizophrenia, and issues relating to sexual abuse. I saw 15 couples and families as part of a family therapy team. I co-facilitated a group with an occupational therapist for nine clients (seven female and two male) with issues relating to self-esteem. Assessment procedures used included the Beck Depression Inventory, the Beck Anxiety Inventory and the Wechsler Adult Intelligence Scale – third edition. Models of intervention used were systemic, behavioural and cognitive behavioural. I also had the opportunity to observe my supervisor undertake systemic and schema focused therapy and to observe psychiatrists during a ward round. Along with another clinical psychologist, I planned and delivered two training sessions on cognitive behavioural therapy for other multi-disciplinary team members. I carried out my service related research project during this placement.

People with learning disabilities placement

This placement was with the Greenwich Community Team for People with Learning Disabilities. During this placement I carried out individual work with eight clients with mild, moderate and severe learning disabilities (five men and three women) aged 19 to 54 years. Presenting problems included autism; depression; relationship difficulties; anxiety; communication difficulties and challenging behaviour. I also co-facilitated a psychoeducational and discussion group regarding sex and relationships for five men with mild learning disabilities and inappropriate sexual behaviour. Models of therapy used were cognitive behavioural and behavioural. Assessment procedures used included the British Picture Vocabulary Scale; the Sexual Knowledge Scale for People with Intellectual Disability; the Social Network Inventory; the Ravens Progressive Coloured Matrices and the Leiter. I also had the opportunity to conduct an assessment
through an interpreter. With my supervisor, I planned and delivered a day-long training package on challenging behaviour for carers working in a group home.

Children, adolescents and families placement

This placement was with the North Southwark Community Child and Family Service. During this placement I undertook work with seven children (four girls and two boys) aged 10 months to 9 years and their families. Presenting issues included night terrors; enuresis; post-traumatic stress; issues associated with child custody dispute; somatisation; bullying; feeding difficulties; behavioural difficulties and school refusal. Models of intervention employed were behavioural; cognitive behavioural; systemic and narrative. Assessment procedures used included the Family Relations Test. I also co-facilitated a parenting group for eight mothers. I had the opportunity to undertake school and nursery observations and liaise with teachers, health visitors and educational psychologists. In addition I gave a case presentation to the multidisciplinary team in which I was working.

Elective systemic placement

This was with the Child and Family Psychological Medicine Department, St Peter's Hospital. I undertook work with nine children and adolescents (seven boys and two girls) aged 7 to 17 years and their families. Presenting problems included anxiety; panic; school refusal; somatisation; bereavement; behavioural difficulties; anger management difficulties; depression; relationship difficulties; bullying and Attention Deficit Hyperactive Disorder. I also participated in family therapy workshops and saw five families in this capacity. Models of intervention employed during this placement were principally narrative and systemic. However, I also carried out some cognitive behavioural and behavioural work. Assessments used included the Spence Children's Anxiety Scale; the Life in School Checklist; the Fear Survey Schedule for Children and the Wechsler Intelligence Scale for Children – third edition. I also had the opportunity to give a case presentation to the multidisciplinary team in which I was working.
Older adults placement

This placement was with the Psychology Service in the Community Mental Health Team for Older People at Tolworth Hospital. During this placement I undertook individual work with eight clients (five female and three male), and couple work with one couple. These clients ranged in age from 65 to 86 years. Presenting problems included difficulties associated with a caring role; post-traumatic stress disorder; bipolar affective disorder; anxiety; depression; marital difficulties; health problems; panic; obsessive compulsive disorder; word finding difficulties; cognitive decline and Diogenes syndrome. Models of intervention employed in this work were narrative, systemic, cognitive behavioural and solution focussed. I undertook a number of assessments as part of this work. Assessment instruments used included the National Adult Reading Test; the Wechsler Adult Intelligence Scale – third edition; the Wechsler Memory Scale – third edition; the Controlled Oral Word Association Test and the Brixton Spatial Anticipation Test. I co-facilitated a coping skills group for inpatients on a psychiatric ward. I also had opportunities to observe a psychodynamic therapy session and a psychiatric outpatient clinic.

Elective child development placement

This placement was with the Kingston Child and Adolescent Mental Health Service Outreach Clinic based at the Maple Children’s Centre and the Disabled Children’s Team at Beaconsfield Children’s Resource Centre. During this placement I undertook assessment and intervention work with nine children and adolescents (eight boys and one girl) aged 2 to 15 years and their families. Some of this involved assessment work as part of a social communication disorder clinic. Presenting problems included suspected and confirmed Autism and Asperger’s syndrome; learning disability; behavioural difficulties and adjustment issues in families with children with disabilities. I also had the opportunity to join a feeding clinic, and undertook assessment and behavioural and psychoeducational intervention for children with failure to thrive and restricted feeding patterns. Other models of therapy used were systemic, developmental and cognitive behavioural. Formal assessment measures used included the Playdos.
assessment, the Symbolic Play Assessment and the Vineland Adaptive Behaviour Scales. I also conducted informal structured play assessments. Along with a social worker, I planned and co-facilitated a group for siblings of children with disabilities. I also had the opportunity to plan and deliver a training session on play in children with special needs to paid carers of children with disabilities.
I. Service related research project
Community mental health team members' perceptions of the role of clinical psychologists within the team and referral to the clinical psychology service

July 2001
Year 1
Abstract

An exploratory questionnaire survey of mental health professionals in a Community Mental Health Team (CMHT) was undertaken. Aims were to describe CMHT members' perceptions of clinical psychologists' roles and of referral to the clinical psychology service, and to explore potential group differences between professions in these perceptions. The measure used was a questionnaire developed in consultation with clinical psychologists. 13/27 (48%) CMHT members responded. Data analysis comprised simple frequencies and content analysis. Findings indicated that clinical psychologists' roles were well defined and recognisable, particularly in relation to consultancy. However further exploration of team members' views regarding best use of psychologists' skills was recommended. Lack of knowledge regarding models of therapy other than CBT was found. It is suggested that, although a clear understanding existed of the suitability of serious and long-term mental health problems for referral to clinical psychology services, discussion of potential referrals should be encouraged.
Introduction

Community Mental Health Teams (CMHT's) (Anciano & Kirkpatrick, 1990) and the roles of clinical psychologists working in them vary enormously (Peck & Norman, 1999). Such diversity presents difficulties in achieving clarity regarding differential roles and the role of clinical psychology services in terms of appropriate referrals.

The issue of clarity in role definition is important for a number of reasons. McGuire, Borowy and Kolin (1986) found that greater familiarity with a professional group was associated with more positive attitudes towards that group. Therefore clinical psychologists who define their role clearly may be perceived more positively by their colleagues. Onyett, Pillinger and Muijen (1995) found that CMHT members who were clear about their roles and the role of their team had lower burnout and higher job satisfaction. Finally, research regarding social stereotypes has shown that these are more likely to be used in complex cognitively demanding situations (Stangor & Duan, 1991; Stangor & Schaller, 1996). It is likely that use of social stereotypes occurs in the pressure and complexity of CMHT's. Since such stereotypes can be inaccurate (Stangor & Schaller, 1996), in a CMHT setting these could result in lack of role clarity between professions. However, Brown and Wade (1987) propose that good role differentiation can be beneficial in overcoming social stereotypes. As such this may be important in overcoming social stereotypes within CMHT's.

The Manpower Planning Advisory Group (MPAG) report (1990) highlighted difficulties created by shortages of clinical psychologists and proposed that the latter develop a consultancy role and should be "undertaking more complex clinical duties..." (MPAG, 1990; pg. 19). As well as developing these aspects of their work, it is important that clinical psychologists receive appropriate referrals. In their survey of CMHT's, Onyett, Heppleston and Bushnell (1994) found that most referrals to clinical psychology services came from team members. Since those with expert knowledge of a subject make better related decisions (Orasanu & Connolly, 1995), it would seem important that CMHT members referring to clinical psychology services have good knowledge of referral issues if they are to make appropriate referrals.
Research examining perceptions of clinical psychologists’ roles has indicated that CMHT members (Cushion, 1997), and nurses and occupational therapists working alongside a psychology consultancy service (Osborne-Davies, 1996), want to use psychologists expertise informally. In these studies, the roles of clinical psychologists were seen as involving assessment and individual therapy. CMHT members have been found to perceive the consultancy role to be important (Cushion, 1997), whereas nurses and occupational therapists have not (Osborn-Davies, 1996). Osborn-Davies (1996) found no between-professional group differences between nurses and occupational therapists in their role perceptions.

Little research has explored CMHT members’ perceptions of referral to clinical psychology services. Hughes, Midence and Jackson (1996) found that CMHT members rate clinical psychology as most likely to accept referrals for obsessive compulsive disorder, phobias, anger management and psychosomatic problems. Clients identified as representing routine referrals included those with sexual problems, phobias, obsessive compulsive disorder and those requiring psychometric testing. Clients identified as unsuitable for referral included those with no underlying mental illness or needing frequent contact. Factors perceived as influencing allocation processes included client gender or age and preferred language.

The present study was conducted in a CMHT based in an affluent middle-class area of Surrey. The client population for which the team provided a service was largely white. The team provided a service for clients with a variety of problems including psychosis, personality disorder, depression and anxiety disorders. Questions regarding perceptions of CMHT members of clinical psychologists’ roles and of referral to clinical psychology were raised due to changes to the organisation of the team. Two CMHT’s had recently merged to form the team in which the study was conducted, and had seen the introduction of a counselling psychology service. The clinical psychology service had previously comprised one B grade psychologist and was joined by another A grade psychologist (equivalent of one full time post). The referral process, which incorporated referrals made from individual team members to clinical psychology as well as via an allocation meeting, remained unchanged. However changes to the team meant that some members might not have been familiar with referral issues or with clinical
psychologists' roles. This led team psychologists to ask the research questions set out below. Answers to these would enable them to provide information to team members regarding their roles and referral systems. It was hoped that data regarding between-group differences in perceptions would enable appropriate information to be targeted at each profession. Although similar research had been conducted previously (Cushion, 1997), this had explored perceptions of community psychiatric nurses, senior nurses, team managers, social workers and psychiatrists. However, professions represented in this CMHT were community support workers, mental health workers, occupational therapists, social workers, counselling psychologists, community psychiatric nurses and psychiatrists. As such it was important to examine perceptions of the range of professions represented in this study.

**Aims and research questions**

**Aim 1**
To describe CMHT members' perceptions of clinical psychologists' roles.

**Specific research questions**

1. What sort of work do participants understand as comprising the role of clinical psychologists?
2. What aspects of the work of clinical psychologists do participants perceive as representing best use of their skills?
3. What models of therapy do participants understand clinical psychologists to be using, and what models are understood to be used most?
4. Which mental health problems do participants understand clinical psychologists to be providing interventions for?
5. Which interventions for which mental health problems do participants perceive as representing best use of clinical psychologists' skills?
Aim 2

To describe perceptions of CMHT members regarding referral to clinical psychology.

Specific research questions

1. Which mental health problems do participants perceive as being appropriate for referral?
2. What models of therapy do participants perceive as being appropriate for which mental health problems?
3. What factors influence participants' decisions to refer?
4. What sorts of clients might participants be unsure whether to refer, and what sorts of clients are perceived as being inappropriate for referral?

Aim 3

To explore potential between-professional group differences in perceptions of clinical psychologists' roles and of referral to clinical psychology.

Method

Design

An exploratory survey.

Participants

All mental health professionals who were members of the CMHT except clinical psychologists were invited to participate. The team was comprised of four community support workers; three mental health workers; three occupational therapists; six social workers; six community psychiatric nurses; two psychiatrists; three counselling
psychologists and two clinical psychologists (excluding the author). In total twenty-seven people were asked to participate.

Measure

A questionnaire (appendix A) was developed in collaboration with the clinical psychologists. Items were generated from previous research and expert sampling. Final questionnaire items were agreed after consultation with the research supervisor, the clinical psychologists and the team manager. Questionnaires were colour coded according to professional group.

Part A concerned perceptions of clinical psychologists' roles and part B examined perceptions of referral to clinical psychology. Closed questions with response options examined perceptions of work comprising psychologists' roles; models of therapy employed by psychologists; mental health problems perceived to be ones for which psychologists might provide interventions; perceptions of types of work and problems representing best use of skills of psychologists; models of therapy used most; problems seen as appropriate for referral; models of therapy seen as appropriate for particular problems; factors influencing team members' decisions to refer, and problems team members were most likely to refer. Additional comments were invited for each of the above questions. Perceptions of types of clients inappropriate for referral or who team members would be unsure whether to refer were examined with open-ended questions. Response options for closed questions were generated from previous research and expert sampling, and participants were permitted to select more than one option.

Procedure

CMHT members were informed of the study and invited to participate in an announcement during the weekly allocation meeting. Questionnaires were distributed to their pigeon-holes along with a covering letter explaining the purpose of the study, that the questionnaires had been colour coded to allow the identification of professional groups but were otherwise anonymous, and that data collected would be treated as
confidential (appendix B). Reminders to complete questionnaires were given during three subsequent allocation meetings. Four weeks following initial distribution a duplicate questionnaire and another covering letter giving a final deadline for submission (appendix C) was distributed to all team members' pigeon-holes.

**Ethical issues**

The principal ethical issue was confidentiality, which was protected through maintaining participant anonymity. The author was aware that due to the small numbers of people within each professional group, the colour coding of questionnaires would partially compromise participant anonymity. This issue was discussed with the research supervisor, the other psychologists and the team manager. It was decided that content of the questionnaires was not sensitive or personal in nature and therefore colour coding could go ahead.

**Data Analysis**

Where closed questions with response options were used, simple frequencies were calculated. Content analysis was used for open-ended questions. These methods were appropriate for this descriptive study, the sample size of which was not adequate for the use of inferential statistics.

**Results**

Thirteen of the twenty-seven questionnaires distributed were returned. This represented a 48% response rate.
Perceptions of clinical psychologists' role

Work perceived as comprising clinical psychologists' roles (closed questions)

Greatest agreement was between responses indicating that assessment of new referrals to the psychology service (13/13) and individual therapy (13/13) formed part of the role (Table 1).

Table 1: Direct work indicated to be undertaken by clinical psychologists.

<table>
<thead>
<tr>
<th>Category of work</th>
<th>Frequency</th>
<th>Percentage (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assessment of new referrals to the psychology service</td>
<td>13</td>
<td>100</td>
</tr>
<tr>
<td>Individual therapy</td>
<td>13</td>
<td>100</td>
</tr>
<tr>
<td>Psychometric assessment</td>
<td>10</td>
<td>77</td>
</tr>
<tr>
<td>Group therapy</td>
<td>8</td>
<td>62</td>
</tr>
<tr>
<td>Complex referrals</td>
<td>8</td>
<td>62</td>
</tr>
<tr>
<td>Consultation for clients</td>
<td>7</td>
<td>54</td>
</tr>
<tr>
<td>Assessment of new referrals to the CMHT</td>
<td>6</td>
<td>46</td>
</tr>
<tr>
<td>Acute/urgent referrals</td>
<td>5</td>
<td>38</td>
</tr>
<tr>
<td>Routine referrals</td>
<td>4</td>
<td>31</td>
</tr>
<tr>
<td>Other</td>
<td>1</td>
<td>8</td>
</tr>
</tbody>
</table>

Of indirect categories of work (Table 2), the greatest number of respondents selected informal advice to other CMHT members (13/13), research (11/13) and supervision for other psychologists (11/13).
Table 2: Indirect work indicated by to be undertaken by clinical psychologists.

<table>
<thead>
<tr>
<th>Category of work</th>
<th>Frequency</th>
<th>Percentage (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Informal advice to other CMHT members</td>
<td>13</td>
<td>100</td>
</tr>
<tr>
<td>Supervision for other psychologists</td>
<td>11</td>
<td>85</td>
</tr>
<tr>
<td>Research</td>
<td>11</td>
<td>85</td>
</tr>
<tr>
<td>Consultation for other CMHT members</td>
<td>10</td>
<td>77</td>
</tr>
<tr>
<td>Training</td>
<td>10</td>
<td>77</td>
</tr>
<tr>
<td>Service planning and development</td>
<td>9</td>
<td>70</td>
</tr>
<tr>
<td>Staff support</td>
<td>8</td>
<td>62</td>
</tr>
<tr>
<td>Service evaluation</td>
<td>8</td>
<td>62</td>
</tr>
<tr>
<td>Audit</td>
<td>6</td>
<td>46</td>
</tr>
<tr>
<td>Supervision for other CMHT members</td>
<td>4</td>
<td>31</td>
</tr>
</tbody>
</table>

*Work seen as representing best use of clinical psychologists' skills (closed questions)*

The most frequent choices were individual therapy (9/11 (82%) of participants) and various assessment activities (8/11 (73%)) (Table 3). Only 3/11 (27%) of participants selected complex referrals.
Table 3: Direct work indicated by respondents to be the best use of skills of clinical psychologists.

<table>
<thead>
<tr>
<th>Category of work</th>
<th>Frequency</th>
<th>Percentage (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual therapy</td>
<td>9</td>
<td>82</td>
</tr>
<tr>
<td>Group therapy</td>
<td>3</td>
<td>27</td>
</tr>
<tr>
<td>Complex referrals</td>
<td>3</td>
<td>27</td>
</tr>
<tr>
<td>Assessment of new referrals to the CMHT</td>
<td>2</td>
<td>18</td>
</tr>
<tr>
<td>Assessment of new referrals to the psychology service</td>
<td>2</td>
<td>18</td>
</tr>
<tr>
<td>Psychometric assessment</td>
<td>2</td>
<td>18</td>
</tr>
<tr>
<td>Consultation for clients</td>
<td>2</td>
<td>18</td>
</tr>
<tr>
<td>Other (assessment of client functioning—depression, anxiety etc.)</td>
<td>2</td>
<td>18</td>
</tr>
<tr>
<td>Routine referrals</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Acute/urgent referrals</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

Consensus regarding categories of indirect work was confined to aspects of the consultant role of clinical psychologists (Table 4). These included informal advice to other CMHT members (8/11 (73%) respondents), and consultation for other CMHT members (7/11 (64%)).
Table 4: Indirect work indicated by respondents to be the best use of skills of clinical psychologists.

<table>
<thead>
<tr>
<th>Category of work</th>
<th>Frequency</th>
<th>Percentage (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Informal advice to other CMHT members</td>
<td>8</td>
<td>73</td>
</tr>
<tr>
<td>Consultation for other CMHT members</td>
<td>7</td>
<td>64</td>
</tr>
<tr>
<td>Training</td>
<td>5</td>
<td>45</td>
</tr>
<tr>
<td>Staff support</td>
<td>3</td>
<td>27</td>
</tr>
<tr>
<td>Service planning and development</td>
<td>3</td>
<td>27</td>
</tr>
<tr>
<td>Supervision for other CMHT members</td>
<td>2</td>
<td>18</td>
</tr>
<tr>
<td>Research</td>
<td>1</td>
<td>9</td>
</tr>
<tr>
<td>Supervision for other psychologists</td>
<td>1</td>
<td>9</td>
</tr>
<tr>
<td>Service evaluation</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Audit</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

Models of therapy perceived to be used by clinical psychologists (closed question) and models of therapy perceived to be used most (closed question).

Cognitive behavioural therapy was most frequently indicated to be a model of therapy used (13/13) (Table 5) and a model of therapy used most (10/10) (Table 6). Behavioural therapy (11/13, 85%) and interpersonal therapy (9/13, 69%) were also identified by a number of respondents as being used. Five comments referred to a lack of knowledge and/or opportunity to gain knowledge of models (appendix E), for example one respondent commented "Never seen a breakdown of different therapies offered".
Table 5: Models of therapy perceived by team members to be used by clinical psychologists

<table>
<thead>
<tr>
<th>Model of therapy</th>
<th>Frequency</th>
<th>Percentage (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cognitive behavioural therapy</td>
<td>13</td>
<td>100</td>
</tr>
<tr>
<td>Behavioural therapy</td>
<td>11</td>
<td>85</td>
</tr>
<tr>
<td>Interpersonal therapy</td>
<td>9</td>
<td>69</td>
</tr>
<tr>
<td>Dialectical behaviour therapy</td>
<td>8</td>
<td>62</td>
</tr>
<tr>
<td>Schema focused cognitive therapy</td>
<td>7</td>
<td>54</td>
</tr>
<tr>
<td>Psychodynamic psychotherapy</td>
<td>6</td>
<td>46</td>
</tr>
<tr>
<td>Systemic therapy</td>
<td>6</td>
<td>46</td>
</tr>
<tr>
<td>Group therapy</td>
<td>5</td>
<td>38</td>
</tr>
<tr>
<td>Integrative therapy</td>
<td>4</td>
<td>31</td>
</tr>
<tr>
<td>No specific model</td>
<td>1</td>
<td>8</td>
</tr>
</tbody>
</table>

Table 6: Models of therapy perceived by team members to be used most by clinical psychologists

<table>
<thead>
<tr>
<th>Model of therapy</th>
<th>Frequency</th>
<th>Percentage (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cognitive behavioural therapy</td>
<td>10</td>
<td>100</td>
</tr>
<tr>
<td>Dialectical behaviour therapy</td>
<td>2</td>
<td>20</td>
</tr>
<tr>
<td>Behavioural therapy</td>
<td>2</td>
<td>20</td>
</tr>
<tr>
<td>Systemic therapy</td>
<td>2</td>
<td>20</td>
</tr>
<tr>
<td>Group therapy</td>
<td>2</td>
<td>20</td>
</tr>
<tr>
<td>Interpersonal therapy</td>
<td>1</td>
<td>10</td>
</tr>
<tr>
<td>Integrative therapy</td>
<td>1</td>
<td>10</td>
</tr>
<tr>
<td>Schema focused cognitive therapy</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Psychodynamic psychotherapy</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>No specific model</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>
Problems perceived to be ones for which clinical psychologists might provide interventions (closed question) and ones for which providing interventions were seen as representing best use of clinical psychologists' skills (closed question).

All categories were frequently selected as problems that psychologists might intervene with except for psychosexual problems (6/13, 46%), addictions (4/13, 31%) and head injury (4/13, 31%) (Table 7). All 13 respondents selected phobias, obsessive compulsive disorder and post traumatic stress disorder.

Table 7: Mental health problems indicated by CMHT members to be ones for which psychologists might provide interventions.

<table>
<thead>
<tr>
<th>Category Mental Health Problem</th>
<th>Frequency</th>
<th>Percentage (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Phobias</td>
<td>13</td>
<td>100</td>
</tr>
<tr>
<td>Obsessive compulsive disorder</td>
<td>13</td>
<td>100</td>
</tr>
<tr>
<td>Post traumatic stress disorder</td>
<td>13</td>
<td>100</td>
</tr>
<tr>
<td>Deliberate self-injury</td>
<td>12</td>
<td>92</td>
</tr>
<tr>
<td>Anxiety and panic</td>
<td>12</td>
<td>92</td>
</tr>
<tr>
<td>Depression</td>
<td>12</td>
<td>92</td>
</tr>
<tr>
<td>Recent onset psychosis</td>
<td>11</td>
<td>85</td>
</tr>
<tr>
<td>Long term/chronic psychosis</td>
<td>11</td>
<td>85</td>
</tr>
<tr>
<td>Personality disorder</td>
<td>11</td>
<td>85</td>
</tr>
<tr>
<td>Relationship difficulties</td>
<td>10</td>
<td>77</td>
</tr>
<tr>
<td>Sexual abuse</td>
<td>10</td>
<td>77</td>
</tr>
<tr>
<td>Eating disorder</td>
<td>9</td>
<td>69</td>
</tr>
<tr>
<td>Issues related to life events</td>
<td>9</td>
<td>69</td>
</tr>
<tr>
<td>Psychosexual problems</td>
<td>6</td>
<td>46</td>
</tr>
<tr>
<td>Addictions</td>
<td>4</td>
<td>31</td>
</tr>
<tr>
<td>Head injury</td>
<td>4</td>
<td>31</td>
</tr>
</tbody>
</table>
Almost no agreement was found regarding problems for which providing interventions represented best use of skills, aside from the 6/10 respondents who selected recent onset psychosis (Table 8). 2/10 respondents selected all categories of problem provided. One respondent commented that “Severity of problems differs greatly and mild/moderate problems could be referred elsewhere” (appendix 5).

Table 8: Mental health problems indicated by CMHT members to be ones for which providing interventions represents best use of psychologists’ skills.

<table>
<thead>
<tr>
<th>Category Mental Health Problem</th>
<th>Frequency</th>
<th>Percentage (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recent onset psychosis</td>
<td>6</td>
<td>60</td>
</tr>
<tr>
<td>Obsessive compulsive disorder</td>
<td>4</td>
<td>40</td>
</tr>
<tr>
<td>Long term/chronic psychosis</td>
<td>4</td>
<td>40</td>
</tr>
<tr>
<td>Depression</td>
<td>4</td>
<td>40</td>
</tr>
<tr>
<td>Deliberate self-injury</td>
<td>4</td>
<td>40</td>
</tr>
<tr>
<td>Anxiety and panic</td>
<td>4</td>
<td>30</td>
</tr>
<tr>
<td>Personality disorder</td>
<td>3</td>
<td>40</td>
</tr>
<tr>
<td>Phobias</td>
<td>2</td>
<td>20</td>
</tr>
<tr>
<td>Post traumatic stress disorder</td>
<td>2</td>
<td>20</td>
</tr>
<tr>
<td>Relationship difficulties</td>
<td>2</td>
<td>20</td>
</tr>
<tr>
<td>Sexual abuse</td>
<td>2</td>
<td>20</td>
</tr>
<tr>
<td>Eating disorder</td>
<td>2</td>
<td>20</td>
</tr>
<tr>
<td>Issues related to life events</td>
<td>2</td>
<td>20</td>
</tr>
<tr>
<td>Psychosexual problems</td>
<td>1</td>
<td>10</td>
</tr>
</tbody>
</table>

Perceptions regarding referral to the clinical psychology service

Problems perceived as appropriate for referral (closed question) and which team members would be most likely to refer (closed question).

Respondents identified recent onset psychosis (7/8) and a range of chronic mental health problems they might refer (Table 9), and obsessive compulsive disorder (6/8) as a
problem they would be most likely to refer. One respondent stated "It's difficult to select
the most likely. It depends on how many other services are involved and progress the
client is making with these. I suppose I tend to select people who stand out as really
needing your service in order to move on and this depends on the individual more than
the diagnosis" (appendix E).

Table 9: Mental health problems that CMHT members might refer and would be most
likely to refer to the clinical psychology service.

<table>
<thead>
<tr>
<th>Category of Mental Health Problem</th>
<th>Might be referred</th>
<th>Most likely to be referred</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Frequency</td>
<td>Percentage (%)</td>
</tr>
<tr>
<td>Obsessive compulsive disorder</td>
<td>11</td>
<td>92</td>
</tr>
<tr>
<td>Post traumatic stress disorder</td>
<td>10</td>
<td>83</td>
</tr>
<tr>
<td>Recent onset psychosis</td>
<td>10</td>
<td>83</td>
</tr>
<tr>
<td>Long term/chronic psychosis</td>
<td>10</td>
<td>83</td>
</tr>
<tr>
<td>Personality disorder</td>
<td>10</td>
<td>83</td>
</tr>
<tr>
<td>Depression</td>
<td>9</td>
<td>75</td>
</tr>
<tr>
<td>Phobias</td>
<td>9</td>
<td>75</td>
</tr>
<tr>
<td>Deliberate self-injury</td>
<td>9</td>
<td>75</td>
</tr>
<tr>
<td>Anxiety and panic</td>
<td>7</td>
<td>58</td>
</tr>
<tr>
<td>Eating disorder</td>
<td>5</td>
<td>42</td>
</tr>
<tr>
<td>Relationship difficulties</td>
<td>5</td>
<td>42</td>
</tr>
<tr>
<td>Sexual abuse</td>
<td>5</td>
<td>42</td>
</tr>
<tr>
<td>Issues related to life events</td>
<td>4</td>
<td>33</td>
</tr>
<tr>
<td>Addictions</td>
<td>4</td>
<td>33</td>
</tr>
<tr>
<td>Psychosexual problems</td>
<td>3</td>
<td>25</td>
</tr>
<tr>
<td>Head injury</td>
<td>3</td>
<td>25</td>
</tr>
</tbody>
</table>
Models of therapy perceived as being appropriate for particular problems (closed question).

There was little agreement amongst responses (Table 11, appendix D). Exceptions were indications that behavioural therapy would be desirable for phobias (9/10) and obsessive compulsive disorder (8/10), that cognitive behavioural therapy would be desirable for depression (8/10 and "anxiety and panic" (7/10). Three comments referred to lack of knowledge regarding models of therapy, for example “Exposed the fact that I need to hear more about the appropriateness of various therapies for various conditions” (appendix E).

Factors influencing decisions to refer (closed questions).

Feeling stuck in your work with a client was selected by the greatest number of respondents (8/13) (Table 10), and two comments were made referring to a need for a "New approach" with certain clients (appendix E). Previous unsuccessful treatment attempts with a psychologist was indicated as a potentially influencing factor by 7/13 respondents. Four comments were made stating that respondents would be less likely to refer a client if they had experienced previous unsuccessful treatment attempts, for example "Less likely to refer if previous unsuccessful treatment" (appendix E). A factor cited by one respondent was “Whether the client presents as being able to work in a psychological way".
Table 10: Factors influencing respondents’ decisions to refer to clinical psychology service.

<table>
<thead>
<tr>
<th>Factor Influencing Referral Decision</th>
<th>Number of respondents</th>
<th>Percentage of respondents (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Feeling stuck in work with a client</td>
<td>8</td>
<td>62</td>
</tr>
<tr>
<td>Previous unsuccessful treatment attempt</td>
<td>7</td>
<td>54</td>
</tr>
<tr>
<td>Insight of the client</td>
<td>5</td>
<td>39</td>
</tr>
<tr>
<td>Motivation of the client</td>
<td>3</td>
<td>25</td>
</tr>
<tr>
<td>Characteristics of the psychologist(s)</td>
<td>3</td>
<td>23</td>
</tr>
<tr>
<td>Age of the client</td>
<td>2</td>
<td>15</td>
</tr>
<tr>
<td>Gender of the client</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

Clients CMHT members might be unsure whether to refer and clients perceived as being inappropriate for referral (open-ended questions).

Themes identified fell into three categories. Three comments referred to participants discussing clients with clinical psychologists before making referrals, for example “I would discuss with psychologist and then refer if in doubt”. Two respondents commented that they would be unsure whether to refer a client with an addiction. Two were unsure whether to refer a client with difficulties for which a specialist service existed (e.g. eating disorders) (see appendix E).

The main theme arising from participants’ indications of clients who would be inappropriate for referral related to those with less complex difficulties (4 respondents), for example “Clients with issues only relating to life events which may better be helped by alternative services.”. Two respondents stated that clients with addictions would not be appropriate for referral to the clinical psychology service (see appendix E).
Perceptions of different professional groups

Perceptions of different professional groups could not be compared due to the small numbers of questionnaires returned and the fact that colour coding indicating professional group had been blanked out on four of the thirteen questionnaires returned.

Discussion

CMHT members' perceptions of the role of clinical psychologists

CMHT members understood consultancy as being an aspect of clinical psychologists' work, and an aspect to be expanded if best use is to be made of their skills. Although this desire for greater use of psychologists as consultants is in keeping with previous findings (Osborn-Davies, 1996; Cushion, 1997), in the past, consultancy has not always been identified as part of existing work by professionals working alongside clinical psychologists (Osborn-Davies, 1996). This recognition of the value of consultancy indicates that recommendations that this role be developed (MPAG, 1990) may have been implemented in this context. Consensus was also found regarding other aspects of clinical psychologists' work. In line with other findings, individual therapy (Osborn-Davies, 1996; Cushion, 1997) and assessment (Osborn-Davies, 1996) were most commonly identified. This consensus suggests that roles of clinical psychologists may be fairly well defined and recognisable by team members. Whilst complex referrals were identified by the majority of respondents as forming part of clinical psychologists' roles, a relatively small proportion selected complex referrals as representing good use of psychologists expertise. This is discussed below. Finally, although the prevailing view of cognitive behavioural therapy (CBT) as the predominant approach may be explained in terms of it's current prominence, participants' comments regarding lack of knowledge of other models suggests that CBT may have been a focus by default. Informal consultation with clinical psychologists revealed that in fact schema-focused cognitive therapy was used most. Provision of more information regarding this and other models of therapy may therefore be appropriate.
CMHT member's perceptions of referral to clinical psychology

In contrast to Hughes et al.'s (1996) finding that sexual problems, phobias and obsessive compulsive disorder were perceived as mental health problems routinely referred to clinical psychologists within a CMHT, participants in this study identified recent onset and chronic psychosis, personality disorder, obsessive compulsive disorder and post traumatic stress disorder as problems that might be referred. This selection fits with current definitions of CMHT's as providers of services to clients with long-term and serious mental health problems (Moss, 1994), and suggests that this team perceives the clinical psychology service as potential providers of this sort of service.

Factors most likely to influence team members' decisions to refer were feeling stuck in their work with a client and previous unsuccessful treatment attempts with a psychologist. Other factors mentioned included "Whether the client presents as being able to work in a psychological way". Therefore it may be that team members are sometimes making rather ad hoc referral decisions. Although a number of respondents stated that they would discuss referrals about which they felt unsure with a psychologist, it may be useful if this process were more explicitly encouraged. Clients for whom a specialist service already existed were identified as ones who respondents would be unsure whether to refer, and it would be useful if protocol were established in this regard. Finally, less complex cases were seen as unsuitable for referral. This is consistent with other findings that complex referrals were overwhelmingly selected as forming part of the current work of psychologists and that chronic mental health problems (which are often complex in nature) are appropriate for referral. In contrast, few participants saw complex referrals as representing best use of clinical psychologists' skills. This apparent contradiction might be due to a lack of clarity in the term "complex referral", which was an item taken from previous research. Alternatively it may be that whilst participants understand the role of psychologists as involving work with complex and more serious mental health problems, this is not where they feel that the best use of psychologists' skills lies. Thus it may be useful for the team to explore this issue further in the context of recommendations that work with complex referrals forms an important aspect of clinical psychologists' roles (MPAG, 1990).
**Critical evaluation and limitations**

Despite several reminders and a second distribution of the questionnaire, only 48% of questionnaires were returned. It is possible that the questionnaire was too long, that participants found it intimidating due to the quantity or nature of information requested, or that colour coding deterred potential participants. A number of participants returned questionnaires with colour coding for professional group blanked out, which meant that professional group differences in perceptions could not be compared. Thus, in future it may be appropriate to shorten the questionnaire, or present two shorter questionnaires and to consult with prospective participants before colour coding. Because of the small size of the sample, generalisability of findings to other members of the CMHT sampled and to other CMHT's is restricted. This difficulty could be addressed through recruiting a larger number of participants from several CMHT's. It would also have been useful to have objective data such as actual models of therapy used by psychologists and a history of referrals accepted by the service to compare with team members' perceptions of these.

**Feedback of results**

Results are to be presented to the team during an allocation meeting later this year.

**Conclusion**

Overall the role of team clinical psychologists appeared to be well defined and recognisable, particularly in relation to consultancy. However, further exploration of views regarding best use of clinical psychologists' skills could be undertaken. Lack of knowledge regarding models of therapy other than CBT could also be addressed through the provision of appropriate information. Although a clear understanding existed of the suitability of serious and long-term mental health problems for referral to clinical psychology services, discussion of potential referrals should be encouraged. Finally, it
would be useful for a protocol to be established regarding referral of problems for which a specialist service exists.
References


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Appendices:

Appendix A: Questionnaire
Appendix B: Initial questionnaire covering letter
Appendix C: Follow-up questionnaire covering letter
Appendix D: Frequency table
Appendix E: Comments from participants
Appendix F: Letter confirming that findings have been fed back to service
Appendix A: Questionnaire
WE WOULD BE GRATEFUL IF YOU COULD TAKE SOME TIME TO COMPLETE THE FOLLOWING QUESTIONNAIRE.

PART A: This part of the questionnaire asks some questions concerning your perceptions of the role of clinical psychologists, and your views regarding the best use of the skills of clinical psychologists. There are no "right" or "wrong" answers to these questions. Your opinions are what count.

1.) In your view, which of the following direct work with clients do clinical psychologists working in **** Community Mental Health Team (CMHT) do? You may tick more than one box.

- Assessment of new referrals to the CMHT
- Assessment of new referrals to psychology service
- Psychometric assessment (intelligence testing)
- Individual therapy
- Group therapy
- Routine referrals
- Complex referrals
- Acute/urgent referrals
- Consultation for clients
- None of the above
- Don't know
- Other please specify below

Any comment?

2.) In your opinion, which of this direct work represents the best use of the skills of clinical psychologists working in **** CMHT and why? You may talk about more than one category.

3.) In your view, which of the following indirect work do clinical psychologists working in **** CMHT do? You may tick more than one box.

- Informal advice to other CMHT members
- Supervision for other CMHT members
Supervision for other psychologists □
Consultation for other CMHT members □
Staff support □
Training □
Service evaluation □
Service planning and development □
Audit □
Research □
None of the above □
Don't know □
Other please specify below □

Any comment?

4.) In your opinion, which of this indirect work represents the best use of the skills of clinical psychologists working in **** CMHT and why? You may talk about more than one category.

5.) In your view, which of the following models of therapy do clinical psychologists working in **** CMHT use? You may tick more than one box.

Cognitive behavioural therapy □
Schema focused cognitive therapy □
Dialectical behaviour therapy □
Behavioural therapy □
Interpersonal therapy □
Psychodynamic psychotherapy □
Systemic therapy □
Group therapy □
Integrative therapy □
No specific model □
Don't know □
Other please specify below □

Any comment?
6.) In your opinion, which (if any) of the above models of therapy are used most by clinical psychologists working in **** CMHT?


7.) In your view, which of the following difficulties might clinical psychologists working in **** CMHT provide psychological interventions for? You may tick more than one box.

- Recent onset psychosis □
- Long term/chronic psychosis □
- Personality disorder □
- Anxiety and panic □
- Depression □
- Eating disorder □
- Issues related to life events □
- Relationship difficulties □
- Phobias □
- Obsessive compulsive disorder □
- Post traumatic stress disorder □
- Sexual abuse □
- Psychosexual problems □
- Addictions (gambling, substance abuse) □
- Deliberate self-injury □
- Head injury □
- None of the above □
- Don't know □
- Other please specify below □

Any comment?


8.) In your view, providing psychological interventions for which of the difficulties listed above represents the best use of the skills of clinical psychologists working in **** CMHT and why? You may talk about more than one category.


PART B: This part of the questionnaire asks some questions concerning the factors that might influence your decision to refer to the clinical psychology service within the **** Community Mental Health Team (CMHT). There are no “right” or “wrong” answers to these questions. Your opinions are what count.

1.) Have you made a referral to the **** CMHT clinical psychology service in the past four months? Please tick one of the boxes below.

- Yes
- No
- Don't know

2.) Which of the following difficulties might you refer to the **** CMHT clinical psychology service? You may tick more than one box.

- Recent onset psychosis
- Long term/chronic psychosis
- Personality disorder
- Anxiety and panic
- Depression
- Eating disorder
- Issues related to life events
- Relationship difficulties
- Phobias
- Obsessive compulsive disorder
- Post traumatic stress disorder
- Sexual abuse
- Psychosexual problems
- Addictions (gambling, substance abuse)
- Deliberate self-injury
- Head injury
- None of the above
- Don't know
- Other please specify below
Any comment?

3.) Which (if any) of the difficulties listed above might you be most likely to refer to the **** CMHT clinical psychology service and why? You may talk about more than one category.
4.) Please complete this table for each of the difficulties that you identified above as ones you might refer to the East Elmbridge CMHT clinical psychology service. For each difficulty please tick the model(s) of therapy that you feel it would be important for the client to receive:

<table>
<thead>
<tr>
<th>Difficulty</th>
<th>Cognitive behaviour therapy</th>
<th>Schema focused cognitive therapy</th>
<th>Dialectical behaviour therapy</th>
<th>Behavioural therapy</th>
<th>Interpersonal therapy</th>
<th>Psychodynamic psychotherapy</th>
<th>Systemic therapy</th>
<th>Group therapy</th>
<th>No specific model</th>
<th>Don't know</th>
<th>Other</th>
</tr>
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<tbody>
<tr>
<td>Recent onset psychosis</td>
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<td>Long term psychosis</td>
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<tr>
<td>Personality disorder</td>
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<tr>
<td>Anxiety and panic</td>
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<td>Depression</td>
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<tr>
<td>Eating disorder</td>
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<td>Life event issues</td>
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<tr>
<td>Relationship difficulties</td>
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<tr>
<td>Phobias</td>
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<tr>
<td>Obsessive compulsive disorder</td>
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<tr>
<td>Post traumatic stress disorder</td>
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<td></td>
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<td></td>
<td></td>
<td></td>
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<td></td>
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<tr>
<td>Sexual abuse</td>
<td></td>
<td></td>
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<td></td>
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<td></td>
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<tr>
<td>Psychosexual problems</td>
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<tr>
<td>Addictions</td>
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<tr>
<td>Deliberate self-injury</td>
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<tr>
<td>Head injury</td>
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</table>

Any comment?

_________________________________________________________________________

_________________________________________________________________________
5.) Would any of the following factors influence your decision whether to refer a client to the **** CMHT clinical psychology service? Please tick one of the boxes for each question.

a.) Age of the client? Yes □ No □ Don't know □
b) Gender of the client? Yes □ No □ Don't know □
c.) Motivation of the client? Yes □ No □ Don't know □
d.) Insight of the client into his/her difficulties? Yes □ No □ Don't know □
e.) Previous successful treatment attempts? Yes □ No □ Don't know □
f.) Previous unsuccessful treatment attempts? Yes □ No □ Don't know □
g.) Other characteristics of the client? Yes □ No □ Don't know □
h.) Feeling stuck in your work with a client? Yes □ No □ Don't know □
i.) Characteristics of the psychologist(s)? Yes □ No □ Don't know □

If you have answered “yes” to any of the above questions please explain your response:

__________________________________________________________________________________________________________________________________________________

6.) In your opinion, what sort of client would not be appropriate for referral to the **** CMHT clinical psychology service and why?

__________________________________________________________________________________________________________________________________________________

7.) What sort of client would you not be sure whether to refer to the **** CMHT clinical psychology service and why?

__________________________________________________________________________________________________________________________________________________

THANK YOU FOR TAKING THE TIME AND TROUBLE TO COMPLETE THIS QUESTIONNAIRE. PLEASE RETURN THIS TO ****’S PIGEON HOLE AS SOON AS POSSIBLE.
Dear ****Community Mental Health Team member,

As you are aware a few months ago the **** and **** Community Mental Health Teams (CMHT's) merged to create the **** CMHT. Since then, a new Counselling Psychology service operating primarily out of G.P. practices in the **** area has also been established. The introduction of this is likely to have a knock-on effect on the sorts of referrals made to the clinical psychology service. In addition, the clinical psychology service has expanded to include a new member, ****, who has brought with him new skills and ideas. In light of these changes to the team and to the clinical psychology service, we are carrying out a study examining the perceptions of team members of the role of clinical psychologists in the **** CMHT and the factors influencing your decisions to refer to the clinical psychology service. This will allow your views to be accounted for during this period of change, and will provide us with an opportunity to ensure that you receive appropriate information about the clinical psychology service.

We are keen to ensure that the views of all members of the team are taken into account, and for this reason it is important that everyone completes the enclosed questionnaire. The questionnaires have been colour coded in order to allow us to identify your professional group. However we have no way of identifying you personally, and to this extent your responses are anonymous.

A report detailing results of this research will be available for those who would like to receive a copy during ****. In addition, **** and **** will be holding a meeting to discuss the findings with the team at around this time.

Please return completed questionnaires to **** pigeon hole as soon as possible. If you have any questions or wish to discuss this further please do not hesitate to approach one of us.
Many thanks in advance for your co-operation.

****
Trainee Clinical Psychologist

****
Chartered Clinical Psychologist
Appendix C: Follow-up questionnaire covering letter
Dear **** Community Mental Health Team member,

A few weeks ago you may remember receiving a questionnaire asking about your perceptions of the role of clinical psychologists in the **** Community Mental Health Team (CMHT), and the factors influencing your decisions to refer to the clinical psychology service. The purpose of this is to enable your views to be accounted for during the recent period of change to the CMHT as a whole and to the clinical psychology service. Results from this research will provide us with an opportunity to ensure that you receive appropriate information about the psychology service.

Many thanks to all those who have already completed and returned a questionnaire. In order to ensure that the views of all team members are taken into account, it is important that everyone completes one of these. So, if you have not already done so, we would be grateful if you could complete the enclosed questionnaire and return this to ****’s pigeon hole no later than **** 2001.

The questionnaires have been colour coded in order to allow us to identify your professional group. However we have no way of identifying you personally, and to this extent your responses are anonymous.

If you have any questions or wish to discuss this further please do not hesitate to approach one of us.
Many thanks in advance for your co-operation.

****
Trainee Clinical Psychologist  Chartered Clinical Psychologist
Appendix D: Frequency table
Table 11: Models of therapy perceived by CMHT members as being appropriate for particular mental health problems

<table>
<thead>
<tr>
<th>Condition</th>
<th>Cognitive behaviour therapy</th>
<th>Schema focused cognitive therapy</th>
<th>Dialectical behaviour therapy</th>
<th>Behaviour therapy</th>
<th>Inter-personal therapy</th>
<th>Psychodynamic psychotherapy</th>
<th>Systemic therapy</th>
<th>Group therapy</th>
<th>No specific model</th>
<th>Other</th>
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<td>0</td>
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<td>3</td>
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<tr>
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<tr>
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<td>1</td>
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<td>Deliberate self-injury</td>
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</tr>
<tr>
<td>Head injury</td>
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<td>0</td>
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<td>0</td>
<td>0</td>
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</tr>
</tbody>
</table>
Appendix E: Comments from participants
1. Comments made in relation to models of therapy perceived by CMHT members to be used by clinical psychologists within the team (closed question with response options provided) and models of therapy perceived to be used most (open-ended question referring to previous response options):

"Don't know enough about some of these therapies"
"Don't know what this is"
"Never seen a breakdown of different therapies offered"
"They don't talk much about models"
"Don't know what integrative therapy is"

2. Comments made in relation to mental health problems perceived by CMHT members as ones for which providing interventions represented the best use of skills of team clinical psychologists (open-ended question referring to previous response options):

"Severity of problems differs greatly and mild/moderate problems could be referred elsewhere".
"Would like to do more joint work with psychologists".

3. Comments made in relation to mental health problems perceived by CMHT members as being appropriate for referral to the clinical psychology service (closed question) and that they would be most likely to refer (open-ended question referring to previous response options):

"Not certain about sexual abuse and psychosexual problem. Need for specialist teams?"
"These appear to be the type of referrals accepted so far"
"It's difficult to select the most likely – it depends on how many other services are involved and progress the client is making with these. I suppose I tend to select people who stand out as really needing your service in order to move on and this depends on the individual more than the diagnosis".

4. Comments made in relation to models of therapy perceived by CMHT members as being appropriate for particular mental health problems (closed question):

"I don't know what schema focused cognitive therapy and dialectical behaviour therapy are"
"I'm not sure what schema focused cognitive therapy is"
"Exposed the fact that I need to hear more about the appropriateness of various therapies for various conditions"

"A lot of schema focused therapy applicable in most areas. Would only refer if it was beyond my own limitations/case capacity to provide input"

"I don’t feel entirely equipped/comfortable with answering this as I feel it is your decision to use the most relevant approach (or one you are most equipped to use!) I am sure your decision would not purely be based on diagnosis".

5. Comments made in relation to motivation of the client as a factor influencing decisions of CMHT members to refer to the clinical psychology service:

"Clients ability to gain some benefit from sessions – would discuss with colleague first".

"No motivation – unlikely to refer".

6. Comments made in relation to insight of the client into his/her difficulties as a factor influencing decisions of CMHT members to refer to the clinical psychology service:

"If little insight wouldn’t be able to grasp concepts easily".

7. Comments made in relation to previous successful/unsuccessful treatment attempts as a factor influencing decisions of CMHT members to refer to the clinical psychology service:

"More likely to refer if previous successful treatment".

"Due to successes I would refer again because the client would benefit by reinforcement".

"Less likely to refer if previous unsuccessful treatment".

"If a previous unsuccessful attempt, may need to look at another service".

"If it works why not".

"Would certainly need considering".

8. Comments made in relation to other characteristics of the client as a factor influencing decisions of CMHT members to refer to the clinical psychology service:

"Whether client presents as being able to work in a psychological way".
9. Comments made in relation to feeling stuck in work with a client as a factor influencing decisions of CMHT members to refer to the clinical psychology service:

"New approach – different model of therapy may be more appropriate for client”.
"I think that in some cases clients can benefit from new approach and working with another professional, this may simply reflect stage reached”.

10. Comments made in relation to characteristics of the psychologist(s) as a factor influencing decisions of CMHT members to refer to the clinical psychology service:

“Inevitably how approachable and willing to take work on does influence me (as does their past good results)”.

11. Comments made in relation to clients perceived by CMHT members as being inappropriate for referral to the clinical psychology service:

“I can think of a wide range of people who would benefit but might not be your priority i.e. less complex problems life events responses, relationship issues, anxiety, addictions.”
“Chronic psychosis – no insight”.
“Where counselling is requested. Straightforward depression and anxiety”.
“Clients with primary alcohol and illicit drug problems. Clients with issues only relating to life events which may better be helped by alternative services e.g. CRUSE, RELATE or social work help. Clients over 65 years or under 18”.
“Patients requiring short-term brief therapy, general support. Can be dealt with by other CMHT member and better use of psychology time”.
“Clients outside age criteria”.
“Age factor”.

12. Comments made in relation to clients who CMHT members would be unsure whether to refer to the clinical psychology service:

“I am usually sure about my referrals. I would probably discuss referral with psychologist first if I was at all unsure”.
“Drug, alcohol problems – would always discuss with psychologist if unsure. Low need clients”.
“I would discuss with psychologist and then refer if in doubt”.
“Substance abuse – different team. Anxiety and panic – anxiety management group”.
“Eating disorders – as we have the eating disorders service”.

“Clients who need short term counselling e.g. 6 sessions. Those without insight.

“Patients who have been repeatedly referred to them”.
Appendix F: Letter confirming that findings have been fed back to service
Ms
Trainee Clinical Psychologist
Psychology Department, Clinical Psychology
University of Surrey
Guildford
Surrey GU2 7XH

16th October 2001

Dear [Name],

Re: Presentation of Service Related Research
(Community Mental Health Team Members’ Perceptions of the Role of Clinical Psychologist within the team and referred to the Clinical Psychologist Service).

Many thanks for coming to present the findings of your research on 9th September 2001. It was very interesting from my point of view, as the only psychologist in the team, but the team also welcomed the feedback and the opportunity for discussion.

With best wishes

Chartered Clinical Psychologist
II. Major research project
July 2003
Year 3
Coping, perceived control, parenting stress and psychological symptomatology in mothers and fathers of children with Autistic Spectrum Disorder

Imogen Clarke

Submitted for the degree of Doctor of Psychology (Clinical Psychology)
Word count: 17,732

Department of Psychology
School of Human Sciences
University of Surrey

July 2003
Abstract

Title
Coping, perceived control, parenting stress and psychological symptomatology in mothers and fathers of children with autistic spectrum disorder (ASD).

Objectives
To investigate relationships between coping and stress and psychological symptomatology in parents of children with ASD. To examine relationships between goodness of fit between perceived control and coping, and parenting stress and symptomatology. To investigate parental differences in coping, parenting stress and symptomatology.

Design
Single cohort cross sectional design

Setting
Specialist child learning disability and child and adolescent mental health services in London.

Participants
37 mothers and 37 fathers with an index child aged 4 to 11 years.

Main measures
Coping Inventory for Stressful Situations: Situation Specific Checklist; the Parenting Stress Index and the General Health Questionnaire-28. A single item controllability rating measured control appraisals.

Results
Avoidance coping was associated with increased parenting stress for both parents. Task oriented coping was related to increased parenting stress for low control appraising fathers. Emotion oriented coping was associated with more parenting stress and psychological symptomatology for high control appraising mothers. Some support was
found for the notion that goodness of fit between perceived control and coping was associated with parenting stress experienced by mothers and fathers. Mothers reported more parenting stress than fathers.

Conclusion
Coping strategies and control appraisals are important in explaining stress and psychological symptomatology. The cognitive transactional model represented a useful heuristic in interpreting findings, and the concept of goodness of fit and the outcome methods of evaluating coping were of use. Findings have implications for cognitive behavioural intervention and for the development of coping measures.
Introduction

This introduction will begin with an exploration of definitions and contextual issues relevant to the study, and move on to a consideration of theoretical models of stress, coping and adaptation. A summary of the relevant literature will then be presented, followed by the rationale for this study and hypotheses and research questions to be explored.

Definitions and contextual issues

In 1943 Leo Kanner described a group of children with an unusual behavioural pattern evident in the first three years of life that he named ‘early infantile autism’ (Kanner, 1943; cited in McLaughlin-Cheng, 1998). In 1944 Hans Asperger published a report describing another group of children with a behavioural pattern similar to that discussed by Kanner, which is now known as Asperger’s syndrome. Some agreement has been reached that both autism and Asperger’s syndrome fall within what has become known as ‘the autistic spectrum’ (Wing, 1996). Consensus exists amongst diagnostic classificatory systems including ICD-10 (WHO, 1992) and DSM-IV (American Psychiatric Association, 1994) that the crucial diagnostic features of autistic spectrum disorder (ASD) are the triad of impairments of social interaction, social communication and imagination (Wing, 1996). Rigid and repetitive patterns of activity are also characteristic of ASD.

ICD-10 criteria for diagnosis of autism include onset before age three years of difficulties in three domains relating broadly to the triad of impairments. In the social interaction domain, difficulties include failure to use eye contact, facial expression and body posture to regulate social interaction and lack of social and emotional reciprocity. In the social communication domain, abnormalities involve language disorder without attempts by the child to compensate using gestures, and stereotyped or repetitive language use. Abnormalities in patterns of behaviour include preoccupation with restricted patterns of interest and rigid adherence to routine. ICD-10 differentiates Asperger’s syndrome from other ASD as being characterised by a lack of delay in development of language and adaptive skills, accompanied by qualitative impairments in reciprocal social interaction.
and communication, and restricted and repetitive interests and activities as in autism. Other sub-groups within the autistic spectrum identified by ICD-10 are ‘atypical autism’, which is diagnosed if there are insufficient features of typical autism or onset after three years, and ‘childhood disintegrative disorder’ where a period of normal development in the first two years are followed by skills loss.

**Stress in parents of children with ASD**

A substantial source of stress experienced by parents of children with ASD has been found to relate to the symptoms described above, particularly language impairment, social impairment (Bebko, Konstantareas & Springer, 1987; Konstantareas & Homatidis, 1989), hyperirritability (Konstantareas & Homatidis, 1989) and socially inappropriate behaviour (Harris, 1984). Although not diagnostic of ASD, the cognitive inconsistency, and aggressive and self-injurious behaviour that these children often exhibit represent sources of parental stress (Harris, 1984; Konstantareas & Homatidis, 1989). Wider issues that contribute to parent stress include poor understanding of ASD (Fisman, Wolf & Noh, 1989; cited in Sharpley, Bitsika & Efremidis, 1997), stigmatisation associated with ASD (Gray, 1993), the child’s ability to be accepted in the community (Koegel et al., 1992), difficulties in accepting the child’s diagnosis (Blancher, 1984; cited in Sanders & Morgan, 1997), concerns regarding the child’s future placement (Konstantareas & Homatidis, 1989) ability to function independently, and limits on family opportunity (Koegel et al., 1992; Sanders & Morgan, 1997).

The cumulative effect of stresses arising from parenting a child with ASD have been found to impact significantly on parents. Bouma and Schweitzer (1990) compared patterns of stress reported by mothers of children with autism and mental retardation¹, cystic fibrosis or without physical or psychological difficulties. Findings indicated that mothers of children with autism reported the greatest stress levels. However the groups were not matched for number of siblings in the family and marital status of mothers, which may have represented confounding variables. Given this and the lack of research

¹ This term is used in DSM-IV (American Psychiatric Association, 1994) to refer to intellectual disability, or learning disability, which is the UK accepted terminology. The author’s terminology will be used here throughout.
replicating these findings, firm conclusions cannot currently be drawn regarding
differential stress levels in these populations. Sanders and Morgan (1997) examined
stress and family adjustment in families with a child with autism, Downs syndrome or a
developmentally normal child. The marital status of parents and number of siblings in the
family did not differ significantly between groups, although the sample size of 18 per
group was rather small. Mothers and fathers of children with autism reported more
stress in raising their child than those of children with Downs syndrome and of children
without disability. Similarly, Konstantareas reports an unpublished study (Konstantareas,
Homatidis & Plowright, 1991; cited in Konstantareas, 1991) which assessed stress in
parents of children with autism, "mental retardation" and learning disability. Parents of
children with autism reported significantly more stress than the other groups. Donovan
(1988) compared stress in 36 mothers of adolescents with autism and 36 mothers of
adolescents with "mental retardation". Groups were well matched. Findings indicated
that mothers of adolescents with autism experienced significantly more stress. Dumas,
Wolf, Fisman and Culligan (1991) also found evidence of elevated stress levels in
parents of children with ASD. These authors assessed levels of stress in 30 parents of
children with autism, Downs syndrome, or behaviour disorders and 60 parents of
children with normal development. Groups were matched for age and gender of child,
number of siblings in the family and marital status of parents. Parents of children with
autism experienced parenting stress levels in relation to their child which were
significantly higher than those of children with Downs syndrome and normal
development, but comparable with parents of children with behaviour disorders. Taken
together, these studies provide evidence of the high levels of stress experienced by
parents of children with ASD in comparison with those of children with Downs syndrome
and of those with children with "mental retardation". Replication is required of research
comparing stress levels of parents of children with ASD with those of children with cystic
fibrosis and behavioural problems.

**Depression and anxiety in parents of children with ASD**

The empirical investigation of anxiety and depression in parents of children with ASD is
limited. However, there is evidence that parents of children with ASD report higher
levels of dysphoria than those of children with Downs syndrome, and higher levels of
depression and anxiety than parents in the general population (Dumas et al., 1991;
Sharpley, Bitsika and Afremidis, 1997).

Reports of stress and affective distress in parents of children with ASD are not surprising
as numerous studies have demonstrated that high stress levels are associated with
depression (Bolger, DeLongis, Kessler & Schilling, 1989; Pruchno & Resch, 1989) and
physical illness (e.g. Goldenhar, Swanson, Hurrell, Ruder & Deddens, 1998; Houston,
Jou & Fukada, 1997). Parental psychological well being has implications for the quality
and quantity of interaction between parent and child (Bramlett, Hall, Barnett & Rowell,
1995). As such, it is likely that the elevated stress, anxiety and depression in parents of
children with ASD will be reflected in the quality of parent-child interactions. Further, high
parental stress levels have been found to impact negatively upon both participation and
outcome in training interventions for parents of children with autism (Konstantareas,
1987; Lovaas, Koegel, Simmons & Long, 1973; cited in Konstantareas, 1991; Plienis,
Robbins and Dunlap, 1988). A greater understanding of variables that may impact upon
parental stress levels, therefore, has both theoretical and practical utility.

Theoretical model of stress coping and adaptation

Several models of the determinants of parenting and parenting stress (Abidin, 1992;
Belsky, 1984; McCubbin and Patterson, 1983; Ostberg and Hagekull, 2000) have been
developed over the years. Lazarus and Folkman's (1987) more comprehensive
cognitive transactional model of stress and coping will be considered here, as this has
been most influential in the existing literature related to stress and coping in parents of
children with disabilities.
Cognitive transactional model of stress and coping

1. Description of the model
Lazarus and Folkman's (1987) cognitive transactional model of stress and coping was developed to provide a framework that could be applied universally to the understanding of stress and coping in response to any given stressor. These authors propose that the quality and intensity of emotional responses to a stressor are a consequence of personal and environmental mediating variables and processes and a constantly changing relationship between person and environment.

Personal variables proposed to mediate between the stressor and immediate affective responses during and after the stressful encounter include the appraisals made of a stressor and the coping efforts employed in the face of this (Lazarus & Folkman, 1991). These authors propose that when faced with a stressor, individuals engage in two types of appraisal. Primary appraisals concern the implications of that stressor for well being and are categorised as appraisals of harm already experienced, threat of anticipated harm, challenge and benefit. Secondary appraisals are evaluative judgements regarding whether action can be taken to address the stressor and if so, which coping efforts might be useful. Secondary appraisal involves an appraisal of the amount of control we have over the stressor, and forms the basis for coping efforts. Appraisal of control is defined as “the belief that one has at one’s disposal a response that can influence the aversiveness of the event” (Thompson, 1981, pg. 89; cited in Vitaliano, DeWolfe, Maiuro, Russo & Katon, 1990). Coping is defined as “changing cognitive and behavioral efforts to manage specific external and/or internal demands that are appraised as taxing or exceeding the resources of the person” (Lazarus and Folkman, 1984, pg. 141). Lazarus and Folkman (1991) suggest that the value of a coping strategy is determined by its effects in a given encounter and in the long term, and that one coping strategy is not inherently better than another. This definition conceptualises coping as a cognitive and behavioural process rather than as a static coping resource (Schwarzer & Schwarzer, 1996). Lazarus and Folkman's definition assumes that coping efforts are influenced by the individual-environment relationship in a stressful encounter and is therefore situational.
functioning and psychological well being, and reduced difficulties with somatic health and illness. This model is depicted in Table 1 below.

Table 1. Lazarus and Folkman’s (1987) cognitive transactional model of stress and coping.

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<th>Causal antecedents</th>
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<th>Immediate effects</th>
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<td>Resources</td>
<td>Emotion focused</td>
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<td>Constraints</td>
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<td>Temporal aspects</td>
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2. Evaluation of the model
This remains the most widely cited model of stress and coping in the literature. Numerous researchers have successfully employed the cognitive transactional model as a heuristic for the study of populations facing a variety of stressors, thus demonstrating the wide range in applicability of this model (e.g. Bramlett, Hall, Barnett & Rowell, 1995; Feldman, Reichman, Miller, Gordon & Hendricks-Munoz, 2000; Jarvis & Creasey, 1991; Miller, Gordon, Daniele & Diller, 1992; Thompson). These researchers and those investigating stressors in parents of children with ASD (Hastings & Johnson, 2001) have also demonstrated Lazarus and Folkman's proposed relationships between mediating processes of coping and the immediate effect of affect and long-term effect of psychological well-being. In addition, a number of authors have demonstrated proposed relationships between mediating processes of appraisal and coping and immediate and
These authors propose that coping has two major functions. Problem focused coping aims to alter the source of stress by acting on it directly, and emotion focused coping aims to regulate an individual's emotional response to the stressor. A consensus exists in the coping literature that this problem focused/emotion focused distinction is reliable (Carpenter, 1992; Parker & Endler, 1992). However, Lazarus and Folkman's (1984) suggestion of a number of sub-categorisations of coping strategies within these broad domains has been contentious. More specifically, they have suggested that emotion focused coping comprises the following sub-categories: distancing, self controlling, accepting responsibility, escape-avoidance and positive reappraisal. Problem focused coping was proposed to comprise confrontive coping, planful problem solving and seeking social support. Lazarus and Folkman's operationalisation of this categorisation in the Ways of Coping Questionnaire has resulted in an unstable factor structure in this measure (Carpenter, 1992; Forsythe & Compas, 1987). This indicates that these coping categories are less reliable concepts than the distinction between problem and emotion focused coping (Carpenter, 1992).

Stress is proposed to represent an immediate response to a stressor. This is defined as "a particular relationship between the person and the environment that is appraised by the person as taxing or exceeding his or her resources and endangering his or her well-being" (Lazarus and Folkman, 1984, pg. 19). This definition privileges situational rather than dispositional influences on the stress and coping process, and conceives of stress as a response that is distinguishable from the stressor. Stress and other immediate affective responses in turn lead to long term effects. As such, like other cognitive behavioural models, this model assumes that cognitive, behavioural and environmental factors are influential in the production of an emotional response. For example, a causal antecedent for a student might be an impending examination. He/she might make a primary appraisal of challenge, i.e. that a potential for gain through passing the examination exists as a result of the situation. He/she might make a secondary appraisal (see below) that he/she has a great deal of control over the outcome of the examination, and on the basis of that appraisal select the problem focused coping strategy of studying for the examination. The immediate effect of this might be positive affect and reduced autonomic activity associated with the perceived increased likelihood of him/her passing the examination. In the long term, the student might experience improved social
long term effects (Compas, McCarne & Fondacaro, 1988; Endler, Speer, Johnson & Flett, 2000; Forsythe & Compas, 1987; Lazarus & Folkman, 1984; Vitaliano, DeWolfe, Maiuro, Russo & Katon, 1990). Hence a persuasive body of evidence exists for this model, in contrast with the limited research supporting the Double ABCX model. In contrast to McCubbin and Patterson's emphasis on family factors influencing overall adjustment to chronic stressors, Lazarus and Folkman emphasise individual and specific cognitive and behavioural factors that allow analysis at an individual and situational level. This fits well with the current predominance of cognitive behavioural approaches to treatment of affective disorders, and may explain the popularity of the cognitive transactional model. Several researchers have outlined how this model might inform interventions of various kinds (Folkman et al., 1991; Miller et al., 1992). Finally this model's recognition of the dynamic and situational nature of stress and coping within a framework that aids comprehension of this must be considered a strength.

Relationships between coping and stress, anxiety and depression

Two models for evaluating the adaptiveness (as measured by subsequent stress, anxiety and depression) of a given coping strategy are described in the literature. These are the outcome and the goodness of fit models.

Outcome model

This model assumes that the quality of a coping process may be evaluated according to its effect on outcomes as long as outcomes selected are of sufficient proximity and relevance to the coping process to be confident that coping is causally related to outcome (Folkman, 1992). The majority of researchers investigating stress and coping have employed this model.

Numerous studies have employed the outcome model in evaluating the use of coping strategies in a variety of populations (e.g. Bramlett, et al., 1995; Feldman et al., 2000; Miller et al., 1992). These have demonstrated relationships between coping strategies and stress, anxiety and depression, which have been interpreted as indicating that some
coping strategies are more adaptive than others. A study of particular note in the present context examined the relationship between coping and parenting stress in 32 parents of 18-month-old infants (Jarvis & Creasey, 1991). Stress was measured using the Parenting Stress Index (Abidin, 1986; cited in Jarvis & Creasey, 1991). Coping was measured using the Revised Ways of Coping Checklist (Folkman & Lazarus, 1985; cited in Jarvis & Creasey, 1991) comprising eight sub-scales measuring the sub-categorisations of coping strategies described above. Escape avoidance coping was found to be significantly positively correlated with maternal and paternal parenting stress and positive reappraisal coping was significantly negatively correlated with maternal and paternal parenting stress. This suggests that use of escape avoidance coping is less adaptive than that of positive reappraisal. Unfortunately Jarvis and Creasey did not follow recommendations that researchers conduct their own factor analyses when using the Ways of Coping Checklist in order to overcome difficulties with it's unstable factor structure (Carpenter, 1992). As such, it is not possible to be confident that the factor structure described above applied to their sample and their findings must be treated with some caution.

To date, four studies have examined relationships between coping and stress, depression and anxiety in parents of children with ASD. The first of these (Bristol, 1987b) employed a sample of 45 mothers of children with communication and/or behavioural problems, 27 of whom had autism. Children were aged between 2 and 10 years. Bristol examined relationships between a number of variables such as coping patterns, family adaptation to the child including acceptance of the child and quality of parenting and depressive symptomatology. Coping was measured using the Coping Health Inventory for Parents (CHIP; McCubbin & Patterson, 1981; cited in Bristol 1987b), which measures perceived helpfulness of three coping patterns in managing the stress of parenting a child with a chronic illness or disability. These are, "maintaining family integration, co-operation and an optimistic definition of the situation", "maintaining social support, self esteem and psychological stability" and "understanding the medical situation through communication with other parents and consultation with medical staff". Greater use of coping strategies as measured by all three CHIP scales were related to increased acceptance of the child and quality of parenting. Mothers who relied on the coping pattern involving "maintaining social support, self-esteem and psychological
stability" were found to report fewer depressive symptoms. However, the CHIP has been
subject to criticism due to a lack of evidence demonstrating the construct and criterion
validity and test-retest reliability of this measure (Parker & Endler, 1991). In addition,
although Bristol reported that scores for mothers of children with autism were not
significantly different from those of non-autistic children, she did not present separate
analyses. Furthermore, a large number of correlational analysis appear to have been
carried out between the variables included, which would have increased the possibility of
false positive findings.

Using the same sample as that included in the above study, Bristol (1987a) conducted a
further study aiming to assess the applicability of the Double ABCX model to this sample.
Employing canonical correlation and multiple regression analyses, Bristol examined the
contribution to family adaptation of severity of handicap, pile up of stresses, family
cohesion, social support, externalisation of blame, the definition of the handicap as a
family crisis and patterns of coping. Findings indicated that coping pattern contributed to
prediction of parenting quality and observer ratings of family adaptation. Unfortunately,
analyses are not presented that would indicate which coping patterns made this
contribution. In contrast to the 1987b study, here Bristol reported that coping patterns
were not predictive of levels of maternal depression. This is somewhat curious as
apparently the same data has been used in both studies. However, the methodological
difficulties with this research mean that findings must be treated with caution. In
examining the findings of these two studies together, it is apparent that the same
sample, and certainly some of the same data has been used in both. This is contrary to
the methodological convention that only one set of hypotheses is investigated using a
particular data set. In addition, Bristol's use of a complex regression analysis with such
a small sample size is contrary to statistical recommendations (Cohen, 1992). Finally, as
the author did not differentiate between mothers of children with autism and those of
children with communication and/or behavioural problems in the analyses, it is not
possible to conclude whether findings pertain specifically to mothers of children with
ASD. This issue is of particular importance in light of findings presented above that
parents of children with ASD experience elevated levels of stress and psychological
symptomatology in comparison with parents of children with other disabilities and chronic
illnesses. These between group differences suggest that aspects of stress and coping
are particular to parents of children with ASD. Therefore, the lack of specificity and methodological flaws of this study limit the conclusions that can be drawn.

Gray and Holden (1992) investigated socio-demographic and family factors affecting the psychosocial well being of a sample of 172 parents of children with autism aged between 3 and 28 years. The proportion of mothers to fathers included was not reported. Family factors examined included coping as measured by the CHIP and social support. Psychosocial well being factors were anxiety, depression and anger. Regression analysis indicated that use of particular coping strategies was not predictive of psychosocial well being, with the most powerful predictor of anger, depression and anxiety being social support.

In 2001, Hastings and Johnson undertook an exploration of a number of predictors of stress in 130 mothers and 11 fathers whose children with autism were receiving intensive home based behavioural intervention. The mean age of children whose participating parents was 5 years. Stress was measured using the Questionnaire on Resources and Stress (QRS; Gliden & Floyed, 1997; cited in Hastings & Johnson, 2001). Parental coping was measured as a potential predictor of stress using the Family Coping Strategies Scale (FCOPES; McCubbin, Olson & Larsen, 1991; cited in Hastings & Johnson, 2001). Reframing coping (positively reframing events to make them more manageable) was found to predict lower scores on depression and parent and family problems sub-scales of the QRS. Acquiring social support coping predicted lower scores on the depression sub-scale. Findings were interpreted as indicating that coping strategies of reframing and acquiring social support are adaptive in parents whose children with ASD are in intensive home based intervention. However, this study does not allow us to determine whether this relationship is the same in mothers and fathers. In addition, these authors state that “the responding sample was unlikely to have been representative of families of children with autism in the UK”. It is therefore unclear whether these findings are applicable to other parents of children with ASD.

From the above it may therefore be seen that evidence exists for a relationship between coping and stress, depression and anxiety in other populations. However findings of studies investigating these relationships in parents of children with ASD remain
equivocal. One of the above studies has demonstrated a relationship between use of coping strategies around "maintaining social support, self-esteem and psychological stability" and maternal depression (Bristol, 1987b). Yet two other studies failed to demonstrate a relationship between coping and depression (Bristol, 1987a; Gray & Holden, 1992). Only one study to date has investigated and provided evidence for a relationship between coping strategies of reframing and acquiring social support and stress in a circumscribed population of parents of children with ASD. As such, this lack of weight of evidence coupled with the methodological difficulties with many of these studies, mean that further research is warranted in this area.

Methodological issues

Methodological issues have seriously hampered attempts to examine relationships between coping and stress, depression or anxiety in parents of children with ASD. The principal issue relates to the measurement of coping itself, which is, as stated by Carpenter (1992) "a difficult exercise". The development of coping measures has mainly been empirically driven resulting in a proliferation of measures and multiple proposed factor structures for the same measure (Aldwin & Revenson, 1987). Many of these coping measures have unsatisfactory psychometric properties, unstable factor structures and lack of cross validation (Schwarzer & Schwarzer, 1996). As such, there is little agreement amongst theorists and researchers regarding the conceptualisation and utilisation of coping measures. Consensus exists however, that a more reliable distinction exists between problem focused and emotion focused coping (Carpenter, 1992; Endler, 1997). Folkman (1992) has pointed out that reducing coping to two or three categories may mask the variety of coping strategies that they encompass preventing a fine grained analysis of the adaptiveness of different strategies in different situations. However, when more categories are used, it seems that their applicability to different populations cannot be assumed. A final issue surrounding the measurement of coping relates to the sort of coping being measured. Some studies have looked at dispositional coping and others at situational coping. In addition, levels of specificity in situations examined vary enormously and authors do not always specify which sort of coping they are measuring, rendering comparison of findings problematic (Zeidner & Saklofske, 1996).
Other methodological issues relate to the samples used in research. Due to the relative rarity of ASD, many studies have used small sample sizes and have included parents whose children vary considerably in age. It has been suggested that the sorts of stresses that parents experience and the coping strategies they use change as their child matures (Bristol & Schopler, 1983b). So, issues of diagnosis and educational placement are likely to be particular sources of stress in parents of pre-school children, whereas emerging sexuality can be a challenge for parents of adolescent children. Thus findings of studies which include parents of children with wide ranges in age may lack the specificity required to produce results which can inform intervention.

**Goodness of fit model**

An alternative model for evaluating a given coping strategy which incorporates and extends the outcome model, is the goodness of fit model. Goodness of fit refers to the appropriateness of a coping response given a particular appraisal and to the affective consequences of match between appraisal and coping (Vitaliano et al., 1990). More specifically, the goodness of fit model predicts that events appraised as controllable are best suited to the use of problem focused coping and events appraised as uncontrollable are best suited to the use of emotion focused coping. Folkman (1992) developed this model as part of the cognitive transactional theory of stress and coping. As such only researchers drawing on this model have used the goodness of fit model for evaluating coping strategies.

The finding that problem focused coping strategies are most frequently employed in situations appraised as being within our control has been replicated a number of times (e.g., Folkman & Lazarus, 1985; Folkman, Lazarus, Dunkel-Schetter, DeLongis & Gruen, 1986; cited in Compas et al., 1988). Although several studies have tested the goodness of fit hypothesis, this has not yet been tested with parents of children with ASD.

Support for the goodness of fit model has been demonstrated in a number of studies of student populations. Using the Ways of Coping Scale (Lazarus and Folkman, 1984),
Lazurus and Folkman (1985), found that students' perceptions of their level of control regarding examinations correlated positively with problem focused coping strategies and negatively correlated with emotion focused coping. Using the Ways of Coping questionnaire, Forsythe and Compas (1987) examined goodness of fit between appraisals of controllability and coping strategy in relation to a distressing major life event and daily hassles. A measure of psychological symptomatology was employed as a criterion variable for adaptiveness of coping strategy and goodness of fit. Appraisal of controllability was measured through dichotomous ratings. Use of more problem focused coping was associated with lower levels of symptomatology when life events were perceived as controllable and were associated with higher levels of symptomatology when they were perceived as uncontrollable. Similarly, use of emotion focused coping was associated with lower symptom levels when events were perceived as uncontrollable and higher symptom levels when events were appraised as controllable. However the goodness of fit hypothesis was not supported in relation to daily hassles. Further support for the goodness of fit hypothesis is seen in Endler et al.'s. (2000) laboratory study of anagram completion under conditions of high and low control. Perceived control was positively correlated with situation specific task oriented (problem focused) coping and less reliance on situation specific emotion oriented coping. Perceived control was also negatively correlated with anxiety and emotion oriented coping.

The goodness of fit model has also been examined in children and adolescents (Compas et al., 1988). Based on the sample's descriptions of their coping with stressful events, their strategies were categorised as either emotion or problem focused by the authors. The participants rated controllability on a rating scale. Low appraised control combined with high problem focused coping was associated with high levels of behaviour problems, as was high appraised control and low problem focused coping. However, the authors' used of an unvalidated measure of coping suggests these results must be treated with caution.

While the above study found an apparent relationship between behaviour problems and ways of coping, the extent to which the results reported above apply to psychiatric populations is unclear. Using the Ways of Coping Checklist, Vitaliano et al. (1990)
compared psychiatric and non-psychiatric groups. Appraisal of controllability was measured using a one item dichotomous variable. They found that goodness of fit was only demonstrated in the non-psychiatric group where in situations appraised as changeable, problem focused coping was negatively related to depression. However there were no significant findings in relation to emotion focused coping.

Only one study to date has produced findings that contradict those described above. Felton and Revenson (1984; cited in Forsythe & Compas, 1987) investigated adaptational status as a function of event-appraisal-coping fit in individuals coping with chronic illness. They found that positive and negative affect and acceptance of illness did not vary as a function of appraised controllability of the illness and use of problem versus emotion focused coping. The authors explain this lack of significant findings in terms of the potentially limited range of perceived control associated with chronic illness.

Methodological issues

Although variations exist between studies in measures of coping and versions of the Ways of Coping Questionnaire used, all of the above studies have examined the problem versus emotion focused coping distinction, which appears to be a reliable one. This and the larger samples included mean that the above studies are less methodologically problematic than those examining the relationship between stress and coping, depression and anxiety. As such it is reasonable to conclude that empirical evidence exists for goodness of fit in the above populations.

_Differences between mothers and fathers of children with ASD in stress and depression experienced and coping strategies employed_

An understanding of whether there are similarities and differences between mothers and fathers in the coping strategies they use to manage parenting difficulties, and the stress and psychological symptomatology they experience, is important in ensuring that they receive support appropriate to their needs.
Stress and depression

The limited research conducted to date has produced some evidence for differences in stress levels in mothers and fathers of children with ASD. Both Sanders and Morgan (1997) and Moes, Koegel Schreibman and Loos (1992) found significantly higher stress levels amongst mothers in comparison with fathers using the QRS. The latter authors also found more depressive symptomatology in mothers as measured using the BDI. Further support for the notion that parenting a child with ASD impacts more significantly on mothers than fathers is found through Gray and Holden’s (1992) study. Findings from the Zung Self-rating depression scale and the State-Trait Anxiety Inventory indicated that mothers reported significantly more depression and anxiety than fathers in a sample of parents whose children’s aged ranged from 3 to 28 years. However, the lack of information regarding the number of mothers and fathers included in this sample make it difficult to determine the robustness of these findings. In contrast Bebko et al. (1987) found no significant differences in stress associated with symptoms of ASD reported by 20 mothers and fathers of children with diagnosed autism and “autistic characteristics”. However, the use of an unvalidated measure, the inclusion of parents whose children had not received a formal diagnosis of autism and the small sample size, mean that findings should be treated with caution. Factor, Perry and Freeman (1990) compared stress as reported by 36 mothers and fathers of children with autism and pervasive developmental disorder (PDD) aged 7 to 17 years on the Questionnaire on Resources and Stress (QRS). Findings of this more methodologically robust study also indicated no significant differences between parents in stress levels experienced.

These contradictory findings lead to a somewhat confused picture. This has been contributed to by the wide range in ages of children whose parents have comprised many of the above samples, inconsistencies between samples in the diagnoses of children whose parents have participated, and the variety of measures of stress, anxiety and depression employed. These difficulties mean that conclusions cannot currently be drawn regarding differential levels of stress, depression and anxiety in parents of children with ASD. Further research is required to clarify these issues.
Very little research has compared coping strategies employed by mothers and fathers in the face of the demands of parenting a child with ASD. As part of the study described above, Moes et al. (1992) administered the CHIP (McCubbin, McCubbin & Cauble, 1979; cited in Moes et al., 1992) to 18 mothers and 12 fathers. Mothers reported using significantly more coping around "maintaining family integration, co-operation and an optimistic definition of the situation". Mothers and fathers used approximately the same number of coping strategies around "maintaining social support, self esteem and psychological stability" and "understanding the medical situation through communication with other parents and consultation with medical staff". As a result of a review of the wider coping literature Verbrugge (1985; cited in Littlewood, Cramerm, Hoekstra & Humphrey, 1991) concluded that men prefer active problem solving and tension reducing coping strategies and women prefer social support and emotion oriented coping strategies. This conclusion is supported by findings of Littlewood et al. (1991) in mothers and fathers whose child has died. Although these conclusions allow predictions to be made regarding the sorts of differences we might expect in coping strategies employed by parents of children with ASD, the lack of research pertaining to this population prevents conclusions from being drawn at this time.

The scarcity of research examining similarities and differences between mothers and fathers in coping strategies used and stress experienced in parenting their children with ASD is a consequence of the wider neglect of fathers of children with ASD in the literature as a whole. The issue of the potential impact of similarities and differences between mothers and fathers in stress, depression and anxiety experienced, and use of coping strategies on parental adjustment has not yet been explored in relation to parents of children with ASD. Osterweis, Solomon and Green (1984; cited in Littlewood et al., 1991) have suggested that the level of synchronicity between parents in the rate at which they adjust to their loss may be an issue for parents following the death of a child. In particular, if one parent adjusts more quickly or using different coping strategies to the other, this may result in misunderstanding and tension for the couple. It is possible that issues of synchronicity in coping strategies used and parenting stress and psychological...
symptomatology experienced, are also important for the adjustment of parents with a child with ASD.

Rationale

Due to its impressive empirical base, and applicability to the study of situational and individual factors in the study of stress and coping, the cognitive transactional model of stress and coping will be employed as a theoretical framework for this study. As outlined in the literature review, this model proposes that examination of coping process (goodness of fit) as well as coping outcome is important in determining the effectiveness of a given strategy. Coping processes as operationalised through the goodness of fit hypothesis have not yet been investigated in parents of children of ASD. In light of findings that stresses of parenting a child with ASD are largely situational and related to symptoms of ASD, the present study will focus on situational coping in relation to stressful parenting situations. In addition, elements of the cognitive transactional model of stress and coping are included in so far as adaptive coping is conceptualised on the basis of the relationship between ways of coping and 'outcome' measures of parenting stress and psychological symptomatology. These relationships will be examined in a sample of parents of children with ASD.

Studies investigating relationships between coping and psychological symptomatology in parents of children with ASD have been methodologically flawed and have produced equivocal findings. As such, the present study aims to address these gaps in the literature.

No research to date has examined relationships between coping and stress or psychological symptomatology in mothers and fathers of children with ASD as separate groups. This study seeks to extend the literature by exploring the similarities and differences in these relationships between mothers and fathers. This is of particular importance due to the absence of research including fathers of children with ASD and in light of the increasingly active role in parenting now adopted by fathers. The lack of research examining similarities and differences between mothers and fathers in coping
strategies used and stress and psychological symptomatology experienced in parenting their children with ASD will also be addressed in the present study.

Only mother-father dyads will be recruited for the present study. Since both parents of the same child will be participating, it will not be possible to assume that mothers and fathers represent independent observations, and mothers and fathers must therefore be treated as separate groups. The exclusion of single parent families and individual parents who agree to participate will render the recruitment process more problematic. However including mother-father pairs will enable comparisons to be made between parents of the same child.
Research questions and hypothesis

Research questions

1. Are particular coping strategies in response to stressful situations relating to parenting a child with ASD associated with less parenting stress in mothers and fathers?

2. Are particular coping strategies in response to stressful situations relating to parenting a child with ASD associated with less psychological symptomatology in mothers and fathers?

Goodness of fit hypothesis

For participants who appraise stressful situations relating to parenting a child with ASD as controllable, task oriented coping will be negatively correlated with parenting stress and psychological symptomatology and emotion oriented coping will be positively correlated with parenting stress and psychological symptomatology. For participants who appraise stressful parenting situations as uncontrollable, task oriented coping will be positively correlated with parenting stress and psychological symptomatology, and emotion oriented coping will negatively correlated with parenting stress and psychological symptomatology.

Exploratory questions

1. What are the similarities and differences between mothers and fathers in coping strategies used?

2. What are the similarities and differences between mothers and fathers in parenting stress and psychological symptomatology experienced?
3. What are the relationships between maternal and paternal coping, parenting stress and psychological symptomatology?
Method

Operationalisation of the cognitive transactional model of stress and coping

The stressor was operationalised as difficult parenting situations encountered by parents of children with ASD. Immediate effects (as defined in the cognitive transactional model) of the coping process were operationalised as levels of parenting stress in several domains and psychological symptomatology. Secondary appraisal was operationalised as parents' appraisals of the controllability of the stressful parenting situation. Both the outcome and the goodness of fit models were employed to evaluate coping strategies used by parents in stressful parenting situations. Levels of parenting stress and psychological symptoms were measured as outcomes of the coping process and of goodness of fit between secondary appraisal and coping strategy employed. Following the cognitive transactional model, it was assumed that stressful parenting related situations cause participants to engage in cognitive appraisal and coping efforts, which in turn result in parenting stress and psychological symptoms, which are in part dependent on goodness of fit between appraisal and coping strategy.

Design

This study used a single cohort cross sectional design.

Measures


Each participant completed the GARS (see appendix D) with the author, as a measure of severity of autistic behaviour in their child. The GARS is a behavioural checklist designed to help identify individuals with autism aged 3 to 22 years. This checklist measures the frequency with which an individual engages in different sorts of behaviour that is symptomatic of autism, and therefore also provides a measure of severity of autistic
symptomatology. This measure comprises four sub-tests each containing 14 items. Each item describes behaviours symptomatic of autism. The Stereotyped Behaviors sub-test contains items concerning stereotyped behaviour, motility disorders and odd behaviour. The Communication sub-test contains items concerning verbal and non-verbal behaviour. The Social Interaction sub-test contains items concerning the individual’s ability to relate appropriately to people, events and objects. The Developmental Disturbances sub-test contains questions regarding the individual’s development during the first three years. Respondents are asked to rate on a scale of 0 to 3 how frequently he/she observed their child engaging in this behaviour. A rating of 0 or “Never Observed” indicates that “you have never seen the person behave in this manner”; 1 or “Seldom Observed” indicates that “person behaves in this manner 1 or 2 times per 6-hour period”; 2 or “Sometimes Observed” indicates that “Person behaves in this manner 3 or 4 times in a 6-hour period”; 3 or “Frequently Observed” indicates that “Person behaves in this manner at least 5 or 6 times per 6-hour period”. Raw scores were converted into standard scores that range from 1 to 20. Sums of standard scores were then converted to produce an Autism Quotient, ranging from 35 to 165. Autism Quotients of 131 or above are classified as indicating a “Very High” probability of autism; scores of 121-130 as indicating a “High” probability of autism; scores of 111-120 as indicating an “Above Average” probability of autism; scores of 90-110 as indicating an “Average” probability of autism; scores of 80-89 as indicating a “Below Average” probability of autism; scores of 70-79 as indicating a “Low” probability of autism; and scores of 69 and below as indicating a “Very Low” probability of autism. For the purposes of the present study, these categorisations were employed to indicate severity of autistic symptomatology (Gilliam, 1997). Percentile scores were obtained for Autism Quotients.

Internal consistency reliability for the GARS has been assessed using the Cronbach coefficient alpha. Correlation coefficients for individual sub-tests are all above 0.88. The alpha for the whole test is 0.9 (Gilliam, 1997). Inter-rater reliability correlation coefficients for GARS sub-tests range from 0.73 to 0.82 (Gilliam, 1997). Concurrent validity for the GARS has been demonstrated through examining the ability of this test to discriminate between individuals who had and had not received a diagnosis of autism.
Autism quotient scores correctly classified 90% of individuals who had received a diagnosis of autism (Gilliam, 1997).

2. Coping Inventory for Stressful Situations: Situation Specific Checklist (CISS:SSC; Endler & Parker, 1999).

The CISS:SSC (see appendix E) is a self-report measure that assesses situational coping behaviour in stressful situations. This was developed from the Coping Inventory for Stressful Situations (CISS; Endler & Parker, 1999), which is a measure of dispositional coping (conceptualised as a personality variable) that has been described as a "state-of-the-art inventory" (Schwarzer & Schwarzer, 1996). The CISS:SSC was developed to address the methodological difficulties associated with other situational measures of coping. The CISS:SSC is comprised of three sub-scales each containing seven items. The Task-Oriented sub-scale measures coping strategies used to solve the problem, cognitively restructure the problem or alter the situation. The Emotion-Oriented sub-scale measures self-oriented emotional reactions that aim to reduce stress, but do not necessarily achieve this. The Avoidance sub-scale measures coping activities that aim to avoid the stressful situation including distraction or social diversion. Respondents are asked to keep a specific stressful situation in mind whilst completing the questionnaire, and in the present context this was a specific stressful parenting situation. They rate on a scale of 1 to 5 with 1 being "Not at all" and 5 being "Very much", how much they engaged in the coping activities detailed in each item. Raw scores for each sub-test range from 7 to 35.

Alpha reliability coefficients for the CISS:SSC have been found to range from 0.72 to 0.80 for Avoidance-Oriented sub-scale, 0.78 to 0.85 for the Task-Oriented sub-scale and 0.83 to 0.86 for the Emotion-Oriented sub-scale (Endler, Kantor & Parker, 1994; Endler & Parker, 1994). Information regarding the test retest reliability of the CISS:SSC is not yet available, however test retest reliabilities for task, emotion and avoidance sub-scales of the CISS are 0.73, 0.68 and 0.55 for men and 0.72, 0.71 and 0.61 for women (Endler, 1997). Multi-sample confirmatory factor analysis has indicated that the three-factor model for the scale was equivalent for two different samples. As such, this scale does
not share the difficulties with unstable factor structure present in other coping measures, and demonstrates good construct validity.

Due to concerns of one of the hospital ethical committees who approved this study regarding the North American bias in the wording of item three of the CISS:SSC, this was amended. Previously this item read “Blame myself for having gotten into the situation”, and was amended to “Blame myself for having got into the situation”.


The PSI (see appendix G) is a 120 item self-report questionnaire developed as a measure of facets of stressful parent-child systems. This measure has been standardised for use with parents of children aged one month to twelve years and has been used widely in research and clinical settings including with parents of children with ASD. Domains of stress measured are the Child Domain, the Parent Domain and Life stress.

Sub-scales within the Child Domain measure parental perceptions of child characteristics that are potential sources of parenting stress. The Distractibility/Hyperactivity sub-scale contains nine items concerning over activity, restlessness and difficulty concentrating. The Adaptability sub-scale contains eleven items measuring difficulty in making task transitions, over reaction to changes in routine and difficulty in calming the child. The Reinforces Parent sub-scale contains six items assessing the extent to which parent-child interactions produce good feelings in the parent. The Demandingness sub-scale contains nine items concerning parental experiences of having too many demands placed upon him/her. The Mood sub-scale includes five items measuring child affective dysfunction, and the Acceptability sub-scale contains seven items assessing parental perception of their child’s characteristics not matching their expectations.

Sub-scales within the Parent Domain measure feelings of inadequacy and being overwhelmed by the task of parenting. The Competence sub-scale includes thirteen items assessing parental sense of parenting competence. The Isolation sub-scale contains six items concerning parental social isolation and lack of spousal support. The
Attachment sub-scale contains seven items measuring parental sense of emotional closeness to their child and ability to understand his/her feelings and/or needs. The Health sub-scale includes five items examining deterioration in parental health that may be a consequence of parenting stress or an additional stress in the parent-child system. The Role Restriction sub-scale contains seven items examining parental perceptions of their parenting role as restricting their freedom or frustrating their attempts to maintain their own identity. The Depression sub-scale contains nine items measuring feelings of depression, guilt and unhappiness in parents. The Spouse sub-scale assesses emotional and practical support from the other parent in the area of child management and contains seven items.

The Life Stress scale provides an index of the extent of stress experienced by parents outside of the parent-child system, and includes nineteen items regarding a range of stressful life events.

Questions take three response formats. The first requires respondents to indicate whether they "strongly agree", "agree", "not sure", "disagree" or "strongly disagree" with a statement. The second asks respondents to indicate which of a series of statement best describes them. When completing the Life Stress sub-scale, respondents were asked to indicate whether or not a number of life events have occurred during the past twelve months in their immediate family using a "yes"/"no" response option. The range of scores was 50 to 145 for the Child Domain, 69 to 188 for the Parent Domain, 1 to 27 for the Life Stress scale, and 131 to 320 for the Total Stress scale.

Coefficient alpha reliability coefficients for sub-scales within the Child Domain range from 0.70 to 0.83 and for the Parent Domain range from 0.70 to 0.84. Reliability coefficients of 0.95 have been found for the Total Stress scale, and of 0.90 and above for the Child and Parent Domains (Abidin, 1995). This demonstrates a good degree of internal consistency in this measure. A number of studies have collected test-retest reliability data for the PSI. These have ranged from 0.55 to 0.82 for the Child Domain, 0.69 to 0.91 for the Parent Domain, and 0.65 to 0.96 for the Total Stress scale. Factor analytic studies have demonstrated that each sub-scale is measuring a moderately distinct
source of stress (Abidin, 1995), and that the proposed factor structure remains stable across populations (Hauenstein, Marvin, Snyder & Clarke, 1989; cited in Abidin, 1995). Therefore, the PSI has demonstrated good reliability and validity.

Again, due to concerns of one of the hospital ethical committees regarding the North American bias in the wording of some items, amendments were made to these. Previously, item 22 read "In some areas, my child seems to have forgotten past learnings and has gone back to doing things characteristics of younger children", and was amended to read "In some areas, my child seems to have forgotten things learnt in the past and has gone back to doing things characteristic of younger children". Previously, item 82 read "I wind up feeling guilty when I get angry at my child and this bothers me", and was amended to read "I end up feeling guilty when I get angry with my child and this bothers me". Items 59 and 60 ask for information regarding parental educational level, and were amended to refer to the UK rather than the US educational system.

4. General Health Questionnaire–28 (GHQ-28; Goldberg & Williams, 1988)

The GHQ was designed to detect non-psychotic psychiatric disorder in individuals in community and medical settings and focuses on an individual’s inability to function normally and the appearance of new phenomena of a distressing nature. The GHQ aims to differentiate between individuals whose psychiatric symptomatology does and does not fall above a clinical threshold rather than to identify specific psychiatric disorders. The GHQ-28 (see appendix F) is a 28 item scaled version of the original GHQ–60. Sub-scales within the GHQ-28 represent dimensions of symptomatology rather than diagnoses and are not independent of one another. Sub-scales are A. somatic symptoms, B. anxiety and insomnia, C. social dysfunction and D. severe depression, and there are 7 items in each. This questionnaire requires respondents to report how he/she has been feeling over the previous two weeks, but not how long he/she has experienced symptoms, and is therefore sensitive to transient disorders. Questions take a standard response format throughout, and respondents are asked to rate on a four-point scale the extent to which they have been experiencing each symptom or behaviour listed. The
four-point response scale may be scored using two methods. It may be treated as a Likert scale with weights of 0, 1, 2, 3 attached to the appropriate positions, which is of utility in comparing degree of disorder. Alternatively it can be treated as a bimodal response scale with only deviations from the norm signalling possession of the item. The latter method is useful in the identification of caseness. For the purposes of the present context, the likert scoring method was most appropriate as degree of symptom severity was of greatest concern here. Given this scoring method, possible scores range from 0 to 21 for each sub-scale. Total scores potentially range from 0 to 84.

Validation studies examining correlations between the GHQ-28 and standardised psychiatric assessment interviews have found correlation coefficients ranging from 0.67 (Goldberg & Hillier, 1979; cited in Goldberg & Williams, 1988) to 0.83 (Rabins & Brooks, 1981) with a median coefficient of 0.76. Furthermore, the sensitivity (or probability that a true case will be identified) of the GHQ-28 has been found to range from 44% (Mann et al., 1983) to 100% (Banks, 1983; Lindsay, 1986; Selzer & Mann, 1987; cited in Goldberg & Williams, 1988), with a variance-weighted mean sensitivity of 84% (Goldberg and Williams, 1988). Specificity (probability that a true normal will be correctly identified) for the GHQ-28 has been found to range from 74% (Medina-Mora et al., 1983) to 93% (Rabins & Brooks, 1981), with a variance-weighted mean specificity of 82% (Goldberg & Williams, 1988). Test-retest reliability for the GHQ-28 has been found to be 0.90 (Robinson & Price, 1982; cited in Goldberg & Williams, 1988). As such, the GHQ-28 has good reliability and validity.

5. Appraisal of controllability and description of stressful parenting situation

In order to have a detailed description of the stressful parenting situations that participants were referring to when completing the CISS:SSC, the author developed a brief questionnaire. This included five open-ended questions asking participants to describe the situation, where it occurred, who was involved, how they acted and the nature of the outcome of the situation. These questions were included because answers to these would provide a description of important aspects of stressful parenting situations.
A single question was employed to measure participants' appraisals of the controllability of the stressful parenting situations they were referring to when completing the CISS:SSC. This item was developed from existing measures of appraisal of controllability. Both Forsythe and Compas (1987) and Vitaliano et al. (1990) measured appraisal of controllability using single dichotomous ratings of the amount of control participants felt that they had over the event. However, the author was aware that participants might be referring to situations that they did not perceive as being clearly controllable or uncontrollable. Therefore, in order to avoid frustrating participants yet still gain a dichotomous rating, the author devised a six-point scale. Participants were asked to rate on this how controllable the situation felt to them as it was happening, with 1 being "completely controllable" and 6 being "completely uncontrollable". Those participants who rated their stressful situation as between 1 and 3 on the scale of 1 to 6 (with 1 being completely controllable and 6 being completely uncontrollable) were classed as high controllability appraisers, and those who rated their situation as between 4 and 6 as low controllability appraisers. Participants were asked to think back to how they felt as the situation was occurring in order to avoid confounding appraisals of controllability during the situation with appraisals of the desirability of the outcome of the situation.

Assessment of demographic, child and family variables

The author developed a questionnaire assessing demographic and family variables (see appendix C). Variables assessed were parental date of birth, ethnic group, marital status, occupation and relationship to their child. Child and family variables assessed were child gender, date of birth and birth order, and number of children in the family. Parents rated their child with ASD's general physical health as "5 = excellent", "4 = good", "3 = alright", "2 = poor" or "1 = very poor". They also indicated which of a list of services were currently being received for the child and which services had been received in the past.
Description of sample

Sample size

An a priori power calculation was undertaken using the G-Power test to determine the number of participants required in order to answer research questions and hypotheses (see appendix B). This indicated that data from 37 mothers and 37 fathers would be required.

Inclusion criteria

a. Parents spoke English with adequate fluency to complete questionnaires in conjunction with the researcher. This was because resources were not available to employ a translator.
b. Parents had not participated in other research studies in the six months prior to participating in the study. This was to avoid over researching families.
c. Children had received a diagnosis of ASD at least 6 months prior to their parents' participation in the study. This was to control for stresses associated with diagnosis.
d. Children were not receiving an intensive home based intervention for ASD at the time of their parents' participation. This was to control for the idiosyncratic stresses associated with these interventions.
e. Children were aged between 4 and 11 years at the time of their parents' participation. This allowed the study to focus on the stresses of parenting children in middle childhood, and excluded stresses associated with parenting pre-school and adolescent children.

Participants

Participants were 37 mothers and 37 fathers from cohabiting families with a child with ASD living at home. Six of these were cohabiting with the other parent of their child with ASD and 68 were married to the other parent of their child with ASD. Demographic and family characteristics of the sample are outlined in Tables 2, 3, 4, 5 and 6. Participants
were recruited from three specialist child learning disability services and two child and adolescent mental health services in South London and one specialist child learning disability service in West London. The service in West London and one of the South London services catered for ethnically and culturally diverse populations, with the West London centre servicing a large refugee population. The other four services catered for largely white middle class populations. These divisions are reflected in the sample. The vast majority were white (see Table 3) and highly educated, with 45.9% of mothers and 32.4% of fathers having a post-graduate degree or diploma (see Table 4). Similarly, although a range of occupations was represented in the sample, these clustered around work in management, accountancy, education and IT for fathers (see Table 5), and teaching, administration and nursery work for mothers (see Table 5). Fourteen of the 37 mothers participating described themselves as full time mothers, whereas only one father cared for his child full time. Paternal mean age was 43 years and 7 months and maternal mean age was 40 and 5 months (see Table 2). The majority of families had two children, and most children with ASD were their parents first or second child (see Table 3).

Table 2: Mean age of mothers, fathers and children with ASD

<table>
<thead>
<tr>
<th></th>
<th>Mothers</th>
<th>Fathers</th>
<th>Children with ASD</th>
</tr>
</thead>
<tbody>
<tr>
<td>N</td>
<td>37</td>
<td>37</td>
<td>38</td>
</tr>
<tr>
<td>Mean Age</td>
<td>40 years, 5 months</td>
<td>43 years, 7 months</td>
<td>7 years, 6 months</td>
</tr>
<tr>
<td>SD</td>
<td>4 years, 9 months</td>
<td>5 years, 4 months</td>
<td>1 year, 11 months</td>
</tr>
<tr>
<td>Range</td>
<td>29 years – 52 years</td>
<td>33 years, 5 months – 57 years</td>
<td>4 years, 4 months – 11 years, 6 months</td>
</tr>
</tbody>
</table>
Table 3: Demographic and family characteristics in sample

<table>
<thead>
<tr>
<th>Parental ethnic origin</th>
<th>Family size</th>
<th>Birth order of child with ASD</th>
<th>Gender of child with ASD</th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td>One child = 6</td>
<td>First child = 21</td>
<td>Female = 8</td>
</tr>
<tr>
<td>Black-African</td>
<td>Two children = 17</td>
<td>Second child = 13</td>
<td>Male = 30</td>
</tr>
<tr>
<td>Latin American</td>
<td>Three children = 11</td>
<td>Third child = 3</td>
<td></td>
</tr>
<tr>
<td>Chinese</td>
<td>Four children = 4</td>
<td>Fourth child = 1</td>
<td></td>
</tr>
<tr>
<td>Mixed race</td>
<td>= 1</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table 4: Parental educational level

<table>
<thead>
<tr>
<th>Highest educational qualification gained</th>
<th>Maternal frequency</th>
<th>Maternal percentage</th>
<th>Paternal frequency</th>
<th>Paternal percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>No educational qualifications</td>
<td>2</td>
<td>5.4</td>
<td>3</td>
<td>8.1</td>
</tr>
<tr>
<td>GCSE/O-level/CSE</td>
<td>8</td>
<td>21.6</td>
<td>6</td>
<td>16.2</td>
</tr>
<tr>
<td>A-level</td>
<td>4</td>
<td>10.8</td>
<td>8</td>
<td>21.6</td>
</tr>
<tr>
<td>Diploma/degree (HND, SRN etc)</td>
<td>6</td>
<td>16.2</td>
<td>8</td>
<td>21.6</td>
</tr>
<tr>
<td>Postgraduate degree/diploma</td>
<td>17</td>
<td>45.9</td>
<td>12</td>
<td>32.4</td>
</tr>
</tbody>
</table>
Table 5: Parental occupations

<table>
<thead>
<tr>
<th>Occupation</th>
<th>Maternal frequency</th>
<th>Paternal frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Full time parent</td>
<td>14</td>
<td>1</td>
</tr>
<tr>
<td>Educator (teacher, trainer, lecturer)</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Administrator</td>
<td>4</td>
<td>0</td>
</tr>
<tr>
<td>Nursery worker</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>Retailer</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>Management</td>
<td>2</td>
<td>7</td>
</tr>
<tr>
<td>Accountant</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Publishing</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>GP</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Nurse</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Technician</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Town planner</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>IT</td>
<td>0</td>
<td>4</td>
</tr>
<tr>
<td>Taxi driver</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Chartered surveyor</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Company director</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Advertising</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Banker</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Insurance broker</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>DJ/record producer</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Catering</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Youth worker</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Royal mail sorter</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Bus driver</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>No occupation given</td>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>
Children with ASD

The mean age of children with ASD was 7 years and 6 months and ranged from 4 years and 4 months to 11 years and 6 months. Thirty children were male and the remaining eight were female. On average, parents rated their child’s physical health as being "good" (4 on a scale of 1 to 5; see Table 6 below).

Table 6: Number of services received currently and in the past for child and parental rating of child health

<table>
<thead>
<tr>
<th>No. services currently received for child</th>
<th>No. services received in the past for child</th>
<th>Parental rating of child current physical health</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean</td>
<td>2.46</td>
<td>3.49</td>
</tr>
<tr>
<td>Median</td>
<td>2.00</td>
<td>3</td>
</tr>
<tr>
<td>Range</td>
<td>0 - 6</td>
<td>0 - 6</td>
</tr>
</tbody>
</table>

All children had received a formal diagnosis of ASD, High Functioning Autism, Autism or Asperger’s syndrome (see Table 7). Diagnoses given varied according to conventions of individual centres, with some centres only diagnosing ASD, and others differentiating between Autism, Asperger’s and High functioning autism. The blanket diagnosis of ASD does not allow for differentiation between children in levels of autistic symptomatology. However, the fact that sixteen children had diagnoses of High functioning autism or Asperger’s suggests that certainly half of these children fell into the mild to moderate range of symptom severity.
Table 7: Frequency of autistic spectrum diagnoses in children

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Autistic spectrum disorder</td>
<td>12</td>
</tr>
<tr>
<td>High functioning autism</td>
<td>3</td>
</tr>
<tr>
<td>Autism</td>
<td>10</td>
</tr>
<tr>
<td>Asperger's syndrome</td>
<td>13</td>
</tr>
</tbody>
</table>

Mean autism quotients and percentile scores from ratings of mothers and fathers of their child with ASD are presented in Table 8. The maternal mean GARS percentile score was 13.76. The paternal mean percentile score was 17.22. These relatively low mean percentile scores are consistent with the distribution of diagnoses in suggesting that symptom severity was not high in this group of children. Interestingly, these scores also indicate that fathers rated their children with ASD as being more symptomatic than mothers.

Table 8: GARS autism quotients and percentile scores from ratings of mothers and fathers

<table>
<thead>
<tr>
<th></th>
<th>Mothers</th>
<th>Fathers</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>GARS autism quotient</td>
<td>GARS percentile score</td>
</tr>
<tr>
<td>Mean</td>
<td>77.7</td>
<td>13.76</td>
</tr>
<tr>
<td>SD</td>
<td>13.94</td>
<td>17.76</td>
</tr>
<tr>
<td>Range</td>
<td>50-106</td>
<td>0-65</td>
</tr>
</tbody>
</table>
**Procedure**

**Recruitment**

Once approval had been obtained from hospital ethical committees (see appendix A), participants were selected randomly from case notes and through consultation with members of multidisciplinary teams from the services described above.

1. **Procedure for contacting families:**
   The researcher contacted potential participants with a covering letter (see appendix I) inviting them to participate, and an information sheet (see appendix J) introducing the project and advising them that she would be in contact by telephone. Approximately one week later, the researcher contacted potential participants by telephone to answer any questions and provide further details regarding the study. Appointments to collect data were arranged with those potential participants who indicated that they wanted to participate. The aims of the research were described as being to find out about ways that mothers and fathers cope with parenting their child with ASD, and whether these coping strategies help them to adjust to the demands of parenting. The researcher's hope that as a result of this research we would know more about how best to help parents to manage the demands of raising a child with ASD, was also explained to parents. All potential participants who were interested in participating and fulfilled inclusion criteria were included in the study.

2. **Participation rates:**
   A total of 86 families were contacted and 38 of these participated in the study, which represented an overall participation rate of 44.2% (see Table 9). Although 37 mother-father pairs were recruited in the first instance, a mother and a father from different families dropped out after data for their partner had been collected. This meant that the sample comprised of 36 mother-father pairs and one individual mother and father from separate families. Unfortunately it was not possible to differentiate between families who were not contactable because their contact details were out of date, and families who did not respond to the researcher's telephone calls because they were not interested in participating. Examination of participation rates across centres indicated that these
ranged from 28.6% to 60%. The lowest rate was for Centre 4, which was located in West London and catered for a large refugee population, who were often housed in temporary accommodation. This meant that contact details were out of date for a number of the families contacted, which may explain the low participation rate for this centre. Similarly, the highest participation rate was for centre 6, which catered for a largely affluent white middle class population who tended to be homeowners, and therefore moved around less.

Table 9: Participant recruitment rates

<table>
<thead>
<tr>
<th>Centre</th>
<th>No. families contacted</th>
<th>No. families who participated</th>
<th>Percentage participation rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>20</td>
<td>8</td>
<td>40</td>
</tr>
<tr>
<td>2</td>
<td>16</td>
<td>6</td>
<td>37.5</td>
</tr>
<tr>
<td>3</td>
<td>13</td>
<td>9</td>
<td>56.3</td>
</tr>
<tr>
<td>4</td>
<td>21</td>
<td>6</td>
<td>28.6</td>
</tr>
<tr>
<td>5</td>
<td>6</td>
<td>3</td>
<td>50</td>
</tr>
<tr>
<td>6</td>
<td>10</td>
<td>6</td>
<td>60</td>
</tr>
<tr>
<td>Total</td>
<td>86</td>
<td>38</td>
<td>44.2</td>
</tr>
</tbody>
</table>

*Administration of measures*

All data collection took place at participants' homes, except for one mother and father who chose to meet with the researcher at their places of work. To avoid parents contaminating one another's responses, participants completed all questionnaires separately. Firstly, participants were asked to re-read the information sheet and sign the informed consent form (see appendix L), this asked participants to indicate whether they wished their GP to be informed of their participation in the study. A standard information letter was sent to participants' GP's when this was requested (see appendix K) By way of an introduction, participants were invited to describe briefly their experience of stresses of parenting their child with ASD and ways that they coped. These and further comments made by participants in relation to stresses and coping during data collection
were noted down by the researcher. Next, participants completed the demographic questionnaire and then the GARS. They were then asked to identify the most stressful situation that had occurred over the previous two weeks in relation to parenting their child with ASD.

Participants described the situation to the researcher. They were then asked to complete the CISS:SSC, in relation to the specific stressful situation they had described. An additional instruction was given in order to prevent discrepancies between participants in their definition of the coping period.

Next participants described the stressful situation in writing on the description of stressful situation questionnaire, and rated their appraisal of the controllability of the situation. Finally, participants completed the GHQ-28, and the PSI.

**Description of analyses**

All variables for the 37 mothers and 37 fathers as separate groups were screened to ensure that they met parametric assumptions. All variables met these assumptions except for GHQ-28 total scores and CISS:SSC avoidance coping scores for mothers. A square root transformation procedure resulted in normal distribution for these variables. All analyses of mothers' psychological symptoms and avoidance coping in relation to research questions 1 and 2 employ these transformed variables.

Variables for maternal and paternal high and low control appraisers as separate groups were also screened as these groupings were required to test the goodness of fit hypothesis. All variables were normally distributed except for maternal GHQ-28 scores in the high control group. Neither the transformed, nor the untransformed scores, for the latter variable were normally distributed. For this reason, the untransformed score was used and non-parametric analyses employed when this group variable entered into the analyses.
For the purposes of the exploratory questions, all variables for the 36 mother-father pairs excluding the one mother and one father whose partner did not participate, were screened. GHQ-28 total scores for mothers did not meet parametric assumptions, however a square root transformation procedure resulted in normal distribution for this variable. Maternal and paternal CISS:SSC avoidance coping scores for the 36 mother-father pairs also failed to meet parametric assumptions, and attempts to transform this variable for fathers did not result in normal distribution. Therefore non-parametric analyses were employed for this variable within both groups.

Parametric statistical tests used were Pearson's product moment correlation coefficients and repeated measures t-tests's. The non-parametric Spearman's rho correlation coefficient and Wilcoxon tests were also employed.
Results

Means, standard deviations and numbers of participants for each study variable are contained in Table 10.

Table 10: Means, standard deviations and numbers for principal study variables

<table>
<thead>
<tr>
<th>Variable</th>
<th>Mothers</th>
<th>Fathers</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean</td>
<td>SD</td>
</tr>
<tr>
<td><strong>Coping sub-scales:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Task</td>
<td>23.16</td>
<td>5.85</td>
</tr>
<tr>
<td>Avoidance</td>
<td>13.43</td>
<td>6.84</td>
</tr>
<tr>
<td>Transformed avoidance</td>
<td>3.57</td>
<td>0.84</td>
</tr>
<tr>
<td>Emotion</td>
<td>16.46</td>
<td>7.44</td>
</tr>
<tr>
<td><strong>Parenting stress:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total stress</td>
<td>286.65</td>
<td>35.72</td>
</tr>
<tr>
<td>Parent domain</td>
<td>135.86</td>
<td>18.72</td>
</tr>
<tr>
<td>Child domain</td>
<td>150.78</td>
<td>21.67</td>
</tr>
<tr>
<td><strong>Psychological symptoms:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>GHQ total</td>
<td>19.46</td>
<td>9.57</td>
</tr>
<tr>
<td>Transformed GHQ total</td>
<td>4.3</td>
<td>0.98</td>
</tr>
</tbody>
</table>

Research questions

Research question 1:
Are particular coping strategies in response to stressful situations relating to parenting a child with ASD associated with less parenting stress in mothers and fathers?

Pearson's product moment correlation coefficients were conducted to evaluate associations between coping and parenting stress for mothers and fathers. These are presented in Table 11.
For mothers, avoidance coping was significantly positively associated with parenting stress in relation to their child \( (r(37) = 0.33, p < 0.05 \) 2-tailed test), and emotion oriented coping was significantly correlated with parent domain stress \( (r(37) = 0.38, p < 0.05, 2\text{-tailed test}) \). The remaining analyses were non-significant.

Fathers' use of task coping was significantly positively correlated with total parenting stress \( (r(37) = 0.39, p < 0.05, 2\text{-tailed test}) \); child domain parenting stress \( (r(37) = 0.34, p < 0.05 \text{ 2-tailed test}) \); and parent domain parenting stress \( (r(37) = 0.37, p < 0.05, 2\text{-tailed test}) \). For fathers, use of avoidance coping was also significantly positively correlated with parent domain parenting stress \( (r(37) = 0.33, p < 0.05 2\text{-tailed test}) \). The remaining analyses were non-significant.

### Table 11: Bivariate correlations between coping and parenting stress in mothers and fathers

<table>
<thead>
<tr>
<th>Coping sub-scales</th>
<th>Parenting Stress</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mothers</td>
</tr>
<tr>
<td></td>
<td>Total</td>
</tr>
<tr>
<td>Task</td>
<td>-0.05</td>
</tr>
<tr>
<td>Avoidance</td>
<td>0.2</td>
</tr>
<tr>
<td>Emotion</td>
<td>0.21</td>
</tr>
</tbody>
</table>

*Correlation is significant at the 0.05 level (2-tailed)

**Research question 2:**

Are particular coping strategies in response to stressful situations relating to parenting a child with ASD associated with less psychological symptomatology in mothers and fathers?

Maternal use of emotion oriented coping was found to be significantly positively correlated with psychological symptomatology \( (r(37) = 0.42, p < 0.05, 2\text{-tailed test}) \). Remaining analyses for mothers were non-significant (see Table 12)
No significant correlations were found between coping and psychological symptomatology for fathers (see Table 12).

Table 12: Bivariate correlations between coping and psychological symptomatology in mothers and fathers

<table>
<thead>
<tr>
<th>Coping sub-scales</th>
<th>Psychological Symptomatology</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mother GHQ-28 total</td>
</tr>
<tr>
<td>Task</td>
<td>0</td>
</tr>
<tr>
<td>Avoidance</td>
<td>0.1</td>
</tr>
<tr>
<td>Emotion</td>
<td>0.42*</td>
</tr>
</tbody>
</table>

*Correlation is significant at the 0.05 level (2-tailed)

**Goodness of fit hypothesis**

For participants who appraise stressful situations relating to parenting a child with ASD as controllable, task oriented coping will be negatively correlated with parenting stress and psychological symptomatology and emotion oriented coping will be positively correlated with parenting stress and psychological symptomatology. For participants who appraise stressful parenting situations as uncontrollable, task oriented coping will be positively correlated with parenting stress and psychological symptomatology, and emotion oriented coping will be negatively correlated with parenting stress and psychological symptomatology.

1. Participant groupings
In order to test the goodness of fit hypothesis, mothers and fathers were grouped into high and low controllability appraisal groups. Nineteen mothers were classified as high controllability appraisers, and 18 mothers were classified as low controllability appraisers. Seventeen fathers were classified as high controllability appraisers and 20 were classified as low controllability.
Means and standard deviations for emotion and task oriented coping, GHQ-28 total scores, and total, parent domain and child domain PSI scores for these four groups are presented in Tables 13 and 14 below.

Table 13: Means, standard deviations and numbers for maternal goodness of fit variables

<table>
<thead>
<tr>
<th>Variable</th>
<th>Mothers: high controllability appraisers</th>
<th>Mothers: low controllability appraisers</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean  SD  N</td>
<td>Mean  SD  N</td>
</tr>
<tr>
<td><strong>Coping sub-scales:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Task</td>
<td>23.68  6.40  19</td>
<td>22.61  5.34  18</td>
</tr>
<tr>
<td>Emotion</td>
<td>14.26  6.43  19</td>
<td>18.78  7.90  18</td>
</tr>
<tr>
<td><strong>Parenting stress:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total stress</td>
<td>276.47  35.70  19</td>
<td>297.39  33.39  18</td>
</tr>
<tr>
<td>Parent domain</td>
<td>132.26  19.08  19</td>
<td>139.67  18.08  18</td>
</tr>
<tr>
<td>Child domain</td>
<td>144.21  20.89  19</td>
<td>157.72  20.82  18</td>
</tr>
<tr>
<td><strong>Psychological symptoms:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>GHQ total</td>
<td>18.16  11.38  19</td>
<td>20.83  7.28  18</td>
</tr>
</tbody>
</table>
Table 14: Means, standard deviations and numbers for paternal goodness of fit variables

<table>
<thead>
<tr>
<th>Variable</th>
<th>Fathers: high controllability appraisers</th>
<th>Fathers: low controllability appraisers</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean</td>
<td>SD</td>
</tr>
<tr>
<td>Coping sub-scales:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Task</td>
<td>22.00</td>
<td>5.91</td>
</tr>
<tr>
<td>Emotion</td>
<td>13.29</td>
<td>4.59</td>
</tr>
<tr>
<td>Parenting stress:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total stress</td>
<td>262.12</td>
<td>37.72</td>
</tr>
<tr>
<td>Parent domain</td>
<td>129.41</td>
<td>23.72</td>
</tr>
<tr>
<td>Child domain</td>
<td>132.71</td>
<td>18.17</td>
</tr>
<tr>
<td>Psychological symptoms:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>GHQ total</td>
<td>18.47</td>
<td>8.79</td>
</tr>
</tbody>
</table>

2. Analyses
Pearson’s product moment correlation coefficients were calculated to evaluate relationships between task or emotion oriented coping and stress or psychological symptomatology in high and low controllability appraising mothers and fathers. These are presented in Tables 15 to 18 below. Spearman’s rho correlations were calculated to examine relationships between task or emotion coping and psychological symptomatology in high control mothers. This is presented in Table 15 below.

a. Psychological symptomatology

(i) Mothers

No predicted positive correlations were found between use of task coping and psychological symptomatology in low control mothers, or between use of emotion coping and psychological symptoms in high control mothers.
No predicted negative correlations were found between task coping and psychological symptomatology in high control mothers, or between emotion coping and symptomatology in low control mothers. Contrary to expectations, emotion coping was significantly positively correlated with psychological symptoms in this latter group (r (37) = 0.51, p<0.05, 2-tailed test).

Table 15: Bivariate correlations between coping and psychological symptomatology in high controllability appraising and low controllability appraising mothers

<table>
<thead>
<tr>
<th>Coping sub-scales</th>
<th>Psychological symptomatology</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mothers: high controlability appraisers</td>
</tr>
<tr>
<td></td>
<td>GHQ-28 total</td>
</tr>
<tr>
<td>Task</td>
<td>-0.1</td>
</tr>
<tr>
<td>Emotion</td>
<td>0.06</td>
</tr>
</tbody>
</table>

*Correlation is significant at the 0.05 level (2-tailed)
Italics indicate conditions of hypothesised good fit between appraisal and coping

(ii) Fathers

No predicted positive correlations were found between emotion coping and psychological symptomatology in high control fathers, or between task coping and symptomatology in low control fathers.

No predicted significant negative correlations were found between task coping and psychological symptoms in high control fathers, or between emotion coping and psychological symptoms in low control fathers.
Table 16: Bivariate correlations between coping and psychological symptomatology in high controllability appraising and low controllability appraising fathers

<table>
<thead>
<tr>
<th>Coping sub-scales</th>
<th>Psychological symptomatology</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Fathers: high controllability appraisers</td>
</tr>
<tr>
<td></td>
<td>GHQ-28 total</td>
</tr>
<tr>
<td>Task</td>
<td>-0.09</td>
</tr>
<tr>
<td>Emotion</td>
<td>-0.24</td>
</tr>
</tbody>
</table>

Italics indicate conditions of hypothesised good fit between appraisal and coping

b. Parenting stress

(i) Mothers

As predicted, a significant positive correlation was found between emotion oriented coping and parent domain parenting stress in high control mothers ($r (37) = 0.55$, $p<0.05$ 2-tailed test). However, no predicted significant positive relationships were found between use of task coping and total, parent domain, or child domain parenting stress in low control mothers.

Again, no predicted negative relationships were found between task coping and total, parent domain or child domain parenting stress in high control mothers, or between emotion coping and total, parent domain or child domain parenting stress in low control mothers.
Table 17: Bivariate correlations between coping and parenting stress in high controllability appraising and low controllability appraising mothers

<table>
<thead>
<tr>
<th>Coping sub-scale</th>
<th>Parenting stress</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mothers: high controllability appraisers</td>
<td>Mothers: low controllability appraisers</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Total stress</td>
<td>Parent domain</td>
<td>Child domain</td>
<td>Total stress</td>
</tr>
<tr>
<td>Task</td>
<td>-0.19</td>
<td>-0.22</td>
<td>-0.12</td>
<td>0.19</td>
</tr>
<tr>
<td>Emotion</td>
<td>0.38</td>
<td>0.55*</td>
<td>0.14</td>
<td>-0.1</td>
</tr>
</tbody>
</table>

*Correlation is significant at the 0.05 level (2-tailed)

Italics indicate conditions of hypothesised good fit between appraisal and coping

(ii) Fathers

As predicted, task coping was significantly positively correlated with total parenting stress \( r (37) = 0.58, p<0.01 \) 2-tailed test, parent domain parenting stress \( r (37) = 0.5, p<0.05, 2\text{-tailed test} \), and child domain parenting stress \( r (37) = 0.58, p<0.01, 2\text{-tailed test} \) in low control fathers. However no predicted positive correlations were found between emotion coping and parenting stress for high control fathers.

No significant negative correlations were found between task coping and parent, child or total parenting stress in high control fathers, or between emotion coping and parenting stress in low control fathers.
Table 18: Bivariate correlations between coping and parenting stress in high controllability appraising and low controllability appraising fathers

<table>
<thead>
<tr>
<th>Coping sub-scale</th>
<th>Parenting stress</th>
<th>Fathers: high controllability appraisers</th>
<th>Fathers: low controllability appraisers</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Total stress</td>
<td>Parent domain</td>
<td>Child domain</td>
</tr>
<tr>
<td>Task</td>
<td>0.23</td>
<td>0.22</td>
<td>0.18</td>
</tr>
<tr>
<td>Emotion</td>
<td>-0.05</td>
<td>-0.01</td>
<td>-0.07</td>
</tr>
<tr>
<td></td>
<td>Total stress</td>
<td>Parent domain</td>
<td>Child domain</td>
</tr>
<tr>
<td>Task</td>
<td>0.58**</td>
<td>0.5*</td>
<td>0.58**</td>
</tr>
<tr>
<td>Emotion</td>
<td>0.17</td>
<td>0.15</td>
<td>0.16</td>
</tr>
</tbody>
</table>

*Correlation is significant at the 0.05 level (2-tailed)
** Correlation is significant at the 0.01 level (2-tailed)

Italics indicate conditions of hypothesised good fit between appraisal and coping

**Exploratory research questions**

Means, standard deviations and numbers for mother-father pairs' coping, parenting stress and psychological symptomatology scores are presented in Table 19.
Table 19: Means, standard deviations and numbers for mother-father pairs' coping, parenting stress and psychological symptomatology scores

<table>
<thead>
<tr>
<th>Variable</th>
<th>Mothers</th>
<th></th>
<th>Fathers</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean</td>
<td>SD</td>
<td>N</td>
<td>Mean</td>
</tr>
<tr>
<td>Coping sub-scales:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Task</td>
<td>22.94</td>
<td>5.78</td>
<td>36</td>
<td>21.25</td>
</tr>
<tr>
<td>Avoidance</td>
<td>12.06</td>
<td>5.00</td>
<td>36</td>
<td>10.17</td>
</tr>
<tr>
<td>Emotion</td>
<td>17.14</td>
<td>7.83</td>
<td>36</td>
<td>14.11</td>
</tr>
<tr>
<td>Parenting stress:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total stress</td>
<td>286.89</td>
<td>36.20</td>
<td>36</td>
<td>272.36</td>
</tr>
<tr>
<td>Parent domain</td>
<td>135.86</td>
<td>18.98</td>
<td>36</td>
<td>131.89</td>
</tr>
<tr>
<td>Child domain</td>
<td>151.03</td>
<td>21.93</td>
<td>36</td>
<td>140.47</td>
</tr>
<tr>
<td>Psychological symptoms:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Transformed GHQ total</td>
<td>4.3</td>
<td>0.99</td>
<td>36</td>
<td>4.3</td>
</tr>
</tbody>
</table>

1. What are the similarities and differences between mothers and fathers in coping strategies used?

Related samples T-tests were undertaken to examine potential differences between mothers and fathers in their reported use of task, emotion and avoidance coping. Because these were exploratory questions, a bonferroni correction was applied to these, and as such the level required for statistical significance was p<0.007. No significant differences were found between parents' use of task or emotion coping (see Table 20).
Table 20: Related samples t-tests examining differences between mothers and fathers in reported task and emotion coping, parenting stress and psychological symptoms

<table>
<thead>
<tr>
<th>Variable</th>
<th>T-value</th>
<th>DF</th>
<th>Significance (2-tailed)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Coping sub-scale:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Task</td>
<td>1.10</td>
<td>35</td>
<td>0.28</td>
</tr>
<tr>
<td>Emotion</td>
<td>1.78</td>
<td>35</td>
<td>0.08</td>
</tr>
<tr>
<td><strong>Parenting stress:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total stress</td>
<td>2.44</td>
<td>35</td>
<td>0.02</td>
</tr>
<tr>
<td>Parent domain</td>
<td>1.05</td>
<td>35</td>
<td>0.30</td>
</tr>
<tr>
<td>Child domain</td>
<td>3.07</td>
<td>35</td>
<td>0.004***</td>
</tr>
<tr>
<td><strong>Psychological symptoms:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Transformed GHQ total</td>
<td>-0.05</td>
<td>35</td>
<td>0.96</td>
</tr>
</tbody>
</table>

*** Difference is significant at the 0.007 level (2-tailed)

A Wilcoxon Matched-Pairs Signed Ranks Test indicated that mothers and fathers did not differ significantly in their use of avoidance coping ($z(35) = 1.86, p = 0.06, \text{2-tailed test}$).

2. What are the similarities and differences between mothers and fathers in parenting stress and psychological symptomatology experienced?

Related samples T-tests were employed to examine possible differences between parents in their reported parent domain parenting stress, total parenting stress and psychological symptomatology (see Table 20). Again no significant differences were found between parents for these variables. In contrast, a related samples T-test indicated that mothers and fathers did differ significantly in their reported child domain parenting stress ($t(35) = 3.07, p<0.007, \text{2-tailed test}$). An examination of the means indicated that mothers reported significantly more parenting stress than fathers.
3. What are the relationships between maternal and paternal parenting stress, psychological symptomatology and use of coping strategies?

Paired samples Pearson's product moment correlation coefficients were calculated to examine relationships between maternal and paternal task and emotion coping, psychological symptomatology and parenting stress. These are presented in Table 21 below. No significant correlations were found between maternal and paternal task or emotion coping or between maternal and paternal symptomatology. However, significant positive correlations were found between maternal and paternal total parenting stress \((r (36) = 0.57, p = 0.000, 2\text{-tailed test})\); parent domain parenting stress \((r (36) = 0.47, p = 0.004, 2\text{-tailed test})\), and child domain parenting stress \((r (36) = 0.53, p = 0.001, 2\text{-tailed test})\).

Table 21: Paired samples bivariate correlations between maternal and paternal task and emotion coping, parenting stress and psychological symptoms.

<table>
<thead>
<tr>
<th>Pair</th>
<th>Correlation</th>
<th>DF</th>
<th>Significance (2-tailed)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maternal &amp; paternal task coping</td>
<td>-0.22</td>
<td>36</td>
<td>0.2</td>
</tr>
<tr>
<td>Maternal &amp; paternal emotion coping</td>
<td>-0.16</td>
<td>36</td>
<td>0.35</td>
</tr>
<tr>
<td>Maternal &amp; paternal total parenting stress</td>
<td>0.57</td>
<td>36</td>
<td>0.000***</td>
</tr>
<tr>
<td>Maternal &amp; paternal parent domain parenting stress</td>
<td>0.47</td>
<td>36</td>
<td>0.004***</td>
</tr>
<tr>
<td>Maternal &amp; paternal child domain parenting stress</td>
<td>0.53</td>
<td>36</td>
<td>0.001***</td>
</tr>
<tr>
<td>Maternal &amp; paternal transformed GHQ total</td>
<td>0.17</td>
<td>36</td>
<td>0.31</td>
</tr>
</tbody>
</table>

*** Correlation is significant at the 0.007 level (2-tailed)
A Spearman's rho correlation indicated that mothers' and fathers' use of avoidance coping was not significantly correlated ($r (36) = 0.1, p = 0.58$, 2-tailed test).
Discussion

This discussion will begin with a consideration of parenting stress and psychological symptomatology reported by parents. Findings pertaining to the two research questions and the goodness of fit hypothesis will be discussed separately, and then together. The exploratory questions will be addressed, followed by an examination of methodological issues and practical implications of this study.

Both mothers and fathers in this sample experienced levels of parenting stress well above that of the normative population, with parenting stress in relation to their child reaching the 95th to 99th percentiles for both parents. Mean parenting stress scores obtained in this study were greater than those obtained by Dumas et al. (1991), who also measured parenting stress in parents of children with ASD using the PSI.

The introductory open ended question regarding parents' current experiences of the stresses of parenting their child and ways that they coped with these, and comments made by parents during data collection provided some descriptive data. This was not subjected to a qualitative analysis, but are referred to here to illustrate quantitative findings. Stresses commented on by parents were largely related to characteristics of ASD themselves, in particular the child's social communication difficulties and lack of predictability in his/her behaviour. For example, one mother commented that "We can't go out for a meal as a family because you don't know what he will be like". This is consistent with previous literature, which has indicated that stresses experienced by parents are situation specific and associated with symptoms of ASD (Bebko et al., 1987; Gray, 1993; Harris, 1984; Konstantareas & Homatidis, 1989). Another source of stress commented upon by participants were stresses engendered by the family's interactions with the larger world including school, services, family, friends and the general public. One father reported that a source of stress was "Not being told about services he was entitled to and having to find out about these by asking questions". Again this is consistent with previous findings indicating that stigmatisation associated with ASD (Gray, 1993) and the child's ability to be accepted by the community (Koegel et al., 1993) represent sources of stress for parents.
Since the likert scoring method was used to score GHQ-28 responses, it was not possible to compare mean scores gained with clinical threshold scores for psychological symptomatology. However mean GHQ scores for mothers and fathers were substantially below maximum possible scores for this questionnaire, and as such this sample did not appear to be experiencing notably high levels of psychological symptomatology. This seems to be in contrast with previous findings that parents of children with ASD reported elevated levels of depression, anxiety and dysphoria in comparison with the normal population (Dumas et al., 1991; Sharpley et al., 1997). However it is not possible to directly compare findings, as these studies employed different measures from that used here.

**Relationships between coping strategies and parenting stress and psychological symptomatology**

Relationships between coping strategies in response to stressful parenting situations and parenting stress were examined. Findings indicated that use of avoidance coping was significantly positively correlated with parenting stress for mothers and fathers. Emotion oriented coping was significantly positively correlated with parenting stress for mothers but not for fathers. Task oriented coping was significantly positively correlated with parenting stress for fathers but not for mothers. Relationships between coping strategies and psychological symptomatology, were also examined. No significant correlations were found between use of avoidance or task oriented coping and psychological symptomatology for mothers or fathers. Mothers’, but not fathers’ use of emotion oriented coping was found to be related to increased psychological symptoms.

The limited previous research investigating relationships between coping and stress and relationships between coping and psychological symptomatology in parents of children with ASD, have employed different measures of coping examining different coping factors to those used here (Bristol’s, 1987b; Gray and Holden, 1992; Hastings & Johnson, 2001). In addition, these have either not included fathers in their samples, or
have failed to differentiate findings for mothers and fathers. This makes it difficult to compare the present findings with those of previous studies. Within this, the current findings that particular coping strategies are significantly correlated with more parenting stress and psychological symptomatology, are consistent with the existing literature in suggesting that coping is a significant factor in stress experienced by both parents, and in psychological symptomatology experienced by mothers, of children with ASD.

It is not possible to make definitive statements regarding direction of causation in these correlational results. However, the cognitive transactional model of stress and coping suggests that the association found between avoidance coping and increased parenting stress for both parents, indicated that the mediating function of avoidance coping meant that the use of this in response to stressful parenting situations resulted in increased parenting stress. Thus, avoidance coping represented a maladaptive coping strategy for mothers and fathers under these circumstances. Avoidance coping is defined in the CISS:SSC as coping activities that aim to avoid the stressful situation including distraction or social diversion. The vast majority of stressful parenting situations for which parents reported their coping efforts involved practically managing aspects of their child’s difficult behaviour and lack of social understanding. It seems likely that use of coping strategies aiming to avoid or distract away from these stressful situations might prevent parents from engaging with their management. As such, it seems that the cognitive transactional interpretation that avoidance coping in response to these stressful situations was maladaptive in resulting in more parenting stress for these parents is a reasonable one. Comments made by parents indicated that having time away from their child was useful in forming part of their general stress management. For example, one father said that “Swimming and football to reward myself” and “Bike rides to clear my head” were helpful. As such, it may be that this and other avoidance coping strategies are actually helpful in managing general stress levels, but are unhelpful on a situational level.

Interestingly, avoidance coping was not associated with psychological symptomatology in parents. The GHQ-28 measured general symptoms of distress that had occurred during the previous few weeks, in contrast to the PSI’s measurement of stress experienced specifically in relation to aspects of parenting. With this in mind, it may
have been that avoidance coping in response to specific difficult parenting situations resulted in more parenting stress, but did not have a wider impact on non-specific levels of psychological distress experienced.

Findings that fathers' use of task oriented coping in stressful parenting situations was associated with increased parenting stress may be interpreted using the cognitive transactional model as indicating that task coping in these situations resulted in increased parenting stress and was therefore not useful. Task oriented coping is defined in the CISS:SSC as coping strategies used to solve the problem, cognitively restructure the problem or alter the situation. The stressful situations in relation to which parents reported their coping mostly involved practical child management issues. As such, the notion that task coping in response to these would be straightforwardly maladaptive seems doubtful. However, it may be that the active nature of task coping means that considerable effort is expended in employing this coping type and that as well as acting upon the situation, this coping strategy also results in parenting stress. The finding that task oriented coping was not associated with psychological symptomatology in fathers, suggests whilst task coping in difficult parenting situations may increase parenting stress, this does not exert a wider impact on fathers' general levels of psychological distress. Comments made by participants indicated that task oriented coping around managing their child's difficulties was an important factor in coping with the stresses of parenting on a situational level. In particular, one mother talked about how useful she found "Maintaining a routine" and "Giving warnings before ending activities" in managing her child's difficulties. Taken together, the lack of association between task coping and psychological symptomatology in parents and the indications from descriptive data that task coping was helpful for parents, these findings suggest that this coping type might be beneficial as well as resulting in increased parenting stress for fathers. The active nature of task coping may also shed some light on differences in findings for mothers. More mothers than fathers in this sample described themselves as full time carers of their child, and a number of fathers commented on their comparative lack of involvement in the care of their child. As such, it is possible that because fathers spent less time with their child with ASD they had less experience of managing their child's difficulties and therefore found engaging in task oriented coping in relation to these more effortful than mothers.
Again, due to the correlational nature of this study it is not possible to make definitive statements regarding causality. However, the cognitive transactional model would interpret the finding that mothers' use of emotion oriented coping in response to difficult parenting situations was associated with increased parenting stress and psychological symptomatology, as indicating that this coping type leads to increased stress and distress for this group. This is therefore not useful. Emotion oriented coping is defined in the CIS:SSC as self-oriented emotional reactions that aim to reduce stress, but do not necessarily achieve this. In light of this definition, reported coping for emotional reactions represented a negative aspect that coping processes possible that this factor in the well-being of mothers but not of fathers, suggesting that their outcomes may be different for mothers and fathers. It is not due to gender per se, but may relate to differing roles with ASD. As discussed above, in this sample mothers spent more time with their children than fathers and it is possible that emotion coping was related to psychological symptoms for the main carers of children with ASD.

The significant finding for parents coping with children, and to a lesser extent the psychological well-being of parents of children with ASD. Longitudinal research and multi-sourcing measures would enable causal statements to be made regarding stress and coping processes for mothers and fathers. Moreover, the current study has demonstrated stress and coping outcomes are different for mothers and fathers. As such it is important for future researchers to examine stress and coping for mothers and fathers as separate groups. In particular, it would be useful to ascertain whether these apparent gender differences in findings for mothers and fathers, are indeed related to gender, or whether they are explained by other factors such as the child's main carer. It is apparent that future researchers examining relationships between these factors cannot assume that a
variable measured on a situationally specific basis will explain variance in a variable measured on a more general basis.

**Goodness of fit hypothesis**

Whilst the research questions discussed above used a straightforward outcome model to examine relationships between coping and parenting stress and psychological symptomatology, the goodness of fit hypothesis introduces the additional variable of perceived control. As such, findings in relation to goodness of fit enable a finer grained analysis of the process as well as the outcome of coping, and allow us to extend and qualify findings discussed above.

The goodness of fit hypothesis predicted that significant negative correlations would exist between use of task oriented coping and psychological symptomatology in high controllability appraising mothers, and between emotion oriented coping and psychological symptomatology in low controllability appraising mothers due to good fit between controllability appraisal and coping strategy. However no such relationships were found. Instead, contrary to expectations, emotion coping was significantly positively correlated with psychological symptoms in low control mothers. Likewise, no predicted negative relationships were found between task coping and parenting stress in high control mothers, or between emotion coping and parenting stress in low control mothers. It was also predicted that significant positive correlations would exist between task coping and psychological symptoms in low control mothers, and between emotion coping and psychological symptoms in high control mothers due to a lack of fit between controllability appraisal and coping strategy. However these predictions were not supported. In addition, no predicted significant positive correlations were found between task coping and parenting stress in low control mothers. In contrast, a predicted significant positive relationship was found between emotion coping and parenting stress in high control mothers.

As was the case for mothers, no predicted significant negative correlations were found between task coping and psychological symptoms in high control fathers, or between
emotion coping and psychological symptoms in low control fathers. Similarly, no predicted negative correlations were found between task coping and parenting stress in high control fathers, or between emotion coping and parenting stress in low control fathers. Again, as for mothers, no predicted positive correlations were found between emotion coping and psychological symptoms in high control fathers or between task coping and psychological symptoms in low control fathers. In contrast to findings for mothers, no expected correlations were found between emotion coping and parenting stress in high control fathers. However, unlike mothers, predicted significant positive correlations were found between task coping and parenting stress in low control fathers.

Results of this study indicate that parents' appraisals of the controllability of stressful parenting situations as well as the coping strategies that they employ may be important factors associated with stress experienced by parents. Furthermore, these findings may be interpreted as providing support for the goodness of fit hypothesis in fathers within this sample. The cognitive transactional model of stress and coping would propose that significant relationships found between task coping and parenting stress in low control (but not high control) fathers are explained by poor fit between appraisals of low control and use of task coping resulting in increased parenting stress. This finding also qualifies interpretations of the above finding that task coping was straightforwardly associated with parenting stress. In particular, this suggests that instead of representing a maladaptive coping strategy for all fathers in this sample, task coping was only maladaptive under conditions of poor fit. As such, the goodness of fit hypothesis provides a better explanation of this relationship than the less fine-grained outcome explanation discussed above. Due to the correlational nature of this study it is not possible to determine whether the goodness of fit interpretation of these findings is correct. Further research using large enough sample sizes for multiple-regression analysis will be required to make definitive statements regarding direction of causation amongst these variables. The predicted positive correlation found between emotion coping and parenting stress in high control mothers also appears to provide support for the goodness of fit hypothesis in this group. In line with the goodness of fit hypothesis, this relationship was not seen in low control mothers. This finding also qualifies interpretations of the above finding that emotion coping was significantly positively correlated with parenting stress in all mothers, regardless of appraisals of control. More
specifically, this suggests that rather than being unhelpful to all mothers, emotion coping is only maladaptive under conditions of poor fit between use of this coping strategy and appraisals of controllability.

Contrary to predictions made by the goodness of fit hypothesis, a significant positive relationship was also found between emotion coping and psychological symptoms in low control, but not high control mothers. Again, this qualifies the above finding of a significant relationship between emotion coping and psychological symptoms in all mothers regardless of appraisals of control. Although taken together, these findings suggest that appraisal of control contributes to levels of psychological symptoms experienced, the cognitive transactional model is of little use in interpreting this. However it is possible that mothers who make appraisals of low control also tend to experience greater levels of psychological distress and engage in more emotion coping.

The finding that poor fit between appraisal of low controllability and use of task oriented coping was associated with increased parenting stress in fathers, is consistent with previous studies in providing further evidence for the notion of goodness of fit in relation to task coping. The present findings are in line with those of Lazarus and Folkman (1984) that level of appraised control was positively associated with problem focused coping and adaptation and negatively correlated with emotion coping in students coping with exam stress. They are also consistent with Endler et al.'s (2000) finding that high perceived control was related to greater use of task coping and less reliance on emotion coping, and that perceived control was negatively correlated with anxiety and emotion coping and positively correlated with task coping. The current significant finding is directly comparable with those of Compas et al. (1988), who found high levels of behaviour problems in children and adolescents when low appraised control was combined with high problem focused coping, and when high appraised control was combined with low problem focused coping. Similarly, Forsythe and Compas's (1987) finding that increased use of problem focused coping was associated with increased symptomatology when students appraised a distressing major life event as uncontrollable, are consistent with those of this study. In contrast to the present study, these authors also found that use of more problem focused coping was associated with lower levels of symptomatology when events were perceived as controllable, and use of
emotion coping was associated with lower symptom levels when events were perceived as uncontrollable and higher symptom levels when events were appraised as controllable. Likewise, Vitaliano et al. (1990) found that in situations appraised as changeable, problem focused coping was negatively related to depression.

Therefore it seems that the present findings are consistent with previous research indicating that poor fit between task coping and appraisal is associated with poor adaptation. However this study has failed to replicate previous findings that poor fit between appraisal and emotion coping is associated with poorer adaptation, and that good fit between emotion or task coping and appraisal is associated with better adaptation. It is difficult to explain these mixed findings. It is noteworthy that Forsythe and Compas (1987) failed to demonstrate goodness of fit in relation to daily hassles. These authors explain this lack of significant findings in terms of the ramifications of mismatch between appraisal and coping being of an insufficient magnitude to result in significant differences in affect. Following this explanation, it is possible that this study's failure to completely replicate previous findings was due to the fact that stressful parenting situations reported by participants were not of adequate importance to them for match or mismatch between appraisal and coping to significantly influence parenting stress of psychological symptomology experienced. This explanation is borne out by comments made by some participants that it was difficult to think of a single stressful parenting situation that was more stressful than any other.

Although no previous research has differentiated between findings for parents, the present study allows the examination of goodness of fit in mothers and fathers as separate groups. For mothers, poor fit between appraisal and emotion coping was associated with increased parenting stress, whereas for fathers it was poor fit between appraisal and task coping that was associated with increased parenting stress. This suggests that task coping may be more significant in the adjustment of fathers, and emotion coping may be more significant in the adjustment of mothers. Or, as discussed above, it is possible that task coping is more significant in the adjustment of the child's principal care giver, and emotion coping is more significant for the secondary care giver. Further research examining goodness of fit in mothers and fathers as separate groups
which controls for factors such as extent of involvement in the care of their child will be required before conclusions may be drawn.

**Exploratory research questions**

No significant differences were found between parents in their use of task, emotion or avoidance coping or in psychological symptoms experienced. However, mothers were found to experience significantly more parenting stress than fathers.

The only previous study examining differences in coping between parents of children with ASD employed a different coping measure examining different factors to that used here (Moes et al., 1992). As such, it is difficult to compare the findings of these two studies. Interestingly, the main findings here are contrary to indications from the wider coping literature that men engage in more active problem focused coping and tension reducing strategy, and that women prefer social support and emotion oriented coping (Verbrugge, 1985; cited in Littlewood et al., 1991).

Findings to date relating to differential stress levels in mothers and fathers of children with ASD have been equivocal. The present finding that mothers are significantly more stressed than fathers replicate those of two previous studies (Moes et al., 1992; Sanders & Morgan, 1997), and are contrary to those of two previous studies which found no significant differences between mothers and fathers (Bebko et al., 1997; Factor et al., 1990). In this sample it is possible that increased levels of parenting stress are explained by parents’ reports that mothers spent more time caring for children with ASD than fathers.

Findings that mothers and fathers did not differ significantly in reported psychological symptomatology are contrary to those of Moes et al. (1992) and Gray and Holden (1992), both of whom found mothers to be more depressed and/or anxious than fathers. These studies used samples of parents whose children ranged considerably in age (3 to 14 years and 3 to 28 years respectively), and it is possible that the significant differences
that were found reflect differences which exist outside of the smaller age range of children whose parents participated in the current study.

No significant correlations were found between maternal and paternal task, emotion or avoidance coping or reported psychological symptomatology. However, significant correlations were found between maternal and paternal parenting stress. Potential relationships between these variables in mothers and fathers have not previously been investigated. The lack of association between parents’ use of coping strategies lends additional weight to the notion that coping processes were different for mothers and fathers within this sample. It is possible that the association found between parental levels of parenting stress was due to stress in one parent resulting in stress in the other parent. It also seems likely that difficulties of children with ASD produced comparable levels of parenting stress in both of their parents. Further research investigating factors underlying this association is warranted.

Methodological issues

Measuring coping

Since the CISS:SSC measured coping in relation to specific stressful parenting situations, by definition, this questionnaire did not address more general strategies employed by parents to cope with the stresses of parenting their child with ASD. Comments made by participants identified several coping factors which parents found helpful, but which were not measured with the CISS:SSC. Participants reported using a number of cognitive coping strategies which aimed to modify their thinking or perspective in relation to their child or their situation. For example, one father talked about “Accepting my child the way he is” as being helpful, whilst a mother talked about how thinking that “Other children are more disabled” was useful. Similarly, support from services, education, friends family and partner was also commented upon by parents. One mother talked about “Talking with my husband over a glass of wine”, and another about “Friends I've made through school and nursery” as sources of help and support. In contrast, the CISS:SSC task oriented coping factor resonated with participants’ reports of
using task oriented coping around managing their child's difficulties, as did the avoidance coping factor (see above). Obviously, conclusions cannot be drawn on the basis of this descriptive data, however this suggests that some coping factors which were important to parents were not measured by the CISS:SSC. A qualitative study investigating coping strategies seen by parents as beneficial would be of use in facilitating the development of a coping questionnaire that encompasses additional coping factors such as those identified here in descriptive data.

Several limitations relating to the CISS:SSC must be highlighted. Firstly, the emotion oriented sub-scale of this questionnaire is defined as measuring self-oriented emotional reactions that aim to reduce stress, but do not necessarily achieve this. It could be argued that an emotional reaction is conceptually distinct from a coping strategy, and that for this reason this sub-scale would be better described as measuring situational emotion oriented reactions than emotion oriented coping. However, this conceptual distinction is not as clear as it first seems. For example, although "Becoming very upset" (an emotion oriented item) may represent an emotional reaction to a stressful situation, it could also constitute a coping strategy which provides an individual with catharsis. A further issue with the emotion oriented coping sub-scale relates to the conceptual closeness of items measuring the coping mechanism of self-blame in this sub-scale, and items referring to guilt, which is measured in the depression sub-scale that forms part of the parent domain of the PSI. Although self-blame and guilt are conceptually close, the CISS:SSC emotion focused sub-scale measured self-blame as a coping mechanism in response to a specific stressful parenting situation, whilst the PSI depression sub-scale measured guilt in relation to how participants perceived their parenting in a general sense. As such, these constructs were deemed to be sufficiently distinct for correlations between the CISS:SSC and PSI to be meaningfully interpreted. However, put together, these concerns mean that findings in relation to emotion oriented coping must be treated with caution.

A more general difficulty with the CISS:SSC is its' limitation to three coping factors. Qualitative findings indicated that parents used a variety of coping strategies, and this variety is not reflected in the factor structure of the CISS:SSC. In particular, parents cited cognitive coping strategies and information seeking as being helpful in the
management of parenting stress. The fact that such coping strategies suggested by the descriptions parents gave of coping that were useful to them were not all measured by the CISS:SSC may explain the lack of significant negative relationships between coping and parenting stress and psychological symptoms. As such, it is imperative that situational coping measures are developed which retain the psychometric robustness of the CISS:SSC, but which reflect the heterogeneity of actual coping.

**Self-report measures**

The present study relied on self-report measures with the concomittant possibility of unreliable retrospective self-reporting (Zeidner & Saklofske, 1996). This is a problem common to many studies examining coping, which is difficult to measure other than through self-report. In order to reduce potential unreliability of self-reporting, in the present study participants were required to report their coping in relation to a situation which had occurred only over the previous two weeks. However, it may be that asking individuals to report their coping with situations that have taken place more recently would increase the chances of reliable self-reporting. In addition, alternative non self report measures of parenting stress could be taken, perhaps from professionals working with families, to reduce reliance on self-report in this area.

**Cross sectional correlational research design**

A further limitation is this study's cross sectional correlational design. This means that definitive statements regarding directions of causality amongst variables cannot be made. Therefore, although this study interprets findings within a theoretically causal framework, predictions regarding causal direction must be treated with caution.

**Generalisability of results**

Limiting the age range of children whose parents participated in this study reduced sources of confounding variables and allowed this research to focus upon coping in response to the stresses of parenting non-adolescent school aged children with ASD. However, this also prevents the generalisation of findings to parents of children outside
this age range. Similarly, this study focused upon two parent families, and the sample was largely white, middle class and home owning. This means that we cannot assume that findings apply to parents who do not fit this description. Finally, comments made by parents who declined to participate suggest that this sample may be biased towards families who were less stressed, busy and overburdened, and more satisfied with services.

**Practical implications**

Several findings from the present study may be used to inform cognitive behavioural intervention for parents of children with ASD. Firstly, avoidance coping was found to be associated with increased parenting stress for mothers and fathers coping with stressful parenting situations. It is hypothesised here that avoidance coping leads to increased parenting stress, and as such cognitive behavioural intervention could focus upon identifying parents' use of avoidance coping in stressful parenting situations, evaluating the usefulness of this strategy and finding alternatives. Descriptive data suggested that cognitive coping strategies such as accepting their child the way he/she is were reported by parents to be helpful. Further research is required to substantiate these indications. However such cognitive coping strategies could form the basis for adaptive thoughts in response to stressful parenting situations and self-coping statements. In addition, since poor fit between control appraisals and choice of coping strategy was found to be associated with increased parenting stress, assisting parents to accurately appraise situations as controllable versus uncontrollable (appraisal training) and to select coping strategies that are appropriate to their appraisal of the situation (coping training) might represent a further focus for cognitive behavioural intervention. Both appraisal and coping training have been found to be effective in the treatment of individuals with HIV (Folkman et al., 1991).

Descriptive data also provided tentative indications regarding service needs of parents. These indicated that interactions with the wider world might represent sources of stress to parents, but that support from that wider world was of help. Taken together this underlines the importance of ensuring that adequate services are provided to families.
More detailed research is required to validate these indications and to identify areas of need for families of children with ASD and exactly how wider networks are alleviating and contributing to families' difficulties.

Conclusion

This study provided evidence that coping strategies employed by parents in response to stressful parenting situations contribute to the explanation of stress and psychological symptomatology experienced, and that differences existed between mothers and fathers in relationships between coping and parenting stress and symptomatology. The association between task oriented coping and increased parenting stress for fathers but not mothers, was explained in terms of fathers' use of task oriented coping resulting in stress due to their comparative lack of experience in managing their child's difficulties. Findings that emotion oriented coping was associated with more parenting stress and psychological symptomatology in mothers, but not fathers provide tentative indications that emotion coping is more important in explaining variations in stress and distress in mothers. The association between avoidance coping and increased parenting stress for mothers and fathers suggested that avoidance coping was maladaptive for both parents. Findings relating to emotion oriented coping must be treated with caution due to concerns regarding this sub-scale.

Some support was found for the notion that goodness of fit between appraisals of control regarding stressful parenting situations and coping strategies employed in those situations was associated with parenting stress experienced by mothers and fathers. Findings regarding relationships between coping and stress and psychological symptomatology were extended and qualified by the additional variable of perceived control of parenting situations included in the goodness of fit hypothesis. As such, when fathers were grouped as high and low control appraisers, it became apparent that the correlation found between task oriented coping and increased parenting stress for fathers as a whole group, in fact was a significant association only in low control appraising fathers. Likewise, when mothers were grouped according to appraisals of control, it became apparent that correlations between emotion coping and increased stress.
parenting stress as a whole group was significant only in high control mothers. In addition, correlations between emotion coping and increased psychological symptomatology turned out to exist solely in low control appraising mothers. However, full support was not found for the goodness of fit hypothesis. This is explained in terms of ramifications of match or mismatch between appraisals and coping for stressful parenting situations being of insufficient significance to have consequences for parenting stress and psychological symptomatology experienced.

Mothers and fathers did not differ significantly in their use of coping strategies or experience of psychological symptomatology, although mothers experienced significantly more parenting stress than fathers. Greater parenting stress in one parent was found to be associated with greater parenting stress in the other, although similar relationships were not found between parental use of coping strategies or reported psychological symptomatology.

The cognitive transactional model represented a useful heuristic in interpreting findings. Both the goodness of fit and the outcome models were useful evaluating coping, however the goodness of fit model allowed for a finer grained analysis.

Findings that appraisal, coping, and match between these are important in explaining parenting stress and psychological symptomology indicated that these factors may constitute areas for cognitive behavioural intervention for parents of children with ASD.
References


Appendices

Appendix A: Permission letters from ethics committees
Appendix B: Power analysis
Appendix C: Demographic questionnaire
Appendix D: Gilliam Autism Rating Scale
Appendix E: Coping Inventory for Stressful Situations: Situation Specific Checklist
Appendix F: General Health Questionnaire-28
Appendix G: Parenting Stress Index
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Appendix A: Permission letters from ethics committees
Dear Ms

Coping, appraisal, parenting stress and psychological symptomology in mothers and fathers of children with autism (ACE/2002/82/Psych) – FAST TRACK

I am writing to inform you that the University Advisory Committee on Ethics has considered the above protocol under its ‘Fast Track’ procedure and has approved it on the understanding that the Ethical Guidelines for Teaching and Research are observed. For your information, and future reference, these Guidelines can be downloaded from the Committee’s website at http://www.surrey.ac.uk/Surrey/ACE/.

This letter of approval relates only to the study specified in your research protocol (ACE/2002/82/Psych) - Fast Track The Committee should be notified of any changes to the proposal, any adverse reactions and if the study is terminated earlier than expected, with reasons.

Date of approval by the Advisory Committee on Ethics: 2002
Date of expiry of approval by the Advisory Committee on Ethics: 2007

Please inform me when the research has been completed.

Yours sincerely
Dear 

Re: Coping, appraisal, parenting stress and psychological symptomology in mothers and fathers of children with autism —

Thank you for your letter of 26th September 2002 which satisfactorily addresses the points raised by the Committee. We are now happy to give final approval for the study to proceed.

Yours sincerely

Vice-Chair/Clinical Secretary
Local Research Ethics Committee

Please Note: All research should be conducted in accordance with the guidelines of the Ethical Committee; the reference number allocated to the project should be used in all correspondence with the Committee and the Committee should be informed:

(a) when the project is complete.

(b) what stage the project is at one year from today's date.

(c) if any alterations are made to the treatment or protocol which might have affected ethical approval being granted.

(d) all investigators whose projects have been approved by this Committee are required to report at once any adverse experience affecting subjects in the study and at the same time state the current total number of Serious Adverse Events that have occurred.
The members of the Committee present agreed there is no objection on ethical grounds to the proposed study, I am therefore happy to give you the favourable opinion of the committee in accordance with the ICH Good Clinical Practice Guidelines.

This decision is given on the understanding that the research team will observe strict confidentiality over the medical and personal records of the participants. It is suggested that this be achieved by avoidance of the subject's name or initials in the communication data. In the case of hospital patients, using the hospital record number can do this; in general practice, the National Insurance number or a code agreed with the relevant GP.

It should be noted:

- The Committee's decision does not cover any resource implications, which may be involved in your project. A favourable opinion by the REC does not automatically mean that the study may proceed. It is the responsibility of the NHS body under whose auspices the research is to take place to decide whether or not a study should go ahead, taking account of the ethical advice of the REC. Therefore, investigators should seek approval from the relevant NHS body before proceeding with the study.

- Although the Committee's decision is for the life of the project, the LREC must be sent an Annual Progress Report. We also need to be informed of any adverse events, amendments or changes to the study that may occur during the course of your investigations, quoting the Ethics Number in any correspondence.

- Where research involves computer data, this may be subject to the Data Protection Act.

- The GPs of any volunteers taking part in research projects should be aware of their patients' participation.

- Every care should be taken to obtain the volunteers' informed consent to participate in the research project with the necessary help being provided for volunteers with language difficulties.

Yours sincerely

Chairman
LOCAL RESEARCH ETHICS COMMITTEE

2002

Clinical Psychology
University of Surrey
Guildford
Surrey
GU2 5XH

Dear

Thank you for your letter of the 14th October. I apologise for the delay in replying but the slightly short notice departure of our Committee Administrator has resulted in the delay processing applications.

I am pleased to take Chairman's action in approving this study as it has already been approved by LREC and there are no adverse issues affecting our local community.

Please will you advise this committee of the outcome of your research in due course.

I wish you well with the project. With kind regards.

Yours sincerely

Chairman
Appendix B: Power analysis
An a priori power analysis for a two-tailed correlation was calculated as follows:

Alpha: 0.05

Power: 0.7

Effect size "r": 0.4

Sample size: 37 per group (37 mothers and 37 fathers)
Appendix C: Demographic questionnaire
BACKGROUND INFORMATION:
Coping, appraisal, parenting stress and psychological symptoms in mothers and fathers of children with autistic spectrum disorder.

Please complete the following questionnaire which asks for some background information about you and your child(ren). The information that you give will not be used to identify you in any way because the research is confidential. However, if you don't want to answer some of these questions, please don't feel that you have to.

1) Which of the following terms best describes your relationship with the child with autistic spectrum disorder (ASD) you care for? (please tick the appropriate answer)
   Mother
   Father
   Step-mother
   Step-father
   Other (please specify)

2) What is your date of birth? ________________________________

3) Which (if any) of the following terms best describes your ethnic group? (please tick the appropriate answer)
   Black-African
   Black-Caribbean
   Black-other
   Chinese
   Indian
   Pakistani
   Bangladeshi
   White
   Other (please specify)

4) What is your current/last occupation? ________________________________

5) What is your current marital status? (please tick the appropriate answer)
   Single
   Married
   Divorced/separated
   Widowed
   Cohabiting

6) How many children do you have (including your child with ASD)? ________________________________

7) What is the date of birth of your child with ASD? ________________________________

8) What is the birth order of your child with ASD (e.g. first child)? ________________________________

9) What is the gender of your child with ASD? (please tick the appropriate answer)
   Male
   Female
0) How would you describe the general physical health of your child with ASD? (please tick the appropriate answer)

Excellent ⬜
Good ⬜
Alright ⬜
Poor ⬜
Very poor ⬜

1) How is your child with ASD currently educated? (please tick the appropriate answer)

At home ⬜
School for children with autism ⬜
School for children with special needs ⬜
Main stream school ⬜
Other (please specify) ________________________________________________________________

2) Which (if any) services do you currently receive in relation to your child with ASD? (please tick the appropriate answers)

Speech and language therapy ⬜
Clinical Psychology ⬜
Educational Psychology ⬜
Family therapy ⬜
Psychiatry ⬜
Physiotherapy ⬜
Occupational therapy ⬜
Social services ⬜
Support worker(s) ⬜
School based service (please specify) ______________________________________________________
Other (please specify) ______________________________________________________________________

3) Which (if any) services have you received in the past in relation to your child with ASD? (please tick the appropriate answers)

Speech and language therapy ⬜
Clinical Psychology ⬜
Educational Psychology ⬜
Family therapy ⬜
Psychiatry ⬜
Physiotherapy ⬜
Occupational therapy ⬜
Social services ⬜
Support worker(s) ⬜
School based service (please specify) __________________________________________________
Other (please specify) ________________________________

THANK YOU FOR YOUR CO-OPERATION
MATERIAL REDACTED AT REQUEST OF UNIVERSITY
Appendix H: Measure of appraisal of controllability of stressful situation
DESCRIPTION OF STRESSFUL SITUATION:

I would like you to think again about the stressful situation in relation to parenting your child with autistic spectrum disorder that you had in mind while you were completing the last questionnaire. Once you have thought of the stressful situation, please provide answers to the following questions in the spaces provided.

1.) Please describe the stressful situation

__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________

2.) Where did the stressful situation happen?

__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________

3.) Who was involved?

__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________

4.) How did you act?

__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________

5.) What was the outcome?

__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________

6.) Please rate on the scale below how controllable this situation felt to you as it was happening.

   1  2  3  4  5  6
  Completely controllable  Completely uncontrollable

   Why did you rate the controllability of the situation in the way that you have? Please explain in the space below, and continue overleaf if necessary.

__________________________________________________________________________
__________________________________________________________________________
Appendix I: Initial letter to participants
Dear

Research project: Coping, Appraisal, Parenting Stress and Psychological Symptoms in Mothers and Fathers of Children with Autistic Spectrum Disorder.

The Child and Adolescent Mental Health Service at xxx, xxx, is helping me to identify parents who might be willing to take part in this research project. They have suggested a number of parents who I might invite to participate, including you. I am enclosing some information about this project so that you can decide whether you would like to participate.

I am a Trainee Clinical Psychologist at the University of Surrey, and I am carrying out this research as part of my Clinical Psychology Doctoral training. This research is being supervised by Dr.xxx, University of Surrey and Dr. xxx, xxx.

I will be contacting you by telephone in about a week in order to find out whether you have any questions about this research project and whether you are interested in taking part. However please feel free to contact me in the meantime if you would like to do so at the above address and telephone number.

I look forward to speaking with you soon.

Yours sincerely,

xxx, Trainee Clinical Psychologist, University of Surrey

Supervised by, Dr. xxx

Dr. xxx

Enc.
Appendix J: Information sheet for participants
INFORMATION SHEET:
Coping, appraisal, parenting stress and psychological symptoms in mothers and fathers of children with autistic spectrum disorder

You are being invited to take part in a research study. Before you decide whether to take part it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Ask the researcher, xxx, if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part.

What is the purpose of this study?
Parents of children with autistic spectrum disorder have reported that at times, caring for their child can be difficult and stressful. This research aims to find out about ways that mothers and fathers cope with parenting their child, and whether these coping strategies help them to adjust to the demands of parenting. It is hoped that as a result of this research we will know more about how best to help parents to manage the demands of raising a child with an autistic spectrum disorder. This study will begin in August 2002 and it is anticipated that a written report of the findings will be ready by August 2003.

Why have I been chosen?
A total of seventy four mothers and fathers from thirty seven two parent families with a child with an autistic spectrum disorder will be recruited to take part in this study. You have been chosen because you meet the following criteria for being invited to participate:
• You are living with the mother/father of your child with an autistic spectrum disorder.
• Your child is aged between four and eleven years at the time that you take part in the study.
• Your child has received a diagnosis of an autistic spectrum disorder at least six months before taking part in the study.
• Your child is not receiving an intensive home based treatment at the time that you take part in the study.

Do I have to take part?
No - It is entirely up to you whether or not you decide to take part in this research. You do not have to give any reasons for not taking part. Even if you do decide that you want to take part, and then later change your mind, you can tell the researcher that you no longer want to take part. You do not have to give a reason. Your decision whether to take part will not affect any services received by the family.

What will happen to me if I take part?
The researcher is looking for both the mother and the father of the same child with an autistic spectrum disorder to participate in this research. This is because we are interested in differences in the coping strategies used by mothers and fathers of the same child. We are also interested in differences in stress related to parenting and psychological symptoms experienced by mothers and fathers of the same child. This means that you and your partner need to agree together whether or not you will both take part. A researcher, xxx, will be in touch about one week after you receive this information to find out if you have any questions about the research and whether you have decided to participate. If you decide to take part the researcher will visit you both once at a time convenient to you either at home or at your child and family service, whichever you prefer. You will be asked to sign an informed consent form, and will be given a copy of this and another copy of this information sheet to keep. You will then be asked to fill in some questionnaires with the researcher about background information about you and your child(ren), your child's symptoms of autistic spectrum disorder, parental coping strategies, stress and your psychological well being. These are standard questionnaires that are aimed at parents
in general, so some of the questions may not apply to you. Completing these questionnaires will take about one hour for each parent.

**What will be the benefits of taking part?**
Taking part in this research may or may not be of direct benefit to your own care, but may prove of benefit in the future. This research will provide valuable information about how best to support families with a child with autistic spectrum disorder in the future. The findings of the research will be fed back to your child and family service, so that they can use this information to help other families. If you are interested, the researcher can send you a summary of the findings of the research once this has been completed.

**What if something goes wrong?**
If you have any complaints as a result of taking part in this study please contact one of the researcher's supervisors Dr. xxx or Dr. xxx. The usual NHS complaints procedure will then be put in place. Dr. xxx may be contacted at xxx telephone: xxx. Dr. xxx may be contacted at xxx, telephone xxx.

**Will my taking part in this study be kept confidential?**
Your answers will be kept confidential. If you take part in this research you will be assigned a number. Questionnaires will only be labelled with this number, and not your name. Only numbers, and not names, will be stored on a computer. The contact details that the researcher has for you will be kept confidential and will be destroyed once you have talked to the researcher, or when you have received your copy of the findings of the research if you decide that you would like these. Any information about you which leaves the child and family service will have your name and address removed so that you cannot be recognised from it. No information that you provide will be passed on to anyone else unless you ask for this to happen, this is required by law, or issues of safety of either the participants or others arise.

**What will happen to the results of the research study?**
A written report detailing the findings of the study will be produced by the researcher for submission to the University of Surrey as part of her Clinical Psychology Doctoral training. Results of the study will be fed back to the child and family services from which participants have been recruited to take part. A summary of the findings will be available to all participants who would like one. The study may be submitted for publication with a peer reviewed psychological journal at a later date. No individual participants will be identified in any report or publication that results from this study.

**Who is organising the research?**
This study is being conducted as part of the researcher’s Clinical Psychology Doctoral training at the University of Surrey.

**Who has reviewed this study?**
This study has been reviewed by the xxx Local Research Ethics Committee, the St xxx Local Research Ethics Committee and the xxx Ethics Committee.

Thank you for taking the time to read this information and consider your decision. If you would like to speak to someone about this, or would like any more information, please contact xxx, Trainee Clinical Psychologist, at xxx, telephone xxx.
Appendix K: Information letter for GPs
Dear Dr,

Re.: Coping, appraisal, parenting stress and psychological symptoms in mothers and fathers of children with autistic spectrum disorder

I am writing to you because your patients have participated in the above research study. They have indicated that they would like me to inform you of their participation and send you some details about the study.

What is the purpose of this study?
Parents of children with autistic spectrum disorder have reported that at times, caring for their child can be difficult and stressful. This research aims to find out about ways that mothers and fathers cope with parenting their child, and whether these coping strategies help them to adjust to the demands of parenting. It is hoped that as a result of this research we will know more about how best to help parents to manage the demands of raising a child with an autistic spectrum disorder. This study will begin in August 2002 and it is anticipated that a written report of the findings will be ready by August 2003.

Why has your patient been chosen?
A total of seventy four mothers and fathers from thirty seven two parent families with a child with an autistic spectrum disorder have been recruited to take part in this study. Your patients have been chosen because they meet the following criteria for being invited to participate:
- They are living with the mother/father of their child with an autistic spectrum disorder.
- Their child is aged between four and eleven years at the time that they took part in the study.
- Their child had received a diagnosis of an autistic spectrum disorder at least six months before taking part in the study.
- Their child was not receiving an intensive home based treatment at the time that they took part in the study.

What has taking part in this research involved for my patient?
I have been looking for both the mother and the father of the same child with an autistic spectrum disorder to participate in this research. This is because I am interested in differences in the coping strategies used by mothers and fathers of the same child. I am also interested in differences in stress related to parenting and psychological symptoms experienced by mothers and fathers of the same child. This means that your patient and his/her partner needed to agree together whether or not they would both take part. I have visited your patient on one occasion at a time convenient to them either at home or at their child and family service. They have completed some questionnaires with me about background information about them and their child(ren), their child’s symptoms of autistic spectrum disorder, parental coping strategies, stress and their psychological well being. This took about one hour for each parent.

What will be the benefits for my patient of taking part?
Taking part in this research may or may not be or direct benefit to your patient’s own care, but may prove of benefit in the future. This research will provide valuable information about how best to support families with a child with autistic spectrum disorder in the future. The findings of the research will be fed back to your patient’s child and family service, so that they can use this information to help other families. However, the confidentiality of your patients’ identities will be protected. Your patient has
been offered the option of receiving a summary of the findings of the research once this has been completed.

**What if something goes wrong?**
If your patient has any complaints as a result of taking part in this study they should contact one of the researcher’s supervisors Dr. xxx or Dr. xxx. The usual NHS complaints procedure will then be put in place. Dr. xxx may be contacted at, telephone: xxx. Dr.xxx may be contacted at xxx, telephone xxx.

**Will my patient’s participation in this study be kept confidential?**
Your patient’s answers have been kept confidential. Your patient has been assigned a number and questionnaires have only been labelled with this number, and not their name. Only numbers, and not names, will be stored on a computer. The contact details that I have for your patient have been kept confidential and destroyed once they have talked to me, or when they have received their copy of the findings of the research if they decide that they would like these. Any information about them which has left the child and family service had had their name and address removed so that they cannot be recognised from it. No information that they have provided will be passed on to anyone else unless they ask for this to happen, this is required by law, or issues of safety of either the participants or others arise.

**What will happen to the results of the research study?**
A written report detailing the findings of the study will be produced by me for submission to the University of Surrey as part of my Clinical Psychology Doctoral training. Results of the study will be fed back to the child and family services from which participants have been recruited to take part. A summary of the findings will be available to all participants who would like one. The study may be submitted for publication with a peer reviewed psychological journal at a later date. No individual participants will be identified in any report or publication that results from this study.

**Who is organising the research?**
This study is being conducted as part of my Clinical Psychology Doctoral training at the University of Surrey.

**Who has reviewed this study?**
This study has been reviewed by the xxx Local Research Ethics Committee, the xxx Local Research Ethics Committee and the xxx Ethics Committee.

Should you wish to discuss your patient’s participation in this research or any of the details above with me, please do not hesitate to contact me at the above address/telephone number.

Many thanks for taking the time to read this information.

Yours sincerely,

xxx
Trainee Clinical Psychologist
CONSENT FORM:

Title of project: Coping, appraisal, parenting stress and psychological symptoms in mothers and fathers of children with autistic spectrum disorder.

Name of researcher: Imogen Clarke

1. I confirm that I have read and understand the information sheet dated 01.06.02 for the above study and have had the opportunity to ask questions.

2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, without my medical care or legal rights being affected.

3. I understand that sections of any of my child’s medical notes may be looked at by responsible individuals from University of Surrey or from regulatory authorities where it is relevant to my taking part in research. I give permission for these individuals to have access to my child’s records.

4. I agree to take part in the above study.

5. I would like the researcher to inform my G.P. that I am taking part in this study and to send him/her some details about this study.

6. I would like to receive a summary of the findings of this study.

Name of Participant __________________________ Date __________ Signature __________________________

Name of Witness __________________________ Date __________ Signature __________________________

Researcher __________________________ Date __________ Signature __________________________
III. Research logbook
<table>
<thead>
<tr>
<th>Research Skill/Experience</th>
<th>Description of how research skill/experience acquired</th>
<th>Date research skill/experience acquired</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conduct a literature search</td>
<td>I conducted computerised literature searches using the Psychinfo and BIDS databases for each of my four essays and five case reports and for my service related, qualitative and major research projects. I have also conducted these in relation to my clinical work. In addition for my research projects and clinical work I have undertaken searches by hand of abstracts from relevant journals, and have consulted with my supervisors, peers and tutor to locate appropriate literature. This has taught me the importance of using multiple sources in undertaking a thorough literature search</td>
<td>Throughout training</td>
</tr>
<tr>
<td>Critically review the literature</td>
<td>I have undertaken critical reviews of the literature for each of my four essays and five case reports and for my service related, qualitative and major research projects, and in relation to clinical work. During this process I have applied knowledge acquired during research methods teaching to my critical thinking. From this experience I have learnt the importance of balancing methodological issues with clinical experience in drawing conclusions regarding research evidence.</td>
<td>Throughout training</td>
</tr>
<tr>
<td>Research Skill/Experience</td>
<td>Description of how research skill/experience acquired</td>
<td>Date research skill/experience acquired</td>
</tr>
<tr>
<td>---------------------------------------------------------------</td>
<td>---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>----------------------------------------</td>
</tr>
<tr>
<td>Formulate a specific research question</td>
<td>I consulted with my research and field supervisors and with my research tutor in formulating research questions for my service related research project and my major research project. I worked in conjunction with a group of peers in formulating a research question for my qualitative research project. This has given me an understanding of the importance of a sound knowledge of the relevant literature base when identifying a research question.</td>
<td>Years 1 and 2</td>
</tr>
<tr>
<td>Write a brief research proposal</td>
<td>I prepared a brief research proposal for my service related research project and my major research project. I consulted with my research supervisors during this process. This provided me with experience of succinctly reviewing existing literature and my research rationale and of communicating research ideas clearly.</td>
<td>Year 1</td>
</tr>
<tr>
<td>Write a detailed proposal/protocol</td>
<td>I wrote a detailed research proposal for my major research project. I consulted with my research supervisor during this process. I discovered the importance of a thorough understanding of the area of suggested research in writing a clear and concise proposal.</td>
<td>Year 2</td>
</tr>
<tr>
<td>Research Skill/Experience</td>
<td>Description of how research skill/experience acquired</td>
<td>Date of skill/experience acquired</td>
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<tr>
<td>---------------------------</td>
<td>--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>-----------------------------------</td>
</tr>
<tr>
<td>Obtain appropriate supervision/collaboration for research</td>
<td>I discussed my service related and major research projects with potential field and university supervisors who had experience in the relevant areas. I collaborated with the team manager in the service where my service related research was conducted. I also recruited five services to assist with data collection for my major research project. I sought appropriate supervision from field and university supervisors to hone my skills in working relationships with those collaborating in the research process. I wrote a covering letter to distribute along with my questionnaire to potential participants in my service related research project. I also wrote an information sheet and consent form for participants in my major research project. This process gave me the opportunity to hone my skills in writing about research in an accessible manner.</td>
<td>Throughout training</td>
</tr>
<tr>
<td>Research Skill/Experience</td>
<td>Description of how research skill/experience acquired</td>
<td>Date research skill/experience acquired</td>
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<tr>
<td>---------------------------</td>
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<td>------------------------------------------</td>
</tr>
<tr>
<td>Obtain approval from a research ethics committee</td>
<td>I approached and obtained ethical approval to conduct my major research project from three hospital ethics committees and the university ethics committee. This process gave me an understanding of the sorts of ethical issues that were of concern.</td>
<td>Year 3</td>
</tr>
<tr>
<td>Collect data from research participants</td>
<td>I collected data for my service related research project through the distribution and collection of questionnaires. In order to increase the participation rate, it was necessary to send out a reminder letter to prompt participants to return questionnaires. For my major research project, I collected data from participants directly through the collaborative completion of measures. This taught me the importance of building a rapport with research participants and providing appropriate information to ensure that they do not feel threatened by the research process.</td>
<td>Years 1 and 3</td>
</tr>
<tr>
<td>Set up a data file</td>
<td>I set up a data file for my major research project. This enabled me to gain further experience of categorising data types.</td>
<td>Year 3</td>
</tr>
<tr>
<td>Analyse quantitative data</td>
<td>I analysed quantitative data in relation to my service related and major research projects. This enabled me to consolidate my knowledge of statistical methods and tests and of assumptions of parametric analyses.</td>
<td>Years 1 and 3</td>
</tr>
<tr>
<td>Research Skill/Experience</td>
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<td>Date research skill/experience acquired</td>
</tr>
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<tr>
<td>Analyse qualitative data</td>
<td>I analysed qualitative data in relation to my qualitative research project using Interpretative Phenomenological Analysis. This process taught me about the importance of familiarity with the data set and of rigorous conceptual thinking when conducting qualitative analysis.</td>
<td>Year 2</td>
</tr>
<tr>
<td>Interpret results from data analysis</td>
<td>I interpreted findings of my service related, qualitative and major research projects. This was facilitated by a good understanding of the method of analysis I was using and of the variables under examination.</td>
<td>Throughout training</td>
</tr>
<tr>
<td>Present research findings/plans to an audience</td>
<td>I presented findings of my service related research project to the service within which the research was conducted. In addition, I presented by proposed major research project to research tutors and to second year students. I also presented this to one of the services which I was hoping would assist with participant recruitment. Through this process I have improved my skills in engaging an audience.</td>
<td>Years 1 and 2</td>
</tr>
<tr>
<td>Produce a written report on a research project</td>
<td>I have produced written reports for the university for my service related, qualitative and major research projects. Through this process my ability to synthesise information and communicate ideas clearly has been important.</td>
<td>Throughout training</td>
</tr>
<tr>
<td>Defend research project at an oral examination</td>
<td>This will be undertaken during my forthcoming viva voce examination.</td>
<td>Year 3</td>
</tr>
<tr>
<td>Research Skill/Experience</td>
<td>Description of how research skill/experience acquired</td>
<td>Date research skill/ experience acquired</td>
</tr>
<tr>
<td>------------------------------------------------------------------------------------------</td>
<td>------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>------------------------------------------</td>
</tr>
<tr>
<td>Apply research findings to clinical practice (give examples of 3 papers published during your training which influenced your practice).</td>
<td>The following research findings published during my training informed my clinical practice:</td>
<td></td>
</tr>
</tbody>
</table>