A PORTFOLIO OF STUDY, PRACTICE AND RESEARCH
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The Assessment Of Body Image In A Community Population Of People With Mild Learning Disabilities

VOLUME ONE

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INTRODUCTION TO VOLUME ONE OF THE PORTFOLIO

This document is Volume One of a portfolio of work completed as part of the PsychD in Clinical Psychology. This volume contains an academic dossier, a clinical dossier and a research dossier. The academic dossier comprises of five essays covering both core and specialist topics. The clinical dossier comprises of summaries of the placements undertaken and summaries of the five case reports presented in Volume Two. The research dossier includes a service related research project carried out in year one, a literature review and the major research project completed in year three.

Volume Two of the portfolio contains five case reports and relevant placement documentation including placement contracts, logbooks and evaluation forms. The information contained in Volume Two is confidential in nature, although names and identifiers have been changed to preserve confidentiality in the case reports.
SECTION ONE

*Academic Dossier*
Discuss The Role Of Cognitive Behaviour Therapy In The Management Of A Psychotic Disorder.
INTRODUCTION

During the last decade cognitive behavioural therapy (CBT) has emerged as a substantial and practicable component in the management of patients with psychosis. Significant proportions of people with psychosis suffer from unremitting psychotic symptoms such as delusions and hallucinations. Kuipers (1996) reported over 50% of people on medication at two year follow up were still deluded. Recent research into the treatment of drug resistant psychotic symptoms with cognitive behavioural approaches has promising results. However it must be remembered that these interventions are still in their infancy (Birchwood & Shepherd, 1992).

Traditionally the treatment and management of psychosis was seen as a medical domain, as it was thought of as a purely biological disease-entity disorder. Kraepelin’s model (1919) assumed dementia praecox (later named schizophrenia by Bleuler, 1950) to be a distinct disease entity with an inevitably deteriorating course. He suggested that psychotic symptoms arose directly from brain disorder and that the beliefs of people with schizophrenia were not amenable to reason. Boyle (1990) and Bentall (1990) both argue that Kraepelin and Bleuler failed to provide evidence of having observed any pattern to justify their constructs. Similarly they failed to find valid diagnostic criteria or reliable support for predictions from these constructs.

Bentall (1990) believes that patients do not fall into discrete types of psychiatric disorder, for example he suggests schizophrenia to be a disorder with “no particular symptoms, no particular course, no particular outcome and which responds to no particular treatment”(pg. 33). Bentall, Kinderman & Kaney (1988) suggest the ideal approach is to consider individual symptoms, for example delusions, as a move away from the syndrome model. This is supported by the individual symptoms being a better predictor of response to antipsychotic medication, than the intact schizophrenic syndrome (Johnstone, Cooling, Frith & Owens, 1988).

When reviewing the literature on cognitive behaviour therapy for psychosis, it becomes apparent that many researchers have done just this. That is, they have proposed a theory for a particular symptom rather than the syndrome of schizophrenia.
as a whole. For the purpose of this essay the role of CBT for delusions and hallucinations will be explored.

Pessimism about the psychological therapies with psychotic clients has warranted from past failure of, for example psychodynamic therapies (Mueser and Berenbaum, 1990). Spring & Ravdin (1992) noted that many researchers believed that the psychological treatment of psychosis was not warranted due to the success of neuroleptics. However despite the success of medication, residual positive symptoms of psychosis, such as delusions and hallucinations, represent a significant problem (Curson, Patel, Liddle & Barnes, 1988). Positive symptoms are associated with distress, low self-esteem, poor social functioning and even suicide (Birchwood & Shepherd, 1992). Concerns regarding non-compliance and side effects of neuroleptics also need to be heeded (Tarrier 1992).

Evidence has been found that people with psychosis actively attempt to cope with symptoms by using behavioural and cognitive strategies, including reducing attention to symptoms and relaxation (Cohen & Berk, 1985; Carr, 1988). This supports the possibility of direct intervention using psychological therapies and the active role of the patient in managing their own problems (Carr, 1988). The development of cognitive models of psychosis and differing cognitive behavioural interventions will later be explored.

In all cases CBT is an adjunct to medication in the management of psychosis. As delusions and hallucinations often survive neuroleptics, CBT is useful in maximising the effectiveness of the medication. As well as complementing pharmacological techniques, CBT also complements other psychosocial techniques in the management of psychosis including family involvement and early intervention. The management of psychosis likewise incorporates a vast array of other areas including care needs, housing, social contact and community support. Unfortunately there is not the scope in this essay to be able to address all these areas.
THE DEVELOPMENT OF COGNITIVE MODELS OF PSYCHOSIS

Cognitive formulations of psychotic problems draw from three key areas, the first being from general cognitive models of emotional disturbance, for example depression and anxiety (Beck, 1979).

The second area has been established by the move away from studying the syndrome of psychosis as an illness, towards looking at the symptoms themselves (Chadwick, Birchwood & Lowe, 1996). This concept has emerged from the assumption of cognitive theories of psychosis that the beliefs and experiences of psychosis run on a continuum with normality (Fowler, Garety & Kuipers, 1998a). For example, delusional beliefs may be on a continuum with commonly occurring eccentric beliefs e.g. beliefs in UFOs; psychotic experiences may be on a continuum with anomalies of normal experience e.g. déjà vu. If this be the case, much of the content of delusions and hallucinations maybe understood in the context of the individual's past and current experience. Similarly, the beliefs of people with psychosis may be modified in similar ways to those of other people. This is in contrast to previous ideas of delusional beliefs being categorically different from those of 'normals' (Jaspers, 1963). Fowler et al (1998a) suggest that instead of viewing psychosis as a disorder or a predicament, psychosis should be viewed as an alteration in an individuals feelings and thoughts and therefore in the way the world is interpreted.

The move away from the purely biological disease-entity model of schizophrenia (Boyle, 1990) has brought in to popularity the third key area, the biopsychosocial models such as the vulnerability-stress model of psychotic illness (Strauss and Carpenter, 1981). This model allows for various types of explanation to assume importance at different stages of an individual's development. It supplies a summary of several factors, which are likely to increase susceptibility to schizophrenia, precipitate its occurrence and influence its course once established as a chronic course.

The vulnerability-stress model suggests premorbid events such as trauma, cognitive deficits, and environmental factors in childhood may play a role in heightened vulnerability to later on set of psychosis. The likelihood of vulnerability becoming
manifest as a psychotic phase will depend on the subsequent exposure to additional stresses. These may be biological e.g. drug abuse; or psychological such as major life events. Strauss and Carpenter go on to suggest that once in the acute phase, the same stresses and any new stresses that will influence the subsequent course and outcome of the disorder. Stigma, social isolation and loss may all influence the chronic course. The involvement of the individual within his or her own course of recovery is seen as important, for example medication compliance.

The vulnerability-stress model of psychosis appears to predominate much of the literature investigating psychosis. Interestingly it is thought that this model has the potential to incorporate and integrate cognitive theories from other spheres such as cognitive-neuropsychological theories, emotional/motivational theories and theories whereby individuals try to make sense of their unusual experiences (Clements & Turpin, 1992). These cognitive theories shall now be explored.

Cognitive-Neuropsychological Theories of Psychosis

Frith (1992) developed a cognitive-neuropsychological model of auditory hallucinations, whereby a cognitive deficit leads to the inability to determine between external and internal sources of stimulation. Subsequently an individual’s thought arising in the mind would appear alien. Frith also devised an account of delusions, suggesting delusion formation may be the inability of an individual to understand accurately the intentions of others. Individuals may therefore make incorrect inferences or become confused about the intentions of others, whilst not realising they have lost this ability to develop correct inferences.

Hemsley (1993) offers a model of psychosis based upon the impairment of the assessment of significance of aspects of sensory input. For example the deficit may lead to unimportant occurrences being perceived as highly personally significant and may form the basis for ideas of reference. Derived from this theory, reasoning biases may be characteristic of some people with delusions, whereby hasty decisions are made about stimuli (Fowler, Garety & Kuipers, 1995).
Although these cognitive-neuropsychological theories are useful and consistent with how the brain functions, these models lead us to believe that psychosis is purely a biological deficit. They omit any role of the environment or adaptation on the individuals part. However the links between brain dysfunction and psychotic experiences are sometimes useful for sharing with the patient in therapy, offering an understanding of the nature of their problems (Fowler et al, 1995).

Emotional/Motivational Theories of Psychosis

Many studies have focused on the role of emotion and its influence and involvement with delusions and hallucinations. Zigler and Glick (1988) suggested that persecutory delusions were a defence against depression, by attributing blame for negative experiences onto others. Also based in psychoanalytic theory Neale (1988) argues grandiose delusions are a consequence of the individual protecting itself from self-related threat. Bentall et al (1994) suggests persecutory delusions are a reaction to the inconsistencies between actual and ideal self during negative life events.

Beliefs about the nature and content of auditory hallucinations will determine the meaning and significance of the experience of hearing the voice to the individual (Beck-Sander, Birchwood & Chadwick, 1997). Romme & Escher (1989) revealed a person’s ability to cope with voices differs depending on their appraisal of the voices, when studying clinical and non-clinical groups. Chadwick and Birchwood (1994) explored the nature of auditory hallucinations and indicated the extent to which voices were often encountered as omnipotent and omniscient. When the voices were described as malevolent, this provoked fear and they were resisted; benevolent voices, on the other hand, were wooed. A further study empirically demonstrated that it is the beliefs about voices that are necessary in understanding the affect and behaviour of an individual that experiences auditory hallucinations (Birchwood & Chadwick, 1997). They propose the possibility that voice beliefs may develop as part of an adaptive process to experiencing voices, whereby there is a core set of beliefs about the individuals self worth and interpersonal relationships.

Fowler et al (1995) argue that it is fundamental to acknowledge emotional disturbance in people with psychosis and its contribution to delusions and hallucinations.
Dysfunctional assumptions surrounding the emotional disturbance can then be addressed.

'Making Sense of Unusual Experiences' Theories of Psychosis

A central theoretical issue of delusions is whether the occurrence of delusions is an attempt to explain unusual perceptual abnormalities. Maher (1988) describes delusions as the culmination of normal cognitive processes but in the presence of unusual perceptual experiences. This in itself is a plausible theory, however this theory does not account for the absence of anomalous perceptual experiences (Chapman & Chapman, 1988) or why abnormal experiences may be present for only some people.

Cameron (1959) proposed that interpersonal incompetencies may bestow a vulnerability to the formation of delusional beliefs. He offers a social learning theory of delusions that states that deficits such as difficulty understanding the intentions of and interacting with others may lead to the formation of suspiciousness. This, when met with rejection from others, leads to further isolation and lack of opportunity to disconfirm beliefs. However there are occasions when paranoid beliefs are developed principally on psychotic experiences, such as the TV talking about the individual. When beliefs can be understood in terms of the individual's history, CBT may help the individual to understand the dysfunctional assumptions about self and others (Fowler et al, 1995).

The partial misinterpretation of real external events has been given as an explanation of hallucinations, for example ambiguous noises (Frith, 1992). Similarly the misinterpretation of bodily experience has been investigated (Fowler et al, 1995). Clinical interventions may involve the exploration of the misinterpretation and the reattribution of the event.

These theories about ways in which people with psychosis attempt to make sense of hostile experiences give us suggestions as to the nature of delusions and hallucinations. They provide grounding for various cognitive strategies such as modifying delusional beliefs and seeking alternative explanations for hallucinations.
CBT INTERVENTIONS FOR DELUSIONS AND HALLUCINATIONS

As with cognitive theories of psychosis, various styles of CBT approaches to delusions and hallucinations have emerged, which all have a part to play in the management of psychosis. Specific therapy techniques consist of adaptations of well-documented procedures used in cognitive behavioural therapies for other disorders such as depression, as well as some techniques developed specifically for psychosis. McNally & Goldberg (1997) identified 9 types of self-talk that people with schizophrenia (based in the community) actively used to manage their psychotic symptoms themselves. They propose these naturalistic coping strategies might serve as guidelines for psychotherapeutic interventions.

Kingdom and Turkington (1991a) suggested cognitive therapy as a logical approach to the treatment of schizophrenia as, for example, a central focus of cognitive therapy is the treatment of disordered cognitive content such as negative thinking and disordered cognitive processes such as dichotomous thinking. Early psychological methods of treating positive symptomatology included token economy, systematic desensitisation, aversion therapy and social skills training (Birchwood & Shepherd, 1992).

CBT Approaches for Delusions

Originally symptoms such as delusions were defined as being unresponsive to rational argument (Jaspers, 1963) and therefore unamenable to talking therapies. However recent research challenges this conventional belief by presenting evidence that delusions are amenable to reasoning approaches when these are used in a non-confrontational and collaborative way, with full exploration of alternative explanations (Kingdon, Turkington & John, 1994).

Beck (1952) first described the possibility of influencing delusional experiences in a psychotic patient with cognitive therapy. Watts et al (1973) went on to describe a model of challenging delusional beliefs, arguing that rejection of the belief would serve to strengthen the belief itself.

Chadwick and Lowe (1994) developed the cognitive management of delusions further proposing a three-stage intervention. In the first assessment stage a collaborative
relationship is developed and target beliefs determined. During the second stage, data surrounding the establishment and maintenance of beliefs are gathered, leading to the final stage where beliefs are verbally challenged. This is done so in a non-confrontational way citing inconsistencies and irrationalities, proposing alternative explanations and operating reality testing.

Kingdon and Turkington (1991b) present a cognitive behavioural approach for psychosis using a normalising rationale. Delusional beliefs are explored in partnership with the client, and explained in terms of stress. The therapist normalises the beliefs suggesting they are common occurrences in the normal population. Anxiety management and cognitive strategies aimed at the symptoms may all pay a part in this therapy. The normalisation process allows the client to feel ordinary and this process assists in destigmatisation.

CBT Approaches for Hallucinations

Focusing has been used as a technique to encourage patients to see the connections between voices and the underlying situational / emotional factors (Fowler & Morley, 1989). Patients are supported in relabelling their hallucinations as perceptual disturbance, and reassessing their beliefs about voices. Reduction of the frequency of the voices and associated distress, by means of a gradual reattribution of the voices to the self is the focus. In some patients this may be anxiety provoking: in such cases alternative strategies may be used such as supporting the patient in seeing the voices as a result of a biological factor (Fowler et al, 1995).

Although the benefits of using distraction techniques appear to be short-lived (Nelson, Thrasher & Barnes, 1991), some distraction techniques may be helpful for patients. Whilst hallucinations are initially being explored, distraction techniques such as activity scheduling and listening to a personal stereo may be beneficial. However, these techniques do not address the underlying disorder.

Chadwick, Birchwood and Trower (1996) present a CBT approach to voices based on Beck’s cognitive therapy (Beck, 1979) and rational-emotive behaviour therapy (Ellis, 1994). An individual’s distress is explored using Ellis’ ABC model whereby ‘A’ is the
activating event, ‘B’ is the belief about the voices and ‘C’ is the emotional and behavioural consequences. An effective collaboration between patient and therapist allows beliefs about voices to be explored, disputed and tested. The weakening or loss of these beliefs leads to a reduction in distress and opens the door to a range of more adaptive coping strategies (Chadwick & Birchwood, 1994).

Coping strategy enhancement, as described by Tarrier (1996), is the cognitive behavioural analysis of a patient's psychotic symptomatology combined with coping strategies. A particular symptom will be explored looking at the antecedents and consequences of the behaviour. A coping strategy would be selected for this symptom and rehearsed under intensifying conditions, for example attention switching, self statements, increased activity.

**Integrated Models of CBT For Psychosis**

Several more integrated models of CBT for psychosis are developing. Fowler et al (1995) propose a 'cognitive-emotional' approach to psychoses, in which both cognitive biases and emotional/motivational factors are recognised and addressed. Various cognitive behavioural techniques are selected to suit the individual. Fowler et al (1998a) suggests there are three main goals: to reduce the distress and interference associated with the remaining psychotic symptom; to reduce the emotional disturbance of psychosis; and to foster an understanding of the disorder aiming to enhance motivation for self-regulation of the disorder. The intervention is carefully tailored to the individual's needs so as to take account of the heterogeneity of the problems displayed by people with psychosis. The necessity of a collaborative therapeutic relationship is seen as critical. As many patients present with multiple problems, in each case a variety of different techniques may be used to address these treatment goals.

Fowler et al (1998a) propose therapy passes through 6 stages: engagement and assessment; promoting self-regulation of psychotic symptoms (may include coping strategies); developing a shared model of psychosis; addressing delusional beliefs and beliefs about voices using cognitive therapy strategies; addressing dysfunctional assumptions about self and others using cognitive therapy; and addressing social

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disability and risk of relapse. Fluctuation between stages may occur, for example if a person becomes paranoid, it will be necessary to return to the engagement stage. A shared view of the meaning and development of an individual's symptoms is seen as the strength of this model; this assists in constructing a less distressing and more adaptive way of understanding the individual's predicament.

Chadwick et al (1996) suggest a further move away from the symptom model to the 'person model'. Symptoms would be understood within the individual's search for meaning and identity. They emphasise the impact of early experience on evaluations of self and others, within the framework of a cognitive developmental theory of the person.

CONTROLLED STUDIES OF CBT FOR DELUSIONS AND HALLUCINATIONS

Despite pronounced differences in the approaches adopted by various researchers, the results so far converge in supporting the assumption that cognitive behavioural therapeutic strategies can positively influence symptomatology in drug-resistant patients. Many of the original studies focused on single case studies, for example using social reinforcement, distraction, use of earplugs, thought-stopping and systematic desensitisation (Haddock, Sellwood, Tarrier and Yusupoff, 1994; Slade & Haddock, 1996; Fowler et al, 1995). In one of the first single case studies, Beck (1952) indicated that talking to people about their psychotic experiences could be profitable if specific techniques were used. These initial single case studies yielded promising results, justifying more extensive trials. The results of the controlled research studies will be reported here, providing empirical evidence for the use of CBT in modifying positive symptoms of psychosis and in the management of psychosis.

One of the first controlled studies of the treatment of drug-resistant residual psychotic symptoms was reported by Tarrier, Beckett, Harwood et al (1993). This followed an earlier observation that patients who experienced persistent delusions or hallucinations actively attempted to reduce their symptoms (Tarrier, 1992). Twenty-seven patients received 'coping skills enhancement'; although there was an emphasis on improving
patients' coping skills, both behavioural and cognitive interventions targeted at particular symptoms were employed. At a nine month follow up these patients showed significant reductions in positive psychotic symptoms compared with those in the problem solving control group. This study highlighted the benefits of an approach that focused primarily on helping patients to use coping strategies to manage positive psychotic symptoms.

A second study by this group of researchers focused further on coping strategy enhancement and problem solving, as well as prevention of relapse (Tarrier, Yusupoff, Kinney et al 1998). CBT was described as more intensive than in the first trial, and combined training in coping and problem solving skills with prevention of relapse. This intervention was compared with a supportive counselling and routine care group, and a routine care group alone. Giving CBT in addition to routine care reduced positive psychotic symptoms more than supportive counselling or routine care. Supportive care did show some effect on the positive symptoms, suggesting that interest and support can be profitable for people with psychosis. Both CBT and counselling were both found to cushion against relapse.

Drury, Birchwood, Cochrane and MacMillan (1996a) explored the application of cognitive therapy to acute psychosis, with the aim of curtailing positive symptoms and reducing residual symptoms. They argue that it is vital to focus on the acute psychotic episode, as this is the source of the residual symptoms; similarly they believe that shortening the duration of acute psychosis may be helpful in itself. Several studies suggest that the first few years after a first episode of psychosis is the crucial period for improving early outcome (Jackson & Birchwood, 1996; Birchwood, McGorry & Jackson, 1997). The experience of acute psychosis and its management has been identified as being traumatic and distressing in itself; McGlashan (1994) links these experiences to post-traumatic stress disorder, post psychotic depression and increased risk of suicide. Drury et al believe that by reducing the severity and duration of acute psychosis using methods adjunct to medication, future difficulties will be reduced.

In the study, forty in-patients were randomly allocated to two groups: the first intervention involved individual and group cognitive therapy whereby beliefs were
challenged and tested out. The patient was led to adopt a curious approach to their illness, wishing to make sense of their psychotic breakdown (as described by Chadwick et al., 1996). Also included in this intervention were family engagement and a structured activity programme aimed at improving interpersonal and self-care skills. The second intervention consisted of flexible and low-key leisure and social activities. Both interventions were adjunct to routine hospital care and medication. Symptomatology was rated weekly using a mental state assessment and a self-report measure of delusional conviction, during admission and the subsequent nine months.

A greater decline in positive symptomatology was found in the cognitive therapy group, suggesting that challenging and testing delusions in acute psychosis can be advantageous. Although the cognitive therapy intervention focused on the positive symptoms, it was also found to generalise to other aspects of psychotic recovery such as insight, dysphoria and low-level psychotic thinking (Drury, Birchwood, Cochrane & MacMillan, 1996b). However 35% of the patients were considered unsuitable during the first four weeks; it is therefore only possible to generalise the results to those who were able to talk about their symptoms and those who were medication compliant (took 50% of their prescribed medication). The researchers suggest this is not a problem specific to this type of therapy but one of acute care anyway. They suggest these excluded individuals may well engage at a later stage of recovery.

Garety, Kuipers, Fowler et al. (1994) conducted a small controlled trial of CBT for drug-resistant psychosis, designed as a pilot for a later randomised controlled trial. The therapy targeted emotional disturbance as well as psychotic symptoms. The results of this pilot study were promising and engagement was high. Benefits on a variety of outcome measures including delusional beliefs, distress and depression were found. However the study had some important limitations including the lack of random allocation to groups and the small numbers of individuals in each group.

This led to the development of the London-East Anglia randomised controlled trial of CBT for psychosis (Kuipers, Garety, Fowler et al., 1997; Garety, Fowler, Kuipers et al., 1997; Kuipers, Fowler, Garety et al., 1998). Sixty participants, who had at least one current positive psychotic symptom that was distressing, unremitting and medication
resistant, were allocated between two conditions. The first group received individual intensive CBT for up to nine months (based on the treatment manual provided by Fowler et al, 1995), as well as routine case management and medication. The second control group received only the standard care of routine case management and medication. Many areas of outcome were assessed including overall mental state, delusions and hallucinations, as well as insight, depression and anxiety.

Significant improvements in overall symptomatology after nine months of treatment were found in the CBT group, with a 25% reduction on the Brief Psychiatric Rating Scale (BPRS) (Kuipers et al, 1997). Fifty per cent of the CBT group responded to treatment, compared with only 31% of the control group. High satisfaction with treatment was expressed (80%) illustrating that CBT can be amenable to clients with long-term illness and continuing distressing symptoms. Participants also had a low drop out rate (11%) suggesting if engagement issues are dealt with, demanding interventions such as these are acceptable.

The improvements made using CBT for medication-resistant psychosis were maintained at 18 month follow-up, by which time delusional distress and hallucination frequency had shown significant reductions (Kuipers et al, 1998). Clinical improvement (5 or more point difference in BPRS scores) was found in 65% of the CBT group, compared to only 17% of the control group. Improvements still being apparent at 18-month follow-up supports a treatment specific change, and not an attention effect, as was previously a possibility.

**ALTERNATIVE MANAGEMENT STRATEGIES FOR PSYCHOSIS**

Thus far the discussion has centred on the management of psychosis using CBT approaches and also briefly, neuroleptics. Although neuroleptics are of proven efficacy in controlling positive symptoms, other psychosocial interventions play an important role in the management of psychosis, reducing relapse rates and disabilities.

Developing a patient's awareness of psychosis through psychoeducation has been suggested as a useful adjunct to the management of psychosis. Patients who attended a didactic psychoeducation group were found to increase their knowledge, but with no
affect on medication compliance and insight (Smith et al, 1992). However Atkinson, Coia, Harper Gilmour and Harper (1996) reported education groups for people with psychosis having had a positive effect on social functioning, social networks and quality of life. Fowler et al (1995) propose that information about an individual’s illness should be provided on an individually tailored basis within the process of CBT, as and when necessary.

Lam (1991) reports that family intervention aimed at improving the knowledge and skills of the relatives can lower expressed emotion levels and decrease relapse rate. However Smith & Birchwood (1990) suggest that family intervention is not without its own problems, for example difficulties in engaging families in therapy and incorporating family interventions within already established rehabilitation programmes. Education of relatives about schizophrenia does not, by itself, produce a useful effect on relapse rate, though it may help them to come to terms with illness and facilitate subsequent family interventions (Lam 1991; Leff 1994). Kuipers (1996) stresses the significance of staff support and training, in the management of psychosis, thus avoiding staff burnout and low morale.

The targeting of early psychosis, immediately after the onset of the first episode offers some promise of reducing secondary disability (Birchwood et al, 1997). Jackson & Birchwood (1996) highlight the first two to three years as the critical period for psychosocial and biological interventions, if long term outcome is to be influenced. Birchwood & Shepherd (1992) suggest a low-dose maintenance of neuroleptics and early intervention in the possibility of governing relapse.

It has been suggested that CBT could improve compliance with treatment in people with psychosis. Kemp, Haywood, Applewhaite et al (1996) examined the outcome of a randomised controlled trial of compliance therapy and non-specific counselling in 47 acutely psychotic inpatients. Significant improvements in attitudes to medication, insight into illness and compliance with treatment were found in the compliance therapy group. Gains were maintained for six months. Global functioning was also enhanced after a delay. Kemp et al suggest that given the high costs of relapse and
persisting symptoms, any proved method of counteracting non-compliance has implications for the management of people with psychosis.

**CONCLUSION**

Together, the studies reported, provide strong support for the use of CBT with people who present with delusions and voices. CBT interventions, alongside medication and other psychosocial adjuncts provide an integrated framework for the management of psychosis.

Cognitive behavioural interventions have greatly developed since initial early attempts at working with people with psychosis. Nevertheless there is still much research to be done in this area investigating why these methods work for some and not others. Fowler et al (1998b) argue that we are still a long way from knowing which patients are likely to shift and why. Similarly it is still unclear as to whether a particular cognitive behavioural method of working is more helpful than another (Kuipers et al, 1998); or whether it is the shared characteristics that makes it successful, for example the collaborative partnership.

Fowler et al (1998a) suggest that although the strategies for CBT approaches to psychosis outlined in manuals offer a systematic, manageable and acceptable approach to therapy for people with psychosis, modification of delusions and voices requires commitment and persistence. Interventions must be led by individual needs. Therapy is challenging often with no immediate change: this is more likely to take several sessions over a period of months. Understanding the complexity of an individual's psychosis may take some grasping. Additionally, although not a focus of this essay, but an important consideration, effects on the negative symptoms of psychosis have been observed to be less consistent across the studies.

Kissling (1992) argues that poor medication compliance is evident in up to 75% of patients with first-episode schizophrenia; similarly Buchanan (1992) reports up to 50% of patients discharged from hospital fail to take even 75% of medication prescribed. It therefore goes without saying that any improvement in drug-resistant symptoms is of considerable benefit to that of the patient. Not only are CBT
innovations of benefit to the patient, but they are also cost effective, typically reducing symptoms and the expense of time in hospital (Kuipers, 1996). Adding CBT approaches for people with psychosis to standard care packages does not appear to increase overall costs of care (Kuipers et al, 1998).

In the past, advice has been for staff and relatives to ignore and not discuss delusions and hallucinations with patients. Evidence now suggests that just engaging with someone and listening can be extremely helpful. CBT for psychosis takes this one step further and leads to improvements that generalise beyond the period of intervention itself (Fowler et al, 1998a). However although the efficacy of such interventions has been demonstrated, attitudinal change to psychological approaches to psychosis may take a while longer. Adequate training and supervision systems need to be introduced to support this worthwhile adjunct to medication in the treatment and management of psychosis.
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PEOPLE WITH LEARNING DISABILITIES ESSAY

Year One
June 1999

Discuss Diagnostic Issues, Dilemmas In Clinical Psychology Practice And Service Provision When Working With People Who Have A Possible Diagnosis Of Learning Difficulties And Mental Health Problems.
INTRODUCTION
Distinctions have long been drawn between learning disabilities and mental illness, but no one can put it more clearly than Esquirol, who in 1845 commented:

“A man in a state of dementia is deprived of advantages which he formerly enjoyed: he is a rich man who had become poor. The idiot, on the other hand, has always been in a state of want and misery”.

Originally many professionals believed people with learning disabilities were incapable of developing emotional disorders that could be characterised as mental illness (Crews, Bonaventura & Rowe, 1994). Early interest in people with learning disabilities and mental illness focused around the condition of ‘Pfropfschizophrenia’ (Reid, 1989). The co-existence of learning disabilities and mental illness has only really come to light in the last few decades (Menolascino & McCann, 1983). This may be due to the recognition of the right of people with learning disabilities to appropriate medical care and the expectation that people with learning disabilities are now required to live in the community and use the facilities there (Szymanski, 1994).

This essay will discuss issues surrounding diagnosis of possible mental health problems in people with learning disabilities, as well as clinical psychology practice dilemmas, and the range of service provisions available.

Definitions
Different terminology for the expression ‘learning difficulties’ is used throughout the literature in this area, although the terms used do share common themes. The most commonly used term in the UK at present is learning disability, although learning difficulty and mental handicap are also utilised. In America the term ‘mental retardation’ is coined. These terms will be used interchangeably in this essay.

One of the most comprehensive and widely accepted definitions of learning disabilities is that put forward by the American Association on Mental Retardation (AAMR) (1992):
“Mental retardation refers to substantial limitations in present functioning. It is characterised by significant subaverage intellectual functioning, existing concurrently with related limitations in two or more of the following adaptive skill areas: communication, self-care, home living, social skills, community use, self-direction, health and safety, functional academics, leisure and work. Mental retardation manifests before age 18.”

Likewise the term ‘mental health problems’ is used interchangeably in this essay with mental illness, psychiatric problems/illness and psychopathology. The Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) (1994) defines mental illness as:

“....a clinically significant behavioural or psychological syndrome or pattern that occurs in an individual and that is associated with present distress (e.g. a painful symptom) or disability (i.e. impairment in one or more important area of functioning) or with a significant increased risk of death, pain, disability, or an important loss of freedom.”

The term ‘dual diagnosis’ will refer to the diagnosis of both learning disabilities and mental illness in this essay (Borthwick-Duffy, 1994; Nezu, Nezu & Gill-Weiss, 1992).

AETIOLOGICAL THEORIES
Matson and Sevin (1994) propose that aetiological theories of mental illness in learning disabled people are still a subject of debate. Theories of mental illness have been thoroughly studied in the general population but not in people with learning disabilities. Even if similar aetiological factors are concerned, the particular course of events leading to the psychiatric illnesses may differ in learning disabled individuals as opposed to the non-learning disabled (Konarski & Cavalier, 1982). Matson and Sevin (1994) suggest as there is a high prevalence of mental illness in people with learning disabilities (Borthwick-Duffy, 1994), there may be additional variables associated with learning disabilities that increase the risk of associated mental health problems. Matson and Sevin (1994) review four different aetiological models of dual diagnosis: organic, behavioural, developmental and sociocultural.
Organic models of psychopathology encompass physiological, biochemical and genetic elements. Learning disabilities are often associated with structural brain abnormalities; it is quite likely that these structural brain abnormalities are also associated with increased risk of mental illness (Szymanski, Rubin & Tarjin, 1989). Chromosomal abnormalities, rare genetic disorders or other biological abnormalities are said to be common in people with learning disabilities (Bregman & Hodapp, 1991). Likewise these may also predispose a person to mental illness. For example people with Downs Syndrome are at increased risk of developing Alzheimer's disease (Collacaot et al, 1992).

Behavioural models of people with learning disabilities and associated psychopathology have also been suggested, based on classical and operant conditioning, and social learning theory. Matson and Sevin (1994) suggest Bijou's original operant explanations for atypical development in mentally retarded people can be equally applied to the aetiology of psychopathology in the learning disabled. Bijou (1966) describes four principles: Inadequate reinforcement of prosocial behaviours, inappropriate punishment, reinforcement of deviant response sets and altered stimulus-response functions.

Developmental models of the aetiology of dual diagnosis evolved from the belief that people develop along universal patterns. The learning disabled develop at a slower rate and all behaviour reflects the underlying developmental stage (Hodapp, Burack & Zigler, 1990). Behaviour that may be considered pathological for a person at a certain chronological age may be seen as normal for a person whose developmental level is behind.

Sociocultural factors have a significant role to play in the aetiology of dual diagnosis. Reiss and Benson (1984) report people with learning disabilities are exposed to many negative social experiences, such as rejection by peers, family or society, social disruption, inconsistent care, and infantilisation. As early as 1944, Pollock recognised people with learning disabilities had a reduced capacity to withstand stress which further predisposed these individuals to emotional conflict. Matson and Sevin (1994) highlight the emotional impact of deinstitutionalisation on people with learning
disabilities as well as economic and environmental deprivation, linked to increased risk of mental illness in the general population.

The clinical presentation and level of severity of dual diagnosis is thought to be a result of an interaction between many of the above contributing factors, which finally determines the person's psychosocial adaptation (Szymanski, 1994; Matson, 1985). The associated brain damage and syndromes, adverse life events, cognitive deficits and inadequate coping mechanisms leave people with learning disabilities vulnerable to experiencing mental illness.

PREVALENCE
Estimates of the prevalence of dual diagnosis vary greatly across different studies. Campbell and Malone (1991) report prevalence rates of between 14.3% and 67.3%; Borthwick-Duffy (1994) summarised prevalence rates ranging from less than 10% to more than 80%. Borthwick-Duffy suggests the discrepancies are due to definitional and identification issues as well as sampling issues and that these must be taken into account when interpreting prevalence of dual diagnosis. Likewise the lack of adequate instruments to measure mental health symptoms across the range of intellectual impairments has hindered prevalence measurements.

If behavioural problems are included as a mental health problem, higher prevalence rates are achieved (Moss, Emerson, Bouras & Holland, 1997), as are found if the study group has been purposefully referred for psychiatric evaluation (Bouras & Drummond, 1992). Prevalence rates fall to between 25-40% for studies using a general learning disabled population, compared to below 15% for studies using case notes to identify psychiatric problems (Reiss, 1990). In a large-scale study, Moss (1995) found the learning disabled population differed greatly to the general population in its pattern of the prevalence of psychiatric problems. People with learning disabilities showed high rates of psychoses and autism, compared to the general population who displayed high rates of neuroses, affective disorders and substance abuse.
Low prevalence rates of dual diagnosis are found in people with profound and multiple disabilities (Borthwick-Duffy & Eyman, 1990). However the literature suggests people exposed to greater vulnerabilities would be more prone to psychiatric problems. The low rates of mental illness that have been found in the more severely disabled may be unrealistic: they could represent unsuitable methods of diagnosis.

Although it is difficult to ascertain a true prevalence rate of dual diagnosis due to differences in methodology, it is more than clear that there are a group of people with learning disabilities who have co-existing psychiatric problem. This group of people show a higher proportion of psychiatric disorders compared to their non-learning disabled counterparts (Dosen, 1993; Bernal & Hollins, 1995).

**DIAGNOSTIC ISSUES**

Psychiatric treatment of people with learning disabilities used to mainly consist of sedation and restraint, with no account being taken of whether there was a co-existing mental illness. Weisblatt (1994) suggests that as there are now distinct treatments with proven effectiveness for psychiatric problems, correct diagnosis becomes essential. However it should be questioned whether diagnosis as a concept is useful or necessary. Some would argue that diagnosis is just a label to compartmentalise people into ‘neat groups’. Yet diagnosis can help by offering a framework for understanding the behaviour and can add to the development of, and allows access to, appropriate services.

The DSM is commonly used to diagnose psychiatric problems in the learning disabled and needs to be considered in the light of above information. Sovner (1986) suggested the standard diagnostic criteria (DSM III) failed to account for the presence of a co-existing learning disability. However since the advent of the DSM III-R, mental retardation has moved from an Axis I disorder to an Axis II disorder, pushing clinicians to make a separate diagnosis from Axis I as well as diagnosing mental retardation from Axis II (Sturmey, 1995). Sovner (1986) highlighted the difficulties of using diagnostic criteria when applied to people with more severe or profound disabilities. Dosen (1993) proposed that DSM III and ICD9 criteria could be applied
to persons with mild learning disabilities without alteration, but in the more severely learning disabled the utility of the criteria became doubtful.

Some diagnosticians have tried to broaden standard psychiatric diagnoses for people with learning disabilities. Ballinger, Ballinger, Reid and McQueen (1991) included some diagnostic groupings normally relating to children in adults with learning disabilities. Sovner and Lowry (1990) pointed out the need for objective behavioural measurement in dual diagnosis and so proposed a modification of symptoms to serve as criteria in the learning disabled. Further thought and research is needed to consider the appropriateness of using diagnostic criteria, particularly DSM-IV criteria, with learning disabled people.

A common question asked of psychiatrists is whether a disturbed learning disabled person has concurrent mental illness or 'just behaviour problems' (Szymanski, 1994). Many community placements may refuse to accept someone with mental health problems, but will accept someone with behaviour problems. Interestingly Szymanski suggests that a distinction between behaviour problems and mental illness is not necessary, citing that the DSM III-R reports mental disorder to be a "...behavioural or psychological syndrome". Bouras and Drummond (1992) found that behavioural disorders and psychiatric problems coexisted in 20-45% of referred clients depending on the measure of psychopathology used. The relationship between non-aggressive challenging behaviours and mental illness in a sample of people with learning disabilities showed significant overlap (Jenkins, Rose & Jones, 1998). There appears to be no dividing line between challenging behaviour and mental health and the extent of their interrelationship has received little attention in current research (Prosser, 1999).

Sovner (1986) describes four factors that could affect the diagnostic process in people with a possible dual diagnosis. The first factor known as 'intellectual distortion' is described as the influence of cognitive deficits on the person’s ability to label his/her own experiences and communicate them to someone else. Likewise Holland and Murphy (1990) report diagnosis can be hampered by limited language skills. The traditional psychiatric diagnosis is done through direct communication with the client,
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who thus needs sufficient language skills for communication and sufficient cognitive skills for some degree of conceptual thinking (Szymanski, 1994). This eliminates all but some of the mild learning disabled individuals, making diagnosis difficult. Additionally Einfield (1992) highlights the proneness of persons with learning disabilities to acquiescence (Sigelman, Budd, Spankel & Schoenrock, 1981) in wanting to provide the professionals with the ‘right’ answers to questions.

Secondly Sovner refers to ‘psychosocial masking’ whereby the lack of real life experiences for the learning disabled individual leads to bland, simple symptomatology which goes unrecognised and undetected as psychopathology. Einfield (1992) reports that many people with learning disabilities suffer symptoms, which do not readily conform to patterns of standard psychiatric disorders. Symptoms of psychopathology are also difficult to diagnose among the learning disabled because of the range and variations of behaviours. Reiss (1988) coined the term ‘diagnostic overshadowing’, referring to those situations which the syndrome of learning disabilities tended to overshadow the presence of an accompanying mental illness.

Thirdly Sovner describes ‘cognitive disintegration’ referring to the tendency of people with learning disabilities to deteriorate in cognitive functioning when they are emotionally stressed. This may lead to the misdiagnosis of psychosis. Research does indicate an over diagnosis of schizophrenia (Einfield 1992: Prosser, 1999) but this may also be because psychotic symptoms such as auditory hallucinations are more observable than most symptoms of depression or anxiety in people with learning disabilities. Finally Sovner describes ‘baseline exaggeration’, which is the increase in severity of already existing maladaptive behaviours that may cause difficulties establishing the symptomatology of any disease entity.

Although there are issues affecting diagnosis of mental illness in people with learning disabilities, essential principles of assessment of dual diagnosis have been listed in various papers (Sovner, 1989; Prosser, 1999). Einfield (1992) recommends several principles: firstly ensuring that all symptoms have some other cause other than the learning disabilities, that is they are ‘state-dependent’ and not ‘trait-dependent’ (Weisblatt, 1994). Secondly, using a biopsychosocial framework; thirdly drawing
information from as wide a source as possible and fourthly allowing enough time for several short interviews with the patient.

**Diagnostic Tools**

The use of standardised clinical instruments for assessing dual diagnosis is much less well developed than it is for other psychiatric populations (Sturmey, Reed & Corbett, 1991). Many structured assessments have been used on people with dual diagnosis such as the Beck Depression Inventory, but they are often not validated for use with people with learning disabilities. If diagnosis is seen as an essential prerequisite to receiving appropriate treatment, reliable and valid diagnostic tools need to be developed. The fact that many of the diagnostic tools are based on DSM or ICD criteria also needs to be considered.

The most recently developed assessment instrument for dual diagnosis is the Psychiatric Assessment Schedule for Adults with a Developmental Disability (PAS-ADD) (Moss et al, 1996a). Based on the ICD-10 clinical interview, the wording has been adapted to maximise responses from people with learning disabilities. Information is gathered from both the individual and an informant. Good reliability and validity have so far been indicated (Costello et al, 1997) and replication continues. However Caine and Hatton (1998) express some limitations when using the PAS-ADD in routine clinical practice: extensive training is needed on the part of the interviewer and assessing can be time consuming. Likewise the PAS-ADD relies on the individuals being verbal.

Rating scales for dual diagnosis are commonly used as screening tools, which can later be followed by clinical interview. Although relatively short and easy to complete they normally gain information entirely from informants. The most commonly used instruments will be introduced here.

The Reiss Screen for Maladaptive Behaviour (Reiss, 1988) has 8 subscales including psychosis, depression and autism. Although this scale generally shows good psychometric properties, Sturmey et al (1996) question the validity of the individual scales. The Psychopathology Instrument for Mentally Retarded Adults (PIMRA),
based on DSM-III criteria, has various subscales such as affective disorder, anxiety disorder and adjustment disorder (Matson, Kazdin & Senatore, 1984). Caine and Hatton (1998) suggest the psychometric properties of the PIMRA are less robust than those of the Reiss Screen for Maladaptive Behaviour. The PAS-ADD Checklist is a checklist designed to be completed by untrained carers whereas the Mini PAS-ADD is a comprehensive assessment of a person's mental health which is completed by trained staff (Moss et al, 1996b: Prosser et al, 1996). Like the main PAS-ADD, research findings so far are encouraging (Moss et al, 1998; Prosser et al, 1998).

Generally mental illness is easier to diagnose in people with mild or moderate learning disabilities, than in those with severe or profound learning disabilities (Campbell & Malone, 1991). Standardised scales for those individuals with severe or profound learning disabilities are lacking. The Diagnostic Assessment for the Severely Handicapped (DASH) is specifically designed for people with more severe and profound disabilities (Matson, Gardner, Coe & Sovner, 1991). The DASH has yet to be independently validated, and Matson et al suggest future investigation looks at rating accuracy and validity. Meins (1996) describes the development of a depression subscale of the Comprehensive Psychopathological Rating Scale. The initial study showed promising results for diagnosis of depression in people with severe or profound learning disabilities, although further replication is needed.

Although diagnostic tools exist, further validation is needed as well as the inclusion of more people with severe and profound learning disabilities (Sturmey et al, 1991).

**DILEMMAS IN CLINICAL PSYCHOLOGY PRACTICE**

Traditionally treatment was confined to psychopharmacology for people with dual diagnosis, with no thought to psychological therapies. People with learning disabilities were assumed to be unable to develop insight or to realise the antecedents or consequences of their behaviour because of their impaired intellectual ability (Hurley, Pfadt, Tomasula & Gardner, 1996). Behavioural therapies, often aimed at controlling or changing the person's behaviour through external contingency management, then became common place (Kroese, 1997). Although behavioural treatments have been shown to be effective in managing, reducing or eliminating
some challenging behaviours (Emerson, McGill & Mansell, 1994), the move to the
community and normalisation have lessened the attractiveness of some of these
methods. Lovett (1985) criticises the traditional behavioural approaches for ignoring
the possible motivation or emotion driving the behaviour.

Dilemmas have therefore arisen for the psychologist in whether intervention should be
continued purely at the service level, or rather at the individual therapy level. It is
now widely recognised that some people with learning disabilities are able to engage
in individual therapies. The role of psychological interventions such as cognitive,
social-learning and psychoanalytic are developing in the treatment of psychiatric
problems. Nevertheless, research and literature on these areas is quite recent, and
therefore efficacy is still limited (Bouras, 1994; Fletcher & Dosen, 1993). The
individual psychological interventions will be introduced here.

The last decade has seen a growing interest in cognitive behavioural therapy (CBT)
for people with learning disabilities, whereby therapists began investigating their
clients 'cognitive contents' and using techniques of self-report and a collaborative
therapeutic relationship to agree and accomplish goals (Kroese, 1997). This early
work has proposed that self-report in people with learning disabilities is a valid and
reliable method of information collection (Dagnan & Chadwick, 1997). Similarly it
has demonstrated that people with learning disabilities can deal with abstract concepts,
as long as their understanding is assessed and the therapist is willing to take on a
didactic role (Kroese, 1997). Additionally self-regulation can be attained, and
therefore maintenance of therapeutic gain, if the person is given the opportunities to
achieve self-determination (Kroese, 1997). Single case studies have been used to
illustrate the use of CBT with people with dual diagnosis (Lindsay, Howells &
Pitcaithly, 1993; Dagnan & Chadwick, 1997) and Lindsay (1999) reports on some
successful cohort groupings. However Lindsay also highlights that these are only
initial case studies and further controlled outcome studies must be conducted.

Hollins, Sinason and Thompson (1994) report psychoanalytically informed treatment
of dual diagnosis to still be uncommon. Previously, psychoanalysis with people with
learning disabilities was seen as not possible because it was originally felt that
someone needed to have a certain degree of intelligence (Kroese, 1997). However it is now thought that therapy relies on emotional intelligence and not cognitive intelligence (Hollins et al, 1994). Gaedt (1995) proposes that psychoanalytic issues direct the therapist towards understanding the inner world of the clients and their developmental processes. Other literature has discussed using techniques emanating from child psychotherapy, such as play therapy, with learning disabled adults (Baum, 1994) and also group and family work (Fletcher & Dosen, 1993). Unfortunately, although theoretically sound rationales, empirical evidence for the effectiveness of psychoanalytical therapies is still somewhat lacking (Nezu & Nezu, 1994) and therefore further evaluation is needed.

Prosser (1999) advises that few clinicians are adopting these individual psychological therapies. Lindsay (1999) indicates there is really no logical excuse to avoid conducting therapy with mild or moderately learning disabled people, now there is evidence that these people experience emotional problems. Nevertheless, there is a need for psychologists to consider the most appropriate intervention for the individual. Traditional behavioural principles are now used as part of more positive, non-aversive therapies which emphasise control, choice and opportunity to express oneself (Kroese, 1997). Likewise it can be argued there is still a place for more behaviourally based service level interventions for people with more severe and profoundly disabilities (Spreat & Behar, 1994).

Working at the service level can also not be ruled out because of the ongoing need for psychologists to work with the carers of the individual as well as the individual themselves. If carers interpret behaviour purely in relation to intellectual ability, rather than as an expression of mood, problems may erupt (Caine & Hatton, 1998). Increasing the carers understanding of the client's emotions will aid intervention because of the key role that many carers have in the lives of learning disabled people. Similarly other professionals may hold the same misconceptions about people with learning disabilities ability to experience emotions and must likewise be informed.
Dilemmas in the Therapeutic Process and Relationship

The therapeutic process itself poses dilemmas for the psychologist. Issues of consent become difficult when working with people with learning disabilities. Some people may not be able to consent if they can not understand the implications or because they are not able to make free choice (Curran & Hollins, 1994). In these situations consent is not made by anyone else but rather treatment decisions are based on the duty of care of doctors to their patients. However it is good practice to consult those concerned with the care of the person. Likewise it is more than likely that a person with learning disabilities will have been referred by another person rather than referring themselves (Caine & Hatton, 1998). It is therefore important to establish what the individual with learning disabilities thinks of the reason for referral, their motivation to change and for whom it is a problem.

The therapeutic process may raise dilemmas in methods of engagement. Nezu et al (1995) believe establishing a therapeutic relationship with a client with learning disabilities may take longer because of lifelong experiences of being rejected. An active role must be taken on the part of the psychologist to initiate and facilitate the interaction and in explaining the process of therapy at the appropriate level for the individual (Hurley et al, 1996). It may be necessary to be more direct in your questioning with a client with learning disabilities, so you are understood (Caine & Hatton, 1998). Nevertheless learning disabled people may not understand much of what is said to them and are therefore in a less powerful position to interrupt or disagree with the psychologist. The development of a working therapeutic 'vocabulary' between client and psychologist is therefore essential (Caine & Hatton, 1998).

Issues of transference may cause dilemmas when working with learning disabled people. More rapid and pronounced transference reactions (than the normal population) may make therapy particularly effective with learning disabled individuals (Gaedt, 1995; Hurley et al, 1996). However the therapeutic relationship must be clarified otherwise the psychologist may be seen as a 'friend'. Caine and Hatton (1998) also highlight the importance of supervision for the psychologist allowing discussion of possible countertransference whereby the psychologist may have
assumed the role of 'parent' or 'advocate' to the client. They also emphasise the importance of supervision so that dilemmas of a more lengthy involvement which may involve some blurring of boundaries can be addressed.

Communication difficulties in the client can lead to the reliance on gathering information from third parties. However Moss et al (1996) reports that this produces under-reporting of psychiatric symptoms. Interviewing both the individual and the informant, where possible, appears the best way to solve dilemmas about accurate information collection (Prosser, 1999).

Regardless of the dual diagnosis, treatment needs to provide an active therapeutic intervention through which stress can be alleviated and opportunities for a better quality of life can be enhanced (Bouras & Drummond, 1992). Nezu and Nezu (1994) state that research and scientifically based clinical practice in dual diagnosis has fallen far behind the social need. The lack of validation has produced many dilemmas for psychologists working in this area, as to what the best input that they are able to provide should be. It will be some time before many of these dilemmas can be solved.

**SERVICE PROVISION**

As deinstitutionalisation occurs, the special needs of many people with learning disabilities and additional mental health problems become more obvious and unmistakable (Davidson, Cain, Sloane-Reeves et al, 1995). People with dual diagnosis often fall through a crack. They are frequently passed between learning disabilities services and mental health services, both services arguing that they are not able to cater for these individuals. Models of care that successfully address their multiple needs have evolved and have resulted in specialised services for people with dual diagnosis being developed.

Nevertheless, many debates have taken place as to whether specialist services should be provided for people with dual diagnosis or whether they should be catered for within generic services. In terms of normalisation, incorporating people with dual diagnosis in the already existing generic services would be the natural thing to do; specialised services would only cause stigmatisation (Moss et al, 1997). However,
although training is possible, given the relatively small number of cases there may be little opportunity for the staff of differing professions in a generic team to capture the essential skills. Similarly learning disabled people are vulnerable and find it difficult to mix in generic settings (Day, 1994). Day (1993) considers that the belief that generic services can and should cope has added to the neglect of services for people with dual diagnoses.

Day (1993; 1994) proposes that special expertise is needed for people with dual diagnosis because of atypical presentations, communication difficulties and the management of behaviour problems. He describes the ideal specialised service as providing a range of service settings from diagnostic services to continuing care. These should offer a variety of treatments including psychological and pharmacological interventions, as well as educational and vocational opportunities. Trained and experienced multi-disciplinary staff would provide input in both inpatient and community based facilities and carry out research and training.

Day (1993) describes an array of models of service for people with dual diagnosis which are currently used. The first model delivers a comprehensive regional service, offering advantages such as being able to provide a full range of services, being cost effective, having a high level of staff expertise and being able to cope with difficult or violent behaviour. However care must be taken to avoid a 'mini-institution', and long distances from people's homes may make rehabilitation and follow-up difficult.

The second model relies on local services set up in the community or on hospital sites with the main emphasis on short-stay for the mildly or moderately learning disabled, or assessment for the more severely learning disabled (Murphy, Holland, Fowler & Reep, 1991; Murphy & Clare, 1991; Hurst, Nadarajah & Cumella, 1994). Trower, Tredwell and Bhaumik (1998) report on a successful 12-bedded short-term acute inpatient unit set up for the assessment and treatment of people with dual diagnosis across the disability spectrum. However, Day (1993) highlights the problems of mixing of clients with different needs, less occupational and recreational facilities, difficulties coping with the more seriously disturbed people and lack of back-up for
the staff. Likewise Cumella (1998) raises the problems of bed-blockers in this type of service, when no appropriate discharge placements can be found.

The third model entails an integrated service of earmarking beds in generic psychiatric units and providing additional care with specialist psychiatrists and community teams (Bouras, Brooks & Drummond, 1994; Mansell, 1993). Nevertheless Day (1993) reports the more severely learning disabled are often excluded from this type of service and the inappropriateness of the ward setting and lack of trained nursing staff can cause problems. Yet Kon and Bouras (1997) report positive results on their evaluation of an integrated service of a specialist psychiatric team using generic psychiatric beds for acute care.

Finally specialist teams have developed to work with the people in their own homes (Van Minnen & Hoogduin, 1998). Newman and Emerson (1991) suggest that management programmes are not easily transferred from inpatient care back to the person's home, and therefore treatment is better implemented in the person's own environment. Still Day (1993) suggests there would be an ongoing need for admissions for respite care or intensive interventions. Davidson et al (1995) describe an interesting crisis intervention team for people with learning disabilities that employs a cross-system access between existing mental health services and learning disability services.

Measuring the effectiveness of any of these services still remains a challenge. The Department of Health (1989) suggested as there was an absence of a proven model, models should be flexible and then modified in the light of experience (Murphy & Clare, 1991; Allen, 1994). Bouras and Szymanski (1997) reviewed services in the UK and the USA: they concluded that evidence so far suggests purchasers and providers should provide services that are community based and locally accessible; be multi-disciplinary; be integrated with generic mental health services; be connected to primary care services and have links with university or professional departments. The Department of Health (1998) suggests there will be a greater demand for inpatient admissions in people with dual diagnosis in areas where there is a lack of specialist
multi-disciplinary teams who can provide support and advice, and good residential care services.

Staff Training
A report published by Department of Health concerning services for people with possible dual diagnosis highlights two themes (Mansell, 1993). Firstly that direct care staff need to be well trained and supported to be able to understand and respond to the needs of people with mental health needs; and secondly that specialist health-care skills are needed locally to support and train direct care staff, and to serve those people with the most challenging needs.

Prosser (1999) suggests there are a great deal of undetected mental health problems in people with learning disabilities. She suggests in order to improve this, facilitating referrals needs to become a focus. Improving carers' awareness and recognition of the features of mental illness will in turn improve psychological well being and reduce the impact on crisis services.

Staff training therefore appears an essential prerequisite to providing efficient services and training packs for direct care staff are beginning to appear (Holt, Kon & Bouras, 1995). Some recent literature also highlights the importance of increasing the primary carer's knowledge of dual diagnosis if detection and referrals are to improve (Kon & Bouras, 1997; Curran & Hollins, 1996). Moss et al (1997) goes on to suggest providing training for general practitioners in communicating with people with learning disabilities.

CONCLUSION
It is no longer seen as acceptable to ignore psychiatric problems in people with learning disabilities. It has been well demonstrated that people with learning disabilities can develop all types of psychiatric problems and that they may well be at increased risk from developing mental health problems (Borthwick-Duffy, 1994). Szymanski (1994) points out that the question of whether people with learning disabilities can have concurrent mental illness need not to be an issue: it is never questioned that someone who is deaf may also have mental health problems.
Nevertheless there are still issues concerning identifying mental health in people with learning disabilities. The appropriateness of current diagnostic criteria and methods of assessment still need further development if they are to assist in the vital identification of those individuals in need of specialised support.

Health professionals and service providers are now beginning to realise the unique complex needs of people with dual diagnosis. Individual and adapted psychological therapies are starting to be utilised as well as specialised service provision. Moss et al (1997) ask why this has taken so long before research has taken place and services developed. They suggest that deinstitutionalisation had to take place beforehand, and with it the change in life circumstances such as housing, work and leisure. Only then could the focus shift to the individual's subjective quality of life and issues such as mental health problems be identified.

The field of dual diagnosis is crying out for empirical attention, with much ‘riding’ on it’s outcome. Professionals need to continue to explore and evaluate the most effective methods of working with people with dual diagnosis, if to succeed in providing for this specialised group of people.
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Diagnostic Classification Systems Have Utility In Relation To Clinical Practice. Discuss In Relation To Conduct Disorder In Childhood.
INTRODUCTION

Diagnostic classification systems have origins in the last century when the Diagnostic and Statistical Manual of Mental Disorders (DSM) (American Psychiatric Association, [APA]1994) was developed from the United States' 1840 census (Cantwell, 1996). The International Classification of Diseases (ICD) (World Health Organisation [WHO], 1992) was the first formal classification system to include mental disorders and it was not until 1965 when Anna Freud began developing psychoanalytical concepts that the first system for diagnosis in children was described (Cantwell, 1996).

Sommers-Flanagan and Sommers-Flanagan (1998) highlight that diagnosis is vital for communication, treatment planning, research and payment for services. And yet there are many questions in the literature as to the utility of diagnosing conduct disorder in children. Currently conduct disorder in childhood is one of the most frequent causes of referral to services (Robins, 1991). Additionally the costs of antisocial behaviour to society are high, because of the continued contact with both health and the criminal justice system (Robins, 1991). It therefore seems that this question is a 'burning question' with many implications.

This essay will focus on the clinical utility of the diagnosis of conduct disorder in childhood, by examining diagnostic systems, the diagnosis of conduct disorder and the implications of the diagnosis for clinical practice.

DIAGNOSTIC CLASSIFICATION SYSTEMS

Kazdin (1995) believes the purpose of developing a diagnostic classification system is to comprehend patterns of functioning, their proceedings and what intervention and preventative work can be done. He believes classification systems do have some utility in relation to clinical practice. He describes how a pattern initially has to be defined if it is to be studied and understood. However this in itself could be a dilemma; in trying to define a dysfunction before all the information is available from study is a near impossible task.
Kazdin (1995) also proposes that diagnosing emotional and behavioural problems to be a much greater task than diagnosing physical problems as there is often no singular test. By applying a medical model of diagnosis to a psychological problem, there is an assumption that there is an identifiable set of symptoms and an underlying cause, which must be treated. Diagnosis itself in the medical world can bring with utility in clinical practice in terms of effective treatment and the development of preventative work (Kazdin, 1995). Although this is true for medical problems a single diagnosis in the emotional and behavioural world does not necessarily lead to a single cure.

Many objections to psychiatric classification systems in general have been raised and in particular to child psychiatric classification. People have suggested classification can bring with it harmful effects focusing on weaknesses (Carr, 1999), as well as the likelihood of social stigma (Tomm, 1990; Cantwell, 1996). However Cantwell (1996) reports that there is belief that the advantages of having a valid and reliable classification system far outweigh the disadvantages, and suggests any harmful effects result only from the abuse of the classification system and not the system itself. In support of the medical model of diagnosis, it has repeatedly been commented that without classification and diagnosis, treatment decisions could not be made in clinical settings. It is also thought to be vital as a basis for research and communication (Carr, 1999).

Much of today's diagnosis for emotional and behavioural problems uses a categorical diagnostic system whereby a person has to display a defined number of varying symptoms for a particular length of time. Additionally these symptoms have to hinder everyday functioning (Kazdin, 1995). Dimensional models of the classification of psychological problems have also been developed whereby disorders lie on a continuum of graded severity (Sonuga-Barke, 1998), for example Achenbach's dimensional approach describes internalising behaviour problems through to externalising behaviour problems (Achenbach, 1991). Interactional models of classification focus on the patterns of interaction between family, and wider social and professional networks in which the family is embedded (Carr, 1999). Both dimensional and interactional models do not appear to be used so extensively as categorical models.
The most widely used diagnostic systems are the categorical DSM-IV (APA, 1994) and the ICD-10 (WHO, 1992). Even though these are believed to provide utility in clinical practice, they are nevertheless, not without criticism. Both the ICD-10 and DSM-IV show some poor reliability and validity as well as high comorbidity (Carr, 1999). Additionally Tomm (1990) writes a strong critique of the DSM classification system accentuating that human behaviour may be more fundamentally grounded in social phenomena than individual phenomena. He also describes concerns of how pathologising psychiatric labelling can be, when an individual is already traumatised both socially and psychologically. Carr (1999) proposes that these categorised systems may be ideologically unacceptable to clinical psychologists who may focus on systemic, constructivist, cognitive-behavioural, psychoanalytical or other models rather than a medical model.

Nevertheless both the DSM and ICD diagnostic classification systems are open to development and refinement, and are believed to facilitate clinical practice, as well as communication and research (Carr, 1999). When considering conduct disorder, it appears that the categorical diagnostic systems DSM and ICD, are the most widely used.

**OVERVIEW OF CONDUCT DISORDER**

**Diagnostic Definitions**

The classification of conduct disorder first appeared in the DSM (American Psychiatric Association, 1980) in 1980. Before this time it was not seen as a clinical problem and this inclusion in the DSM separated it from the juvenile justice system and the term 'delinquency' (Steiner et al, 1997). DSM-IV (APA, 1994) describes the fundamental feature of conduct disorder as "a repetitive and persistent pattern of behaviour in which the basic rights of others or major age-appropriate societal norms or rules are violated" (pg 85). Individuals have to show at least three symptoms from a list of fifteen symptoms, of which all three must be displayed in the last year, and at least one symptom within the last six months. The list includes behaviours in the following categories: aggression to people and animals, destruction of property,
deceitfulness or theft and serious violations of rules. The behaviour must cause significant impairment in social, academic or occupational functioning. Type of conduct disorder can also be specified according to age of onset (childhood-onset type versus adolescent-onset type) and severity (mild, moderate and severe).

ICD 10 (WHO, 1993) describes conduct disorder in a similar way, only it divides its categorisation into subdivisions such as conduct disorder confined to the family context, unsocialised conduct disorder and socialised conduct disorder. Depending on which category is being diagnosed defines which number and type of symptoms are needed to fulfil the ICD 10 diagnosis. Age of onset and severity are also specified, as in the DSM. In addition it is recommended that the people are described along the dimensions of disturbance for hyperactivity and emotional disturbance.

Prevalence & Course of Conduct Disorder
Kazdin (1995) concludes from other literature that using standardised diagnostic criteria and assessment methods the prevalence of conduct disorders amongst 4-18 year old children is approximately 2-6%. Steiner et al (1997) report prevalence rates between 1.5% and 3.4% when clinical interviewing is used for assessment of conduct disorder. Steiner et al (1997) suggest that conduct disorder is not only one of the most prevalent forms of psychopathology, but is also one of the most devastating causing loss to clients, families and society. Kazdin (1995) suggests children are unlikely to 'grow out of it', leaving prognosis as being poor. Intervention is also difficult due to the complexity and pervasive nature of conduct disorder, and the likelihood that the children will be handled by probation systems rather than psychiatric professionals (Steiner et al, 1997). Moreover Kazdin (1995) concludes that conduct disorder in childhood is a likely perquisite to problems in adulthood such as criminality, alcoholism, antisocial personality and other psychiatric problems.

Risk Factors
Many risk factors for conduct disorder are cited in the literature including poverty, low socio-economic status, temperament, hyperactivity, low IQ and chronic illness/disability (Steiner et al, 1997; Robins, 1991). Conduct disorder is also thought to follow in families, whereby antisocial behaviour in childhood predicts similar
behaviour in one's children (Kazdin, 1995). Family characteristics notable in children with conduct disorders include parent psychopathology and maladjustment (Kazdin, 1993).

The Continuing Development and Refinement of Diagnostic Criteria
Richters & Cicchetti (1993) describe a wonderful rendition of how Mark Twain's 'Tom Sawyer' and 'Huckleberry Finn' would both achieve a diagnosis of conduct disorder by today's psychiatric diagnostic standards. This highlights how the diagnosis of conduct disorder has developed over the years. With each new edition of the DSM and ICD, the classification of conduct disorder has been developed and refined (Robins, 1991). For example, following empirical evidence, the DSM-IV (APA, 1994) has included further subtyping corresponding to age of onset as well as the severity of the conduct disorder (Steiner et al, 1997). Refinements suggest a better understanding of childhood conduct disorder, and so positively inform any clinical practice.

Although both the DSM and ICD describe conduct disorder, it is apparent that at least in the research world, the DSM is favoured over the ICD. More studies appear to use the diagnostic criteria laid down by the DSM than the ICD. For this reason most of the discussion in this essay will centre on the DSM diagnostic criteria.

CRITICISMS AND THE CLINICAL UTILITY OF THE DIAGNOSTIC CLASSIFICATION OF CONDUCT DISORDER
Kazdin (1995) reports that although there is agreement that conduct disorder is a problem in youths, debates about diagnostic criteria are ongoing. It is therefore difficult to judge the utility of a diagnosis of conduct disorder, and to see the impact a diagnosis would have on clinical practice. Shamsie and Hluchy (1991) propose that until the notion of conduct disorder is sufficiently researched, clinicians need a way of identifying youths who primarily present with antisocial behaviour. They suggest the diagnostic system serves a definite purpose for clinical work, as long as its limitations are considered. But what are these limitations?
Validity and Reliability of the Diagnostic Criteria:
Although the diagnostic classification systems participate in ongoing refinement of their criteria, it would appear that they still have further to go in terms of validity and reliability of the diagnostic criteria (Carr, 1999). Even in the ICD 10, it is suggested that further research is needed to validate the proposed subdivisions of conduct disorder such as socialised conduct disorder and unsocialised conduct disorder (WHO, 1993). Various other studies have questioned the validity and reliability of diagnostic classification systems such as the DSM and the ICD (Carr, 1999; Loeber et al, 1993; Hart, Lahey, Loeber & Hanson (1994); Cantwell, 1996). Diagnostic classification of conduct disorder therefore needs to be used with caution in clinical practice, with an awareness of particularly weak areas of validity and reliability.

Criticisms of Actual Diagnostic Criteria
Concerns regarding the diagnosis of conduct disorder being too broad have been put forward, suggesting many youths have nothing in common except the antisocial behaviour (Shamsie and Hluchy, 1991). Kazdin (1995) challenges the criteria by which a diagnosis of conduct disorder is decided, for example why three symptoms are required for diagnosis and not two or five. He points out that this determines who is included and excluded in the category and so is a very salient notion. The delineation of symptoms in a fixed way regardless of age or gender is another criticism of Kazdin (1995) whereby he questions whether a four year old would really confront a victim or force sex on someone. All these criticisms of the diagnostic criteria for conduct disorder impact on the classification systems' utility for clinical practice.

Comorbidity and Differential Diagnosis
An apparent difficulty when using classification systems to diagnose conduct disorder is the high comorbidity of other syndromes with conduct disorder. Research into conduct disorder and its associated syndromes has produced such support that a possible underlying psychopathology is being considered (Steiner et al, 1997). If comorbidity is so high, it is then difficult to know how useful a diagnosis of conduct disorder is for clinical practice if there are such large overlaps. Kazdin (1995) lists
many other diagnoses in which similar behaviours to conduct disorder are present but suggests there are critical features such as age of onset or duration that may differ.

Attention deficit hyperactivity disorder (ADHD) is the most common comorbid problem (Kazdin, 1995), with estimates of coexistence between 45%-70% (Offord, Boyle & Racine, 1991). In fact the comorbidity of conduct disorder and ADHD is so high that merging them into one diagnosis had been considered, but later rejected because of differing risk factors and predictive powers for later adult criminality (Farrington, Loeber & Kammen, 1990). Loeber, Green, Keenan and Lahey (1995) suggest ADHD may be involved in the appearance of conduct disorder rather than acting to maintain it.

Oppositional defiant disorder (ODD) is regularly found to be comorbid with conduct disorder. Some researchers propose that ODD develops into conduct disorder whilst others believe that ODD is a single diagnosis by itself (Loeber et al, 1993; Ferguson, Horwood & Lynskey, 1994). Hinshaw, Lahey and Hart (1993) reported that 84%-96% of youths meeting the criteria for conduct disorder, also met the criteria for ODD. This high rate of overlap poses questions about the accuracy and meaningfulness of the diagnostic criteria, as well as complicating any future clinical procedures (Sommers-Flanagan & Sommers-Flanagan, 1998).

Substance abuse and dependence disorders are frequently comorbid with conduct disorder (Kazdin, 1995). Mood and anxiety disorders are also reported as having high comorbidity with conduct disorder, with between 15%-35% of children with conduct disorder also reported as having a depressive disorder (Harrington, 1993). Borderline personality disorder in girls and antisocial personality disorder in boys is found to be highly comorbid with conduct disorder (Steiner et al, 1997). Epright, Kashani, Robinson, and Reid (1993) question the validity of current diagnostic criteria of conduct disorder due to the high comorbidity of personality disorders. Comorbidities of learning disabilities, specific developmental delay, head trauma and seizure disorders are more common than in the general population (Steiner et al, 1997).
Additionally, since the introduction of child-onset and adolescent-onset subtypes of conduct disorder in DSM-IV, different comorbidity patterns have been identified for each subtype (Lahey, Applegate, Barkely et al, 1994). Higher rates of neuropsychiatric disorders, ADHD, aggression and low IQ have been found in the childhood-onset group (Steiner et al, 1997).

It has been argued that the DSM-IV is not useful as a clinical tool because of the high comorbidity within each category (Sonuga-Barke, 1998). Interestingly Sommers-Flanagan & Sommers-Flanagan, (1998) suggest it is often more useful to treat the comorbid problem initially rather than the conduct disorder. The comorbid problem is described as sometimes antagonising the conduct disorder itself and also often being more treatable. They suggest it is possible to see improvement of conduct disorder following treatment of depression, attention-deficit and substance abuse problems. Whether treatment of the comorbid problem is the answer or not, great heed must be taken in regards to treatment plans for conduct disorder that is comorbid with another problem. A multimodal clinical approach will need to occur in cases of comorbidity (Steiner et al, 1997).

Gender Differences

Boys show a higher rate of conduct disorder than girls do, often 3-4 times higher (Zoccolillo, 1993). Boyle, Offord, Racine et al (1992) report the ratio of boys to girls with conduct disorder as 5:1. This may not seem all together surprising as boys tend to show a higher rate of externalising types of behaviour (e.g. stealing, fighting, lying) over the course of normal development, whereas girls show greater internalisation (anxiety, shyness, physical complaints) (Rutter, Tizard & Whitmore, 1970). In general antisocial behaviours categorised in conduct disorder are of the externalising type and are therefore more evident in boys than girls. Zoccolillo (1993) believes diagnostic systems favour boys because of the many violent or confrontative behaviours used in the criteria.

However trying to compare boys and girls on the same diagnostic scale brings with it many complications. The original diagnostic criteria were derived mainly from boys and so the criteria have never been specifically validated on girls (Zoccolillo, 1993).
Further research on the effective psychosocial treatment of conduct disorder likewise revealed a much larger proportion of boys in past studies than girls (Brestan & Eyberg, 1998). Also different base rates exist for both boys and girls as to what behaviours they exhibit, and therefore different significances are put on the different behaviours when they do occur (Kazdin, 1995). For example a girl getting into a couple of fights would probably be seen as more antisocial than a boy having a couple of fights.

Zoccolillo (1993) even makes a case for separate diagnostic criteria for each gender, with steps built in to take account of different male and female cultures and different base rates of aggression and criminality. Zahn-Waxler (1993) suggests building upon and broadening the current diagnostic categories to cater for both males and females would be more appropriate. If diagnostic classification for conduct disorder does not equally identify girls as well as boys, clinical practice may also not be so equally informed. Nevertheless the current recognition of the differences between boys and girls with conduct disorder will hopefully produce additional information on how best to diagnose and clinically intervene with both girls and boys with conduct disorder.

**Variation in Possible Subtypes of Conduct Disorder**

Classification systems for conduct disorder have been questioned over the variability of subtypes that have been suggested in the process of diagnosing conduct disorder (Kazdin, 1995). If there are so many different suggested subtypes of conduct disorder, how meaningful can these be to understanding and intervening with someone with conduct disorder.

Loeber, Keenan, Lahey, Green and Thomas (1993a) and Loeber, Wing, Keenan et al (1993b) suggested splitting delinquent behaviour into three divisions following different developmental patterns: authority-conflicted (usually appears in relationships with people in authority); covert (e.g. stealing) and overt (e.g. violence). They suggested these divisions would allow specific interventions for each group of behaviours, with the intention of increasing positive prognosis.
Steiner et al (1997) discuss the ongoing debate over the dropping of socialised and undersocialised delinquents from DSM-IV and its clinical implications. They question whether the distinction between delinquents whose behaviour is influenced by the environment rather than internal deficits should be ignored. The clinical implications of working with someone who is influenced by a delinquent peer group rather than the individual's inability or unwillingness to comply is markedly different.

Kazdin (1995) discusses aggressive types and delinquent types of conduct disorder. These have come about through efforts to identify patterns of symptoms that do fall together using factor analysis. However even these more thoroughly developed subtypes are not mutually exclusive, and youths can be in one or both subtype.

Steiner et al (1997) conclude that there are many subtypes of conduct disorder which more than likely overlap. He suggests only a more complex model of subclassification would be adequate in classifying these groups, although he suggests the descriptions of various subtypes may describe the same core children but from different perspectives. This again adds to the difficulties of using diagnostic criteria to inform clinical practice.

Differentiating Conduct Disorder from Normal Development

Most children display some elements of antisocial behaviour as part of the course of normal development (Steiner et al, 1997). As not all antisocial behaviour requires psychiatric intervention, the symptoms of conduct disorder must be differentiated and also viewed in the light of normal development. Richters & Cicchetti (1993) discuss the boundary between what is normal and what is abnormal behaviour, and consequently whether children with conduct disorder should be labelled as suffering from a mental disorder at all.

Kazdin (1995) recommends several factors useful in clinical practice for delineating conduct disorder from that of normal development. He suggests the frequency and intensity of the behaviours determines whether or not the child warrants attention. However he points out many antisocial acts are low-frequency, high-intensity acts such as setting fires, where the importance rests with the consequences rather than the
frequency of the behaviour. Kazdin (1995) also suggests repetitiveness and chronicity of the acts helps to determine the degree of antisocial behaviour. He suggests that often the antisocial behaviours will come in a multiple form as a 'package' rather than just one behaviour on its own. However the individual symptoms of the package will vary from child to child, as not all children will display the key problems as identified by conduct disorder. Sonuga-Barke (1998) argue that the DSM-IV is not useful as a clinical tool because of the heterogeneity of the individuals within each category.

Placing Antisocial Behaviours within a Context
As Richters & Cicchetti (1993) identify in their tales of 'Tom Sawyer', regardless of a child's background and circumstances, if a child engages in the types of behaviour listed in the DSM, s/he will be given a diagnosis of conduct disorder. The importance of the social and cultural context to understanding a person's difficulties can not be ignored in making this diagnosis (Sonuga-Barke, 1998). The antisocial behaviours need to be studied within a context before a decision can be made about diagnosis of a clinical problem. If diagnostic classification disregards the environment and any relevant circumstances, then its use as a clinical tool appears somewhat lacking in completeness.

If this were the case, it would seem a valid argument to draw on Scotti, Morris, McNeil and Hawkins' (1996) model of using the DSM as well as a functional analysis to look at the reasons and context of the behaviour. Scotti et al (1996) emphasise the utility of the DSM criteria for diagnosis in terms of providing diagnosis to receive financial support from health care agencies, to enhance communication and to inform prognosis and intervention. However they believe to gain increased utility in clinical practice, the DSM criteria are only the starting point upon which to build behavioural formulation of the difficulties and intervention. They propose a functional analysis be added to the classification system, so eliciting information on the antecedent and consequent events, thereby informing treatment and clinical practice.

Missing Areas and Features
Atkins, McKay, Talbott & Arvantis (1996) believe the DSM-IV criteria do not address a number of areas including community poverty and its links with violence and
aggression. They also believe there is an omission of academic factors in the DSM-IV criteria, stating students with conduct disorder are generally poor achievers at school, and have poor relationships with their teachers.

Dodge (1993) lists many features common in children with conduct disorder, but that are not required for the diagnostic classification. These include lack of guilt or remorse, lack of concern for others and low self-esteem. Although not needed for diagnosis, he suggests these problems have great implications in terms of working with and managing someone with conduct disorder. If this is the case, and these features are missing from diagnostic criteria, how useful can classification systems be to clinical practice?

CONCLUSION
Kazdin (1995) summarises that a broad diagnosis of conduct disorder can easily be made to this heterogeneous group of antisocial behaviours. However this broad diagnosis seems to help little in informing clinical practice with children with conduct disorder. Richters & Cicchetti (1993) propose that most researchers do not believe that conduct disorder is a mental disorder, but rather that the diagnosis allows a common language and ensures research is perceived as relevant to funders. Despite this, a diagnostic label offers little guidance in how to proceed with clinical intervention (Carr, 1999). The clinician is left with the task of trying to treat one of the most prevalent diagnoses in this population with little proven interventions.

Due to the large variety of functions that conduct disorder affects, Steiner et al (1997) suggest a multidimensional assessment procedure. Many informants are needed to collect all available information across differing settings to gain the whole picture. However when using the DSM-IV criteria for assessment process, problems may occur as there are no operational definitions to guide the clinician in deciding whether symptoms are present in a sufficient form for diagnosis (Kazdin, 1995).

Kazdin (1995) suggests more specific patterns or key problems of conduct disorder need to be studied further to find better ways of grouping these children. This grouping process would prove extremely useful for clinical practice, allowing more
focus on particular problem domains. Similarly diagnostic classification systems
would then provide a great deal more information to clinical practice, if they were
expanded to include a much broader context to the problems (Sonuga-Barke, 1998;
Scotti et al, 1996). There is little doubt that the current diagnostic systems provide
reliable enough criteria on which to base research and on which to base policies and
costs of services (Kazdin, 1995). However providing more context to the problems,
such as family circumstances, would bring with it a wealth of information on which to
base clinical interventions. The diagnostic system itself does well in providing the
types of difficulties of which the child may be having, but does little to provide
information about how these problems came about and what is serving to maintain
them. Kazdin (1995) suggests a dimensional system would provide greater
understanding of a child's difficulties, by providing a profile of patterns of
characteristics.
REFERENCES


What Approaches Have Been Used In The Treatment Of Anorexia Nervosa? Consider The Strengths And Limitations Of These Approaches, As Well As The Evidence Base That Would Support Their Use In Clinical Practice.
INTRODUCTION

In 1873, Gull commented on people with anorexia nervosa: "None of these cases, however exhausted, are really hopeless as long as life exists" (Russell, 1995). It appears the treatment of anorexia nervosa has long been seen as a difficult and demanding task, which can transfer hopelessness on to the people involved in the treatment of the individual. Fairburn, Shafran & Cooper (1998) suggest that anorexia nervosa is "still seen by clinicians as one of the most frustrating and recalcitrant forms of psychopathology" (pg 1).

This difficulty in treatment is somewhat unsurprising given the lack of agreement or evidence as to the best forms of treatment approaches for anorexia nervosa. Herzog et al (1992) conducted a study on the status of treatment for eating disorders. Fifty per cent of respondents thought that there was little consensus regarding the best treatment of eating disorders, yet talking therapies were seen as extremely important for treatment.

Although estimates of the prevalence of anorexia nervosa appear fairly low, between 0.5%-3.7% (APA, 2000), anorexia nervosa is associated with a significant mortality rate between 5-15% (Johnson et al, 1996; Serfaty et al, 1999). In fact the mortality rate is twice that of any other psychiatric illness (Treasure & Kordy, 1998). This in itself produces pressures on people to 'treat' and 'cure' people with anorexia nervosa. Evidence from a ten-year follow-up study of anorexia nervosa suggested intensive treatment is needed for maintenance of weight and to help reduce other weight control behaviours (Eckert et al, 1995). It appears that psychological treatment of some kind is essential in the management of anorexia nervosa.

This essay will focus on exploring some of the approaches utilised in the treatment of anorexia nervosa. The theoretical framework, treatment practices and the efficacy of the treatment approach will be presented for three different approaches. Although it is recognised there are many treatment approaches available, including inpatient treatment, pharmacological interventions (Johnson, Tsoh & Varnado, 1996), cognitive analytic therapy (Treasure & Ward, 1997; Treasure, Todd, Broily et al, 1995) and interpersonal psychotherapy (McIntosh et al, 2000), there is not scope in this essay to
explore them all. The three approaches that will be presented are cognitive-behavioural therapy, family therapy and Crisp's model of treatment for anorexia nervosa (Crisp, 1980).

**DIAGNOSTIC CRITERIA FOR ANOREXIA NERVOSA**

Richard Morton (1689) described one of the first versions of what was probably anorexia nervosa. He outlined a condition referred to as 'a nervous consumption' caused by 'sadness and anxious cares' (Silverman, 1997). It was not until 1873, that Lasegue first named anorexia nervosa in Paris, followed shortly by Gull (1874) publishing an article about several cases of anorexia nervosa in London.

In 1970, Russell produced specific criteria for the diagnosis of anorexia nervosa. Further attempts to define anorexia nervosa have generally developed from Russell's original criteria (Russell, 1970). Commonly used today are the criteria provided by the Diagnostic and Statistical Manual of Mental Disorders, 4th edition (DSM-IV) (American Psychiatric Association [APA], 1994). They propose four criteria for the diagnosis of anorexia nervosa. The first criterion states that there is a refusal to maintain body weight at or above a minimally normal weight for the person's age and height. The DSM-IV suggests weight loss leading to maintenance of body weight less than 85% of that expected would fulfil this particular criterion. The second criterion is that there is an intense fear of gaining weight or becoming fat, even though the person is underweight. The third criterion states that a person must also have a disturbance in the way in which their body weight or shape is experienced. The fourth and final criterion is that there should be the absence of at least three consecutive menstrual cycles in postmenarcheal women. The World Health Organisation (1992) produced very similar diagnostic criteria for anorexia nervosa in the form of the ICD-10 Classification of Mental and Behavioural Disorders.

**TREATMENT APPROACHES TO ANOREXIA NERVOSA**

Differing approaches have been developed over the years for interventions with anorexia nervosa. Initially treatment stemmed from a psychoanalytic framework (Silverman, 1997). In 1940 Waller, Kaufman & Deutsch reported the symptoms of anorexia nervosa resulting from "symbolic or unconscious fantasies stemming from
fears of oral impregnation" (pg 7) (Silverman, 1997). However this understanding provided little treatment guidance. Bruch (1973) suggested that self-starvation in anorexia nervosa represented an individual's battle for autonomy, control and self-respect. She proposed that inner confusion resulted from the mother's inability to nurture the child's expression of independent need. By gradually re-labelling any misconceptions and errors in thinking from developmental experiences in treatment, Bruch (1973) suggested a 'genuine self' could be discovered.

Beginning in the 1960's, Crisp (1967, 1980) emphasised the importance of a developmental model in treatment approaches in anorexia nervosa. He described his model whereby anorexia nervosa was considered to be a fear of psychobiologic maturity. Bruch's (1973) work had provided a starting point for cognitive approaches to be developed for the treatment of anorexia nervosa in the early 1980's, by placing an emphasis on an individual's beliefs and assumption (Silverman, 1997). Similarly around this time, forms of family therapy were introduced in the treatment of anorexia nervosa, initially following a structural family therapy approach (Minuchin et al, 1975).

Cognitive-Behavioural Therapy for Anorexia Nervosa

The cognitive-behavioural model of anorexia nervosa proposes that anorexic symptoms are maintained by a person's beliefs about their weight and eating (Vitousek, 1995). The model suggests a person's sense of self-worth is represented in the weight and shape of their body. Once these beliefs have formed, further factors such as processing any information in line with their cognitive biases, serve to strengthen and maintain their underlying assumptions (Garner, Vitousek & Pike, 1997). Vitousek (1995) suggests that anorexics form weight-related schemas that extend symptoms in an automatic way, by affecting the way in which an individual will perceive, explain and recollect their experience.

Cognitive-behavioural approaches to the treatment of anorexia nervosa are largely adapted from those outlined by Beck and his associates (Beck, 1976). However there have been suggested revisions to meet the specific requirements of the anorexic client (Vitousek, 1995). These include taking in to account the egosyntonic nature of the
anorexic's symptoms; the connection between physical and psychological symptoms; the typical beliefs related to weight and food; and the deficits in individuals' self-concept. Garner, Vitousek & Pike (1997) suggest that cognitive-behavioural treatment for anorexia nervosa will last one to two years, unlike other cognitive-behavioural therapies. This lengthened therapy is to allow time for the individual to develop motivation to want to change, to gain weight and possible time out for hospitalisation.

Garner et al (1997) propose three phases in the cognitive-behavioural treatment of anorexia nervosa: The first phase is concerned with building trust and setting the treatment parameters. One of the key areas in this first phase is the focus on the individual's motivation for treatment. As the main goal of treatment is weight gain, anorexics are frequently seen as difficult to motivate (in addition to sustaining a level of motivation). For this reason the establishment of a strong therapeutic alliance and 'collaborative empiricism' (Vitousek, 1995) is seen as vital. Providing education about starvation symptoms, in addition to other medical complications, is necessary to help the individual to realise that not all symptoms being experienced may be due to the eating disorder itself, such as food preoccupations and cognitive impairments. Explaining the different functions of symptoms and suggesting there are two tracks to treatment, the weight-related issues and the other psychological issues such as self-esteem and perfectionism, is seen as important. The cognitive rationale will be presented as well as advice about restoring a proper diet and weight. Meal plans may be suggested following the use of a food diary and initial cognitive interventions may begin in this first phase to increase cognitive dissonance in an attempt to begin altering the cognitive schema surrounding the eating disorder.

The second phase of the cognitive-behavioural model focuses on changing the individual's beliefs relating to weight and food. The particular meanings and functions of the individual's symptoms are explored as a means of helping the individual to find better ways of achieving realistic goals. An emphasis on weight gain and normal eating patterns is continued alongside more formal cognitive methods (Kleinfield, Wagner & Halmi, 1996). Dysfunctional thoughts and thinking patterns such as overgeneralisation and all-or-nothing reasoning, are explored as well as the
development of cognitive restructuring skills. The self-concept also becomes an area of focus exploring and developing an individual's self-esteem and self-awareness.

The third phase focuses on the termination of therapy with the development of relapse prevention techniques. Successful progress is reviewed with exploration of continuing vulnerabilities. The warning signs of a possible relapse are discussed as well as advice on when it may be necessary to seek additional treatment in the future.

Interestingly Gamer et al (1997) also highlight the importance of the involvement of the family if the individual is living at home or in close contact with the family, in this intervention. They suggest that the individual's cognitions and feelings are normally intertwined with the family and that the family interactional patterns may contribute to the maintenance of anorexia nervosa. Although family involvement is not a normal adjunct to cognitive-behavioural therapy, Gamer et al (1997) propose that ideas from family therapy could be used whilst still remaining in the cognitive format, or as an adjunct alongside individual sessions.

Cognitive-behavioural therapy for anorexia nervosa carries with it a number of advantages. Using this approach allows the individual to learn about their illness as part of the therapy process. This psychoeducation in itself may act as a trigger for change. It also allows the individual to separate the eating problems from the underlying issues: it allows the individual to see the eating problems as a 'symptom' of the underlying issues. The focus can then be directed to immediately tackle the 'symptoms' ie the eating problems, and so giving the individual a sense of progress and success, to deal with the underlying issues.

An apparent difficulty with applying cognitive-behavioural approaches to anorexic patients is the possibility that the patient may have a degree of cognitive deterioration due to the effects of low body weight and starvation (Johnson et al, 1996). The patient's ability to engage in such tasks as cognitive restructuring may therefore be hampered, at least initially until there is significant weight gain. Nevertheless sometimes using cognitive-behavioural techniques may be more successful than using
other interventions when the individual is having difficulties with abstract thinking (Slade, 1994).

Interestingly in a recent survey of psychologists working the USA, cognitive-behavioural therapy was endorsed as the primary approach used by about one third of the psychologists approached (Mussell et al, 2000). Many more of the psychologists admitted to using used cognitive-behavioural techniques although they did not select cognitive-behavioural therapy as their primary approach.

Empirical studies using cognitive-behavioural therapy for anorexia nervosa

Although cognitive-behavioural therapy is often seen as a popular choice for the treatment of anorexia nervosa, Garner et al (1997) stated "research on the effectiveness of cognitive-behavioural therapy for anorexia nervosa has been conspicuous by its absence" (pg 94). Even though there have been studies of the outcome of CBT for anorexia nervosa, few are controlled trials with comparisons of different treatments. Garner et al (1997) suggest several reasons why this may be the case, for example the lower incidence rate of anorexia nervosa compared to bulimia nervosa, the necessity of a longer treatment period and the complication of the need for hospitalisation of some clients. They suggest that support for the cognitive-behavioural approach of working with anorexia nervosa clients comes largely from clinical evidence.

Channon, De Silva, Hemsley & Perkins (1989) explored the effectiveness of cognitive-behavioural treatment for anorexia nervosa in a controlled trial providing outpatient therapy. They compared the cognitive-behavioural treatment group with the treatment received by two other groups: a standard behavioural treatment and routine outpatient management. The cognitive-behavioural therapy administered was based on the premise proposed by Garner & Bemis (1982) that dysfunctional cognitions and schemata play a part in the development and maintenance of anorexia nervosa. Treatment was set up to address the cognitive processes as well as the eating behaviours. All groups showed significant improvement at the end of six months of intervention, and the improvements were sustained at six month and twelve month follow-ups. However the cognitive-behavioural therapy group was not shown to be
superior over the other two groups. Yet there was a significant difference in compliance. There were a greater number of sessions attended by the members of the cognitive-behavioural group than the other two groups, an important aspect given the difficulty of engaging anorexic patients in therapy. This study has a number of methodological concerns including a small sample size (eight participants in each group), limited treatment duration and the only therapist also being the evaluator of the study (Vitousek, 1995).

Serfaty, Turkington, Heap, Ledsham & Jolley (1999) carried out another study comparing cognitive therapy with a control dietary counselling group in an outpatient setting. All of the participants in the cognitive therapy group made significant improvements when followed up at six months. However at the same follow-up, all participants in the dietary control group had lost contact with the eating disorders service. This made direct comparison of the two groups impossible. Though this in itself could be seen as important; it highlighted the differences between the two groups such as the importance of engagements skills and collaborative empiricism found in cognitive approaches. However the study realistically required greater numbers of participants in the treatment groups, and suggests comparisons to other interventions would have been more useful.

Unfortunately it seems there are few conclusions to be drawn from these studies either in support or against cognitive behavioural treatment approach to anorexia nervosa. It seems further research is needed for conclusions to be drawn.

Family Therapy for Anorexia Nervosa

Anorexia nervosa has long been a focus of family therapists. In fact anorexia nervosa played an important role in the development of some family therapies such as the work of Minuchin or Selvini Palazzoli (Dare & Eisler, 1997). The recognition of problems having some relation to the family has been accepted by many for a long time, as has the potential for family interventions.

Family therapists utilise a number of different models when considering anorexia nervosa including structured, strategic, Milan and post-Milan (Dare & Eisler, 1997).
Although these different models share many issues, they bring with them very different views of family therapy and different mechanisms of change. There is not scope in this essay to explore all these different models of family therapy as applied to anorexia nervosa and so only the structural and Milan models will be presented here. These two models are thought to have the greatest influence on the family therapy of eating disorders (Dare & Eisler, 1997; Carr, 2000).

**Structural Family Therapy**

Minuchin et al (1975) developed the structural family therapy approach. This is based on the 'psychosomatic family model' as described in the following excerpt:

"This model holds that three factors in conjunction are necessary for the development of severe psychosomatic illness in children. First, the child is physiologically vulnerable; second, the child's family has the four following transactional characteristics: emeshment, overprotectiveness, rigidity and lack of conflict resolution. Third, the sick child plays an important role in the family's pattern of conflict avoidance; and this role is an important reinforcement for his symptoms." (Minuchin et al, 1975, pg 1032)

The aim of structural family therapy intervention is to shape the perceived dysfunctional situation of the family (Dare & Eisler, 1997). For example in anorexia nervosa, conflict at dinner is avoided by the parents deciding together what they want their daughter to eat before they get to the table. This in itself forces a different pattern of interaction by the parents taking control of the problem and so forming an alliance together. They also distance themselves from their daughter. These types of interventions are said to provide immediate effects on the way the family relate to the anorexia nervosa (Dare & Eisler, 1997).

**The Milan systems family therapy**

The Milan systems group of family therapists initially developed from the strategic models of working (Dare & Eisler, 1997). The main idea of the Milan systems therapists is that the family's pattern of interaction has become rigid and organised around the symptoms of the illness. This serves to act as a powerful homeostatic
mechanism. The aim of the therapist is to unbalance the homeostatic dysfunctional transactional pattern and then reorganise the family around more open and healthy communications. A style of interviewing was developed by Selvini Palazzoli et al (1984) to gather information about the family system as well as accentuating the 'interconnectedness' of different aspects of the family life. Reframing at the end of the sessions is used to give positive meanings to observed patterns. Prescriptions may also be used to challenge the perceived patterns.

Additionally, in Milan interventions the therapist has to maintain a neutral stance in relation to both the family and whether change should occur or not. (Dare & Eisler, 1997). It is thought that due to the homeostatic nature of the family, pressure for change would be met with pressure back from the family to resist the change and remain in the same state. The therapist's role is to show differences and new information so the family themselves can challenge their own beliefs about the family relationships. In this respect the Milan systemic does not label the family as dysfunctional, as in the structural family therapy.

Family therapy could be seen as displaying advantages over cognitive-behavioural therapy in that it involves the whole family. It focuses on the system as a whole rather than supposing that the individual can 'lift' themselves out of the system i.e. out of the environment in which they function on a day to day basis.

However much of the family therapy work for anorexics appears better suited to children and adolescents rather than adults. Also by working with the whole family, the members may feel 'pathologised'. They may already be feeling guilty, and then will take on greater responsibility for the suffering of the anorexic family member. Dare & Eisler (1997) question which came first: the dysfunctional aspects of the family resulting in the anorexia nervosa, or the anorexia nervosa followed by the dysfunctional aspects of the family.

Empirical studies using family therapy for anorexia nervosa

Family therapy does not lead to easy evaluation using the "habitual tools of behavioural sciences" (pg39) Dare, Eisler, Russell, & Szmukler (1990). There are
difficulties defining the exact nature of the therapy and whether change should be measured on an individual or family basis. Comments have also been made suggesting evaluation impedes on the therapy by introducing artificial restrictions.

Nevertheless Minuchin, Rosman & Baker's study (1978) provided support for the structural family therapy intervention with people with anorexia nervosa, analysing the treatment and outcome of fifty families undergoing weekly therapy. At follow-up (between six months and seven years) 80% of the available cases had 'a good outcome'. A 'good outcome' was perceived as the individual having normal patterns of eating and generally good adjustment. However there was no control or comparison group in this study.

One of the most recognised systemic controlled studies was conducted by Russell, Szmukler, Dare & Eisler (1987) comparing family therapy to individual supportive therapy in 57 patients with anorexia nervosa (and 23 patients with bulimia nervosa). On discharge from a unit to restore weight loss, patients were randomly allocated to either family therapy or individual supportive therapy. After one year of treatment the patients were reassessed using the Morgan & Russell scales, the body mass index and the return of the menstrual cycle. Family therapy was found to be more effective in patients whose illness had not reached the chronic stage and whose illness had started before the age of 19 years. Interestingly individual therapy was tentatively thought to be more effective for older patients, in that they achieved a higher weight gain.

Although Russell et al's study (1987) was one of the few controlled studies carried out using family therapy, several methodological issues were identified. Concerns as to the matching of the two therapy groups were raised as the individual therapy group received a longer duration of inpatient treatment and were also more often prescribed anti-depressants. Nevertheless random allocation to the two therapy groups was used. Also the choice of using a former in-patient population group means that the group is not necessarily representative of anorexia nervosa patients in general (Crisp, Norton, Gowers et al, 1991).
Despite these concerns an important five year follow-up provided additional support for the original study's findings as well as demonstrating the enduring benefits of the family therapy (Eisler, Dare, Szmukler, Le Grange & Dodge, 1997). Significant improvements were found throughout the groups at five year follow-up, unsurprisingly most evident in the early onset and short history group. Although a lot of the improvements were attributed to the natural outcome of anorexia nervosa, it was still seen to be possible to detect some long-term benefits of the previously completed psychological therapies.

Le Grange (1999) also provided support for successful family therapy interventions although only in describing a single case study of an adolescent with anorexia nervosa. Robin, Siegel, Moye et al (1999) compared the effectiveness of behavioural family systems therapy with the effectiveness of ego-orientated therapy for adolescents with anorexia nervosa. Both were found to be effective treatments for anorexia nervosa in adolescent females. The study reported losing several participants at follow-up and reflects on the impact that this could have on the results, especially if less successfully treated cases failed to show up at the follow-up. Russell, Dare, Eisler & Le Grange (1992) compared family therapy, individual psychodynamic therapy and individual supportive therapy. Family therapy was found to be more effective than the other two treatment groups.

Although these studies provide support for the efficacy of family therapy with anorexia nervosa, it would again be useful for further studies to be carried out. Exploring family therapy for an adult rather than an adolescent would be beneficial.

Crisp's Model of Anorexia Nervosa
A.H. Crisp has published many papers concerning his theory and treatment of anorexia nervosa (Crisp, 1980; Crisp et al, 1985; Crisp et al, 1991; Crisp, 1997). In this approach, anorexia nervosa is seen as a "phobic avoidance response to the strains of adolescent development consequent upon the thrust of puberty" (Crisp et al, 1991; pg 326). The individual is fearful of achieving normal body weight and shape, pointers for the female's perceptions for their 'fatness'. They therefore avoid food, albeit unconsciously, in order to reverse physical development (Crisp, 1997). As body
weight reduces, puberty ceases and with it the feared change in body shape and 'fatness'. However the body will fight to get food to grow and so further weight loss will be necessary as insurance of not reaching the feared 'fatness'. The anorexic's fear is that they will lose control over the avoidant position. The avoidant position is seen as some 'miraculous place' that will reverse puberty and therefore all social and psychological issues relating to it.

Assessment and diagnosis of anorexia nervosa using this model are usually based on a three hour consultation with the individual and their family (Crisp, 1997). Apart from the diagnosis, Crisp suggests the aim of the assessment is to engage and involve the individual so as not to leave a feeling of 'everything being done to him/her'. After the assessment, the understanding is shared with the family at four levels: (i) the apparent abnormal behaviour; (ii) the direct or indirect recognition of the phobia of normal body weight and shape; (iii) the identification of the original maturational problem, although this may be no longer existing and is rarely evident to the individual; and (iv) the identification of the psychological resources available both in the individual and the family to contribute to the individual's growth.

Crisp suggests treatment should last over a six year period with no more than 50 sessions to provide a brand new learning experience for the individual. He proposes psychotherapy should be offered alongside good dietary advice and the use of a log-book for self-reflection purposes. The aims of the psychotherapy are to provide support to the individual whilst s/he is moving out of the avoidant position and to contain any anxiety surrounding this. In addition containment will be required for the individual's subsequent depression. The individual's sense of competence and ownership of her body needs to be explored with the therapist as well as facilitating the development of the individual's self-esteem. The individual will be encouraged to find alternative ways to realise their own potential, using resources other than just their physical appearance. Finally any related psychosocial issues would need addressing in therapy. Crisp (1997) suggests these aims for the therapy sessions are similar to those faced developmentally by any individual as they develop a sense of identity.
Crisp (1997) proposes that there are important components of psychotherapy for people with anorexia nervosa. He identifies trust as a vital quality that needs to be established between therapist, client and family. The development of the 'conditional' aspects of the treatment, such as the contracts for weight gain, are also vital. Crisp highlights the possibility of transference issues between the therapist and client, because of the clients limited experience, concrete thinking and undeveloped psychological defences. He states that explanation, clarification and interpretation are the vital aspects of psychotherapy, along with coaching in communication skills and assertiveness. Crisp (1997) encourages the involvement of parents and suggests they should not just be dismissed. He sees their involvement as very important to "liberate their daughter" (pg 263). This may be from an anxiety about the growth, separation or from feelings of rejection or indifference during their life.

Crisp's approach to anorexia nervosa has been utilised for many years. It carries with it much hope when suggesting that the steps that have to be taken in therapy are much the same as any one would need to achieve in normal development. However Crisp suggests therapy should last six years, ideally with the same therapist. In reality this is unlikely to be fulfilled (as was found in their own research study [Crisp et al, 1991]). Also criticisms have been made about the model being more applicable to adolescents than adults with anorexia nervosa.

*Empirical studies using Crisp's model of anorexia nervosa*

Crisp has produced several outcome studies over the years (Crisp et al, 1985; Hall & Crisp, 1987). In one of the more recent studies, Crisp et al (1991) carried out a controlled study of the effect of different therapies on adolescents with anorexia nervosa. Ninety participants were randomly allocated to four groups: (i) an inpatient treatment package; (ii) an outpatient treatment package incorporating individual therapy and psychotherapy with the parents; (iii) an outpatient treatment approach involving separate therapies for the individual and the parents; and (iv) a 'no further treatment by us' group. All three treatment groups were found to be highly significant at one year when measured on weight gain, return of the menstrual cycle and in differing aspects of social and sexual adjustment. All three treatment groups managed to gain greater weights than their so called 'pubertal onset thresholds', that is they...
achieved mean weight gains above a mean of 45 kg. The no-treatment group touched this threshold, but then retreated again.

In a further follow-up study at two years, further improvements were made in terms of weight gain and social and psychosexual adjustment (although the improvements in weight gain were not statistically significant) (Gowers, Norton, Halek & Crisp, 1994). The ability to gain weight at a very early stage was found to correlate well with outcome at both one and two years follow-up.

Several methodological problems were discussed by Gowers et al (1988) including the difficulties encountered in not providing any treatment to the control group. Issues were also expressed about having to allocate an individual to a differing group from that which would have been best suited to the individual. For example treating someone on an outpatient basis, when in reality an inpatient basis would have been more beneficial. The study was also only able to provide 12 follow-up outpatient sessions to the former inpatients spread over one year. Ideally a six year contract was recommended.

Again although this research provides support for Crisp's approach to the treatment of anorexia nervosa, yet further studies are needed to support these findings.

**CONCLUSION & IMPLICATIONS**

Many different approaches have been used in the treatment of anorexia nervosa, including cognitive-behavioural therapy, family therapy and Crisp's model of anorexia nervosa. Each of these approaches has its own strengths and limitations, yet generally the research findings do not conclusively support any one approach to the treatment of anorexia nervosa over another approach (Peterson & Mitchell, 1999).

However the research findings are encouraging. For example there is some evidence suggesting family therapy may be more beneficial for younger patients and individual therapy more successful for older patients. Interestingly, little is known about individuals with comorbid problems, or about male sufferers of anorexia nervosa (Peterson & Mitchell, 1999).
Nevertheless Peterson & Mitchell (1999) question how much the results concluded from research studies can be generalised to clinical practice because of restraints such as time-limited interventions. Randomised controlled trials (RCTs) are seen to be the 'gold standard' in creating evidence, whereas clinical experience is seen to be of less worth (Treasure and Kordy, 1998). And yet Black (1996) states that many questions concerning severe psychiatric illnesses can never be answered using RCTs. For example too many different treatment alternatives exist for anorexia nervosa including the approach, setting and duration of treatment.

Treasure & Kordy (1998) suggest carefully conducted observational studies can be useful to help judge which RCTs would be most useful. They propose the perceived and actual difficulties of carrying out RCTs in anorexia nervosa may have contributed to the lack of studies. In addition, many of the studies that have been carried out have commented on the constraints that RCTs bring with them. Treasure & Kordy (1998) suggest longitudinal observational studies can alternatively be used with complex mathematical modelling to analyse the data. They report on a study currently being carried out, using the method to explore over 5000 patients across 19 European countries. They hope that this study will produce guidelines on the intensity of intervention, systematic treatment selection and cost effectiveness for eating disorders.

To conclude, there is already some evidence to suggest that particular treatment approaches, such as cognitive behavioural therapy, family therapy and Crisp's model of anorexia nervosa, are successful for treatment of certain groups of people with anorexia nervosa. Nevertheless, as well as further research to find greater support for the treatment approaches, there is an obvious need to expand these treatment approaches, or integrate to reach greater numbers of people with anorexia nervosa. Examples of integrative models are proposed by Greben, & Kaplin (1995) and Steiger & Israel (1999). As with any mental health problem there appears to be a group more resistant to any intervention. New innovative approaches still need to be developed to assist the more resistant patients. There is now even some suggestion that anorexia nervosa is a familial disorder with biological correlates (Kaye, 1999). This could bring with it a greater understanding of this curious disorder. This is surely essential
when the high mortality rate of people with anorexia nervosa is remembered. After all when sufferers may die, is it really acceptable to have so little research on what is effective in the treatment of anorexia nervosa?
REFERENCES


OLDER ADULT ESSAY

Year Three
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Critically Evaluate Theories Of Bereavement And Loss And Their Treatment Implications For Older People.
INTRODUCTION
Life is made up of a series of losses and adjustments from the time we are born to our death (Alty, 1995). As well as loss in terms of bereavement following the death of someone, there are many other types of loss including the loss of a relationship, home or of physical health. Unfortunately, these losses are often more common in older adults. At the age of 65 years, over half of all women and more than 10% of all men have been widowed at least once. At age 85 years and older, 81.3% of women and 40.5% of men are widowed (Rosenweig, Prigerson, Miller & Reynolds, 1997). The issue of death is experienced more commonly in older age, with the loss of siblings, friends and colleagues. Additionally older people are also more likely to suffer physical health problems, loss of role through retirement and possible relocation.

Bereavement and loss appears paramount in older adults. For this reason it could be concluded that the study of bereavement and loss should hold a central place in research in older adults. However this does not appear to be the case. Most current knowledge of bereavement is derived from research on conjugal loss in younger adults, and to a lesser extent, on the loss of a child or parent (Stroebe et al, 1993). Greater input is needed into the study of loss and bereavement in older people.

This essay will initially introduce the main theories of bereavement and loss. The issues experienced by older adults concerning bereavement and loss will then be presented as well as treatment implications.

THEORIES OF BEREAVEMENT AND LOSS
Bereavement can be defined as the objective situation of having lost someone or something significant. The term loss suggests we no longer have someone or something that we used to have. As a result of bereavement and loss, people experience grief as the emotional response (Stroebe, Stroebe & Hannson, 1993). Parkes (1993) described grief as "an emotion that draws us toward something or someone that is missing. It arises from awareness of a discrepancy between the world that is and the world that 'should be'" (pg242). A person's experience of grief is
individual and unique: individuals experience different feelings and reactions to each other when experiencing grief and at different times during the grieving process. Bereaved individuals may report some of the following grief reactions: shock, pain, anger, guilt, loneliness, regrets, intrusive images and feelings of being overwhelmed (Schuchter & Zisook, 1993).

Some people are at a specific risk of suffering greater bereavement reactions. Parkes (1985) suggested an individual's reaction to bereavement and loss may differ dependent on the characteristics of the relationship, the characteristics of the survivor, the type and cause of death and the social circumstances such as culture as well as other possible losses.

Integrated theories of bereavement and loss are few and far between, rather there are many different complementary theories that each add to the understanding of bereavement and loss.

**Psychoanalytic Theories of Bereavement and Loss**

The earliest theory of bereavement emanated from psychoanalytic theory. Freud (1917) described mourning as a normal reaction by which the bereaved individual gradually withdrew his/her libido that had been invested in the lost object in readiness for reinvesting it in a new object. He believed normal mourning to take the form of repeated 'reality testing' that allows the ego to free its investment in the lost object. Pathological mourning arose out of intense ambivalence that impeded the detachment process. Freud's theory and further psychoanalytical contributions, for example from Klein (1948), were criticised for developing theories of bereavement and loss based on depressive illnesses rather than of the bereavement process (Littlewood, 1992).

**Stage Theories of Bereavement and Loss**

Stage theories of bereavement and loss have been very influential in understanding the process of grief. According to these theories, individuals go through several stages of
emotional response as they attempt to come to terms with the loss of the person or object.

Bowlby (1980) offered a stage theory of bereavement based on his attachment theory. Littlewood (1992) suggested Bowlby's theory of bereavement and loss incorporated an evolutionary perspective as well as a psychoanalytic perspective. Bowlby's attachment theory included grief as a normal response to separation. Following a loss or bereavement, grief is seen as a form of separation anxiety in adulthood when an attachment bond has been disrupted (Stroebe et al, 1993). Bowlby suggested that following a loss or bereavement, a person passed through various stages. The person first experienced shock or numbness followed by a period of yearning and protest. A period of disorganisation and despair often characterised by feelings of depression and social withdrawal occurred before finally reorganisation and recovery.

Kubler-Ross (1969) described the classic stage theory of death and dying explaining the processes involved in accepting one's own death. The stages incorporated in this theory included denial, anger, bargaining, depression and acceptance. The denial stage protected the individual from experiencing the extent of the reality all at once.

Schucter & Zisook (1993) proposed a slightly different stage theory suggesting that grief was linear and did not have concrete stages. They instead proposed three partly overlapping, fluid phases of the grief process which they suggested differed from individual to individual. They described an initial period of shock and disbelief, followed by an acute period of mourning which encompassed somatic and emotional discomfort and social withdrawal. They described their third phase as a "culminating period of restitution" (pg24).

Although stage theories of bereavement serve as a useful guidance to the possible stages that an individual can experience when having suffered a loss or bereavement, there are also some criticisms of these theories. Wortman et al (1993) highlighted the lack of studies providing evidence for the efficacy of these theories. In fact they
found the data often did not support the theory and sometimes even contradicted the theory. Wortman et al (1993) concluded that there was great variability in the range of emotions people displayed, as well as variability in sequence and intensity.

However there is a contrary belief by some caregivers and professionals that these stages do occur and the stages are often used as measures to assess someone's progress. This in itself could be seen 'dangerous' if a person's grief was judged as pathological because they had not reached a certain stage by a certain time (Schwartzberg, 1992).

Wortman & Silver (1989) argued that distress may not be a necessary feature of bereavement and loss. If distress is not thought to be a natural response to bereavement and loss, the staged approach to grieving can not operate. Another concern regarding the stage theories of loss and bereavement is that a person may experience more than one stage at the same time, skip one stage or move backwards and forwards through the stages. It is beginning to be more widely accepted that this can happen: that is, that a person may not move systematically through the stages, but that grieving is an individual response and an individual process. However if a person can move backwards and forwards through the stages this renders testing of these stage theories virtually impossible (Kato & Mann, 1999).

Stage theories also fail to account for how a person, such as an older adult, experiences multiple losses, or for those experiences commonly described by gay men of AIDS-related bereavements (Wright, 1993). It is unclear how a person with more than one loss can fit into the structure and process of the stage models of bereavement and loss.

Wortman et al (1993) believed the stage theories, particularly Bowlby's attachment model (1980), provided very useful descriptive analyses of bereavement and loss, describing specifically the emotions and specific processes that each individual experienced. However they omitted to account for the adverse physical health
outcomes that were often associated with bereavement and loss. Likewise, the theory provided no explanation for the differing outcomes displayed in response to loss by different people, for example when one person may appear to be coping with a loss whereas another person may be completely devastated.

Stress Theory of Bereavement and Loss
Stress theory accounts for bereavement and loss outcomes by summarising bereavement and loss as a stressful life event (Stroebe et al, 1993). The stressful event causes disequilibrium in the person, which requires a period of readjustment. Unfortunately this can itself leave the person more open to stress and its psychological and somatic consequences. The processes of appraising a stressor (ie the bereavement or loss), and of readjustment, will be affected by the individual's own available resources. These may include coping strategies, social support and financial assets.

This theory of bereavement and loss provides an account of the variability in people's response to bereavement and loss (Wortman et al, 1993). Each individual's vulnerability or resistance factors will differ producing different responses to the loss. Therefore if an individual has greater social support and coping resources he/she may recover more quickly than someone without these resources. It also provides an explanation for the physical health consequences of bereavement, proposing that stress can either directly influence health as a result of physiological changes that co-occur with bereavement, or indirectly through health behaviours (Irwin & Pike, 1993). However again the assumptions of the stress theory of bereavement and loss have not consistently been supported by empirical evidence, for example Wortman et al (1993) conclude there is little evidence to support the notion that intense distress or disequilibrium is destined following a loss.

Personal Construct Theories of Bereavement and Loss
Parkes (1993) considers bereavement and loss in terms of a psychosocial transition, whereby particular events such as a loss or bereavement, produce major changes in an individual's internal model of the world. Grief involves a person giving up their set of
assumptions about the world and building new ones to fit the changed circumstances. Similarly Rosenblatt (1993) applied the symbolic interaction theory to bereavement and loss. This emphasised the social nature of reality, whereby part of the individual's context for understanding the world and acting in it was removed when a significant person died. The loss of the person is likened to a loss of reality and created a new search for meaning allowing the person to make sense of what had happened and to feel sure about him or herself. Again, these theories of loss and bereavement have only limited empirical evidence to support their assumptions (Wortman & Silver, 1989; 1990).

Wortman, Silver & Kessler (1993) have developed a new theoretical framework for bereavement and loss drawing from the stage models and the stress models of bereavement and loss. It attempts to predict conditions under which major losses are more likely to cause lasting difficulties. They proposed that the impact of a life event such as a loss or bereavement depended on whether the loss could be incorporated into the individual's system of beliefs, assumptions and expectations about the self, others and the world. The individual's world view provided a sense of meaning and coherence, which may or may not be violated by the loss. The individual's family experiences, culture and religious beliefs as well as their previous life experiences determined the person's world view. A loss or bereavement will normally have violated the world view causing a period of distress. Some individuals will be able to reinterpret the loss as compatible with their pre-existing views over time, leading to the distress being alleviated more quickly. Other individuals will need to alter their world view to accommodate the loss, which will probably take longer. Wortman et al (1993) suggested other individuals may never be able to integrate the loss into their view of the world.

Wortman et al's (1993) theory of bereavement and loss accounts for the variability in response to loss from one individual to another. It also suggests that an individual's vulnerability to loss may not be directly related to resources. It provides an account of
why some people who do not appear to be vulnerable in terms of resources, are susceptible to certain types of losses.

An Integrative Perspective on Bereavement and Loss

There are many different theories of bereavement and loss, all of which enrich our understanding of the processes a person may experience following a loss or bereavement. Yet much of the work was criticised for not providing empirical evidence to support the theories (Stroebe & Stroebe, 1987; Wortman & Silver, 1989; Bonanno & Kaltman, 1999). This criticism led to a quiet period in the development of theories of bereavement and loss. However recently Bonanno & Kaltman (1999) have proposed an integrative perspective on bereavement and loss that they hope will facilitate further research and empirical studies in this area. After looking at various loss and bereavement theories they drew out four fundamental components of the grieving process. These are the context of the loss, the meaning of the loss, the representations of the lost relationship, and the coping and emotion-regulation processes. They suggested these components both impacted and interacted over the course of bereavement, for example the bereaved person's age may affect the impact of the expectedness of a loss; and minimising negative emotions may allow a person to work more on problem-focused coping. Further research is needed to continue developing the efficacy of theories of loss and bereavement if a greater understanding of this area is to be gained.

BEREAVEMENT AND LOSS AS EXPERIENCED BY OLDER PEOPLE

Theories of loss and bereavement can be applied to any person including older adults. Yet older adults may experience bereavement and loss in a different or additional way to younger people. In terms of their own death, older adults may view death and dying in a different way to younger adults. McKiernan (1996) explored differences in a person's view of their own death when the person was at a closer proximity to dying, and the impact on their psychological adjustment to old age. For example Erikson (1963) identified a final stage for old age of either 'ego integrity' or 'despair' when faced with the end of life. McKiernan (1996) concluded that unfortunately we know
relatively little about older adults' concerns and anxieties about dying and how they manage them. Kastenbaum (1992) suggested older people were more fearful of the circumstances of their death than death itself, whilst adolescents and adults were more fearful of death itself than older people. Older people are thought to talk more and think more about death than younger people (McKiernan, 1996), considering the circumstances and the possibility of pain for themselves and their families.

Breckenbridge, Gallagher, Thompson & Peterson (1986) presented evidence suggesting that older adults experienced less severe distress following bereavement than middle-age people. Yet Raphael (1984) highlighted that older adults will have been encouraged to suppress emotion and show a brave face when younger, which may result in an unwillingness to discuss present losses or past suppressed losses. Yet Gallagher-Thompson et al (1993) concluded that levels of grief in older people were not lower than for younger people following bereavement.

McKiernan proposed that grief in older adults may not be more or less than in younger people but may just be different. She cited several studies (Sanders, 1981; Bolger, Wortman & Kessler, 1988) suggesting older adults' initial reactions to bereavement may be less distressed than that of younger adults. However, the length of recovery was longer in older adults, and the older adults' initial lower grief intensity was often followed by denial, increased physical symptoms and greater loneliness and anxiety. Likewise Bowling & Cartwright (1982) found amongst a group of older widows, feelings of loneliness and isolation were common as well as a tendency to depend on relatives following bereavement.

Many studies described the effects of bereavement on an older adult's mental health. Although the majority of people make the adjustments to cope with bereavement and loss, some people experience depression (Lund, Caserta & Dimond, 1989; Harlow, Goldberg & Comstock, 1991; Thompson et al, 1989). Depression in older people following bereavement is generally found to have returned to a similar level as a control group at a two-year follow-up. Loneliness appeared to be one of the most
pervasive problems following bereavement in older adults, lasting for at least two years (Lund, Caseta & Dimond, 1989; Anderson & Dimond, 1995; Van Baarsen et al, 1999). Bowling & Cartwright (1982) recounted that two-thirds of their widowed sample reported it to be difficult living alone, often it being their first experience of having to do so. They also found loneliness happening in older adults where they were not living alone, but in shared accommodation.

Interestingly many studies reported few or no significant differences in the physical health of older people who had been bereaved compared to a non-bereaved group of older people (McKiernan, 1996). In fact Thompson et al (1984) reported some positive findings whereby older bereaved people reported new illnesses or the deterioration of old illnesses, rather than experiencing the illness but not reporting them to a professional. Bowling & Cartwright (1982) suggested that it may be that health problems of older widowed people were the same as other older adults, but that these problems were emphasised by problems with loneliness and adjustment. Yet Stroebe, Stroebe & Hannson (1993) concluded from studies that bereaved persons were at an increased risk of mortality than married persons, with older men being particularly at risk.

The expectedness of the bereavement also appears to impact on the grief process. Older people appeared more likely to have considered death or bereavement and therefore may view a death as less untimely than younger people (McKiernan, 1996). Ball (1977) found that middle-aged and older people scored lower on grief response measures than younger people following bereavement. Ball (1977) also found that a sudden death produced higher scores on the grief response measures than an expected death. This finding is supported by other studies such as Byrne & Raphael (1994) who found that widowers who were unable to anticipate their wife's death had a more severe bereavement response.
Older Adult Essay

Other Losses Experienced by Older Adults

As well as the loss of loved ones through bereavement older adults will more than likely experience many additional losses as they grow older. Grief and mourning for the loss of unfulfilled hopes and wishes may occur as older adults realise that their chance of attaining certain things may have passed (Raphael, 1984). Older adults may also experience loss of physical abilities such as vision, hearing, memory, sexual function and other bodily functions. A general loss of health or well being in line with normal ageing is also a loss experienced in older adults. Retirement from employment can result in a loss of role and identity for some older adults, as well as a change in financial stability. Older age may also be associated with a move in accommodation, for example to warden assisted housing or a nursing home. Often ignored, is the loss of a pet, often vital company for an older adult. In addition following a bereavement or change in physical health, well-meaning relatives may try to take over the decision-making from the older persons. As well as causing great frustration to the older person, it may also contribute to their losses, as the older person may feel they are losing their role and identity.

TREATMENT IMPLICATIONS FOR OLDER PEOPLE

The theories of loss and bereavement were not designed specifically for older people. However the theories do have an impact on treatment of bereavement and loss in older adults. Yet McKiernan (1996) suggested that the majority of bereaved older adults do not require any specific interventions, because of the risk of undermining the person's own successful attempts at dealing with their grief. Facilitating an older person's coping may be all that is required for successful intervention. However a significant minority of older adults will need some intervention because of the potential risk of further mental and physical health problems (McKiernan, 1996). Brink (1985) emphasised that it was important for the intervention to suit the person when working with bereaved older adults.

Lund et al (1985) identified various factors that would allow for early identification of older people who would benefit from intervention. These included people who soon
after the bereavement had an intense wish for their own death, felt confused, cried excessively, were not proud of how they were coping and did not attempt to keep occupied. Parkes (1980) reported evidence suggesting there was no particular value in providing input to all bereaved individuals, in comparison to control groups, but rather to selected bereaved persons only.

Caserta & Lund (1993) highlighted the need for targeted interventions for bereaved older adults following an evaluation of self-help groups. They also emphasised the danger of discrediting older people's own coping resources with nonessential interventions, as also suggested by McKiernan (1996). For example they found those members of the group with high competencies in self-esteem and life satisfaction, became more depressed whilst attending the group (although the depression reverted if the members continued to attend for more than eight sessions).

Wortman & Silver (1990) suggested several mediating factors that may help or hinder the mastery of bereavement. These factors have implications if treatment is to be successful. They included the nature of the lost relationship, circumstances surrounding the loss, the presence of concomitant stressors and the availability of social support. Many of these factors were more pertinent for older adults, particularly the latter two factors.

The question of an individual dealing with concomitant stressors or more than one loss at a particular time has not been adequately addressed in some of theories of bereavement and loss, particularly the stage theories. Older people, especially, may have to deal with many losses at the same time, both in terms of bereavement, and loss and change in their environment. For example, older people who are grieving the loss of a partner have found it even more difficult to cope if they subsequently have had to move home as well, away from their familiar surroundings (Watson, 1994). Interventions need to adequately address the multiple losses experienced by older people.
A normal part of adjustment to bereavement or loss is the talking with friends or family about the person or object that is missing. The importance of social support is highlighted in many of the different theories of bereavement and loss. A deficit in social support has been associated with poor grief reaction (Stylianos & Vachon, 1993). Nevertheless, as previously mentioned, loneliness and isolation is prevalent in older adults for example following a bereavement, move to new accommodation or reduced mobility (Watson, 1994; Anderson & Dimond, 1995). In these instances the chance to share memories and talk through difficulties are greatly reduced. It is at these times that life review and reminiscence therapy can become invaluable in validating someone's past experiences and reviewing relationships and past events (Alty, 1995). The social contact of these therapies is also vital to counter the effects of any possible stigma associated with the cause of death or the nature of the individual's relationship with the deceased (Biller & Rice, 1990).

Walter (1996) built upon the view that survivors of bereavement and loss typically want to talk about the lost person or object and talk to those who knew the person or object. He suggested that during treatment the person needs to integrate the memory of the lost person or object into their ongoing lives through the construction of a double biography, achieved through conversation with others. This intervention approach appears most relevant to older people who have been bereaved as this allows the person to re-create their own identity within the process.

Helping older adults incorporate the bereavement or loss into their own world view, as suggested in the personal construct theories, is essential during intervention, but may prove difficult for some older adults. Although cognitive therapies have been found to be useful with older people (Kavanagh, 1990), the individual may have to adapt many of his or her beliefs about the world that have been held for a long time. Nevertheless Parkes (1993) suggests that asking people in transition to explain their situation can help them to take stock, review and relearn their beliefs and assumptions about the world.
Brink (1985) suggested the stage theories of bereavement and loss may be more useful in working with children and young adults. He suggested loss reactions in older people did not fit neatly into the prefabricated course with clear-cut stages. He suggested the more usual course for older people is for a gradual adjustment, with possible brief slides in and out of more severe distress. However the stage theories do provide a basis for the understanding of the bereavement process which can be used in a descriptive sense during treatment.

Wortman & Silver (1989) challenged the generalisations about the process and time of recovery following a bereavement or loss suggested in some of the theories of bereavement and loss. They emphasised people's immense adjustments to what may be the most difficult time in their lives. They also suggested that there was no finite recovery time and that people may go on grieving for more than two or three years. Rosenzweig et al (1997) also suggested that grief does not necessarily follow stages and that people may be unresolved after several years. Most of the theories of bereavement and loss suggested that eventually the person will reach a state of 'peace' following acceptance and adjustment. Cutcliffe (1998) suggested that this was not necessarily the case and that some bereaved individuals do not reach resolution. When multiple losses are occurring for older adults accompanied by increasing isolation, resolution may seem impossible. This throws doubt on theories of bereavement and loss that specify a period of grief resolution. McKeirnan (1996) concluded that resolution may be particularly inappropriate for older people and suggested the normal reaction may be to compartmentalise the distress and 'live with it', finding appropriate times to express the grief. Alternatively older adults may be encouraged during intervention to reach a state of increased ability to function in a new set of circumstances (Wortman & Silver, 1990).

Treatment interventions for bereavement and loss in older adults also need to take into consideration the mourning and grieving practices of different cultures, as well as those of frail and more disabled older adults (Klausner & Alexopoulos, 1999).
CONCLUSION

Various theories of bereavement and loss have been developed, yet research into this area has been hindered by many factors. These include lack of measures of grief that are complex enough whilst remaining subtle, the delicateness of the situation for collecting data when a bereavement has just occurred and the limited knowledge base. Consequently many theories of bereavement and loss are thought to be largely theoretical with further empirical knowledge still needed. In addition older adults have often been excluded from research because of the variety and number of losses experienced by this most commonly bereaved group (McKiernan, 1996). Indeed most of the studies on the widowed involve younger adults rather than older people.

Bereavement and loss appears to be personal and unique to the individual involved, and dependent upon the meaning that a particular loss has for the particular person. Therefore support systems and interventions should not advise the person how they should be feeling, but rather attempt to recognise the individual nature of grief. Theories of bereavement and loss are beginning to acknowledge the individuality in each person's experience of loss which brings with it individual treatment implications.
REFERENCES


SECTION TWO

Clinical Dossier
ADULT MENTAL HEALTH CORE PLACEMENT

Year One

NHS Trust: Surrey Oaklands NHS Trust
Location: Epsom
Supervisor: Sally Austen
Dates of Placement: 14/10/98 - 31/03/99
Based/Settings: Community Mental Health Team

Client Demographics:
11 clients (5 female, 6 male) ranging in age from 23 - 48 years.

Presenting problems:
Individual work: Depression, relationship problems, anxiety, bereavement, agoraphobia, panic attacks, obsessive compulsive disorder, anger management, schizo-affective disorder, neuropsychological assessment.

Observed work: Observed self-harm assessment of 16 year old and an additional substance misuse assessment.

Assessment Procedures:
➢ Assessment interviews using mainly cognitive behavioural framework.
➢ Questionnaires/Inventories: Beck Depression Inventory, Beck Anxiety Inventory.
➢ Neuropsychological assessment: WAIS-R.

Interventions:
➢ Cognitive behavioural therapy
➢ Solution focused therapy
➢ Psychoeducation
➢ Graded exposure programme
Summary of Clinical Experience
Adult Mental Health Placement

Settings:
- CMHT
- Acute psychiatric ward
- Home visits

Other experience:
- Attended relevant meetings including psychology department meetings, CMHT business, allocation and audit meetings, peer supervision, community psychology meetings.
- Attended seminars and an 'Introduction to group processes' workshop.
- Attended CBT for psychosis workshop by David Fowler.
- Provided consultation for CPN using CBT for psychosis.
- Supervised a support worker carrying out a graded exposure programme.
- Assisted Team Manager in setting up an outcome study for clients seen at the CMHT.
- Carried out a service related research project.
PEOPLE WITH LEARNING DISABILITIES CORE PLACEMENT
Year One

NHS Trust: Surrey Oaklands NHS Trust
Location: Epsom
Supervisor: Dr Karen Dodd, Geetha Langheit & Julie Nixon
Dates of Placement: 21/04/99 - 01/10/99
Base: Community Teams for People with Learning Disabilities / Hospital based learning disabilities team.

Client Demographics:
Individual work: 9 clients (4 female, 5 male) ranging in age from 5-59.
Group work: 6 clients (4 male, 2 female) ranging in age from 34-58.

Presenting problems:
Individual work: Autism, chronic epilepsy, depression, self-injurious behaviour, Prader-Willi Syndrome & over-eating, assessment of cognitive abilities, anger management, challenging behaviour, Rett's Syndrome & feeding difficulties, dementia, assessment of parenting ability, relationship & communication problems, assessment of client's testimony to stand up in court following allegations of being abused in past.

Group work: Varying problems & concerns about feelings and rights of having to live on locked ward.

Observed work: Inappropriate public sexual behaviour.

Assessment Procedures:
➢ Assessment interviews with clients and staff using cognitive behavioural and behavioural frameworks.
➢ Functional analysis.
➢ Observation.
Summary of Clinical Experience
People with Learning Disabilities Placement

➢ Questionnaires/Inventories: SIB checklist, dementia assessment including the Vineland, BPVS & HALO.
➢ Formal assessment: WAIS-R., Leiter, RMBT.

Interventions:
➢ Cognitive behavioural approaches
➢ Behavioural approaches
➢ Feedback, discussion and consultation with carers

Settings:
➢ CTPLD
➢ Inpatient ward
➢ Home visits
➢ Group homes

Other experience:
➢ Attended relevant meetings including psychology department meetings, CTPLD business and allocation meetings, PLD SIG meeting.
➢ Attended autism seminar presented by Pat Howlin
➢ Prepared and presented teaching sessions on dementia and people with learning disabilities for care staff with older adults with learning disabilities.
➢ Actively asked to pick up some children with learning disabilities form Child and Adolescent Department.
➢ Attended Child Protection Case Conference.
CHILD AND ADOLESCENT CORE PLACEMENT

Year Two

NHS Trust: Kingston & District NHS Trust
Location: Surbiton, Kingston & Roehampton
Supervisor: Dr Claire Tyler
Dates of Placement: 13/10/99 - 24/03/00
Base: Child & Adolescent Mental Health Team

Client Demographics:

Individual work: 7 clients (3 female, 4 male) ranging in age from 4-16.
Family Therapy: 3 families (2 male, 1 female) ranging in age from 10-13.

Presenting problems:

Individual work: Separation anxiety, over-protective family style, severe learning
disabilities and behavioural problems, obesity, migraine, Asperger's Syndrome,
problem solving difficulties in looked after child, adaptation to mother's double
amputation and living in new country.

Family work: Disruptive behaviour, non-compliance, ADHD, chronic fatigue
syndrome, high expectations in family, anxiety, school refusal.

Observed work: Encopresis, diabetes, being bullied at school, blood phobia, panic
attacks, sleep difficulties.

Assessment Procedures:

➤ Assessment interviews using cognitive behavioural and behavioural frameworks.
➤ Family interviews.
➤ Functional analysis.
➤ School and home observation.
Summary of Clinical Experience
Child & Adolescent Placement

➤ Questionnaires/Inventories: Anxiety Rating Scale, Locus of Control Scale, Child Behaviour Checklist, Children's Headaches Assessment, Strange Stories, Social Skills Assessment, Smarties Test, Australian Checklist for Asperger's Syndrome.
➤ Formal assessment: WISC-III

Interventions:
➤ Cognitive behaviour therapy
➤ Behavioural therapy
➤ Graded exposure programme
➤ Systemic family therapy (Milan & Post-Milan)
➤ Awareness of psychoanalytic processes

Settings:
➤ CAMHS
➤ Paediatric outpatient appointments in hospital setting
➤ Home visits
➤ School visits

Other experience:
➤ Attended relevant meetings including child speciality psychology department meetings, systemic CAMHS team meeting, Child SIG meeting.
➤ Observed and discussed role of play therapists.
➤ Attended seminars within team and at SIG meeting.
EATING DISORDERS SPECIALIST PLACEMENT
Year Two

NHS Trust: Surrey Hampshire Borders NHS Trust
Location: Frimley
Supervisor: Dr Leigh Claire
Dates of Placement: 13/04/00 - 29/09/00
Base: Eating disorders day hospital and outpatient unit.

Client Demographics:
Individual work: 5 female clients ranging in age from 25-36.
Group work: Body Image Group - 10 female clients ranging in age from 18-34.
Living with Anorexia nervosa Support Group: 3 female clients ranging in age from 40-58.

Presenting problems:
Individual work: Anorexia nervosa, bulimia nervosa, depression, history of rape, panic attacks, anxiety, low self esteem, abusive relationships, suicidal ideation,

Group work: Anorexia nervosa, bulimia nervosa, body image disturbance, self-esteem.

Observed work: Psychoeducation group, vomit phobia, atypical anorexia nervosa, binge-eating disorder.

Assessment Procedures:
➢ Assessment interviews using a cognitive behavioural framework.
➢ Assessment of current and past eating behaviours.
➢ Measurement of weight, height and Body Mass Index.
Summary of Clinical Experience
Eating Disorders Specialist Placement

- Questionnaires/Inventories: Beck Depression Inventory-2, Beck Anxiety Inventory, Eating Disorders Inventory-2, Sterling Eating Disorders Scale, St George's Questionnaires, Silhouette figure rating scale, Body shape Questionnaire.

Interventions:
- Cognitive behaviour therapy
- Motivational interviewing
- Psychoeducation
- Awareness of psychoanalytic processes
- Group processes
- Supportive counselling within a group setting

Settings:
- Outpatient appointments
- Day hospital

Other experience:
- Attended relevant meetings including day patient review, referral meetings, business meetings, service development meetings, monthly training and journal club meetings, eating disorders SIG meeting.
- Attended group supervision for all staff members facilitated by an outside psychoanalytic supervisor.
- Presented information on the assessment of body image to the team.
- Presented research on eating disorders and people with learning disabilities to the team.
- Discussed CBT for bulimics' group and transition group.
- Liased closely with team members including dietician, nursing staff and psychiatrist.
OLDER ADULT CORE PLACEMENT
Year Three

NHS Trust: St Georges & South West London Mental Health NHS Trust
Location: Surbiton
Supervisor: Dr Sue Webb
Dates of Placement: 11/10/00 - 23/03/00
Based/Settings: Older adult psychology department

Client Demographics:
10 clients (7 female, 4 male) ranging in age from 63 - 83 years.

Presenting problems:
Individual work: Depression, adjustment to physical health problems, anxiety, panic attacks, manic depression, fear of rejection, terminal illness of best friend, parenting issues (bringing up grandchildren), loss of role of grandparent, psychosomatic problems, schizo-affective episode, memory problems, neuropsychological assessment.

Observed work: Depression following bereavement, stroke and aggression.

Assessment Procedures:
➤ Assessment interviews with clients and carers using mainly cognitive behavioural framework.
➤ Semi-structured assessment interviews for anxiety management group.
➤ Questionnaires/Inventories: Hospital Anxiety and Depression Scale, Geriatric Depression Scale.
➤ Neuropsychological assessment: WAIS-R, NART, AMIPB, Verbal Fluency Test, Graded Naming Test, Memory Recognition Test.

Interventions:
➤ Cognitive behavioural therapy
Summary of Clinical Experience

Older Adult Placement

➢ Reminiscence
➢ Life Review
➢ Feedback, discussion and consultation with carers

Settings:
➢ Outpatient appointments
➢ Inpatient psychiatric ward
➢ Home visits
➢ Residential home

Other experience:
➢ Attended relevant meetings including older adult speciality meetings, psychology department meetings, older adult CMHT meetings, ward review meetings.
➢ Attended presentations including neuropsychological assessment.
➢ Ward staff consultation particularly about psychosomatic problems.
➢ Visited stroke unit, day hospital, dementia and mental health day centres.
SYSTEMIC CHILD AND ADOLESCENT SPECIALIST PLACEMENT
Year Three

NHS Trust: Ashford & St Peters NHS Trust
Location: Chertsey & Ashford
Supervisor: Bruce Holroyd
Dates of Placement: 04/04/01 - 21/09/01
Base: Child & Adolescent Mental Health Team

Client Demographics:

Individual work: 5 clients (1 female, 4 male) ranging in age from 10-16.
Family Therapy: 6 families (4 male, 2 female) ranging in age from 11-17.

Presenting problems:

Individual work: Separation anxiety, school refusal, anger problems, disruptive
behaviour emeshment with mother, obesity, suicidal ideation, body dysmorphic
disorder, self-esteem and confidence issues, agoraphobia, being bullied.

Family work: ADHD, family history of abuse, disruptive behaviour, agoraphobia,
terminal illness, sexuality issues, marital conflict and new parents re-marrying, self-
harm, anger and aggression.

Observed work: Obesity, poor school attendance.

Assessment Procedures:

➤ Assessment interviews informed by Narrative, Milan and Post-Milan systemic
therapy.
➤ Assessment interviews informed by a cognitive behavioural framework.

Interventions:

➤ Narrative approaches
➤ Systemic family therapy (Milan and Post-Milan Therapy)
Summary of Clinical Experience

Systemic Child & Adolescent Specialist Placement

➢ Reflective team
➢ Cognitive behavioural approaches

Settings:
➢ CAMHS
➢ Systemic family therapy clinic
➢ Home visits

Other experience:
➢ Attended relevant meetings including child speciality psychology department meetings, CAMHS business, allocation, audit and case presentations, Child SIG meeting.
➢ Attended educational and clinical psychology liaison meeting and presentation on the home and hospital school service.
➢ Attended one-day workshop on substance misuse in adolescents.
ADULT MENTAL HEALTH CASE REPORT SUMMARY

Year One
March 1999

COGNITIVE BEHAVIOURAL ASSESSMENT AND INTERVENTION OF A LADY WITH AGORAPHOBIA
Reason for Referral

SS was a 36 year old woman referred by her GP to the Community Mental Health Team (CMHT) for assessment and treatment of agoraphobia, which developed following the onset of ME approximately 12 years beforehand.

Assessment

The assessment procedure included face to face interviews at the client's home and the completion of the Beck Depression Inventory (BDI) and Beck Anxiety Inventory (BAI). SS was unable to get out of the house beyond her garden alone and described intense anxiety and panic attacks when trying to leave the home, indicative of agoraphobia. This had kept her confined to the house for approximately 12 years. The interview gathered data on the development of the problem, her own history, her family and her expectations from therapy.

Formulation

A cognitive behavioural model was used for formulation. SS's past experiences of critical parents with high expectations and feeling unloved, led SS to develop dysfunctional assumptions about feeling unlovable, having no control and everything having to be perfect. Following her marriage she experienced separation anxiety difficulties after leaving the parental home and an increased expectancy to take on an independent role. She also developed ME. SS developed agoraphobia including panic attacks, which were maintained by her avoidance, hypervigilance to her internal sensations and her negative automatic thoughts. In addition her negative relationship with her parents, her husband taking over her roles around the home and a fear of taking on responsibility if she got better, also served to strengthen and maintain the agoraphobia.

Intervention

Intervention followed a cognitive behavioural approach including graded exposure, relaxation, challenging dysfunctional beliefs and looking for alternative hypotheses. Intervention was also necessary for the depression that SS later experienced as a reaction to the realisation of what she had lost whilst being confined to her home for
12 years. Therapy began at home due to SS's inability to leave the home but later moved to the CMHT base. Intervention continued for 20 sessions, following which ongoing support was provided by a support worker.

**Outcome**

SS progressed well through her hierarchy of targets and became able to visit the pub with her husband, go shopping on her own and visit friends at their homes. Her scores on the BDI and BAI became lower and she reported a better relationship with both her husband and her parents. SS learnt how to manage her anxiety and developed useful coping techniques.
AN ASSESSMENT OF PARENTING SKILLS IN A MAN
WITH MILD LEARNING DISABILITIES
Reason for Referral
Mr J was referred by a social worker to a clinical psychologist in the Community Team for People with Learning Disabilities. The referral requested an assessment of the impact of Mr J’s learning disability on the ability to care for his daughter.

Background
A year previously, Mr J assaulted his 5 month old daughter by hitting her round the head resulting in some bruising. Following this incident, Mr J’s daughter was placed on the Child Protection Register under the category of physical abuse and it was stipulated that Mr J live apart from his partner and his daughter. However, with agreement from Social Services, Mr J had since moved back in to the family home with his partner and daughter for approximately the last eight months, although he was not allowed sole supervision of his daughter. The assessment by psychology was requested after it was suspected that Mr J may have learning disabilities and this may impact on his ability to care for his daughter. A psychological report was required for the forthcoming child protection conference, where it would be decided whether Mr J would be allowed sole supervision of his daughter and whether his daughter would need to stay on the child protection register.

Assessment
Information was gathered from the social worker and during two sessions with Mr J. The Parental Skills Model (PSM) (McGaw & Sturmey, 1994)\(^1\) was used to guide the assessment, which included gathering information on the parent’s life skills, family history and available support and resources. In addition the WAIS-R was completed to assess Mr J’s cognitive abilities (Full Scale IQ = 69). Mr J had previously refused to attend a parenting group, but revealed that he felt awkward attending them as all the other attendees were mothers.

Formulation

Despite Mr J's mild learning disabilities, he presented as an able man in full-time employment running his own business and able to drive. He had learnt to respond to people in a way that was expected of him, but he understood less than people anticipated. Having a learning disability did not mean that Mr J would be a poor parent, but rather that he would need increased support and help in learning the new skills. Mr J had a wide network of support both from his family and professionals, and his partner was the prime carer for their daughter providing an opportunity for Mr J to learn the new skills required of him. No further incidents of violence or anger were reported and Mr J showed great regret over the incident, saying that he had since learnt how to deal with his anger.

Recommendations & Outcome

A psychological report was prepared for the child protection conference with several recommendations: a one-to-one parenting programme for Mr J in which he would be given time to gain confidence and learn the new skills; continued support from his partner, family and professionals; communication to be conducted with Mr J on a one-to-one level to facilitate Mr J’s understanding of events; possibility of couple therapy and bereavement counselling for Mr J to deal with issues of loss. Mr J’s daughter was removed from the at risk register following positive reports from all concerned with the family at the child protection conference. Mr J was referred to the CTPLD for more appropriate parenting education and ongoing support.
CHILD & ADOLESCENT CASE REPORT SUMMARY

Year Two
March 2000

THE ASSESSMENT AND MANAGEMENT OF MIGRAINES IN AN 11 YEAR OLD BOY
Reason for Referral
A consultant paediatrician referred 11 year old Ben to a clinical psychologist working in the Paediatric Department. The referral stated Ben had a probable diagnosis of 'classical migraine, frequent'. Becoming stressed before exams, as well as his general anxiety 'to do the right thing' were suggested as possible triggers for some of Ben's migraines.

Assessment
Information about Ben's current concerns, his developmental history and family history were gathered in the assessment sessions with Ben and his mother. Information was also gained from the Children's Headache Assessment Scale (CHAS) (Budd et al, 1994) and a pain diary completed by Ben. Information regarding CT scans and other possible medical causes of Ben's migraines were collected from the Paediatrician. Ben reported having migraines at least twice a week that would stop him carrying out whatever he was doing, including school work. He described two triggers for his migraines: worrying about exams and worrying when family members went out and did not tell him where or when they would be coming back. Ben had several methods of coping with his migraines such as going somewhere quiet, sleeping and taking Migraleve.

Formulation
Lask & Fosson's psychosomatic model (1989) was used for formulation of Ben's migraines. This suggested that all problems are multifactorial including developmental, biological, social and psychological factors. Anxiety appeared to be the key trigger in the presentation of Ben's migraines. Although there could also have been biological reasons for Ben's migraines, Ben appeared to feel particularly 'unheard' by his family when he was feeling anxious which often resulted in


frustration. Ben felt particularly anxious when he had tests and exams, or when a member of his family went out and he was unsure of their whereabouts. Ben perceived he had a lack of opportunity to express himself and therefore he somatised his anxiety in the form of migraines. At this point Ben achieved the feeling of 'being heard' as his family reacted to his migraines. This attention only served to maintain the physical symptoms of the migraine.

**Intervention**

Intervention mainly followed a cognitive-behavioural model, although ideas from other models were incorporated, such as using some more systemic modes of thinking for exploring family relations. The intervention included psychoeducation, relaxation to reduce arousal levels, cognitive skills training in the form of distraction and self-instructional training, as well as stress reduction and the enhancement of support.

**Outcome**

Both Ben and his mother reported improvements in the management of Ben's migraines. The number of migraines Ben encountered reduced, as did his score on the CHAS. Ben reported putting his relaxation and cognitive strategies in to immediate practise. Providing Ben and his family with new skills and improved communication pathways appeared to reduce Ben's need to somatise his anxiety as migraines.
EATING DISORDERS CASE REPORT SUMMARY
(SPECIALIST PLACEMENT)

Year Two
September 2000

A BODY IMAGE GROUP FOR DAY PATIENTS WITH
EATING DISORDERS
Background to the Group
People with anorexia nervosa or bulimia nervosa could attend the eating disorders unit as an outpatient or a day patient, after being referred to the service by their GP or a member of a Community Mental Health Team. The patients attending the day unit were mainly women with anorexia nervosa. Some people were also accepted to the day unit with extremely chaotic eating patterns characteristic of bulimia nervosa. A common feature of the day patients was their distorted body image, a key feature of eating disorders. The body image group was established to address some of the patients' concerns about their negative body image. The body image group was part of the therapeutic programme of the day unit of the Eating Disorders Service.

Participants of the Body Image Group
Five women attended the group, of which four members had anorexia nervosa and one member had bulimia nervosa. They ranged in age from 20-32 years and all had chronic histories of eating disorders and body image concerns since childhood.

Assessment
There was no specific initial assessment of each group member expressly for the body image group due to the group being part of the therapeutic programme of the day programme. However a thorough assessment of each individual was undertaken when first attending the eating disorders unit including an interview, measurements of BMI and various standardised assessment measures of eating disorders. In addition, each member was asked to complete a silhouette figure rating scale and the Body Shape Questionnaire (Cooper et al, 1987) at the beginning and end of the body image group.

Formulation
Slade's model of body image (Slade, 1994) provided a useful grounding for understanding the factors that influenced the body image for the members of the

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group. It was hypothesised that many of the areas covered in Slade's model could predispose someone to have a negative body image. Experiences in early life may have left an individual more vulnerable to negative feelings about their body. For example, a family history of body image disturbance or eating disorders, a history of teasing or bullying because of the weight issues, a genetic predisposition to being bigger than wanted, as well as personal characteristics such as low self-esteem and a high need for approval. A later event such as unwanted sexual contact, maturity fears, depression, peer pressure and cultural and societal pressure to be thin (and therefore attractive and successful) may have acted as triggers for the development of a negative distorted body image. Individuals expressed their negative feelings about their life and/or situation through their body, and so forming a negative and disturbed body image. Maintaining factors such as other eating disorder characteristics for example fear of normal body weight, the continued suppression of feelings, cognitive thinking errors and dysfunctional coping strategies only served to reinforce the disturbed negative body image.

**Intervention**

The aims of the body image group were to enable the day patients to look at their bodies more objectively by challenging their perceptions of how they saw themselves, as well as encouraging them to identify their feelings and beliefs that lay behind their negativity towards their bodies. The programme attempted to incorporate a range of approaches in order to target the following: the over-estimation of body size; the preference for a thin ideal image; the negative attitudes towards the body; the exaggerated importance placed on body weight and shape; the subjective experience of feeling fat and the meaning of 'fatness' and 'thinness' for the individual. The group ran for 14 sessions and used material such as pictures from magazines, photographs of the participants, body tracing tasks, sentence completion tasks and discussion of responses to various body image questionnaires.
Outcome
The scores on the BSQ generally fell and members of the group chose slightly more realistic figures on the Silhouette Judgement Scale. In addition the members of the group reported it to be very interesting and helpful, but hard work. The group members appeared to find the group a safe, non-judgmental place where group members could express openly how they felt, and hear other people share their experience, as well as be challenged on any distorted perceptions. Additionally it was decided the group would continue as part of the day unit programme.
OLDER ADULT CASE REPORT SUMMARY

Year Three
March 2001

A NEUROPSYCHOLOGICAL ASSESSMENT OF THE COGNITIVE FUNCTIONING OF A 77 YEAR OLD MAN
Reason for Referral
Mr H was a 77 year old man referred for a re-assessment of his cognitive functioning. Mr H had previously had a neuropsychological assessment one year beforehand, after complaining to his GP that he had some memory difficulties. This second referral requested a re-assessment of Mr H's cognitive functioning to see if there had been a further change in his cognitive profile, after Mr H presented himself again to his GP with memory problems.

History of Presenting Complaint
The neuropsychological assessment carried out one year previously had indicated Mr H had significant problems recalling information after a delay and some mild word finding difficulties. His general intellectual functioning, language and executive functioning skills were all found to be in the range expected for his age, education and occupation.

Assessment
The neuropsychological assessment was carried out over three sessions with Mr H and included gathering data on his personal and family history as well as his presenting memory difficulties. Mr H was a German Jewish man bought up in Nazi Germany during the war before being evacuated to England. He had since lived in different countries around the world and married several times. He currently lived alone. He had mainly been employed in the Arts, for example doing voice-overs for the BBC and managing a dance company, and currently participated in voluntary work at a local hospital. He described a minor heart attack 10-15 years previously and currently had prostate problems and some hearing difficulties. He complained of difficulties with his memory, particularly when anxious. Interestingly Mr H believed that his memory problems may have been due to his early negative experiences in his relationship with his mother and from his persecution experiences in Germany. He felt he had hidden away these bad occurrences and consequently his memory problems had developed.
The neuropsychological tests that had been administered one year previously were repeated for this re-assessment. These included the WAIS-R to assess for general intellectual functioning, the National Adult Reading Test (NART) to estimate premorbid intelligence, the Adult Memory and Information Processing Battery (AMIPB) which includes verbal and visual memory tasks, and measures of information processing. The Graded Naming Test was used as a measure of impaired language function and the Controlled Oral Word Association Test (COWA) was used as a measure of verbal fluency. The Geriatric Depression Scale and Hospital Anxiety and Depression Scale were also included in the assessment.

Results of Assessment
Mr H showed indications of memory impairment during his first neuropsychological assessment, in that he had significant problems with recall of information after a delay. He also had word finding difficulties. When the neuropsychological assessment was repeated during this assessment, Mr H's general level of intellectual functioning, motor speed and executive functioning remained in the range expected for someone of his age, education and occupational background. However Mr H continued to demonstrate significant problems in his ability to recall information after a delay and word finding difficulties. In addition, Mr H demonstrated deterioration in his ability to learn new information.

Conclusion and Outcome
Mr H was not given a formal diagnosis, however the information that was gathered from both the neuropsychological reassessment and the original assessment appeared to suggest a possible diagnosis of dementia. It was recommended that all symptoms, both physical and psychological, continued to be monitored over time to gain a greater understanding of Mr H's functioning and cognitive deficits. Time was spent with Mr H discussing the activities that were not affected by his difficulties allowing him to recognise what he was still able to achieve. In addition, the part played by anxiety in his difficulties was also discussed, along with some basic strategies that may help him with his memory problems.
SECTION THREE

Research Dossier
SERVICE RELATED RESEARCH PROJECT

Year One
August 1999

COMMUNITY MENTAL HEALTH TEAMS' PERSPECTIVES ON THE PRIORITIES FOR A CLINICAL PSYCHOLOGIST
ABSTRACT

An exploratory study was undertaken using a questionnaire to examine the priorities of clinical psychologist services within a community mental health team (CMHT). After the clinical psychology waiting list in the Epsom CMHT (ECMHT) became unmanageable, it was decided to undertake a formal assessment of how team members thought clinical psychologist time should be best spent. All professional members of the ECMHT were asked to complete a questionnaire exploring the areas and types of roles they currently perceived as priorities for the clinical psychologist, as well as their expectations for future roles. Additionally ECMHT members were asked about how much time the clinical psychologist should spend in each role. The findings indicated clinical roles, followed by consultancy roles were seen as the priorities for the clinical psychologist in terms of current perceptions, future expectations and the amount of time allocated. Although team roles were perceived as third most important, the team requested less future involvement in team roles and more research and audit roles from the clinical psychologist. Overall the role of the clinical psychologist in ECMHT appears to be relatively well defined although the clinical psychologist’s specific involvement in team roles needs further clarification.
INTRODUCTION
The community care initiative caused an increase in the demand for and development of multi-disciplinary CMHTs (Osborne-Davies, 1996). Previously clinical psychologists had always worked in their own professional departments and debate occurred as to whether they should become members of CMHTs. Concerns were raised by some about the role security of the clinical psychologist and the loss of the day-to-day contact with their own professional group (Trepka & Marsh, 1990; Alexander, 1992). However some believed there were advantages of being a team member including improved communication and greater inter-professional awareness (Watson, 1990; Osborne-Davies, 1996). Onyett, Pillinger and Muijen (1995) concluded from their study of CMHTs that clinical psychologists had high professional identification but low team identification.

As the debate over clinical psychology team membership versus professional group membership continues (Mistral & Velleman, 1997; Ovretveit, 1991), clinical psychologists have developed a key role in CMHTs. With the call for more effective community care in the New NHS White Paper (1997), this role looks something that can only continue.

Nevertheless within CMHTs, different professionals have different perspectives on what the other professional’s roles are within the team (Morgan, 1993; Trepka & Marsh, 1990). The Sainsbury Centre Report (1997) suggests there is a great diversity of unique skills already within the teams, and that these existing professional frameworks should be built upon with training. However some team members will expect all disciplines to work as generic mental health workers, regardless of their different training backgrounds, whereas other team members will recognise an individual discipline’s areas of expertise (Hughes, Midence & Jackson, 1996). Anciano and Kirkpatrick (1990) suggest the expectation of professionals working as generic mental health workers often develops out of lack of role definition. If team working is to be successful, roles of each professional need to be clear and defined (Mistral & Velleman, 1997; Onyett, 1997; Norman, Peck & Richards, 1998). Interestingly job satisfaction was found to be associated with clarity of the role of the team (Onyett et al, 1995).
Hughes, Midence and Jackson (1996) reported on the types of case the CMHT believed should be allocated to the clinical psychologist, suggestive of their beliefs about the role of a clinical psychologist. This included clients requiring psychometric testing, formal assessment, specific intensive therapy, those with complex or severe psychological problems and people who had not responded to other treatments. They described clinical psychologists as having a more structured way of working, an empirical approach, more interest in research, greater theoretical knowledge and a smaller, more specialised caseload. Blumenthal and Lavender (1997) explored the role of the clinical psychologist in CMHTs and found acting as a consultant for the team on clinical difficulties and the assessment of a client’s suitability for psychological treatment as important identified roles.

However in the realities of today’s pressures of working in the NHS, priorities have to be identified within the CMHT if workloads are to be managed effectively. Each discipline’s skills need to be utilised to their best advantage. Increased pressure from managers to cut waiting lists due to government targets (Skinner & Baul, 1997) has added further pressures to the need to identify priorities for the clinical psychologist. Some roles in which the clinical psychologist participates may be carried out by all members of the CMHT, for example supportive counselling. However other roles may be seen as unique to the clinical psychologist, for example psychometric testing. It is my view that it is these specialised roles which need to be utilised by the CMHT members. Onyett and Ford (1996) report that it is essential that shared core roles and responsibilities are clarified among team members. Similarly specific, unique skills that individuals and disciplines contribute likewise need to be clarified.

In ECMHT, the psychology waiting list had to be closed in November 1998 due to the length of the list being unmanageable. Much has been written about clinical psychology waiting lists, and how to manage them (Shawe-Taylor, Richards, Sage & Young, 1994; Startup, 1994; Herlihy, Bennett & Killick, 1998). Following discussions by the team manager and other clinical psychologists, several ideas were proposed including encouraging GPs initially to refer to the CMHT and use the link-CPN for assessment, and employing more counselling psychologists at the primary
Another suggestion focused upon the specialised skills of the clinical psychologist; it was proposed that ideas were invited from CMHT members on how they would like to see psychology time best spent in terms of priorities.

Although a few recent studies have explored the roles of the clinical psychologist within the CMHT, there is a lack of literature on what team members believe are the priorities for the clinical psychologist. Therefore this study will explore the priorities of the clinical psychologist as identified by other members of the CMHT. Due to this study being exploratory in nature, research questions proposed by the ECMHT were used instead of hypotheses. The research questions asked were:

1) What types of roles were perceived by the CMHT as the priority for the clinical psychologist?

2) Which areas of work were perceived by the CMHT to be the priority for the clinical psychologist?

3) Was there a difference between the CMHT's perceived current roles and their future expectations of the clinical psychologist?

4) Were clients with severe and enduring needs seen as an important priority for the CMHT?
METHODOLOGY

Design:
An exploratory survey was carried out using a structured questionnaire.

Participants:
All fifteen members of the multidisciplinary ECMHT were invited to take part in this study (Figure 1). The inclusion criterion was that all participants had been with the team for at least six months.

Figure 1: Pie Chart Displaying the Professional Composition of the Epsom CMHT

Measures:
A questionnaire was developed in collaboration with other psychologists and CMHT members within the Trust, whom were not members of ECMHT. The questionnaire assessed the participant’s perceptions and beliefs about the priorities of a clinical psychologist. A focus group held for the other psychologists, and exploratory interviews with various disciplines from the other CMHTs, were used to elicit people’s beliefs about the priorities of a clinical psychologist (Appendix 1). This material gathered along with a literature search formed the basis for the questionnaire (Appendix 2). In addition, questions 1 and 15-18 were adapted from Blumenthal & Lavender's questionnaire (1997) which explored the roles of clinical psychologists. The final questionnaire was piloted on two clinical psychologists in the Trust. The
questionnaire was designed to be anonymous and confidential, however participants were asked to indicate their professional group.

For questions 6-13, respondents were asked to place a mark on a line to indicate which role category of the pair they perceived to be more important, and so indicating it as a priority for the clinical psychologist. The line was divided into ten parts with the first four parts indicating the first role category of the pair to be more important. The middle two sections were taken to indicate that both role categories were of equal importance and the last four parts taken to indicate the second role category of the pair to be more important.

Procedure:
All members of ECMHT were introduced to the research study during a team meeting. They were later given the questionnaire and asked to complete it. With the assistance of a secretary, questionnaires were returned to a tray where the participants were asked to tick their name from a list. Non-respondents could therefore be identified and reminded whilst their data remained anonymous.

Statistical Analyses:
Due to the low number of actual participants in this study (N=13), it was deemed inappropriate to attempt any statistical analyses. Descriptive analyses of the results were therefore carried out.
RESULTS

Response Rate:
Thirteen questionnaires were completed, representing an 87% response rate (N=15).

ECMHT's perceptions of the clinical psychologist's current roles and their future expectations of the clinical psychologist:
Respondents were asked to identify which areas of work they thought the clinical psychologist to be currently undertaking from a list of 22 different areas, as well as which areas of work they would like to see being undertaken in the future (Table 1).

Interestingly those areas identified as being an important current area of work were the same areas identified as being important future areas of work. These include assessment of client’s suitability for treatment (current\(^1=13\), future\(^2=11\)), being able to consult on clinical difficulties (current\(^1=12\), future\(^2=12\)), clinical supervision for team members (current\(^1=13\), future\(^2=12\)), cognitive behaviour therapy (current\(^1=13\), future\(^2=12\)) and psychometric testing (current\(^1=13\), future\(^2=12\)).

The final column in Table 1 indicates the difference between current and future areas of work. The team members identified a desire to have more family therapy (+6) and group work (+3), as well as the clinical psychologist’s increased involvement in evaluating team policy (+5) and setting up services (+5). They thought representing the team at meetings (-3) and the role of the keyworker (-3) were not such important activities for the clinical psychologist to be involved in the future.

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\(^1\) Number of respondents identifying this particular area of work as an important current area of work.
\(^2\) Number of respondents identifying this particular area of work as an important future area of work.
\(^3\) Numbers proceeded by a plus sign (+) indicate an increase in the number of respondents who identified the area of work as a desired future area of work for the clinical psychologist. Numbers proceeded by a minus sign (-) indicate a decrease in the number of respondents who identified the area of work as a desired future area of work for the clinical psychologist.
Table 1: Current Perceptions and Future Expectations of the Role of the Clinical Psychologist as Perceived by the ECMHT.

<table>
<thead>
<tr>
<th>Possible areas of work undertaken by a clinical psychologist</th>
<th>Current areas of work - Number of respondents</th>
<th>Future areas of work - Number of respondents</th>
<th>Difference between current and future areas of work</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allocation of cases to team members</td>
<td>7</td>
<td>6</td>
<td>-1</td>
</tr>
<tr>
<td>Assessment of clients’ suitability for psychological treatment</td>
<td>13</td>
<td>11</td>
<td>-2</td>
</tr>
<tr>
<td>Assisting in resolution of difficulties arising in the team</td>
<td>10</td>
<td>10</td>
<td>0</td>
</tr>
<tr>
<td>Being available to consult on clinical difficulties</td>
<td>12</td>
<td>12</td>
<td>0</td>
</tr>
<tr>
<td>Clinical supervision for team members</td>
<td>13</td>
<td>12</td>
<td>-1</td>
</tr>
<tr>
<td>Cognitive behavioural therapy</td>
<td>13</td>
<td>12</td>
<td>-1</td>
</tr>
<tr>
<td>Deciding which referrals the team accepts</td>
<td>8</td>
<td>9</td>
<td>+1</td>
</tr>
<tr>
<td>Emergency duty rota</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Evaluating team policy</td>
<td>2</td>
<td>7</td>
<td>+5</td>
</tr>
<tr>
<td>Family therapy</td>
<td>1</td>
<td>7</td>
<td>+6</td>
</tr>
<tr>
<td>General mental health assessment</td>
<td>5</td>
<td>4</td>
<td>-1</td>
</tr>
<tr>
<td>Group work</td>
<td>1</td>
<td>4</td>
<td>+3</td>
</tr>
<tr>
<td>Psychodynamic therapy</td>
<td>6</td>
<td>6</td>
<td>0</td>
</tr>
<tr>
<td>Psychometric testing e.g. IQ, memory testing</td>
<td>13</td>
<td>12</td>
<td>-1</td>
</tr>
<tr>
<td>Representing the team at meetings</td>
<td>6</td>
<td>3</td>
<td>-3</td>
</tr>
<tr>
<td>Research and audit of the team’s activities</td>
<td>3</td>
<td>4</td>
<td>+1</td>
</tr>
<tr>
<td>Service planning</td>
<td>6</td>
<td>8</td>
<td>+2</td>
</tr>
<tr>
<td>Setting up services</td>
<td>4</td>
<td>9</td>
<td>+5</td>
</tr>
<tr>
<td>Supportive counselling</td>
<td>4</td>
<td>4</td>
<td>0</td>
</tr>
<tr>
<td>Teaching / education</td>
<td>11</td>
<td>11</td>
<td>0</td>
</tr>
<tr>
<td>The role of the key worker</td>
<td>8</td>
<td>5</td>
<td>-3</td>
</tr>
<tr>
<td>Other psychological interventions</td>
<td>10</td>
<td>9</td>
<td>-1</td>
</tr>
</tbody>
</table>
The areas of work shown in Table 1 were divided into four role categories (Table 2).

**Table 2: Role Categories displaying the Areas of Work in each Category**

<table>
<thead>
<tr>
<th>Team Roles</th>
<th>Clinical Roles</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allocation of cases to team members</td>
<td>Assessment of clients’ suitability for psychological treatment</td>
</tr>
<tr>
<td>Deciding which referrals the team accepts</td>
<td>Cognitive behavioural therapy</td>
</tr>
<tr>
<td>Emergency duty rota</td>
<td>Group work</td>
</tr>
<tr>
<td>General mental health assessment</td>
<td>Psychodynamic therapy</td>
</tr>
<tr>
<td>Representing the team at meetings</td>
<td>Psychometric testing</td>
</tr>
<tr>
<td>The role of the key worker</td>
<td>Supportive counselling</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Consultative Roles</th>
<th>Research &amp; Audit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assisting in resolution of difficulties arising in the team</td>
<td>Evaluating team policy</td>
</tr>
<tr>
<td>Being available to consult on clinical difficulties</td>
<td>Research and audit of the team’s activities</td>
</tr>
<tr>
<td>Clinical supervision for team members</td>
<td>Service planning</td>
</tr>
<tr>
<td>Teaching / education</td>
<td>Setting up services</td>
</tr>
</tbody>
</table>

The clinical and consultative roles have the highest number of identified areas of work in their categories both in current perceptions and future expectations of the clinical psychologist (Figure 2).

**Figure 2: Current Perceptions and Future Expectations of the Clinical Psychologist**
Similarly when respondents were asked to indicate how the psychologist's time should be spent between the four role categories (Appendix 2, question 14), the respondents identified that 51% of the clinical psychologist's time should be spent participating in clinical roles and 25% of the time in consultative roles. The respondents identified only 14% of the clinical psychologist's time should be spent in team roles, and 10% of their time in research and audit roles (Appendix 3).

Areas of work within the role categories identified as priorities for the clinical psychologist by the ECMHIT:

Respondents were asked to rank order areas of work within role categories in order of priority for the clinical psychologist.

a) Clinical Roles Category

Assessment of a client’s suitability for psychological treatment and cognitive behaviour therapy were clearly ranked as the two most important clinical roles for the clinical psychologist within this category (Figure 3). 84% of respondents regarded assessment of a client’s suitability for psychological treatment as the most important clinical role. Responses to the remaining areas of work were more variable (Appendix 4).

![Figure 3: Clinical Roles Category](image-url)

- Assessment of client’s suitability for psychological treatment
- Cognitive behaviour therapy
- Family therapy
- Psychodynamic therapy
- Group work
- Psychometric testing
- Other psychological interventions
b) Consultative Roles Category

Figure 4 demonstrates the great importance that the team members assigned to being able to consult on clinical difficulties and seek supervision from the clinical psychologist, ranking them most important in this category.

![Consultative Roles Category](image)


c) Team Roles Category

There was a lack of agreement about which team roles were most important for the clinical psychologist to participate in, with no clear area of work being ranked higher than the other areas of work. Nevertheless, representing the team at public meetings and the emergency duty rota were more clearly identified as the least important team roles (Appendix 5).

d) Research & Audit Roles Category

The team identified service planning and setting up services as the most important in this category (Figure 5).
Role categories perceived as priorities for the clinical psychologist by the ECMHT:

When asked to decide which role the team thought was more important between pairs of the role categories (Table 3 & Appendix 6), clinical roles were seen as more important than any of the other roles in all the comparisons. Similarly research and audit roles were seen as less important than any other role in all the comparisons. Consultative roles were seen as more important than team roles. Although it was generally clear in all pairs which role was thought to be more important, in some pairs, equal importance was given by some respondents to both roles.
Table 3: Comparisons of Importance of Pairs of Role Categories

<table>
<thead>
<tr>
<th>ROLE CATEGORY</th>
<th>Versus</th>
<th>ROLE CATEGORY</th>
</tr>
</thead>
<tbody>
<tr>
<td>No. &amp; Percentage of respondents selecting particular role category (Maximum=13)</td>
<td>No. &amp; Percentage of respondents selecting equal importance of both role categories (Maximum=13)</td>
<td>No. &amp; Percentage of respondents selecting particular role category (Maximum=13)</td>
</tr>
<tr>
<td><strong>Clinical roles</strong></td>
<td>Both important</td>
<td><strong>Research &amp; audit roles</strong></td>
</tr>
<tr>
<td>12 (92%)</td>
<td>1 (8%)</td>
<td>0 (0%)</td>
</tr>
<tr>
<td><strong>Consultative roles</strong></td>
<td>Both important</td>
<td><strong>Team roles</strong></td>
</tr>
<tr>
<td>11 (84%)</td>
<td>1 (8%)</td>
<td>1 (8%)</td>
</tr>
<tr>
<td><strong>Clinical roles</strong></td>
<td>Both important</td>
<td><strong>Consultative roles</strong></td>
</tr>
<tr>
<td>7 (54%)</td>
<td>6 (46%)</td>
<td>0 (0%)</td>
</tr>
<tr>
<td><strong>Research &amp; audit roles</strong></td>
<td>Both important</td>
<td><strong>Team roles</strong></td>
</tr>
<tr>
<td>2 (16%)</td>
<td>5 (38%)</td>
<td>6 (46%)</td>
</tr>
<tr>
<td><strong>Team roles</strong></td>
<td>Both important</td>
<td><strong>Clinical roles</strong></td>
</tr>
<tr>
<td>0 (0%)</td>
<td>5 (38%)</td>
<td>7 (54%)</td>
</tr>
<tr>
<td><strong>Research &amp; audit roles</strong></td>
<td>Both important</td>
<td><strong>Consultative roles</strong></td>
</tr>
<tr>
<td>1 (8%)</td>
<td>3 (23%)</td>
<td>9 (69%)</td>
</tr>
</tbody>
</table>

* 8% (N=1) missing data

**ECMHT's view of the clinical psychologist's priorities for working with clients with severe, enduring needs versus simple, short-term needs:**
CMHT members were asked their opinion of clinical psychologists working with people with severe and enduring mental health problems. 31% of respondents thought working with people with enduring needs was more important than working with clients with short-term needs. However 54% of respondents indicated that clients with enduring needs or short-term needs were of equal importance (Appendix 7).
When comparing clients with simple versus complex needs, 54% of respondents identified the clinical psychologist working with clients with complex needs as more important whereas no respondents identified simple needs as most important. 38% of respondents thought both simple and complex needs were of equal importance (Appendix 8).

Contribution of the clinical psychology service to ECMHT:
The majority of respondents believed the clinical psychology service definitely provided a useful contribution to the CMHT (62%) (Appendix 9). The remaining 38% believed the clinical psychology service provided a useful service most of the time. No respondents were dissatisfied with the service. The preponderance of difficulties with the clinical psychology service were identified as arising from there being too little psychology time (Figure 6).

Additional comments were invited from the respondents. These included concern for the length of the waiting list, requesting more psychology personnel and time, a greater focus on people with severe and enduring mental health problems, more supervision time and opportunity for the psychologist to work in a proactive way to prevent future mental health problems.
DISCUSSION

The ECMHT members clearly identified the clinical role category as the role they perceived to be the overall priority for the clinical psychologist both currently and in the future. Consultative roles were identified to be second in priority, followed by team roles and lastly research and audit roles. Many of the areas of work identified by the team as current roles of the clinical psychologist, were also identified as areas of work they would like to see undertaken by the clinical psychologist in the future.

Clinical roles:
The team identified that 51% of the clinical psychologist’s time should be spent carrying out clinical work. This is consistent with Skinner and Baul’s study (1997) of psychologist’s caseloads in which they found 49% of the psychologist’s time was taken up on direct clinical casework. The current perceptions and future expectations of the clinical psychologist’s participation in clinical roles were virtually equal although there was a marked desire for group work and family therapy. The limited team’s resources prevented the adoption of family therapy, but it was available elsewhere in the Trust. However introducing group work should be considered and may help alleviate the waiting lists.

When the categories were broken down into areas of work, the team identified assessment of client’s suitability for psychological treatment, cognitive behaviour therapy and psychometric testing as priorities for the clinical psychologist. Osborne-Davies (1996) established similar findings and likewise Blumenthal and Lavender (1997) found the assessment of a client’s suitability for psychological treatment as an important role.

Consultative roles:
Consultative roles were seen as second in priority to clinical roles. The current perception, future expectation and perceived amount of time that should be spent on consultative roles were remarkably similar suggesting the team were relatively content with the consultative service they received from the clinical psychologist. The ECMHT findings suggest that in contrast to Osborne-Davies’s study (1996), being able to consult on clinical difficulties and providing clinical supervision for team
members, were seen as high priorities. Likewise, teaching and education also scored highly. Historically, consultancy has been recognised as being important (MPAG Report, 1990) and more recently the Sainsbury Centre report (1997) has highlighted the need for the profession to be involved in consultancy, support and advice to other CMHT members.

Team Roles:
ECMHT did not perceive team roles to be as high a priority as clinical or consultative roles for the clinical psychologist. The team actually requested less participation of the clinical psychologist in team roles as a future expectation, and only allocated 14% of the psychologist’s time to team roles. This may reflect recognition from the team of the limited amount of time the clinical psychologist has in the team, as well as the clinical psychologist’s skills being better utilised in other roles.

Participation in the emergency rota was not perceived as an area of work for clinical psychologists at all. The team also thought there was less need for representation of the team at meetings and acting as keyworker in the future. However when asked to rank order the various team role areas, there was little consensus between the team in terms of which actually were the most important team roles for the clinical psychologist to be involved in. This is an area that needs further discussion in the team to clarify team roles and expectations.

Research & Audit Roles:
Little attention currently seems to be paid to the clinical psychologist’s research and audit skills within ECMHT. It was perceived to be the least important role and was only allocated a tenth of the clinical psychologist’s time by the team. Although this seems to be a neglect of the clinical psychologist’s specialist skills in research, Norcross and Prochaska (1982) similarly found the median time of those psychologists participating in research to be 10 per cent.

However there was a request by the ECMHT for more research and audit roles in the future, including the clinical psychologist’s greater involvement in evaluating team policy and setting up services. There is a trend across the health professions to
increase research as a way of developing future health care. This has been promoted further by the introduction of clinical governance (The New NHS, 1997). It is hoped that the clinical psychologist’s skills can be used to assist in this and other research roles.

Complex, enduring needs versus simple short-term needs:
ECMHT indicated that clinical psychologists in the team should have greater involvement with people with complex and/or enduring needs than people with simple and/or short-term needs. This was not to totally exclude those with more simple and short-term needs, but rather reflected the move by CMHTs to focus more on clients with severe and enduring mental health problems. This move followed the care programme approach and care management guidance (Onyett, Hepplestone & Bushell, 1994) and the governments concerns.

LIMITATIONS OF THE STUDY
Given the aims of this study it has been useful as an exploratory study, however it does carry with it a number of limitations. Firstly, the use of a questionnaire results in the possibility of response bias and the limited choice of answers must be considered. Also the questionnaire was not standardised. Although using rank order questions was useful in informing us about the priorities of the team, rank order in itself does not tell us anything about the distance between each priority.

The limited number of participants in this study (N=13) excluded statistical analysis. This prevents firm conclusions from being drawn and there may be problems with generalisation of the findings. Similarly if the constituents of the team change, the priorities of new members would not be represented.

CONCLUSION
ECMHT perceived clinical and consultative roles to be the priorities for the clinical psychologist in the team. Although team roles were also seen as important, the team requested more participation in research and audit roles. A particular strength of ECMHT was that the role of the clinical psychologist appeared to be relatively clear, although the clinical psychologist’s involvement in team roles needs clarification.
Many of the areas of work that were currently offered to the team were likewise sought after as future expectations, although there were still a few unmet needs. One of these was for more involvement from the clinical psychologist with people with severe and enduring mental health problems. However there were still a range of clinical psychology skills and expertise that were not recognised and utilised by the team. This could be perceived as frustrating for clinical psychologists after having undergone such long, specialised, academic training.

The study has highlighted the demands on the clinical psychologist in the team. However these demands need to be balanced against the specialised skills and resource constraints. It is anticipated that these findings will open the debate as to the way forward for the team.
REFERENCES


APPENDICES
APPENDIX 1

INTERVIEW SCHEDULE

CLINICAL PRIORITIES:

1. At the moment, what is the role of the clinical psychologist working within your team in terms of clinical work? What clinical activities does the psychologist participate in?

2. What are the clinical priorities of the clinical psychologist within that role?

3. How were these clinical priorities devised within the team?

4. Is this method of prioritising the psychologists' clinical work successful?

5. What do you believe are the clinical priorities for the clinical psychologist in your team?

6. How does this differ from other professions?

7. How much time is allocated to each of these roles of a clinical psychologist?

ORGANISATIONAL PRIORITIES:

1. At the moment, what is the role of the clinical psychologist working within your team in terms of organisational work? What organisational activities does the psychologist participate in within the NHS, Social Services, independent/voluntary organisations etc.?

2. What are the organisational priorities of the clinical psychologist within that role?

3. How were these organisational priorities devised within the team?
4. Is this method of prioritising the psychologists' organisational work successful?

5. What do you believe are the organisational priorities for the clinical psychologist in your team?

6. How does this differ from other professions?

7. How much time is allocated to each of these roles of a clinical psychologist?

ADDITIONAL QUESTIONS:

1. Are there any other priorities/roles of the clinical psychologist that we have not mentioned?

2. Overall what do you see as the most important priority for the clinical psychologist in your team?
APPENDIX 2: Questionnaire
A Questionnaire on the Roles and Priorities of a Clinical Psychology Service within the CMHT

I am carrying out a study of the Epsom CMHT's perspectives on the priorities for a clinical psychologist. I am interested in your views on what you believe are the important roles of the clinical psychology service within the team. These views will be used to inform and build upon the psychology service within Epsom CMHT.

I would be extremely grateful if you could complete this questionnaire and return it to me by Wednesday 19th May 1999. The questionnaire will be completely anonymous, and all replies will be treated in the strictest confidence. There will be no way of identifying individual responses in the final report. Therefore please seal your completed anonymous questionnaire in the envelope provided and leave it in my tray in the secretary's office. Please also tick your name off the list that is in the tray when you return your completed questionnaire so I am aware who has returned their completed questionnaire.

The questionnaire should take no more than 10 minutes to complete. It is important that all members of the team fill in this questionnaire, so that all the different professional viewpoints can be fairly represented. Additionally if you feel that the choice of questions given does not give you the opportunity to express your point of view, please feel free to add additional comments. If you would like any further information or would like to discuss your reply directly, please contact myself, Sarah Johnstone, at St. Ebbas Hospital on ex 3165.

I very much appreciate your time taken to fill in this questionnaire.

Thank you.

SARAH JOHNSTONE
1) To your knowledge, which of the following areas of work are currently undertaken by the clinical psychology service in the team? Please tick the areas that you think are undertaken. *(Please do not consult other members of the team in answering this: it is your own view in which I am interested)*

<table>
<thead>
<tr>
<th>Area of Work</th>
<th>Ticked</th>
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</thead>
<tbody>
<tr>
<td>Allocation of cases to team members</td>
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<tr>
<td>Assessment of clients' suitability for psychological treatment</td>
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<tr>
<td>Assisting in resolution of difficulties arising in the team</td>
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<tr>
<td>Being available to consult on clinical difficulties</td>
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<tr>
<td>Clinical supervision for team members</td>
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<tr>
<td>Cognitive behavioural therapy</td>
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<tr>
<td>Deciding which referrals the team accepts</td>
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<tr>
<td>Emergency duty rota</td>
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<tr>
<td>Evaluating team policy</td>
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<tr>
<td>Family therapy</td>
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<tr>
<td>General mental health assessment</td>
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<tr>
<td>Group work</td>
<td></td>
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<tr>
<td>Psychodynamic therapy</td>
<td></td>
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<tr>
<td>Psychometric testing e.g. IQ, memory testing</td>
<td></td>
</tr>
<tr>
<td>Representing the team at meetings</td>
<td></td>
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<tr>
<td>Research and audit of the team's activities</td>
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<tr>
<td>Service planning</td>
<td></td>
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<tr>
<td>Setting up services</td>
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</tr>
<tr>
<td>Supportive counselling</td>
<td></td>
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<tr>
<td>Teaching / education</td>
<td></td>
</tr>
<tr>
<td>The role of the key worker</td>
<td></td>
</tr>
<tr>
<td>Other psychological interventions</td>
<td></td>
</tr>
</tbody>
</table>

*Are there any other areas not mentioned above*
The possible areas of work of the clinical psychology service listed on the previous page can be split into 4 categories:

- RESEARCH & AUDIT ROLES
- CONSULTATIVE ROLES
- CLINICAL ROLES
- TEAM ROLES

The following 4 questions will refer to each of these categories in turn.

2) Research & Audit Roles Category:

Please rank order the following items in terms of what you consider to be the most through to the least important research & audit roles for the clinical psychologist to be involved in.

Put number 1 by the item you think is the most important research & audit role, through to number 4 next to the least important research & audit role.

- Evaluating team policy
- Research and audit of the team’s activities
- Service planning
- Setting up services

3) Consultative Roles Category:

Please rank order the following items in terms of what you consider to be the most through to the least important consultative roles for the clinical psychologist to be involved in.

Put number 1 by the item you think is the most important consultative role, through to number 4 next to the least important consultative role.

- Assisting in resolution of difficulties arising in the team
- Being available to consult on clinical difficulties
- Clinical supervision for team members
- Teaching / education
4) **Clinical Roles Category:**
Please rank order the following items in terms of what you consider to be the most through to the least important clinical roles for the clinical psychologist to be involved in.
Put number 1 by the item you think is the most important clinical role, through to number 7 next to the least important clinical role.

- [ ] Assessment of clients' suitability for psychological treatment
- [ ] Cognitive behavioural therapy
- [ ] Family therapy
- [ ] Group work
- [ ] Psychodynamic therapy
- [ ] Psychometric testing e.g. IQ, memory testing
- [ ] Other psychological interventions

5) **Team Roles Category:**
Please rank order the following items in terms of what you consider to be the most through to the least important team roles for the clinical psychologist to be involved in.
Put number 1 by the item you think is the most important team role, through to number 7 next to the least important team role.

- [ ] Allocation of cases to team members
- [ ] Deciding which referrals the team accepts
- [ ] Emergency duty rota
- [ ] General mental health assessment
- [ ] Representing the team at public meetings
- [ ] Supportive counselling
- [ ] The role of the key worker
For the following 8 questions, mark on the line the extent to which you think one aspect of work is more important for the clinical psychologist to be involved in than the other aspect. The nearer your mark to an aspect, the more you show you think it is important.

6) Do you think it is more important that the clinical psychologist participates in:

Clinical work [-----------------------------] Research & audit work

7) Do you think it is more important that the clinical psychologist participates in:

Consultative work [-----------------------------] Team roles

8) Do you think it is more important that the clinical psychologist participates in:

Clinical work [-----------------------------] Consultative work

9) Do you think it is more important that the clinical psychologist participates in:

Research & [-----------------------------] Team roles audit work

10) Do you think it is more important that the clinical psychologist participates in:

Team roles [-----------------------------] Clinical work
11) Do you think it is more important that the clinical psychologist participates in:

Research [----------------------------------------] Consultative & audit work work

12) Do you think it is more important that the clinical psychologist participates in work with clients with:

Simple needs [----------------------------------------] Complex needs

13) Do you think it is more important that the clinical psychologist participates in work with clients with:

Enduring [----------------------------------------] Short-term needs needs

14) How should the clinical psychologist's time be split between the below 4 categories? Write a percentage figure on the line which represents the amount of time you believe the clinical psychologist should spend carrying out each of the 4 roles (all 4 percentages should total 100%).

Research & Audit Roles
Consultative Roles
Clinical Roles
Team Roles
TOTAL

100%
15) In which of the following areas of work would you like to see the clinical psychology service involved in the future? Please tick the appropriate boxes.

Allocation of cases to team members
Assessment of clients' suitability for psychological treatment
Assisting in resolution of difficulties arising in the team
Being available to consult on clinical difficulties
Clinical supervision for team members
Cognitive behavioural therapy
Deciding which referrals the team accepts
Emergency duty rota
Evaluating team policy
Family therapy
General mental health assessment
Group work
Psychodynamic therapy
Psychometric testing e.g. IQ, memory testing
Representing the team at meetings
Research and audit of the team's activities
Service planning
Setting up services
Supportive counselling
Teaching / education
The role of the key worker
Other psychological interventions

Are there any other areas not mentioned above
16) Do you think the clinical psychology service provides a useful contribution to the CMHT?

- Definitely □
- Most of the time □
- Some of the time □
- Never □

If selected 'definitely', go straight to Question 18.
Continue with Question 17.

17) If you selected one of the bottom 3 boxes above, in which areas are there difficulties (More than one may apply)?

- Too little time □
- Need for more psychology personnel □
- Members of the team do not make sufficient use of the psychologist □
- Insufficient information available about psychology service □
- Members of the team are unsure about what psychology can provide □
- Inadequate planning by team members □

Please mention any other reasons

18) Please indicate which professional group you belong to:

- CPN □
- Management □
- OT □
- Psychiatrist □
- Psychologist □
- Social Worker □

Any other, please state:
19) Finally, please feel free to add any additional comments:

Thank you for your help, time and cooperation!
How should the Clinical Psychologist’s Time be Spent between the Four Categories?

- Research & Audit roles: 25%
- Consultative roles: 14%
- Clinical roles: 10%
- Team roles: 51%
APPENDIX 4

Clinical Roles Category

1. Assessment of client's suitability for psychological treatment
2. Cognitive behavioral therapy
3. Family therapy
4. Group work
5. Psychodynamic therapy
6. Psychometric testing
7. Other psychological interventions

APPENDIX 5

Team Roles Category

1. Allocation of cases to team members
2. Emergency data note
3. Representing the team at public meetings
4. The role of the key worker
5. Deciding which referrals the team accepts
6. General mental health assessment
7. Supportive counselling
APPENDIX 6

Clinical Roles Versus Research & Audit Roles

Consultative Roles Versus Team Roles

Clinical Roles Versus Consultative Roles
Research & Audit Roles Versus Team Roles

Team Roles Versus Clinical Roles

Research & Audit Roles Versus Consultative Roles
APPENDIX 7

Enduring Needs Versus Short-term Needs

APPENDIX 8

Simple Needs Versus Complex Needs
APPENDIX 9

Do You Think the Clinical Psychology Service Provides a Useful Contribution to the CMHT?

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<th>Number of People</th>
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<td>Definitely</td>
<td>8</td>
</tr>
<tr>
<td>Most of the time</td>
<td>4</td>
</tr>
<tr>
<td>Some of the time</td>
<td>2</td>
</tr>
<tr>
<td>Never</td>
<td>0</td>
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</table>
PF/bei

24th September 1999

Sarah Johnstone
Cavell House
St. Ebba's

Dear Sarah

Just a brief note on behalf of the Epsom Community Mental Health Team to thank you for the wonderful presentation that you undertook to the Team on the 9th of August 1999. The discussions that followed your presentation indicated your Research findings were both informative and thought provoking.

The Team wish me to relay to you their best wishes for your future career.

Yours sincerely

Phyllis Flynn
Epsom Community Mental Health Team
LITERATURE REVIEW

Year Two
August 2000

THE ASSESSMENT OF BODY IMAGE USING
SILHOUETTE & SCHEMATIC FIGURE RATING SCALES
INTRODUCTION
In a large study carried out in the USA by Psychology Today, overall appearance dissatisfaction had increased between 1972 and 1997 from 23% to 56% in women and from 15% to 43% in men (Thompson et al 1999). A person's body image is rapidly increasing in importance in today's society and increasing amounts of dissatisfaction with appearance are being expressed.

This has led to the development of the area of body image, in particular, the assessment of body image. The treatment of body image remains more of an elusive area with no published controlled trials of treatment for body image dissatisfaction. Nevertheless many different assessment measures have been developed to assess body image, in particular, in relation to eating disorders.

This literature review will initially introduce body image and body image measurement before focusing on the use of silhouette and schematic figure rating scales for the assessment of body image. Other types of measurement of body image will be mentioned, but unfortunately, discussion of these other measures is outside the scope of this review.

DEFINITIONS OF BODY IMAGE
Body image has been described in many different ways over the years and there has been much debate over the varying definitions (Thompson et al, 1999). Schilder (1935) was one of the first to describe body image. He defined body image as

"the picture of our own body which we form in our mind, that is to say, the way in which the body appears to ourselves".

Slade (1994) expanded Schilder's definition of body image, describing it as

"the picture we have in our minds of the size, shape and form of our bodies; and to our feelings concerning these characteristics and our constituent body parts" (pg 497).
This definition of body image included not only a perceptual component of how the body looks, but also an attitudinal component of how the body felt. Thompson, Heinberg, Altabe & Tantleff-Dunn (1999) summarised body image as the

"internal representation of your own outer appearance - your own unique perception of your body" (pg 4).

Originally body image was described very much as a picture of our appearance. Descriptions of body image have since developed to take in to account an individual's perceptions, thoughts and feelings about their own body.

THE DEVELOPMENT OF BODY IMAGE

Schilder (1935) was the first to describe the concept of body image as an important psychological phenomenon in his book 'The Image and Appearance of the Human Body'. Before this time body image was only studied in relation to distorted body perceptions as a result of brain damage (Grogan, 1999). Schilder's move away from a neurological usage of the concept of body image, also led to development of psychodynamic theories of body image based on the work of Freud, Adler and Jung (Thompson et al, 1999).

The 1940s and 1950s saw the beginning of studies focusing on self-ratings of attractiveness and subjective appearance (Burgess & Wallen, 1944; Jourard & Secord, 1955). However it was not until the 1960s that attention to body satisfaction was tied in to eating and weight-related problems (Stunkard & Mendelson, 1967; Stunkard & Burt, 1967). The association between disturbed body image and eating disorders began when Bruch (1962) originally included disturbed body image in her diagnostic criteria for anorexia nervosa. In fact Bruch believed that the treatment of anorexia nervosa had to include change in the body image or the long-term outcome would not be successful. Slade & Russell (1973) also added to the association of body image and eating disorders by discovering that people with anorexia nervosa overestimated their emaciated body size.
The interest in body image research increased dramatically as body image was associated with anorexia nervosa. Thompson (1992) and Rosen (1992) both proposed that body image was the primary factor in the development of eating disorders, whilst disordered eating patterns and strategies to control weight were secondary. Research to support this belief has been produced by Cattarin & Thompson (1994) who carried out a three year longitudinal study of female adolescents. Body dissatisfaction was found to be predictive of restrictive eating behaviours. Stice & Agras (1998) found body image dissatisfaction not only predicted the onset of bulimic behaviours, but also that dissatisfaction in body image predicted the remission of these behaviours in a group of female adolescents.

Nevertheless, distorted body image has also been indicated in people with out eating disorders (Thompson & Thompson, 1986). Rodin, Silberstein & Striegel-Moore (1985) described what they believed to be a 'normal level' of dissatisfaction with one's body and termed this dissatisfaction as 'normative discontent'. Thompson et al (1999) remarked on the idea of 'normative discontent', suggesting that the body image discontent should not be ignored as it could mark the way as a precursor to a possible clinical problem.

Today, disturbances in body image are associated with a variety of areas other than eating disorders. It may also be associated with body dysmorphic disorder and disfigurement, as well as certain vocations such as dancing and athletics (Grogan, 1999; Thompson et al, 1999). Yet the majority of the research and theories continue to be around body image disturbance in eating disorders.

**MODELS OF BODY IMAGE**

Slade (1994) proposed a model of body image whereby he described body image as a 'loose mental representation of the body that is affected by different factors'. These factors included history of sensory input to the body; history of weight change/fluctuation; cultural and social norms; individual attitudes to weight and shape; cognitive and affective variables; individual psychotherapy and biological variables. Slade emphasised that both clinicians and researchers need to appreciate the complexity of body image when working with individual's on body image.
Biological, social and interpersonal factors all have a great impact on an individual's body image.

Thompson et al (1999) proposed a continuum model of body image whereby the level of body image concern or dissatisfaction ranged from none to extreme, with most people falling in the middle. Although this may not give an answer to where a person's concern for body image became a problematic clinical condition, it may help to give greater understanding of the concept of body image and body image disturbance. People who would be found at the higher level of this scale with high concern for body image, have been found in other research to be at the higher level of measures of other clinical problems such as depression and eating disorders (Thompson, 1996). At the lower end of this scale, Thompson et al (1999) concluded that low to moderate levels of body image concern should be conducive to promote healthy eating and exercise.

**MEASURES OF BODY IMAGE ASSESSMENT**

The research literature on body image often distinguishes between two types of measures of the assessment of body image: perceptual measures and attitudinal measures (Keeton, Cash & Brown, 1990; Gardner, 1996; Thompson et al, 1999).

**Perceptual Measures of Body Image Assessment**

The first type of assessment of body image relates to the perceptual task of an individual's ability to accurately estimate their own body size (Smeets, 1997). The size perception component of body image was the first area to develop following Bruch's (1962) and Slade & Russell's (1973) revelations about eating disordered respondents overestimating their body size compared to non-eating disordered groups. Body size estimation can be measured using movable calliper techniques (Slade & Russell, 1973); adjustable light beam apparatus (Thompson & Spana, 1988); distorting mirrors (Brodie, Slade & Rose, 1989) or television-video distortion methods (Gardner & Moncrieff, 1988; Probst, Vandereycken, Vanderlinden & Coppenolle, 1998).

However the perceptual tasks of body size estimation are now being questioned as to whether they can be seen as purely a perceptual task. Gardner & Bokenkamp (1996)
have recently applied the signal detection methodology to the perceptual process of body image disturbance to try and re-establish the interest in this area. The signal detection model or integrative model accepts the separate involvement of both sensory and cognitive factors into perception. This is unlike the older bottom-up model that believed perception to be affected purely by sensory factors, with cognitions being applied separately and afterwards. Nevertheless, in the integrative model the cognitive factors are thought to still occur unconsciously. For example women who have negative associations with their bodies may use their body image attitude at an unconscious level to bias their judgement of how they see their actual body size (Williamson, 1996; Gardner & Bokenkamp, 1996; Smeets & Panhuysen, 1995)

**Attitudinal Measures of Body Image Assessment**

The second type of assessment of body image relates to the individual's subjective feelings and attitudes towards their own body (Cash & Pruzinsky, 1990; Slade, 1994). This notion developed after the initial interest in the perceptual task of body size estimation began to wane. Questionnaire measures are commonly used to assess the individual's subjective view of their body image. These types of measures of body image may relate to body image satisfaction such as the Body Shape Questionnaire (Cooper, Taylor, Cooper & Fairburn, 1987); Multidimensional Body Self-Relations Questionnaire (Cash, 1996) and the Body Mapping Questionnaire and Colour-the-body-Task (Huon & Brown, 1989). Additionally some questionnaires may explore an individual's cognitions and schemas in relation to their body image, such as the Body Image Ideals Questionnaire (Cash & Syzmanski, 1995) and the Body Image Automatic Thoughts Questionnaire (Cash, Lewis & Keeton, 1987).

**Silhouette or Schematic Figure Rating Scales of Body Image Assessment**

Silhouette or schematic figure rating scales appear somewhere in the middle of the perceptual measures and attitudinal measures of body image. Although silhouette or schematic figures originally used to be included in the literature of the first type of assessment, as a measure of body size perception, they are now more often reported in the literature as an attitudinal measure of body image (Thompson et al, 1999; Smeets, 1997). They are thought to tap in to the subjective attitudinal experiences of body image as well as the perception of body size estimation.
Although there are a multitude of body image assessment measures that focus in on the many different aspects of body image, the sheer number of assessment measures makes the discussion of all of them unfeasible. As previously mentioned, this literature review will focus on the silhouette or schematic figure rating measures of body image assessment.

SILHOUETTE OR SCHEMATIC FIGURE RATING SCALES AS MEASURES OF BODY IMAGE

An Introduction to Silhouette or Schematic Figure Rating Scales

The silhouette or schematic figure rating scales are a commonly used measure of body image. They usually consist of between five and twelve silhouettes ranging from underweight to overweight. Individuals are asked to select their current and ideal figure from the collection of silhouettes of the same gender. As previously stated, silhouette scales were originally developed as a measure of body-size perception accuracy (Thompson & Gray, 1995), yet silhouette scales are also used as a measure of body image satisfaction. This can be measured by comparing an individual's current body size with their ideal body size, and taking the discrepancy as a subjective indicator of body image satisfaction (Cash & Pruzinsky, 1990).

The most common finding with the use of silhouette scales is that respondents chose a silhouette larger than their actual size when asked to pick a silhouette that matches their current size (Thompson et al, 1999). This finding is more marked when the respondents have eating disorders (Williamson et al, 1985; Thompson, 1996). However it has been found that different responses to the assessments are achieved dependent on whether the instructions are worded cognitively (Do you 'think'...?) or affectively (e.g. Do you 'feel'...?) (Thompson, 1990). Slade (1994) concluded from four studies of body image accuracy judgements that eating disordered respondents significantly overestimated their body size in response to 'affective' instructions, that is "how you feel you look", when compared to 'cognitive' instructions, that is "how you think you look". This was found to be equally true for non-eating disordered individuals (Thompson, 1996).
Many silhouette and schematic figure scales have been developed (Thompson & Gray, 1995) but often they have not demonstrated the psychometric properties of their scales (Furnham & Alibhai, 1983; Tucker, 1984; Counts & Adams, 1985; Bell, Kirkpatrick & Rinn, 1986; Carroll, Gleeson, Risby & Dugdale, 1986; Powers & Erickson, 1986; Silberstein, Striegel-Moore, Timko & Rodin, 1988; Rodin, 1992; Winitch, 1993). More recently the importance of the psychometric properties of silhouette scales have been recognised and some information on the validity and reliability of the scales is provided. Table 1 provides a summary of those scales that provide some psychometric properties to support their use as measures of body image.
<table>
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<th>TR  = Test-Retest</th>
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Table 1: Silhouette and Schematic Figure Rating Measures of Body Image
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Adult Measures of Silhouette or Schematic Figure Rating Scales of Body Image

The Figure Rating Scale (Stunkard, Sorenson & Schulsinger, 1983) is one of the most widely used silhouette scales in which people are required to select a figure from nine male or nine female figures ranging from very underweight to very overweight. The scale was originally developed to build an obesity and thinness register to allow heritability of weight to be studied. Respondents used the Figure Rating Scale to identify the weights of their parents. Nevertheless no tests of reliability or validity were given in Stunkard et al's original paper although it was reported that validity trials were being carried out. Fallon & Rozin (1985) used the same scale a few years later to study gender differences in perception of body shape and again the psychometric properties of the scale were not reported.

Thompson and Altabe (1991) recognised not only the popularity but also the omission of the psychometric properties of the Figure Rating Scale. They proceeded in testing the validity and reliability of the scale on two different samples of male and female college students. Test-retest reliability was found to be good over a two week period when the subjects were asked to identify their 'ideal figure', how they 'thought' they looked and how they 'felt' they looked. They also reported that the Figure Rating Scale correlated moderately with other scales of body image dissatisfaction, eating problems and self-esteem, suggesting adequate validity. In another study using the Figure Rating Scale, Altabe & Thompson (1992) concluded that figural ratings were strongly associated with body dissatisfaction and eating dysfunction. Thompson and Altabe (1991) proposed that the psychometric properties of the Figure Rating Scale were adequate but needed to be continued with other samples such as adolescents and with additional measures of body image.

However recent criticism of this scale has reduced its popularity. Gardner, Friedman & Jackson (1998) criticised the Figure Rating Scale for the lack of consistent size gradations between each figure. In addition they reported a lack of consistency between waist and chest measurements, and between males and females. Gardner et al (1998) also highlighted that the figures were not of identical heights.
Following these criticisms Thompson et al (1999) suggested a consideration of using figures developed by M. Thompson & Gray (1995). The Contour Drawing Scale (Thompson & Gray, 1995) again consists of nine male and nine female schematic figures, ranging from underweight to overweight. The scale was developed by the authors following their criticisms of other scales for showing unrealistic representations of the human form and for not demonstrating valid or reliable measures. The Contour Drawing Scale portrayed figures with finer degrees of variation between them as well as consistent differences in size between the figures. They suggested that the figures illustrated progressive and realistic waist-to-hip ratio as well as defined facial and bodily features. The figures were designed so that they could be split at the waist to give accurate upper and lower body comparisons (M. Thompson, 1993).

The Contour Drawing Rating Scale demonstrated good test-retest reliability over a week, as well as good validity of the drawings for assessing perceived body size (Thompson & Gray, 1995). This was examined by the degree of correspondence between the individual's reported weight and current self-ratings, as well as the degree of correspondence between Quetelet's body mass index (BMI) and current self-ratings. The coefficients compared well with those of Fallon & Rozin (1985) and Williamson et al (1989). Nevertheless this study only sampled female undergraduate participants and used a relatively small sample size, suggesting further replications are needed. Yet Thompson & Gray (1995) also reported findings from an unpublished report (Thompson, 1993) that supported the use of the Contour Drawing Rating Scale. In this second study 250 men and women were recruited to test the validity of the figures in the Contour Drawing Rating Scale for assessing perceived body size. Strong correlations were again found between current self-ratings and BMI.

Another of the more commonly used silhouette scales is the Body Image Assessment (BIA) originally developed and used by Williamson, Kelley, Davis, Ruggiero & Blouin (1985) and Williamson, Davis, Bennett, Goreczny & Gleaves (1989). The BIA consists of nine silhouettes of females ranging from thin to obese in incremental steps. Beebe, Holmbeck & Grzeskiewicz (1999) have recently provided new normative and psychometric data for their adapted version of the silhouette scale, the Body Image
Assessment-Revised (BIA-R). Although emerging supporting data was found in terms of validity and reliability for the original BIA (Williamson et al, 1989), Beebe et al (1999) believed the data presented were limited. For example they stated that the norms ignored the individual's height, and were based on grouping people by weight alone. They suggested that the BMI should be used instead. Additionally, Beebe et al (1999) commented that only norms were presented for the participants cognitively made choices, whilst the norms for the affective estimates were omitted.

Beebe et al (1999) have developed norms for both the cognitively and affectively based body size estimates for the BIA-R. Reliability was found to be moderate over a two week period and preliminary convergent validity was also demonstrated: body size estimation was found to be most highly related to eating pathology, body focus, body dissatisfaction and depressed affect. Beebe et al (1999) suggested that the BIA-R was more psychometrically sound than the original BIA and was relatively inexpensive as a measure of body image satisfaction. Nevertheless it must still be noted that the BIA and BIA-R only used silhouettes of women, ignoring male body image satisfaction altogether.

Children's Measures of Silhouette or Schematic Figure Rating Scales of Body Image

Silhouette and schematic figure scales for the assessment of body image have also been developed for children. Until recently it was thought that eating disorders were relatively rare in preadolescent children resulting in a dearth in assessment measures (Veron-Guidry & Williamson, 1996). However, in a recent study of 244 8-12 year old children in Australia, 26 percent of those classified as underweight wanted to be thinner, and 62 per cent of the children had tried to lose weight (Rolland, Famhill & Griffiths, 1998). Questionnaire and interview studies report body shape and size dissatisfaction in children from eleven years upwards (Dowdney et al, 1995). Other studies propose that children as young as seven years old describe body dissatisfaction and restrictive eating behaviours (Kostanski & Gullone; 1999; Grogan & Wainwright, 1996). For this reason psychometrically sound silhouette or figure rating scales for children are essential.
Collins (1991) developed a silhouette scale for preadolescent children adapting Stunkard et al.'s (1983) adult figures from the Figure Rating Scale. Collins's measure consisted of seven girl figures, seven boy figures, seven male adult figures and seven female adult figures. 1118 children were asked to identify their current self, ideal self, ideal other gendered child, ideal adult, ideal other gendered adult. These questions were presented to large groups of 7-9 year old children. The measure was found to show only fair reliability after a three-day period: current self revealed respectable reliability, whilst others were more questionable. However, Collins's (1991) established criterion-related validity for the measure. This scale has since been used in other further studies focusing on children's weight satisfaction (Kostanski & Gullone, 1999; Parkinson, Tovee & Cohen-Tovee, 1998).

Wood, Becker & Thompson (1996) criticised Collins's measure for the lack of uniformity in the facial expression. They described how one of the female child figures had a more down-turned mouth than the figures either side of her. Wood et al (1996) therefore blanked out the faces, suggesting this would avoid confounding figure size with facial expression. The hair was also removed to avoid racial bias, as it was thought that the hair was drawn in a Caucasian or Asian manner. Wood et al used this adapted measure, the Child Figure Drawing task, along with a revised version of the Body Dissatisfaction Scale of the Eating Disorders Inventory (EDI-BD) (Garner et al, 1983) to assess body dissatisfaction in a group of 204 8-10 year old children. Wood et al's (1996) data appeared similar to that of Collins's study in that the task was found to be not totally appropriate for the younger age children, as they could not complete the tasks reliably enough. Again the reliability coefficient for the current self was acceptable, but large variations occurred with different combinations of age and gender. In contrast the EDI-BD, a questionnaire, surfaced as a psychometrically valid measure of body dissatisfaction in 8-10 year old children.

Dowdney, Woodward, Pickles & Skuse (1995) stressed the importance of obtaining a reliable measure, when developing their Body Image Perception and Attitude Scale for Children. This measure looked additionally at height as well as body shape and was tested on growth-retarded children as well as a normal community sample of children. In this study cards with the figures on were placed in random order to stop
the child picking the middle figure, as was found as a critique in Collin's (1991) study. The Body Image Perception and Attitude Scale for Children showed acceptable reliability although it varied according to the population. How this measure may converge with other measures of body image satisfaction, or correlates of body dissatisfaction in children or adults, was not examined. In addition replication of this measure would probably be necessary to provide additional support for this scale due to the relatively low number of participants.

Veron-Guidry & Williamson (1996) again wanted to develop a measure of body image in children that was valid and reliable. A sample of 257 children aged eight to thirteen years completed the Body Image Assessment Procedure for Preadolescents (BIA-P) and the Body Image Assessment Procedure for Children (BIA-C). These measures were adapted from the BIA for adults described previously (Williams et al 1989). As dissatisfaction with body image increased, the presence of eating disordered patterns were also found to increase, providing concurrent validity for the BIA-P and the BIA-C. One week test-retest reliability was found to be acceptable although slightly lower than that of the adult version of the BIA (Williamson et al, 1989). It should be noted that the sample used for this study had a disproportionate number of girls (58%) and the authors stated that the sample differed slightly in terms of distribution of race compared to the national norms in USA.

Further Issues and Concerns with the Use of Silhouette or Schematic Figure Rating Scales as Measures of Body Image

As can be seen, concerns about the adequacy of the reliability and validity of the silhouette or schematic figure rating measures of body image occur in both the child and adult assessment measures. Although this area now has gained greater attention, further work is needed to produce psychometrically sound measures of body image. Additionally some measures need further replication due to inadequate sample sizes. There are also some general concerns and criticisms of silhouette or figure rating measurements of body image discussed below. These are areas that need addressing in future research to allow for the successful use of these measures for the assessment of body image.
Gardner et al. (1998) questioned the 'coarseness' of the scales by having a finite number of figures. They explored various other continuous scales of measurement such as adjustable light-beam apparatus (Thompson & Spana, 1989) and proposed a continuous scale for the measurement of body size. They suggested that a continuous line should run between two figures: one small silhouette at one end and a large silhouette at the other end. Respondents would be asked to mark on the line the point that they think corresponds to their perceived or ideal size. Precise measurements of the distance marked could then be taken. Gardner et al. (1998) suggested this information would then comprise an interval or continuous scale, which would allow for more powerful parametric statistics to be used.

Additionally this continuous scale of measurement may assist respondents who find it difficult to identify themselves with any of the figures presented in the scale (Thompson et al., 1999). Respondents may not feel that they look like any of the figures presented and therefore have difficulties selecting a figure. Yet respondents may find it easier to place a mark on a line in terms of what size they think they are on a continuous scale of measurement.

In addition some of the scales appeared to omit some of the facial features on their silhouettes, for example many are missing the eyes and mouth (Fallon & Rozin, 1985; Roddin, 1992; Winitch, 1993). This may make identification with the figures even more difficult. Nevertheless some criticisms about facial and hair features appearing Caucasian on the figures has resulted in some scales purposefully omitting features (Wood, Becker & Thompson, 1996; Koff & Benavage, 1998).

Gardner et al. (1998) questioned the number of figures used in each scale. Although most silhouette scales ranged between five and twelve figures, Brodie, Bagely & Slade (1994) found that more than 90% of their participants chose from only three of the twelve silhouettes presented. Buree, Papageorgis & Solyom (1984) presented a nineteen silhouette scale to their respondents with systematic variations in the size of different body parts. There is no reference to how many different silhouettes were chosen by the participants, but following Gardner et al.'s (1998) criticism it would appear nineteen silhouettes is too many. Gardner et al. (1998) question the test-
retest reliability of such scales when in reality, probably only a few silhouettes are being used by each respondent, equating to only a subset of the whole scale.

The test–retest reliability can also be questioned when the focus is turned to the method of presentation. Gardner et al (1998) highlighted the possible practice affect when the silhouettes are placed in front of the respondent in the same order for the original test and the retest. When the respondent was asked to pick their current and ideal from a set line of figures, it may remain easy for them to remember which figure they picked previously. Placing the figures on separate cards in random order may help to alleviate this possible bias.

Questionnaire studies often allow a person to identify with which part of their body they are dissatisfied (Grogan, 1999). This differs from the silhouette scales that generally only allow whole body measures. However some scales have been developed to look specifically at particular areas of the body such as the Breast / Chest Rating Scale (Thompson & Tantleff, 1992).

Although some of the studies described the different ethnicity in their sample (Collins, 1991; Beebe et al, 1999), many other studies did not. Cultural aspects are thought to contribute greatly to an individual’s body image, and yet research studies comparing different culture’s ideas about body image are only just beginning to surface (Wardle, Bindra, Fairclough & Westcombe, 1993; Lake, Staiger & Glowinski, 2000). This is an area that urgently needs further investigation to assist in the understanding of culture and it’s effect on body image.

Rand & Wright (2000) have recently adapted Collins’s (1991) scale and Stunkard et al’s (1983) original silhouette scale and drawn figures across five different age groups ranging from babies to older adults. They explored continuity and change in the evaluation of acceptable and ideal body sizes across various age groups. These scales may be useful in terms of further research as at present there are only scales for children or adults. This variety of silhouettes across the ages will allow age differences in body size to be taken in to account when assessing body image.
CONCLUSION

Body image is a fast growing subject, with greater interest being attached to it every day. A recent government summit about the media’s effect on body image fuelled great debate and discussion amongst people at all levels. A distorted body image is a key factor in both anorexia nervosa and bulimia nervosa. It appears both researchers and clinicians agree the assessment of body image is crucial to treatment programmes targeting eating disorders (Thompson, 1995). And yet the assessment of body image still has a great deal further to go in developing reliable and valid measures that are applicable for people of different ages, backgrounds and cultures.

Beebe et al (1999) suggested body image was not measured systematically partly because of the lack of psychometrically valid, sufficiently normed, inexpensive and suitable measures of body image. Although there is a vast array of different measures of body image, silhouette or schematic figure measures still remain a relatively straightforward, inexpensive and commonly used measure of body image. With the development of further psychometric standards, as well as the inclusion of different cultural and age-related factors, these measures could be utilised to their full potential in the assessment of body image.
REFERENCES


*Journal of Eating Disorders, 2*, 15-34.


MAJOR RESEARCH PROJECT

Year Three

July 2001

THE ASSESSMENT OF BODY IMAGE IN A COMMUNITY POPULATION OF PEOPLE WITH MILD LEARNING DISABILITIES
1. **ABSTRACT**

*Aim:* To explore body image in people with mild learning disabilities using a schematic figure rating scale. **Objective:** To develop a reliable and valid measure of body image for people with mild learning disabilities. **Method:** Fifty participants with mild learning disabilities living in the community completed the Body Image Assessment. This included a self-rating task in which participants identified their current and ideal body size using an adapted version of the Contour Drawing Rating Scale (Thompson & Gray, 1995). Participants were also weighed and their height measured. **Results:** A reliable and valid measure of body image was developed for people with mild learning disabilities. Participants were able to accurately perceive their own body size in a similar manner to that of the general population. Nearly two-thirds of the participants were dissatisfied with their body size, the majority wanting to be smaller in size. Participants were not as successful at rank-ordering the figures in correct size order as the general population. Participants were able to correctly label the different size figures in the scale. IQ and gender did not affect the participants' ability to accurately perceive their body size. **Conclusion:** Good preliminary support for the use of the Body Image Assessment as a measure of body image in people with mild learning disabilities was established. Replication would provide additional support for the measure, thereby allowing a contribution towards the assessment of potential body image disturbance and eating disorders in people with learning disabilities.
2. **INTRODUCTION**

This report relates to an exploratory study of body image in adults with learning disabilities. The prior literature review (pg 188-215) considered definitions of body image and reviewed the methodology of body image measurement. This review will briefly re-present body image and its measurement, including the use of silhouette and schematic figure rating scales as this type of measure is employed in the current study. Subsequently, it will review current studies of eating problems and possible eating disorders in people with learning disabilities, and finally the rationale for the current study will be presented.

2.1 **BODY IMAGE & BODY IMAGE DISTURBANCE**

2.1.1 **Definition Of Body Image**

As body image was introduced in greater detail in the literature review (pg 188-215), a brief description will be presented here. Originally body image was described very much as a picture of our appearance:

"the picture of our own body which we form in our mind, that is to say, the way in which the body appears to ourselves" (Schilder, 1935)

However definitions have since developed to include not only a person's perceptions, but also their thoughts and feelings about their body (Thompson et al, 1999). Various definitions describing body image in this way have been proposed:

"the picture we have in our minds of the size, shape and form of our bodies; and to our feelings concerning these characteristics and our constituent parts" (Slade, 1994, pg 497)

"internal representation of your own outer appearance - your own unique perception of your body" (Thompson et al, 1999, pg 4)

These later definitions of body image appear to be more useful in that they incorporate the various elements of body image and therefore give an idea of the wider picture of
a person's experience of their own body. Body image disturbance is also a multi-dimensional phenomenon that contains a perceptual, attitudinal and a behavioural element when describing an individual's idea of their own body (Cash & Prusinsky, 1990).

2.1.2 The Relationship Between Body Image And Eating Disorders
Thompson (1995) described body image as having a "long and storied association with eating and weight related problems" (pg 119). Body image has been linked directly with eating disorders since 1962, when Bruch originally included distorted body image as one of the diagnostic criteria for anorexia nervosa. In one of the first studies, Slade & Russell (1973) used a calliper device to show that females with anorexia nervosa overestimated their body size compared to normal females. Fichter et al (1986) demonstrated that anorexics overestimated their body size more than controls using a moveable calliper, image marking and a video monitor. Interestingly, more recent research has indicated that non-eating disordered people also may overestimate their body size, though to a lesser degree than either anorexics or bulimics (Thompson, 1991; Thompson et al, 1999).

Garfinkel et al (1992) surveyed 524 bulimic females and found higher levels of body dissatisfaction than in non-bulimic women of a similar age. Similar findings were reported by Bunnell et al (1992) who reported higher body dissatisfaction in anorexic and bulimic adolescents compared to non-eating disordered adults. Kostanski & Gullone (1999) recounted that children as young as 7 years were reporting body image dissatisfaction and restricted eating behaviours as a direct consequence.

2.1.2.1 Anorexia nervosa & Bulimia nervosa
Today, a disturbance in body image remains a central diagnostic feature of both anorexia nervosa and bulimia nervosa, the two key diagnoses of eating disorders (APA, 1994). The Diagnostic and Statistical Manual of Mental Disorders, 4th edition (DSM-IV) (American Psychiatric Association [APA], 1994) outlines anorexia nervosa as being a person's refusal to maintain a minimally normal/healthy body weight, an intense fear of gaining any weight, amenorrhoea and a disturbance of body image. Bulimia nervosa is identified by frequent episodes of binge eating succeeded
by a variety of compensatory actions such as using laxatives, vomiting, starving oneself or inappropriate exercise. These behaviours are accompanied by an overconcern about body shape and weight. The International Classification of Diseases (ICD-10)(World Health Organisation [WHO], 1992) provides similar diagnostic criteria for anorexia nervosa and bulimia nervosa to the DSM-IV including a description of a distortion of body image and fear of fatness as features of anorexia nervosa and bulimia nervosa.

The DSM-IV (APA, 1994) suggested 0.5-1.0% of females in late adolescence and early adulthood would fulfil criteria for anorexia nervosa, and that figures for the prevalence in males was limited. The DSM-IV (APA, 1994) suggested 1-3% of adolescent and young adult females have bulimia nervosa. Men are thought to suffer from bulimia nervosa at one-tenth of the rate of bulimia in women (APA, 1994). Eating disorders prevalence has not only been found to be higher in young female populations, but also higher prevalence rates have been found in populations with co-existing psychiatric problems (Palmer, 2000). Eating disorders are commonly found to occur with major depression and anxiety disorders (Cooper, 1995a).

2.1.3 Body Image Assessment Measures

Various types of body image assessment measures exist including questionnaires (Cooper et al, 1987; Cash & Syzmanski, 1995), adjustable light beam apparatus (Thompson & Spana, 1988), distorting mirrors (Brodie et al, 1989) and silhouette or schematic figure rating scales (Thompson et al, 1999). Body image measures are often divided into perceptual and attitudinal measures (Keeton et al, 1990; Gardner, 1996). Perceptual measures assess an individual's ability to accurately perceive their own body size, whilst the attitudinal measures assess an individual's subjective view of their body image (Smeets, 1997; Thompson et al, 1999). Although there are many body image assessment measures, only the silhouette and schematic figure rating scales are pertinent to this review.

2.1.4 Silhouette And Schematic Figure Rating Scales

Various silhouette and schematic figure rating scales have been devised to measure body image in the general population. They normally consist of between five and
twelve figures ranging from underweight to overweight, from which the person is required to select their current and ideal body size. Silhouette and schematic figure rating scales were originally used as a measure of body size perception accuracy. However they are now often used to provide a subjective measure of body image satisfaction using the discrepancy between the person's current and ideal choice of figures as a measure of body satisfaction (See 'The Assessment of Body Image using Silhouette and Schematic Figure Rating Scales' reported earlier in this portfolio, pg 188-215).

Body image assessments for adults and children which portray figural stimuli have been found to distinguish eating disturbance from normal eating patterns, to have good test-retest reliability as well as comparing well with other measures of body image and eating disturbance (Dowdney et al, 1995; Thompson et al, 1999). Thompson (1991) assessed 120 eating-disturbed and asymptomatic subjects using the Figure Rating Scale (Stunkard et al, 1983; Fallon & Rozin, 1985), a bulimia test and a physical appearance evaluation subscale. The eating-disturbed participants saw themselves as larger than the asymptomatic group when using the Figure Rating Scale, as well as reporting more dissatisfaction with their general appearance.

Bell et al (1986) explored disturbances in body image perception comparing 24 participants with anorexia, obesity and a normal control group. Using an 8-figure silhouette scale, a trend was reported in that the anorexics overestimated their body size and the obese underestimated their body size. Although Bell et al suggested that their silhouette scale would indicate the presence of anorexia nervosa, further validity and reliability checks need to be carried out on this measure before the findings can be generalised.

Altabe & Thompson (1992) used the Figure Rating Scale (Stunkard et al, 1983), an Adjustable Light Beam Apparatus and several subscales from the Eating Disorders Inventory (EDI) (Garner et al, 1983) to compare different types of size estimation measures. They found the figural ratings to be much more strongly linked to the EDI measures of body satisfaction and eating disturbance than the traditional Adjustable Light Beam Apparatus in a sample of 337 participants. They suggested that the
figural discrepancy ratings showed greater predictive power over the more traditional perceptual measure of the Adjustable Light Beam Apparatus.

2.2 EATING PROBLEMS IN PEOPLE WITH LEARNING DISABILITIES

While anorexia nervosa and bulimia nervosa within the general population have generated considerable research, interest in eating difficulties and/or disorders in those with learning disabilities has only recently emerged. The various types of eating difficulties that are found in people with learning disabilities are often labelled under differing terms such as eating disorders/problems/difficulties. For the purpose of this research study, 'eating disorders' will refer to anorexia nervosa and bulimia nervosa, whilst 'eating problems' will refer to any other eating difficulties such as pica, regurgitation, rumination and lack of appetite.

Various eating problems have been described in people with learning disabilities, particularly in prevalence studies of residents in large hospital settings (Hill, 1999; Smith et al, 1996; Matson et al, 1991; Danford & Huber, 1981). There is a lack of clarity in definitions such that most of the prevalence studies appear to refer to eating problems in people with learning disabilities, and not eating disorders such as anorexia nervosa or bulimia nervosa.

Gravestock (2000) reviewed a wide number of prevalence studies of eating problems in people with learning disabilities. The eating problems studied included continuous eating and drinking, vomiting, pica, regurgitation, food stealing as well as some unspecified 'feeding problems'. He concluded between 6-42% of adults with learning disabilities in institutions have some form of eating problems, as well as between 1-19% of adults with learning disabilities living in the community. He summarised that higher prevalence rates of eating problems were found in those adults with learning disabilities in hospital settings, males, younger adults, those with weight difficulties, autism and other behavioural problems (Gravestock, 2000). Eating problems have also been identified as more prevalent in those adults with severe and profound learning disabilities (Reid, Ballinger & Heather, 1978).
2.2.1 Pica

Pica is one of the most commonly identified eating problems in people with learning disabilities. Described as the "persistent eating of non nutritive substances" (WHO, 1992), Danford & Huber (1981) described prevalence rates of 26% in a sample of 991 learning disabled adults and adolescents in an institutionalised population. Using observation and staff report, they found pica to be associated with severe and profound learning disabilities, ageing, sleep disturbance, self-injury and other food-related problems such as stealing and faddiness.

O'Brien & Whitehouse (1990) examined the reported and observed eating behaviours of 48 adults living in community settings using a semi-structured interview adapted from the Present Behavioural Examination (a semi-structured measure of behaviour in elderly adults with organic brain disease). Food pica (eating frozen or uncooked food) (15%) and non-food pica (4%) were found to be related to autism and depression. However this sample was relatively small and consisted of mainly autistic participants and so generalisation should only occur with caution. Hill (1999) surveyed 284 adults with learning disabilities living in an institution. Ten per cent of the sample were found to exhibit pica using a standardised questionnaire completed by nursing staff. Higher rates of pica were found also in those with autism as well as those with increasing behavioural problems. However these were nurse-reported ratings rather than observed ratings. Tewari et al (1995) reported the same prevalence rates as Hill's study (10%) in a sample of 246 hospital learning disabled residents, although the level of learning disability was not provided.

2.2.2 Rumination

Gravestock (2000) reviewed several studies and reported prevalence rates of 5-10% for rumination or regurgitation and psychogenic vomiting amongst institutionalised adults with learning disabilities. Singh (1981) surveyed 349 learning disabled adults and children in an institution. Rumination rates of 6% were found using nurse-reported, case note-reported and observed rumination. In Danford & Huber (1981)'s study of 991 institutionalised learning disabled adults and children, 6% of their population exhibited rumination. Rumination was found to be higher in those with severe and profound learning disabilities, males and those who were severely...
underweight. Again these studies often used non-standardised methods for collecting the information which was collected from a secondary source such as the carer.

2.2.3 **Food Faddiness And Lack Of Appetite**
Gravestock (2000) reported that food faddiness was more common than total food refusal or psychogenic loss of appetite in people with learning disabilities. He also emphasised the necessity of distinguishing these from a reduced appetite and weight loss caused by other physical or psychiatric disorders. Thommessen et al (1991) assessed children with learning disabilities and found 30% of the children presented with food faddiness and 19% had poor appetite. Hill (1999) reported 30% of her sample population were reported by staff to show reluctance in eating. Danford & Hubber (1981) described 7.2% of its study of 991 participants as having a lack of appetite that was associated with being underweight and other medical problems. It is therefore not clear as to the cause of the lack of appetite in this study, whether it be due to physical illness or psychological problems.

2.2.4 **Critique Of The Studies Of Eating Problems In People With Learning Disabilities**
The majority of studies of eating problems in people with learning disabilities have been concerned mainly with institutionalised populations. With this may well come a higher rate of severe and profound learning disabilities which could in turn sway the types of eating problems reported in people with learning disabilities. Additionally in institutionalised settings, greater nurse-reported or case note-reported assessments of the eating problems may be relied upon. This results in secondary perceptions of the eating problems, rather than a first hand account from the people with learning disabilities themselves or through observation.

Gravestock's review included studies where the prime objective of the study was to identify behaviour problems in people with learning disabilities, and not specifically gather data on eating problems (Smith et al, 1996; Matson et al, 1991). Standardised measures for the assessment of eating problems in people with learning disabilities are scarce (Hill, 1999). Some studies only briefly described their method of assessment (Tewari et al, 1995; Singh, 1981). However some of the studies had produced initial
findings in support of their assessments of eating problems in people with learning disabilities, although further validity and reliability checks were required for these measures (Hill, 1999; Danford & Huber, 1981).

In spite of the methodological limitations of the above studies, it can be seen that eating problems appear prominent in a substantial proportion of those with learning disabilities and warrant further investigation. What remains unclear is how such eating problems differ from, or contribute to, the development of eating disorders in this population.

2.3 EATING DISORDERS IN PEOPLE WITH LEARNING DISABILITIES

There are no known prevalence studies of anorexia nervosa and bulimia nervosa in people with learning disabilities. The evidence that such disorders could exist in this population stems from a few single case studies describing anorexia nervosa (see section 2.3.2). This lack of research may stem from the difficulties with assessing eating disorders in people with learning disabilities, both in terms of communication (Babbitt et al, 1995; Gravestock, 2000) and appropriate diagnostic criteria (Thomas, 1994; Gravestock, 2000). Difficulties with differential diagnosis between eating disorders and depression in people with learning disabilities may also contribute to the lack of interest in this area (Holt et al, 1988; Gravestock, 2000). However, in reality these difficulties should help to promote well-needed research into potential eating disorders in people with learning disabilities.

Hill (1999) developed the Patterns of Eating Questionnaire (PEQ) to measure eating patterns in people with learning disabilities. As well as measuring different types and severity of eating problems in this population, the PEQ also included questions measuring eating patterns often associated with anorexia and bulimia nervosa. Hill (1999) reported that a group of people with mild learning disabilities in the study exhibited 'concerns for body image'. In the light of her findings on patterns of eating and an apparent awareness of body image in this population, Hill (1999) emphasised the need for the development of appropriate measures to assess body image, body image disturbance and eating disorders in people with learning disabilities.
2.3.1 Possible Symptoms Of Bulimia Nervosa In People With Learning Disabilities

Some prevalence studies for eating problems in people with learning disabilities identify particular characteristics that could be recognised as symptoms of bulimia nervosa such as continuous eating or drinking, hyperphagia and constant food seeking (Danford & Huber, 1981; Matson et al, 1991; Smith et al, 1996). These prevalence studies surveyed a wide range of people with learning disabilities, but it is not clear how many people were included with Prader-Willi Syndrome. People with Prader-Willi Syndrome are known to have compulsive eating tendencies and often binge eat and constantly seek out food. However these behaviours are thought to occur due to particular characteristics of the Prader-Willi Syndrome such as an impaired food satiety response (Emerson et al, 1998).

2.3.2 Single Case Studies Of People With Learning Disabilities & Anorexia Nervosa

Cottrell & Crisp (1984) described a case of a 35 year old lady with Down's Syndrome and mild learning disabilities showing many features of anorexia nervosa. She displayed a marked weight loss, amenorrhea, insisted that she was overweight and was described as "weight phobic" (pg195) by the researchers. She also had a history of vomiting and complained of being unable to swallow. Following hospital admission, treatment included a re-feeding programme with individual, couple and family psychotherapy involving the patient's parents (the patient lived with her parents). This produced a return to normal body weight as well as the return of menstruation.

Syzmanski & Biederman (1984) described a case of a 33 year old lady with Down's Syndrome and moderate learning disabilities who exhibited amenorrhea and extreme weight loss due to a refusal to eat. She constantly sought reassurance from people to say she was not "plump" (pg247), but also suffered from depression. She engaged in a treatment programme including behaviour therapy, individual therapy and medication. Three years later, after one relapse, her weight stabilised.

Heal & O'Hara (1993) presented a case of a 28 year old Down's Syndrome lady with mild learning disabilities. She exhibited marked weight loss, a selective food intake, vomiting and expressed a desire to be thinner. She had a fear of putting on weight and...
refused to look in a mirror. She was admitted to a residential health unit where she engaged in individual therapy and music therapy and gained weight.

Morgan (1989) described a 35 year old lady with Down's Syndrome, insulinoma, moderate learning disabilities and anorexia nervosa. She had a marked loss of weight, self induced vomiting, loss of appetite and amenorrhoea. Following attendance as a day patient at a hospital for people with learning disabilities, a programme was set up for her to improve her social skills and communication. Her parents were also given counselling. Her weight increased, her eating pattern stabilised and she was seen to be more sociable and communicative. Morgan (1989) reported that she fulfilled the majority of the criteria for anorexia nervosa, but highlighted the difficulties of assessing the patient's body image and possible wishes to be thin because of limited communication skills.

Several other single case studies have also presented descriptions of anorexia nervosa in people with learning disabilities (Hurley & Sovner, 1979; Mohl & McMahon, 1980; Fox et al, 1981; Darby et al, 1981; Clarke & Yapa, 1991; Holt et al, 1988; Thomas, 1994; Raitasuo et al, 1998). Gravestock (2000) summarised the factors identified in the single case studies that appeared to be related to anorexia nervosa in people with learning disabilities. These included a history of dieting; family psychopathology and discord; concerns about sexuality; bereavement issues; physical and behavioural regression and an increased mortality.

These single case studies provide some evidence for the existence of eating disorders in people with learning disabilities. However, they are only single examples and provide limited information on the assessment techniques, including body image assessment, used to elicit the information required for a potential diagnosis. Although reference is made to particular diagnostic criteria for anorexia nervosa in some of the studies (Raitasuo et al, 1998; Syzmanski & Biederman, 1984), measurement of the desire to be thinner and more often, the presence of a distorted body image, is often not demonstrated (Heal & O'Hara, 1993; Morgan, 1989; Hurley & Sovner, 1979). In addition other psychiatric problems are described alongside the anorexia nervosa in some of the single case studies, without a clear distinction as to whether the eating
problems could actually be a symptom of the other psychiatric disorder, such as depression (Szymanski & Biederman; 1984; Hurley & Sovner, 1979). Suresh (1994) criticised the case of anorexia nervosa in a lady with learning disabilities presented by Thomas (1994). He suggested Thomas's description of 25% weight loss was nonsensical unless expressed in relation to the subject's body mass index or expected weight. It is unclear whether this may also be the case in the other single case studies.

2.4 THE ASSESSMENT OF EATING DISORDERS IN PEOPLE WITH LEARNING DISABILITIES

The single case studies published often present plausible characteristics of anorexia nervosa in people with learning disabilities that could possibly warrant a diagnosis of an eating disorder. In addition it is unclear whether other eating problems displayed in people with learning disabilities such as food seeking, lack of appetite or continuous eating and drinking also are symptoms of an undiagnosed eating disorder. Given the possible communication and cognitive difficulties in this population, it is currently difficult to establish the presence or absence of eating disorders in this population. For example, Morgan (1988) highlighted the difficulties of collecting body image information when assessing his patient for possible anorexia nervosa because of the client's poor communication skills.

Assessments of eating disorders in the non-learning disabled population employ standardised interview schedules such as the Eating Disorders Inventory-2 (EDI-2) (Garner, 1991), the Eating Disorders Examination (EDE) (Fairburn & Cooper, 1993), the Eating Attitude Test (EAT) (Garner & Garfinkel, 1979) and the Bulimia Investigatory Test Edinburgh (BITE) (Henderson & Freeman, 1987). For people with learning disabilities, there are no suitable measures. In addition, the majority of the information is likely to be collected from the person's carers. Although this may be necessary at times, it does mean the information collected is another person's perceptions of the situation.

2.4.1 Absence Of Standardised Assessment Measures

No standardised measures of eating disorders in people with learning disabilities have been developed. Babbitt et al (1995) stated that eating disorders did not occur just in
"young, white, middle-class females" (pg 431) but across all ages, genders, races, cultures, and ranges of physical, mental and developmental disability. They argued that few psychometrically sound eating behaviour instruments had been developed specifically for any of these populations and emphasised the need for researchers to focus the validation of instruments and the development of new instruments, if necessary, on these unique unique populations.

Measurements for assessing the nutritional status of people with learning disabilities have been promoted and these are often used with children with developmental delay (Babbitt et al, 1995, Ekvall, 1993). Data are gathered on the person's feeding history, feeding skills and food preferences using clinical interviews and observation. In addition anthropometric, dietary and biochemical data may be collected. However these assessments tend to have a different focus, looking instead at feeding problems and weight issues, and not eating disorders per se.

The lack of identification of eating disorders in those with learning disabilities is likely to stem from a number of factors. First, there are the likely communication and cognitive difficulties that make direct assessment by standardised interview schedules problematic. Related to this is the lack of standardised instruments appropriate to this population. There is also the issue of what would constitute suitable diagnostic criteria for eating disorders in this population. The identification of other mental health difficulties in this population is of relatively recent onset, as it took a considerable time for common psychiatric problems such as depression to be formerly recognised in this population (Caine & Hatton, 1998). While we may conclude that the extent of, and the type of, eating disorders in this population have yet to be established, it is clear that such recognition would be facilitated by the development of standardised instruments measuring eating problems and disturbance.

2.5 RATIONALE FOR THE CURRENT STUDY
In addition to direct measures of eating problems, it would also be extremely useful to establish whether it is possible to assess body image in those with learning disabilities. If so, then measures of body image could be incorporated into the assessment of those presenting with eating problems. The need for such an assessment has been
highlighted by both Hill (1999) and Gravestock (2000) on the basis that body image disturbance is a risk factor for eating disorder in the general population. Whether this is so for a learning disabled population has yet, of course, to be established. It is therefore essential initially to ascertain whether body image can be measured in a reliable and valid way with adults with learning disabilities.

2.5.1 Important Considerations For The Current Study
Communication difficulties impact on the assessment of eating problems and disorders in people with learning disabilities (Morgan, 1988; Hill, 1999; Gravestock, 2000). Using figurual stimuli to explore body image has the advantage of being able to collect information directly from the person with learning disabilities, rather than from carers. Additionally, figurual stimuli will lessen the importance of expressive language skills during the assessment, although receptive language skills will still be needed to comprehend instructions. The instructions to the respondents can be adapted more easily using a schematic figure rating scale than using a full questionnaire measure.

Hill (1999) reported that in her study population adults with mild learning disabilities showed a greater concern and awareness of body image than those with moderate, severe or profound learning disabilities. Additionally, the single case studies presented earlier described eating disorders solely in people with mild learning disabilities. Consequently it was thought that the inclusion of adults with mild learning disabilities only, would be a suitable starting place to begin exploring body image in people with learning disabilities.

Gravestock (2000) highlighted that there was little community-based research exploring eating disorders or eating problems in people with learning disabilities. Following the Community Care Act and the closure of long-stay hospitals, the majority of people with learning disabilities no longer live in large institutions (Caine, Hatton & Emerson, 1998). The sample for this study was chosen from people living in a variety of accommodations in the community. In these community settings, it may be true to suggest that the people with learning disabilities have different control over their eating/weight-related issues and also may have been influenced by society's
attitudes to body image. These issues are outside the scope of this study, but are explored further in McCarthy's study (McCarthy, 1998).

2.6 THE CURRENT STUDY
The current study will explore body image in people with learning disabilities using an adapted version of a schematic figure rating scale, the Contour Drawing Rating Scale (Thompson & Gray, 1995) to explore whether people with learning disabilities can accurately perceive their own body size. This scale was chosen for its psychometric properties (see Method, Section 4.3.1.2, pg 234). It consists of a range of figures from underweight to overweight, from which the person is required to select their current and ideal body size. The scale was adapted for this study to accommodate the needs of the learning disabled participants, both in terms of language and numbers of schematic figures from which to choose.
3. **AIM, OBJECTIVE AND RESEARCH QUESTIONS**

3.1 **AIM**
To explore body image in people with mild learning disabilities using a schematic figure rating scale.

3.2 **OBJECTIVE**
To develop a reliable and valid measure of body image for people with mild learning disabilities.

3.3 **RESEARCH QUESTIONS**
Given the exploratory nature of the study, it was designed to address questions of interest and relevance rather than as a hypothesis driven study. The major questions addressed by the study were as follows:

1. Can people with mild learning disabilities accurately perceive their own body size? How does this compare to findings concerning the general population's ability to perceive their own body size?

2. Are people with learning disabilities satisfied with their perceived body size as measured by a schematic figure rating scale?

3. Does IQ or gender influence a person with learning disabilities' ability to perceive their own body size?

4. Do people with learning disabilities use similar labels to describe different body shapes as people in the general population?
4. METHOD

4.1 STUDY DESIGN

A cross-sectional interview design was used to assess body image in people with mild learning disabilities.

4.2 THE SAMPLE

Fifty participants were recruited from seven community homes and a Social Services Day Centre located in Surrey. They lived in a variety of community settings including 24 hour-staffed group homes, individual homes with staff always available on site, individual homes with support workers visiting several times weekly or in homes with their parents/family.

Home managers/keyworkers nominated individuals under their care who met inclusion criteria for the study, namely that they had had an IQ in the mild learning disabilities range (IQ between 50-70 [WHO, 1992]). Potential participants with an IQ less than 50 were excluded from the study. Only one participant was excluded after he failed to understand the initial introduction and aims of the study, and was therefore deemed to not meet the inclusion criteria of having an IQ between 50-70.

4.3 MEASURES

4.3.1 The Body Image Assessment

The Body Image Assessment (Appendix A) was developed for use in this study to explore body image in people with learning disabilities and incorporated the Contour Drawing Rating Scale (Thompson & Gray, 1995). It was designed to be completed by the researcher during individual sessions with each participant. The Body Image Assessment consists of the four following components:
4.3.1.1 Assessment Of Ability To Rank Order By Size Using The Square Rank Ordering Task

Nine squares of graduating size from small to large were printed separately on to individual laminated cards measuring 4 x 4 inches. Participants were asked to rank these in size order from smallest to largest. This square rank ordering task was included for two reasons. First it helped orientate participants to the concepts of relative size and rank ordering. Second, it assessed whether the participants could understand and complete a size rank ordering task as would be subsequently required in the Contour Drawing Rating Scale task (Thompson & Gray, 1995).

4.3.1.2 The Contour Drawing Rating Scale (Thompson & Gray, 1995)

The Contour Drawing Rating Scale (Thompson & Gray, 1995) is a measure of body-size perception and body-size satisfaction. The scale consists of nine male and nine female contour drawings, graduating in size from an underweight figure to an overweight figure (Appendix B). The figures are all of equal height, have clearly defined facial and body characteristics and have consistent increases between each figure with genuine enlargements in waist-to-hip ratio. Each 6 inch tall figure was printed on a separate card measuring 6 x 8.25 inches. The figures on the cards were labelled from number 1, the most underweight figure, through to number 9, the most overweight figure.

The scale was used as a 9-figure card set (Figures 1-9), as it was originally designed, but also as a 5-figure card set (Figures 1,3,5,7 & 9) adapted for people with learning disabilities for this study. The instructions for the tasks were also simplified for people with learning disabilities. Participants were asked to complete the self-rating task by selecting their current self and ideal self from the figures. Also the participants were asked to rank order the figures by size to check each individual's ability to differentiate between the figures in the scale.

The Contour Drawing Rating Scale has demonstrated good test-retest reliability ($r = .78$, $p < .0005$) over a one week period when used on a non-learning disabled adult population. In addition, good validity of the drawings for assessing perceived body size has been found. This was determined by assessing the degree of correspondence
between each participant's current self rating using the scale and their reported weight and BMI \( (r = .71, p < .0005; r = .59, p < .005, \text{ respectively}) \) (Thompson & Gray, 1995; Thompson, 1993).

4.3.1.3 The Vocabulary used by People with Learning Disabilities when Talking about Body Image

Two interview questions were included to gather information about the vocabulary used by people with learning disabilities when describing their own bodies as well as the shape of the other figures on the Contour Drawing Rating Scale (Thompson & Gray, 1995). It was gathered to gain a greater understanding of people with learning disabilities' perceptions of body image (Question nos. 9 & 10, Appendix A).

4.3.1.4 Demographics, Height, Weight and Body Mass Index \((\text{BMI})\) (WHO, 1992)

Participant demographics were collected including age, gender, ethnicity, living arrangements, developmental disorder and any mental health problems. Where possible this information was collected directly from the participants with unknown or additional information collected from staff. In addition each participant was weighed (lightly clothed, without shoes) using the same weighing scales for each participant, and their height measured. The participants' weight and height were used to calculate each individual's Body Mass Index \((\text{BMI})\) \( (\text{kg/m}^2) \) (WHO, 1992), which is thought to be a better measure of weight status as height is also taken into consideration.

4.3.2 Short-Form Of The WAIS-R (Crawford, Allan & Jack, 1992)

The Weschler Adult Intelligence Scale - Revised \((\text{WAIS-R})\) (Weschler, 1981) is a standardised battery of verbal and performance sub-tests which yields an extensive assessment of general intellectual ability. The short-form WAIS-R (Crawford, Allan & Jack, 1992) consists of four sub-tests only: block design, object assembly, comprehension and similarities and provides a broad estimate of cognitive abilities. All participants completed this assessment to verify an IQ in the mild learning disabilities range, i.e. an IQ between 50-70 (WHO, 1992).
4.4 PILOT STUDY AND CONSULTATION
The Body Image Assessment was piloted on 2 trainee clinical psychologists and two qualified clinical psychologists. Several amendments were made at this stage in terms of the order of the tasks and the language used. The Body Image Assessment was later piloted on two people with learning disabilities living in their own flats with staff available 24 hours on site. The female pilot participant had mild learning disabilities (IQ = 58), whilst the male pilot participant was found to have borderline learning disabilities (IQ = 76). Only minor amendments were made to the wording of some of the questions as a result of the pilot study.

4.5 PROCEDURE
Prior to the study taking place, written ethical approval was obtained from two ethics committees (Appendix C).

4.5.1 Recruitment of Participants and Informed Consent
The researcher initially telephoned or met with the home managers of the group homes, and the manager of the day centre. The study was explained to the managers, along with what it would entail for potential participants. Information sheets (Appendix D) were left with the managers who approached those they considered suitable for participation according to study criteria. These information sheets allowed residents/attenders to consider and discuss their participation with staff, relatives and friends. The researcher agreed a particular day to visit the home/day centre subsequently when the potential participants could choose to meet with the researcher if they wished.

Meeting with the researcher gave potential participants the opportunity to discuss their involvement with her before agreeing to take part. The study was explained using appropriate language, with the additional use of the information sheet. Potential participants were given further time to talk again with staff if they wanted. Individual consent was obtained for each participant using a carefully worded consent form (Appendix E). The researcher assisted with any difficulties in understanding information and explained to each person that they could stop or leave at any time if they wanted to, and that there would be no repercussions for doing so.
4.5.2 Confidentiality Of Information
Participants were assured of total confidentiality of all information given during the Body Image Assessment. Participants were advised that all material given to the researcher would be kept "secret" and their names would not be told to anyone. Questionnaires were coded rather than using the participants' name, ensuring anonymity. Only the researcher was allowed access to the identity of the codes on the questionnaires. Names and data were stored separately at all times.

4.5.3 Participant Distress during the Assessment
Concerns and procedures for managing potential distress were also discussed with each participant. They were as follows. If a participant became distressed, the assessment would be halted and the participant would be allowed to speak either with the researcher or a member of staff for a debriefing session. Following the assessment, the researcher would explain to the participant that a contact phone number would be left with staff at the home should the participant wish to contact them again or ask any further questions. Although it was thought unlikely to occur, if the Body Image Assessment revealed information that the participant was at risk in any way, consent would be sought from the participant to discuss this with their keyworker. The keyworker could then make an informed decision as to whether to inform the GP and/or Consultant involved in the participant's care.

Only one participant became distressed during the Body Image Assessment due to previous personal experiences which were known to the staff within the setting she was seen. The participant wanted to complete the assessment and then spent 20 minutes debriefing with the researcher. The participant also wanted the researcher to speak to her keyworker and explain what had happened during the assessment. A three-way meeting then took place between the participant, the keyworker and the researcher. The researcher emphasised that she could be contacted at a later stage if necessary by telephone, although no such contact was made.

4.5.4 Body Image Assessment Procedure
Part of the procedure for informing the participants about the study and gaining consent, was a discussion about 'how things are different' (as introduced on the
Major Research Project

information sheet, Appendix D). Initially in the assessment, this conversation was used to allow the participants to feel more relaxed and to act as preparation for the later tasks.

The interview with each participant was ordered in the following way: the square rank ordering task, the figure rank ordering and self-rating task, the short-form WAIS-R and finally a collection of any demographic information and the person's weight and height.

4.5.4.1 Square Rank Ordering Task

The squares were numbered 1-9, number 1 being the smallest square and number 9 being the largest square (the numbers were unknown to the participants). The square cards were placed in a random order on the table in front of each participant. They were then asked to rank order them in size order (Q1, Appendix A).

Part of the square rank ordering task included a demonstration by the researcher, whilst later the participants were required to carry out the tasks alone (Table 1). Initially the participants were required to rank order only three cards that had been demonstrated and left on the table by the researcher. Secondly the participants had to rank order 4 cards that were demonstrated by the researcher and then taken away. Finally the participants had to rank order 5 square cards and then 9 square cards with no demonstrations from the researcher. The numbers on the back of the cards aided the random ordering and enabled checking of the accuracy of the participants' responses.
TABLE 1: Rank Ordering Tasks for the Square Cards

<table>
<thead>
<tr>
<th>Square Card</th>
<th>Numbers Placed In Random Order On The Table</th>
<th>Task Required Of The Participant</th>
</tr>
</thead>
<tbody>
<tr>
<td>1,5,9</td>
<td>The researcher demonstrated the task of ordering the cards in to size order and left the completed task on table. The participant was then asked to do the same task with a duplicate set of the three cards.</td>
<td></td>
</tr>
<tr>
<td>2,4,6,8</td>
<td>The researcher demonstrated the task of ordering the cards in size order and then removed the completed task. The participant was then asked to order the same 4 cards.</td>
<td></td>
</tr>
<tr>
<td>1,3,5,7,9</td>
<td>The participant was asked to order the five cards in size order. No demonstration was given from the researcher.</td>
<td></td>
</tr>
<tr>
<td>1,2,3,4,5,6,7,8,9</td>
<td>The participant was asked to order the nine cards in size order. No demonstration was given from the researcher.</td>
<td></td>
</tr>
</tbody>
</table>

4.5.4.2 Figure Rank Ordering Task and Self-Rating Task

Next participants were presented with two male figures and two female figures from the Contour Drawing Rating Scale (Thompson & Gray, 1995) and asked to point to the 'pictures of men' and then to the 'pictures of women' (Q2, Appendix A). This task was used to ensure the participants could distinguish between the male and female figures.

The participants were then presented with the 5-figure card set (figures 1,3,5,7 & 9) of their own gender placed in a random order on the table in front of them. It was explained to them that the figures on the cards were all the same height, but had different shaped bodies. The participants were asked to rank order the figures in terms of the smallest (most underweight) person to the biggest (most overweight) person (Q3, Appendix A). They were then asked to select a figure that they perceived to most accurately depict their current shape by being asked to "Point to the card with a
man/woman on it whose shape is most like you now" (Q4, Appendix A). They were also asked to identify the figure that they perceived to most accurately depict their ideal shape by being asked to "Point to a card with a man/woman on it who is the same shape as you would like to be". Participants were told that it may be the same card or a different card from the one that they picked for their current shape, so that they were not made to feel that there was something wrong with their current shape (Q5, Appendix A).

The figure rank ordering task and self rating task were then repeated with each participant using the 9-figure card set (figures 1-9) (Q6,7 & 8, Appendix A).

4.5.4.3 Description of Own Body and the Figures on the Cards
Each participant was asked to describe the shape of their own body and that of the figures on the cards (Q9 & 10, Appendix A). The participants were specifically asked to describe the figures 1-3, figures 4-6 and figures 7-9.

4.5.4.4 Demographic Information, Weight, Height & BMI
Information relating to the demographic information (Appendix A) was collected where possible from the participants, for example their age and where they lived. Any questions concerning the demographic information that the participants were unable to answer, was gained from the home managers/keyworkers after the assessment had finished. The participants were then asked to remove their shoes and jackets before being weighed (kg) and their height (m) measured. The BMI was calculated from these measurements.

4.5.4.5 Short-Form WAIS-R
The short-form WAIS-R was carried out at the end of the assessment with each participant. It was introduced to the participants as "a few puzzles and word games, to help us find out what things you are good at". Following the completion of the short-form WAIS-R the participants were thanked for their assistance and reminded of the researcher's telephone number should they want to discuss any issues later on.
4.5.5. **Test-Retest Reliability**

Between 2-3 weeks later, 16 participants were randomly selected from the larger sample and asked to complete the figure rank ordering task and the self-rating task again to assess the test re-test reliability of the measure in this population.

4.6 **STATISTICAL ANALYSES**

The data were analysed using the Statistics Package for the Social Sciences (SPSS), version 10. Non-parametric statistics were used because the assumptions for parametric analyses had been breached as the data were not normally distributed and were at a nominal or ordinal level of measurement. The Spearman Rank Order Correlation Coefficient Test, Chi-Square Test, the Binomial Test and Mann-Whitney \(U\) Test were used to assess the reliability and validity of the Body Image Assessment, and to explore factors influencing the participants' ability to carry out the Body Image Assessment. Demographic data collected in the study were used for descriptive analyses.
4. RESULTS

4.1 SAMPLE CHARACTERISTICS

4.1.1 Demographics
There were no missing data. Twenty-nine participants (58%) were recruited from seven community homes whilst the remaining 21 participants, (42%) were recruited from a Social Services Day Centre. The participants' age ranged from 18 to 74 years (mean = 44.52 years, s.d. = 16.04) and included 25 female participants (mean age = 44.68, s.d. = 14.5) and 25 male participants (mean age = 44.36, s.d. = 17.7).

Forty-four participants (88%) were described as having unknown developmental disorders, five participants (10%) had Down's Syndrome and one participant (2%) had Fragile X Syndrome. The majority of the sample (86%) was not identified as having any mental health problems. However two people were identified as having schizophrenia, 2 as having a diagnosis on the Autistic Spectrum and one person each was identified as having a diagnosis of Obsessive Compulsive Disorder, Attention Deficit Hyperactivity Disorder and Depression.

Thirty-two participants (64%) in the sample lived in group homes staffed 24-hours, 5 participants (10%) lived in their own flats but with staff on site. Eight participants (16%) lived with their parents or family and a further 5 participants (10%) lived in their own flat and had support workers visiting several times a week.

4.1.2 IQ Data as Assessed by the Short-form WAIS-R (Crawford, Allan & Jack, 1992)
Each participant's IQ was measured using the short-form WAIS-R (Crawford, Allan & Jack, 1992). The participants' Full Scale IQ (FIQ) ranged from 50 to 70 (mean = 59.08, s.d. =5.65), indicating each participant had mild learning disabilities. The sample's verbal IQ (VIQ) ranged from 56 to 78 (mean = 65.72, s.d. = 4.53) whilst their performance IQ (PIQ) ranged from 57 to 79 (mean = 66.62, s.d. = 6.25). There were no significant differences between male and female participants on FIQ (p>.85), VIQ (p>.64) or PIQ (p>.82) (Table 2).
Table 2: Participants' IQ Data as Assessed by the Short-form WAIS-R (Crawford, Allan & Jack, 1992)

<table>
<thead>
<tr>
<th></th>
<th>Total sample (n=50)</th>
<th>Male participants (n=25)</th>
<th>Female participants (n=25)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Range</td>
<td>Mean (s.d.)</td>
<td>Range</td>
</tr>
<tr>
<td>Full Scale IQ (FIQ)</td>
<td>50-70</td>
<td>59.08 (5.65)</td>
<td>52-70</td>
</tr>
<tr>
<td>Verbal IQ (VIQ)</td>
<td>56-78</td>
<td>65.72 (4.53)</td>
<td>56-78</td>
</tr>
<tr>
<td>Performance IQ (PIQ)</td>
<td>57-79</td>
<td>66.62 (6.25)</td>
<td>57-79</td>
</tr>
</tbody>
</table>

4.1.3 Weight And Body Mass Index (BMI) (WHO, 1992)

Participants' weight ranged from 46.4 kg to 130 kg (mean = 77.3 kg, s.d. = 17.2), whilst their height ranged from 1.41m to 1.87m (mean = 1.65m, s.d. = 0.1m). The participants' BMI ranged from 18 kg/m² to 41.2 kg/m² (mean = 28.1 kg/m², s.d. = 5.5) (Table 3). The weight and BMI for male and female participants is presented in Table 3.

Table 3: Participants' Height, Weight and BMI

<table>
<thead>
<tr>
<th></th>
<th>Total sample (n=50)</th>
<th>Male participants (n=25)</th>
<th>Female participants (n=25)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Range</td>
<td>Mean (s.d.)</td>
<td>Range</td>
</tr>
<tr>
<td>Height (m)</td>
<td>1.41 - 1.87</td>
<td>1.65 (.10)</td>
<td>1.48 - 1.87</td>
</tr>
<tr>
<td>Weight (kg)</td>
<td>46.4 - 130</td>
<td>77.3 (17.2)</td>
<td>46.4 - 106.6</td>
</tr>
<tr>
<td>BMI (kg/m²)</td>
<td>18 - 41.2</td>
<td>28.1 (5.5)</td>
<td>18.6 - 32.5</td>
</tr>
</tbody>
</table>
According to classifications of weight status based on the BMI scale (WHO, 1992), 3 (6%) participants were underweight (BMI 19 and below) and 17 (34%) participants fell in the normal/healthy category (BMI = 20-25). Nineteen participants (38%) were overweight (BMI = 26-30) and 11 (22%) participants were obese (BMI greater than 30) (Table 4).

Table 4: Weight Status Classifications of BMI Scale (WHO, 1992)

<table>
<thead>
<tr>
<th>BMI Score</th>
<th>Percentage of whole sample</th>
<th>Number of participants</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Total</td>
</tr>
<tr>
<td>Underweight</td>
<td>19.9 and below</td>
<td>6%</td>
</tr>
<tr>
<td>Normal</td>
<td>20-25.9</td>
<td>34%</td>
</tr>
<tr>
<td>Overweight</td>
<td>26-30.9</td>
<td>38%</td>
</tr>
<tr>
<td>Obese</td>
<td>31 and above</td>
<td>22%</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>100%</td>
</tr>
</tbody>
</table>

4.1.5 Demographics Of Retest Sub-Sample
The sixteen participants in the retest sub-sample consisted of 7 women and 9 men with an age range from 18 to 66 years (mean = 38 years, s.d. = 16). The Full Scale IQ for the sub-sample ranged from 53 to 70 (mean = 60.00, s.d. = 5.68), whilst the verbal IQ ranged from 59 to 73 (mean = 65.94, s.d. = 4.17) and the performance IQ ranged from 60 to 79 (mean = 67.75, s.d. = 16.38). The sub-sample's weight fell between 49.6kg and 106.6 kg (mean = 79.7 kg, s.d. = 17.2) and their BMI ranged from 18 to 39.2 kg/m^2 (mean = 27.3 kg/m^2, s.d. = 6.0).

4.2 VALIDITY OF THE BODY IMAGE ASSESSMENT

4.2.1 Concurrent Validity Of The Figures For Assessing Perceived Body Size
This was explored by examining the relationship between each participant's weight, their BMI and their current self rating of their body size. Correlational analyses using the Spearman rank order correlation coefficient (r_s) were undertaken. The self-rating selections for the 5-figure card set correlated significantly with both BMI (r_s = .62, p <.01) and weight (r_s = . 59, p <.01). Likewise the self-rating selections for the 9-
figure card set were found to be significantly correlated with both BMI \((r_s = .59, p < .01)\) and weight \((r_s = .56, p < .01)\) (Table 5). The positive correlations indicated that as the participants' weight and BMI increased, their choice of the figure size that represented themselves increased. Significant relationships were also found when the sample was divided into male and female participants (Table 5).

Table 5: Concurrent Validity of the Figures for Assessing Perceived Body Size as Measured by Spearman Rank Order Correlation Coefficient \((r_s)\)

<table>
<thead>
<tr>
<th></th>
<th>5-Figure Card Set</th>
<th>9-Figure Card Set</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Whole sample</td>
<td>Male participants</td>
</tr>
<tr>
<td></td>
<td>((n=50))</td>
<td>((n=25))</td>
</tr>
<tr>
<td>BMI ((\text{kg/m}^2))</td>
<td>.62*</td>
<td>.66*</td>
</tr>
<tr>
<td>Weight ((m))</td>
<td>.59*</td>
<td>.52*</td>
</tr>
<tr>
<td></td>
<td>.56*</td>
<td>.58*</td>
</tr>
</tbody>
</table>

* Significant at the .01 level

4.2.2 **Validity of the figures for depicting underweight figures, normal/healthy weight figures and overweight figures.**

The participants were asked to give words that they thought described the first three figures, the middle three figures and last three figures on the 9-figure card set. Forty-five participants offered various words, whilst five participants declined to describe the figures. These labels are listed in Table 6 where they have been categorised into words associated with being underweight, normal/healthy weight or overweight.
Table 6: Words Used by Participants to Describe the Figures

<table>
<thead>
<tr>
<th>Words used associated with</th>
<th>Words used associated with</th>
<th>Words used associated with</th>
</tr>
</thead>
<tbody>
<tr>
<td>being 'underweight'</td>
<td>being 'normal/healthy weight'</td>
<td>being 'overweight'</td>
</tr>
<tr>
<td>Anorexic</td>
<td>All right</td>
<td>Bad for your heart</td>
</tr>
<tr>
<td>Can see bones</td>
<td>Fine</td>
<td>Big</td>
</tr>
<tr>
<td>Might die</td>
<td>Good weight</td>
<td>Big built</td>
</tr>
<tr>
<td>Not eaten anything</td>
<td>Healthy</td>
<td>Chubby</td>
</tr>
<tr>
<td>Not healthy</td>
<td>Just right</td>
<td>Eaten too much</td>
</tr>
<tr>
<td>Skin &amp; bones</td>
<td>Looks fine</td>
<td>Fat</td>
</tr>
<tr>
<td>Skinny</td>
<td>Nice</td>
<td>Horrible</td>
</tr>
<tr>
<td>Slim</td>
<td>Normal</td>
<td>Massive</td>
</tr>
<tr>
<td>Small</td>
<td>Not too thin or too fat</td>
<td>Might have a baby</td>
</tr>
<tr>
<td>Starving self</td>
<td>OK</td>
<td>Needs to take more exercise</td>
</tr>
<tr>
<td>Thin</td>
<td>Right shape</td>
<td>Not healthy/Unhealthy</td>
</tr>
<tr>
<td>Thin as a rake</td>
<td>Round, nice bodies</td>
<td>Not nice</td>
</tr>
<tr>
<td>Too thin</td>
<td>Strong</td>
<td>Overweight</td>
</tr>
<tr>
<td>Very skinny</td>
<td></td>
<td>Pregnant</td>
</tr>
<tr>
<td>Very thin</td>
<td></td>
<td>Too heavy</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Very huge</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Very plump</td>
</tr>
</tbody>
</table>

Of the 45 participants who offered words to describe the figures, all (100%) offered words associated with thin/slim to describe the first three figures that were meant to depict underweight people. None of the participants used words that would be associated with someone being overweight, or even at a healthy weight to describe the first three figures (Table 7). Using a binomial test (non-parametric test using categorical data), a statistically significant difference was found between the proportion of participants who offered words associated with thin/slim to describe the first three figures, and that which would have been expected ($p < .001$). This was similar when the participants were asked to describe the last three figures depicting people that were overweight. All but one participant (98%) offered words associated with big/heavy to describe the overweight figures. None of the participants used
words associated with underweight people, although one participant described the overweight figures as normal (Table 7). Using a binomial test, a statistically significant difference was again found between the proportion of participants who offered big/heavy words to describe the overweight figures, and that which would have been expected ($p < .001$).

Table 7: Participants' choices of underweight words, normal/healthy weight words and overweight words to describe the varying figures.

<table>
<thead>
<tr>
<th>Figures 1-3 (underweight)</th>
<th>'Underweight' words</th>
<th>'Normal/healthy weight' words</th>
<th>'Overweight' words</th>
</tr>
</thead>
<tbody>
<tr>
<td>n=45</td>
<td>45</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>(100%)</td>
<td>(0%)</td>
<td>(0%)</td>
<td>(0%)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Figures 4-6 (normal/healthy weight)</th>
<th>'Underweight' words</th>
<th>'Normal/healthy weight' words</th>
<th>'Overweight' words</th>
</tr>
</thead>
<tbody>
<tr>
<td>n=45</td>
<td>7</td>
<td>36</td>
<td>2</td>
</tr>
<tr>
<td>(16%)</td>
<td>(80%)</td>
<td>(4%)</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Figures 7-9 (overweight)</th>
<th>'Underweight' words</th>
<th>'Normal/healthy weight' words</th>
<th>'Overweight' words</th>
</tr>
</thead>
<tbody>
<tr>
<td>n=45</td>
<td>0</td>
<td>1</td>
<td>44</td>
</tr>
<tr>
<td>(0%)</td>
<td>(2%)</td>
<td>(98%)</td>
<td></td>
</tr>
</tbody>
</table>

The participants were not quite as precise when describing the centre three figures depicting normal/healthy weight figures. Forty-five participants responded, of which 36 (80%) used words associated with healthy/normal weight people. Seven participants (16%) used words associated with underweight people to describe the normal/healthy figures, whilst 2 participants (4%) used words associated with overweight people (Table 7). Nevertheless, a binomial test again indicated a statistically significant difference between the proportion of participants who offered normal/healthy words to describe the healthy/normal weight pictures, and that which would have been expected ($p < .001$).
To conclude, the participants always described the underweight figures as underweight, the normal/healthy figures were mostly described as normal/healthy and the overweight figures were virtually always described as overweight. Interestingly, the labels used to describe the figures were similar to those labels and portrayals used by the participants to describe their own body shape (Appendix F).

4.2.3 **BMI Category And Desire To be Smaller, Bigger Or The Same In Size, As A Measure Of The Body Image Assessment Scale's Validity.**

A size discrepancy score was calculated for participants by subtracting the participant's choice of ideal figure card number from their choice of current figure card number. For example if a person picked card 7 as their current size and card 4 as their ideal size in the self-rating task, this would give a discrepancy score of -3', suggesting they would like to be smaller in size. Alternatively if the person picked card 3 as their current size and card 5 as their ideal size, this would give a discrepancy score of +2, suggesting they would like to be bigger in size.

A Spearman Rank Correlation Coefficient was used to measure the relationship between the discrepancy score and each participant's BMI. Significant negative correlations were found for both the 5-figure card set ($r_s = -.56$, $p< .01$) and 9-figure card set ($r_s = -.56$, $p< .01$). This suggests that the higher the person's BMI, the more likely they were to choose an ideal size less than their perceived current size. This finding is similarly illustrated in the tables below displaying the desire to increase in size, stay the same or decrease in size dependent on each participant's BMI category, for both the 5-figure and 9-figure card set (Tables 8 & 9).
Table 8: BMI Category and the Participants' Desire to be Smaller, Bigger or the Same in Size, using the 5-Figure Card Set

<table>
<thead>
<tr>
<th>BMI Category</th>
<th>No. of participants wanting to be smaller (negative discrepancy score)</th>
<th>No. of participants wanting to stay the same size (zero value for discrepancy score)</th>
<th>No. of participants wanting to be bigger (positive discrepancy score)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Underweight -</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>BMI 19.9 and below</td>
<td>0 (0%)</td>
<td>2 (67%)</td>
<td>1 (33%)</td>
</tr>
<tr>
<td>(n=3)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Normal/healthy -</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>BMI 20-25.9</td>
<td>2 (12%)</td>
<td>9 (53%)</td>
<td>6 (35%)</td>
</tr>
<tr>
<td>(n=17)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Overweight -</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>BMI 26-30.9</td>
<td>9 (47%)</td>
<td>8 (42%)</td>
<td>2 (11%)</td>
</tr>
<tr>
<td>(n=19)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Obese -</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>BMI 31 and above</td>
<td>10 (91%)</td>
<td>1 (9%)</td>
<td>0 (0%)</td>
</tr>
<tr>
<td>(n=11)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>21 (42%)</td>
<td>20 (40%)</td>
<td>9 (18%)</td>
</tr>
<tr>
<td>(n=50)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Table 9: BMI Category and the Participants' Desire to be Smaller, Bigger or the Same in Size, using the 9-Figure Card Set

<table>
<thead>
<tr>
<th>BMI Category</th>
<th>No. of participants wanting to be smaller (negative discrepancy score)</th>
<th>No. of participants wanting to stay the same size (zero value for discrepancy score)</th>
<th>No. of participants wanting to be bigger (positive discrepancy score)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Underweight - BMI 19.9 and below (n=3)</td>
<td>0 (0%)</td>
<td>2 (67%)</td>
<td>1 (33%)</td>
</tr>
<tr>
<td>Normal/healthy - BMI 20-25.9 (n=17)</td>
<td>3 (18%)</td>
<td>6 (35%)</td>
<td>8 (47%)</td>
</tr>
<tr>
<td>Overweight - BMI 26-30.9 (n=19)</td>
<td>11 (58%)</td>
<td>8 (42%)</td>
<td>0 (0%)</td>
</tr>
<tr>
<td>Obese - BMI 31 and above (n=11)</td>
<td>9 (82%)</td>
<td>2 (18%)</td>
<td>0 (0%)</td>
</tr>
<tr>
<td>Total (n=50)</td>
<td>23 (46%)</td>
<td>18 (36%)</td>
<td>9 (18%)</td>
</tr>
</tbody>
</table>

4.2.4 Rank-Ordering the Figures in Size Order

All participants (100%) were able to distinguish the male figures from the female figures. The participants were asked to rank order the male and female figures in size order for both the 5-figure and 9-figure card sets.

The percentages of correctly rank ordered figures were obtained for all 50 participants. Of the 250 responses for the 5-figure card set, 74.4% and 69.9% demonstrated correctly positioned figures for the male set and female set respectively. Of the 450 responses for the 9-figure card set, 49.6% and 53.3% of the responses demonstrated correctly positioned figures for the male set and female set respectively.
For both the 5-figure and 9-figure card sets, the percentages of figures placed by all participants in an ascending sequence was also calculated. This calculation allowed more lenience for the participants and measured the trend for the figures to increase in size. For the 5-figure card set, 84% and 85% of the figures were positioned in an ascending sequence for the male set and female set respectively. For the 9-figure card set, 73% and 75% of the figures were positioned in an ascending sequence for the male set and female set respectively.

4.3 RELIABILITY OF THE BODY IMAGE ASSESSMENT

4.3.1 Test-Retest Reliability Of Self-Rating Task

Test-retest procedures were carried out for the self-rating task with a sub-sample of 16 participants 2-3 weeks after the first assessment. The Spearman rank order correlation coefficient ($r_s$) was chosen as an appropriate measure of reliability (non-parametric measure of correlation for ordinal data). Using the 5-figure card set, significant reliability coefficients were achieved for the participants' choice of both their current size ($r_s = .79, p < .01$) and ideal size ($r_s = .83, p < .01$) at time 1 and time 2, as were the correlation coefficients for the 9-figure card set for current size ($r_s = .78, p < .01$) and ideal size ($r_s = .69, p < .01$) (Table 10).

<table>
<thead>
<tr>
<th></th>
<th>5-Figure Card Set</th>
<th>9-Figure Card Set</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>(n=16)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Current Size</td>
<td>$r_s = .79^*$</td>
<td>$r_s = .78^*$</td>
</tr>
<tr>
<td>Ideal Size</td>
<td>$r_s = .83^*$</td>
<td>$r_s = .69^*$</td>
</tr>
</tbody>
</table>

* Significant at the .01 level

4.3.2 Test-Retest Reliability Of Figure Rank Ordering Task

The percentages of correctly rank ordered figures were obtained for all 16 participants in the retest sub-sample, and compared with responses at time 1. Of the 80 responses for the 5-figure card set, 71.6% and 75.8% demonstrated correctly positioned figures.
for the male set and female set respectively (in comparison to 74.4% and 69.6% in the first assessment). Using the 9-figure card set, of the 144 responses for each set of figures 67.9% and 44.4% of the responses demonstrated correctly positioned figures for the male set and female set respectively (in comparison to 49.6% and 53.3% in the first assessment) (Table 11).

Table 11: Test-Retest Reliability of the Percentages of Correctly Rank Ordered Figures in the Figure Rank Ordering Task

<table>
<thead>
<tr>
<th></th>
<th>5-Figure Card Set</th>
<th>9-Figure Card Set</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Male</td>
<td>Female</td>
</tr>
<tr>
<td>Time 1</td>
<td>74.4%</td>
<td>69.9%</td>
</tr>
<tr>
<td>Time 2</td>
<td>71.6%</td>
<td>75.8%</td>
</tr>
</tbody>
</table>

The percentages of figures positioned in an ascending sequence by the retest subsample were also calculated. For the 5-figure card set, 86% and 82% of the figures were positioned in an ascending sequence for the male set and female set respectively (in comparison to 84% and 85% in the first assessment). For the 9-figure card set, of the figures 74% and 60% were positioned in an ascending sequence for the male set and female set respectively (in comparison to 73% and 75% in the first assessment) (Table 12).

Table 12: Test-Retest Reliability of the Percentages of Figures Positioned in an Ascending Sequence in the Figure Rank Ordering Task

<table>
<thead>
<tr>
<th></th>
<th>5-Figure Card Set</th>
<th>9-Figure Card Set</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Male</td>
<td>Female</td>
</tr>
<tr>
<td>Time 1</td>
<td>84%</td>
<td>85%</td>
</tr>
<tr>
<td>Time 2</td>
<td>86%</td>
<td>82%</td>
</tr>
</tbody>
</table>

4.3.3 Level Of Exact Agreement Between Figures Selected At First Assessment And Retest Assessment

Participants' choices of current and ideal figures at time 1 and time 2 were compared to determine the exact level of agreement in their choices. For the current and ideal...
figure selections combined together on the 5-figure card set, the level of exact agreement between the initial assessment and retest assessment was 75%. However, the 9-figure card set's level of exact agreement was only 34.4% (Table 13).

Table 13: Level Of Exact Agreement Between Figures Selected At First Assessment And Retest Assessment

<table>
<thead>
<tr>
<th></th>
<th>5-Figure Card Set</th>
<th>9-Figure Card Set</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level of Exact Agreement</td>
<td>75%</td>
<td>34.4%</td>
</tr>
</tbody>
</table>

4.4 FACTORS INFLUENCING THE PARTICIPANTS' ABILITY TO CARRY OUT THE BODY IMAGE ASSESSMENT

4.4.1 Accuracy of selection of body size in self-rating task

To enable examination of the factors influencing the participant's ability to carry out the body image assessment, a measure of accuracy of body size selection in the self-rating task was initially established. For the 5-figure card set, each participant's choice of figure was deemed to be an accurate selection of body size if they selected:

a) figures 1 or 3 and they themselves had a BMI that fell in the underweight BMI category
b) figure 5 and they themselves had a BMI that fell in the normal/healthy weight BMI category
c) figures 7 or 9 and they themselves had a BMI that fell in the overweight or obese BMI category

Any other selections that did not fit in the categories above were taken as an inaccurate judgement of body size.
For the 9-figure card set, each participant's choice of figure was deemed to be an accurate selection of body size if they selected:

a) figures 1, 2 or 3 and they themselves had a BMI that fell in the underweight BMI category
b) figures 4, 5 or 6 and they themselves had a BMI that fell in the normal/healthy weight BMI category
c) figures 7, 8 or 9 and they themselves had a BMI that fell in the overweight or obese BMI category

Likewise, as for the 5-figure card set, any other selections that did not fit in the categories above were taken as an inaccurate judgement of body size.

Using the above procedure the whole sample were split in to two groups for both the 5-figure and 9-figure card sets. The first group consisted of those participants that were deemed accurate at estimating their body size from the figures in the self-rating task. This consisted of 64% of the sample for the 5-figure card set and 68% of the sample for the 9-figure card set. The second group was made up of those participants that were deemed inaccurate at measuring their body size from the figures in the self-rating task. This group consisted of the remaining 36% of the sample for the 5-figure card set and the remaining 32% of the sample for the 9-figure card set.

4.4.2 The Influence of IQ On The Participants' Ability To Carry Out The Body Image Assessment

4.4.2.1 IQ and accuracy of selection of body size in self-rating task

A Mann-Whitney-U test (non-parametric test) was used to see if there were differences between those participants deemed accurate and those deemed inaccurate at estimating their body size in terms of Full Scale (FIQ), Verbal (VIQ) and Performance IQ (PIQ). For the 5-figure card set, there were no significant differences found between these two groups in terms of FIQ ($z = - .50, p > .62$), VIQ ($z = -.32, p > .75$) or PIQ ($z = - .30, p > .77$). Likewise no significant differences were found for the 9-figure card set for the FIQ ($z = - .09, p > .92$), VIQ ($z = -.34, p > .74$) or the PIQ ($z = - .17, p > .87$).
4.4.2.2 IQ and individual accuracy of figure rank ordering task
A measure of individual accuracy for the figure rank ordering task was calculated on the basis of the percentage of figures positioned correctly by each individual. Using a Spearman rank order correlation coefficient test, Full Scale IQ was found to be significantly correlated with individual accuracy for rank ordering the figures on both the 5-figure card set ($r_s = .38, p < .01$) and the 9-figure card set ($r_s = .53, p < .01$). Performance IQ was also found to be significantly correlated with individual accuracy for rank ordering the figures on both the 5-figure card set ($r_s = .42, p < .01$) and the 9-figure card set ($r_s = .56, p < .01$). However Verbal IQ was only found to be significantly correlated for the 9-figure card set ($r_s = .35, p < .05$), whilst the 5-figure card set rank ordering task was not found to be significantly correlated with Verbal IQ ($r_s = .22, p < .01$).

4.4.3 The Influence Of Gender On The Participants' Ability To Carry Out The Body Image Assessment

4.4.3.1 Gender and accuracy of selection of body size in self-rating task
Accuracy of selection of body size was calculated as described in section 4.4.1. When completing the 5-figure card set self-rating task, 60% of males were accurate at selecting their correct body size, compared to 68% of the female sample. For the 9-figure card set, the male participants appeared to be slightly more accurate at selecting their body size in the self-rating task, with 76% of males being accurate compared to 60% of the female participants.

4.4.3.2 Gender and ability to rank order figures
Using a Mann-Whitney-U test, no significant differences were found between the male and female participants in terms of their ability to rank order the figures for either the 5-figure card set ($z = -.58, p > .56$) or the 9-figure card set ($z = -.20, p > .85$). Gender did not have an effect on ability to rank order the figures.

4.4.4 Successful Completion Of The Square Rank Ordering Task And The Participants' Ability To Carry Out The Body Image Assessment
The number of participants who successfully rank ordered all the squares into correct size order was counted, in addition to the number of participants who successfully
rank ordered all the figures in to correct size order. The number of participants that could correctly rank order both the squares and all the figures was also calculated.

Thirty-eight participants (76%) were able to sort all 5 squares into the correct size rank order and 25 participants (50%) were able to sort all 5 figures in to the correct size rank order. Forty-six per cent of the sample was able to sort both the squares and the figures into correct rank order for the 5-card sets. This suggests that most of the sample were unable to sort both the squares and the figures into correct size rank order. A Chi-Square Test was used to explore whether the participants who could successfully sort the squares and figures using the 5-figure card set were more accurate at choosing their own body size in the self-rating task. A non-significant result was found ($X^2 = .03, p > .87$) (Table 14).

Table 14: Square & Figure Rank Ordering Tasks and Accuracy of Selection of own Body Size using the 5-Figure Card Set

<table>
<thead>
<tr>
<th>Square &amp; Figure Rank Ordering Tasks</th>
<th>Both correct</th>
<th>Incorrect*</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accurate Selection Of Own Body Size</td>
<td>15</td>
<td>17</td>
<td>32</td>
</tr>
<tr>
<td>Inaccurate Selection Of Own Body Size</td>
<td>8</td>
<td>10</td>
<td>18</td>
</tr>
<tr>
<td>Total</td>
<td>23</td>
<td>27</td>
<td>50</td>
</tr>
</tbody>
</table>

*Both incorrect OR square task correct & figure task incorrect OR square task incorrect & figure task correct.

Only 18 participants (36%) were able to sort all 9 squares in to the correct size rank order and 10 participants (20%) were able to sort all 9 figures in to the correct size rank order. Fourteen per cent of the sample was able to sort both the squares and the figures into correct rank order for the 9-card sets. This again suggests that most of the sample were unable to sort both the squares and the figures into correct size rank
order. A Fisher Exact Test\(^1\) was used to explore whether the participants who could successfully sort the squares and figures were those that had successfully chosen their own body size in the self-rating task. An non-significant result was also found for the 9-figure card set using the Fisher Exact Test \((p > .19)\) (Table 15).

Table 15: Square & Figure Rank Ordering Tasks and Accuracy of Selection of own Body Size using the 9-Figure Card Set

<table>
<thead>
<tr>
<th>Square &amp; Figure Rank Ordering Tasks</th>
<th>Both correct</th>
<th>Incorrect*</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Accurate Selection Of Own Body Size</strong></td>
<td>3</td>
<td>31</td>
<td>34</td>
</tr>
<tr>
<td><strong>Inaccurate Selection Of Own Body Size</strong></td>
<td>4</td>
<td>12</td>
<td>16</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>7</td>
<td>43</td>
<td>50</td>
</tr>
</tbody>
</table>

*Both incorrect OR square task correct & figure task incorrect OR square task incorrect & figure task correct.

\(^1\) The Fisher Exact Test was used due to there being an expected value of less than 5 in two cells.
6. DISCUSSION

The aim of the present study was to explore body image in people with mild learning disabilities using a schematic figure rating scale. The Contour Drawing Rating Scale (Thompson & Gray, 1995) was adapted for this purpose. Generally good preliminary validity and reliability were established for the Body Image Assessment when tested on a group of fifty people with mild learning disabilities living in the community. This provides initial support for the Body Image Assessment as a measure of body image in people with mild learning disabilities, although replication is necessary. The participants' weight and BMI are initially discussed, followed by the validity and reliability results. Factors influencing the participants' ability to carry out the Body Image Assessment are also presented as well as methodological issues and ideas for future research.

6.1 WEIGHT & BMI

Twenty-two per cent of the participants were categorised as obese and only 6% were underweight. These findings fall within the range reported by Gravestock (2000) who found that 2-35% of adults with learning disabilities were obese and 5-43% were significantly underweight. Rimmer et al (1993) also reported high rates of obesity and being overweight in adults with learning disabilities. In the current study, the rate of obesity was higher than that found in the general population (10%), however the rate of being underweight was less than that found in the general population (9%) (OPCS, 1991).

Wood (1994) suggested that populations of people with learning disabilities often display weight distributions that are polarised at either end of the scale. However in this study the majority of the participants were overweight or obese (60%) rather than underweight (6%). Previous studies have suggested people with mild learning disabilities were more likely to be overweight than those with more severe learning disabilities (Gravestock, 2000). People with more severe and profound learning disabilities are more likely to be underweight possibly as a result of assisted feeding, poorer mobility and greater eating problems such as regurgitation (Wood, 1994;
Gravestock, 2000). Differences in population characteristics may, therefore, explain these differences in findings.

McCarran & Andrasik (1990) suggested being overweight or obese may assist in perpetuating a negative attitude towards people with learning disabilities. Indeed being overweight appears to carry a stigma along with it in general society (Grogan, 1999; Thompson et al, 1999). Nevertheless people with learning disabilities may be more likely to be overweight for reasons out of their immediate control such as side effects from medication, lack of opportunity to attend activities related to exercise and food being used for reinforcement purposes (Wood, 1994; Babbitt et al, 1995). In addition the role that eating disorders plays in weight issues for people with learning disabilities is still unknown.

6.2 VALIDITY OF THE BODY IMAGE ASSESSMENT

6.2.1 Performance On The Self-Rating Task

When asked to select their current body size from the schematic figures, the participants' choice of figure size increased as their own weight and BMI increased. Importantly, it would appear that participants with mild learning disabilities in this study were able to accurately perceive their own body size. This in turn, provides supporting evidence for the concurrent validity of the Body Image Assessment scale when used with people with mild learning disabilities.

While validity data were satisfactory for both the 5-figure and 9-figure card sets, the correlation coefficient for the 5-figure card set was higher than the 9-figure card set. However the differences between the card sets were minimal (.03 for both BMI and weight). The participants with mild learning disabilities seemed similarly able to accurately perceive their own body size when having to select from 9 figures, as they did when having to select from 5 figures. This suggests it may not be necessary to limit the scale to 5 figures, although further investigation on another sample could help to confirm this. Concurrent validity was found for both the male and female card sets independently of each other, suggesting that both males and females have accurate perceptions of their body size as judged by this task.
The correlation coefficients between the choice of figure size, and weight and BMI, compared well with those of the original Contour Drawing Rating Scale's (Thompson & Gray, 1995) and those of an additional study using the Contour Drawing Rating Scale with 250 men and women (Thompson, 1993). This indicated that the participants with mild learning disabilities in the current study performed as well on the self-rating task as the non-learning disabled participants in other studies.

6.2.2 Labelling Of The Figures
The participants used appropriate words to describe the body size of the figures on the scale using labels that matched the body size categorisation of the schematic figures. For example, they were able to appropriately label the underweight pictures as underweight, the normal/healthy weight pictures as normal/healthy and the overweight pictures as overweight. No participants used overweight words to describe the underweight pictures, and none labelled the overweight pictures using underweight labels. Appropriate labelling of the figures provides supplementary evidence for the validation of the Body Image Assessment, in that people with mild learning disabilities were able to accurately identify that the scale depicted underweight, normal/healthy weight and overweight people.

Similar findings were found during the validation of the original Contour Drawing Rating Scale (Thompson & Gray, 1995) with a non-learning disabled sample. However the procedure was somewhat different, in that the participants were asked to identify which figures were anorexic and which figures were obese. Only the underweight figures were labelled anorexic and never overweight (male figures 1-3, female figures 1-4), and the overweight figures were labelled as obese and never underweight (male and female figures 7-9). A strength of the current study, is that participants were not given the labels 'anorexic' and 'obese' to apply to the figures, but instead were asked to label the figures in their own words. This avoided the possibility of response compliance and demonstrated that those with mild learning disabilities used descriptive words similar to those used by adults in the general population.
6.2.2.1 The range of labels used by participants to describe the figures and their own body shape

The range of labels offered by the participants to describe the figures and their own body shape were quite varied and encompassed underweight to overweight body size. Interestingly some connotations of labels that have been used in association with eating disorders were spontaneously provided by the participants, for example "anorexic; starving self; not eaten anything". Although the label 'obese' was not suggested when describing the overweight figures or themselves, some of the descriptions provided by participants appeared to recognise the negative implications that obesity can have, for example "bad for your heart; unhealthy". Some labels also recognised the necessity for a change in body size to achieve a healthy lifestyle, such as "needs to take more exercise". Two female participants identified that women could be large for reasons other than poor health, suggesting instead pregnancy.

The range of labels given by the participants to describe body size was plentiful, although it could be argued that simpler vocabulary was used than would have been used by non-learning disabled people. This is to be expected given the participants' cognitive level of functioning. Their range of labels reflected common social attitudes to weight and body size. Unfortunately further investigation of the labels used was outside the scope of this study, although further research exploring the source of the labels would provide greater insight in to the concept of body image in people with learning disabilities.

6.2.3 Desire To Be The Same Or A Different Body Size & Body Image Satisfaction

The higher the participants' BMI, the more likely the participants were to choose an ideal figure size that was smaller than their perceived current figure size. Thus, those with higher BMIs were more likely to choose a smaller ideal size whilst those with lower BMIs were inclined to choose a bigger ideal size. It could be speculated that the above finding is the same as that which would be expected in a general population. That is to say, where people are given a choice of ideal size, and are dissatisfied with their current size, those who are more overweight would generally be expected to want to be smaller in size and those who are underweight would generally be expected
to want to be bigger in size. The data provided further validation for the Body Image Assessment as a measure of body image in people with learning disabilities.

The results also suggested the Body Image Assessment discrepancy score was a useful gauge for measuring how participants would like to be different in relation to their current body size, as a measure of body size satisfaction. As the previous results indicated that people with mild learning disabilities could accurately perceive their body size using the Body Image Assessment (section 6.2.1), an understanding of body size satisfaction could be derived from the data.

Interestingly, for both the 5-figure and 9-figure card sets the majority of the participants wanted to be a different size (60% and 64% respectively) indicating a level of body size dissatisfaction. However, over a third wanted to stay the same size (40% and 36% respectively) indicating that they were satisfied with their body size. Of those that were dissatisfied with their body size, the majority wanted to be smaller in size (42% for the 5-figure card set and 46% for the 9-figure card set), and the minority wanted to be bigger in size (18% for each card set).

The higher level of body size dissatisfaction could be related to the fact that 60% of the participants in the sample were overweight or obese. In addition, it may also be that the participants have been influenced by society's pressure to be thinner (Grogan, 1999). Further interviews with people with learning disabilities would need to take place to explore this possibility.

**6.2.4 Performance On The Figure Size Rank-Ordering Task**

The participants were more successful at sorting the figures in an ascending sequence than correctly rank ordering all the figures for both the 5-figure and 9-figure card sets. Additionally the participants found the 5-figure card set easier to order than the 9-figure card set, particularly in the size rank order task. Few differences were found for either task between the male and female sets of figures. This appears to indicate that the participants were generally able to tell the differences in the successive figures, although this became more difficult for them when there were a greater number of figures.
The participants with mild learning disabilities in this study were not as successful at completing the size rank order task in comparison to the participants in the original validation of the Contour Drawing Rating Scale (Thompson & Gray, 1995). Although they found the task of sorting in ascending order easier than size rank ordering, the percentages of correctly positioned figures were moderately lower than those of Thompson & Gray's original study.

The participants in this study found the task of rank ordering the figures more difficult than that of the primary task of this study, accurately identifying their own body size. It may be that the rank order task requires the person to utilise different cognitive abilities than the self-rating task. The rank-ordering task may require the person to have greater concentration and attention, sequencing ability, planning skills and perceptual organisation. The rank ordering task may also promote greater anxiety in the participants, due to the perceived concern about completing the task incorrectly. Thus, the participants with learning disabilities may have found the rank-ordering task more difficult because it requires different skills to the primary self-rating task. The rank ordering task was used as a measure of validity in Thompson & Gray's (1995) original study. However this study questions the use of the rank-ordering task as a measure of validity for the Body Image Assessment for people with learning disabilities.

6.3 RELIABILITY OF THE BODY IMAGE ASSESSMENT

6.3.1 Reliability Of The Self-Rating Task
Highly significant test-retest reliability coefficients were found between time 1 and time 2 for both the choices of the current body size and ideal body size. This was true for both the 5-figure and 9-figure card sets indicating that both card sets were used reliably by this population.

The test-retest coefficients for the selection of current body size were virtually identical to those reported with the original Contour Drawing Rating Scale (Thompson & Gray, 1995). In addition, the test-retest reliability compared very well

The level of exact agreement between choices of current and ideal body size at time 1 & 2 could also be seen as contributing to the reliability data for the Body Image Assessment. This closer look at the reliability of the self-rating task revealed satisfactory exact agreement on the 5-figure card set, but poor exact agreement on the 9-figure card set. It could be that the 9-figure task provided too much choice for people with learning disabilities. Often participants had selected their choice of card that was just one position up or down on the 9-figure card set, and so lowering the number of exact agreements. Using the 5-figure card set there was less choice of cards and so allowing for greater chance of picking the same figures in the first assessment and the retest assessment. This more exacting definition of agreement revealed difficulties within this population with the 9-figure card set that were not apparent using reliability coefficients.

Other studies using the general adult population have not scrutinised the test-retest reliability of the self-rating task in this way, including the original Contour Drawing Rating Scale study (Thompson & Gray, 1995). Yet Dowdney et al (1995) found similar and slightly higher rates of exact agreement as this present study's 5-figure card set data, when using a 5-figure schematic rating scale with children. Unfortunately Dowdney et al's (1995) rating scale only consisted of five figures, allowing no comparison with the present study's poorer level of exact agreement using the 9-figure scale. Further investigation could determine whether providing a greater number of figures to choose from, would also result in less exact agreement in figure choice over time in adults from the general population, as well as in people with learning disabilities.

6.3.2 Reliability Of The Figure Rank-Ordering Task

Good test-retest reliability for the figure rank-ordering task was found for both card sets, although there was greater variation at time two between male and female participants for the 9-figure card set. Good test-retest reliability was also found for the
percentages of figures placed in ascending sequence for the 5-figure card set, but the reliability for the female participants on the 9-figure card set was not so strong. Again these findings were similar, but not as clearly defined, to those of Thompson & Gray's original testing of the Contour Drawing Rating Scale (1995) where the percentages of correctly positioned cards increased very slightly at time 2 for both card sets.

The performance on the rank ordering task (section 6.2.4) may not have been so good as when originally carried out using the Contour Drawing Scale with non-learning disabled participants, however the data still suggests sufficient test-retest reliability for the rank-ordering task of the Body Image Assessment.

6.4 THE INFLUENCE OF IQ ON THE BODY IMAGE ASSESSMENT
No differences in the mean IQ levels were found between those who could and those who could not accurately estimate their body size. Level of IQ (Full Scale, Performance or Verbal) was not found to have an effect on the participants' ability to accurately estimate their body size from the figures in the self-rating task on either the 5-figure or 9-figure card set.

Although it might have been expected that those participants at the higher end of the mild learning disabilities IQ group would have been more accurate at perceiving their own body size, this does not appear to be the case in this sample. It may be that there is a limited range of abilities in the mild learning disabilities group because the IQ only spans 20 points. Including people with moderate learning disabilities in a further study would provide further opportunity for investigation of the effects of IQ on the ability to accurately perceive body size.

IQ did appear to influence the accuracy of responses to the figure rank ordering task. Both Full Scale IQ and Performance IQ scores correlated significantly with accuracy of performance on rank ordering for both 5-figure and 9-figure card sets. Verbal IQ was only significantly correlated with accuracy of performance on the rank ordering task for the 9-figure card set, but not the 5-figure card set. The rank ordering task requires greater performance skills than verbal skills, needing only receptive language skills in terms of verbal abilities in order to understand the instructions. This may
explain why the participants with a higher Performance IQ and higher Full Scale IQ were more successful at the rank order task.

6.5 THE INFLUENCE OF GENDER ON THE BODY IMAGE ASSESSMENT

There were no significant differences between the male and female participants in the accuracy of selection of their body size using both the 5-figure and 9-figure card sets, although the male participants had slightly higher scores using the 9-figure card set. Neither were there significant gender differences in the participants' ability to rank order the figures on either card set. Fallon & Rozin (1985) reported gender differences for accuracy of self-ratings using another schematic rating scale for adult males and females. Yet although they concluded that women overestimated their heaviness more than men, they had no true measure of weight or BMI on which to base their findings. No other gender differences have been reported using schematic rating scales. Further, some studies use measures that have only female figures in their scales (Williamson et al, 1989; Beebe et al, 1999) or have used only female participants (Thompson & Gray, 1995) and so gender differences are not investigated.

6.6 THE INFLUENCE OF THE SQUARE RANK ORDERING TASK ON THE BODY IMAGE ASSESSMENT

Participants completed the square rank ordering task to explore their ability to complete a rank order task and to provide them with practice at ordering shapes in terms of their relative size. This task was not found to be a good indicator of the success rate of the figure rank-ordering task, particularly when using the 9-figure card set. For both card sets, those participants who could rank order both the squares and figures were no more accurate at choosing their body size than those who could not rank order both the squares and figures. These analyses throw into question the usage of the square rank ordering task as a predictor of successful completion of the Body Image Assessment.

Nevertheless, the square rank ordering task's value as a practice tool for introducing relative size and rank ordering tasks is more difficult to quantify. This task provided a useful demonstration of how to rank order items in size order and thereby offered the
participants a learning opportunity for the later completion of the figure rank ordering tasks. Participants had the opportunity to gain confidence in the practice of ordering shapes by initially copying the researcher's demonstration and later moving on to completing the square rank ordering task alone.

6.7 DISCUSSION OF METHODOLOGICAL ISSUES

6.7.1 Strengths Of The Present Study
The current study showed that it was possible to measure certain aspects of body image in people with learning disabilities in a reliable and valid fashion. Previously measures have been developed without people with learning disabilities in mind. This study suggests that the Contour Drawing Rating Scale (Thompson & Gray, 1995) can be successfully adapted for people with mild learning disabilities in terms of the language used on the questionnaire and the presentation of the questions during the actual interview. Additionally there was a good response rate from participants recruited for the study in that all but one potential participant agreed to take part. Further, even though the subject matter of the interview was of a sensitive nature, all participants who met study criteria commenced the interview without any dropout of participants.

This was in part due to a component of the interview being devoted to an initial engagement period, but also perhaps because the material presented in the Body Image Assessment was mainly visual stimuli. These acted as visual prompts for the interview questions and, resulted in fewer problems in communication, given the possibility of somewhat limited expressive language abilities in this population. The structured nature of the Body Image Assessment, along with the marrying of visual and verbal material, could also be seen as a strength as it assisted the participants in their responses.

6.7.2 Limitations Of The Present Study
Although initial validity and reliability were established for the use of the Body Image Assessment with people with mild learning disabilities, further evidence to support this measure needs to be provided. The current study was exploratory in nature and
provided relatively small numbers of participants. Replication with greater numbers of participants would allow generalisation of the results of the current study. In addition, caution must be used in inferring causality between the related variables, as much of the analysis was correlational in nature.

The sample included equal numbers of male and female participants, and participants of differing age, weight, BMI and IQ. However the socioeconomic status of the population was not recorded. Sobal & Stunkard (1989) noted that higher socioeconomic status has been associated with an increased desire for thinness in adults and adolescents. This would have been an interesting additional variable to explore in relationship to body image in people with learning disabilities.

6.8 FURTHER RESEARCH
Several areas for potential further research have arisen from this study. Replication of the use of the Body Image Assessment with additional samples of people with mild learning disabilities would assist in establishing further validity and reliability data for the measure. Use of the Body Image Assessment with people with moderate learning disabilities would allow exploration of body image in a wider range of people with learning disabilities, as well as investigating whether people with moderate learning disabilities are also able to accurately perceive their body size. Additionally, greater exploration of the concept of body image in people with learning disabilities is necessary for the understanding of how body image in people with learning disabilities may differ or be the same as that in the general population. This should include the exploration of body image satisfaction and body image disturbance in people with learning disabilities.
7. CONCLUSION

This study demonstrated good initial validity and reliability data for the self-rating task, in which the participant identified their current and ideal body size from figures on the Body Image Assessment. The successful completion of the self-rating task suggested that people with mild learning disabilities were able to accurately perceive their own body size in this study. The findings compared well to those of the original Contour Drawing Rating Scale (Thompson & Gray, 1995) with a non-learning sample. The data also suggested the participants were able to use the 9-figure card set just as well as the 5-figure card set for this task.

As the participants were identified as being able to accurately perceive their own body size, body size satisfaction was also measured. The body size discrepancy score provided a useful measure of body size satisfaction. Nearly two-thirds of the participants were identified as being dissatisfied with their body size in this study, and most of these participants wanted to be smaller in size. Participants were also able to correctly identify underweight figures, normal/healthy weight and overweight figures on the scale, as well as providing a wide range of labels to describe the various different body sizes.

Although the participants were able to successfully complete the self-rating task, participants were not so successful at completing the rank-ordering task. They found the 5-figure card set easier to rank order than the 9-figure card set. The participants also were not as successful at this task as those non-learning disabled participants in the original Contour Drawing Rating Scale study (Thompson & Gray, 1995). The rank-ordering task may require different cognitive abilities to those required in the self-rating task and therefore may not be a suitable way to establish reliability and validity data for people with learning disabilities. Nevertheless satisfactory test-retest reliability was established for the rank-ordering task.

IQ was not found to have an effect on ability to accurately estimate body size in people with mild learning disabilities. This may be due to the narrow range of IQ scores available in the mild learning disabilities category providing little variation
between different participants. Yet those participants with a higher PIQ or FSIQ were more accurate at rank-ordering the figures in size order. Further research into the use of the Body Image Assessment with people with moderate learning disabilities would provide a different group for IQ comparisons as well as validating the tool on a wider range of people with learning disabilities.

No significant gender differences were found in the participants' ability to accurately perceive their own body size. Similarly, no gender differences were found in the rank-ordering task. The square rank-ordering task was not found to be a good predictor of successful completion of the Body Image Assessment, however its value as a practice exercise for introducing relative size and rank ordering was thought to be significant.

Replication of this study using the Body Image Assessment would provide additional support for this use of this tool as a measure of body image and body size satisfaction in people with learning disabilities. This could contribute to the assessment of body image disturbance and, along with an assessment of eating problems, indicate further investigation is necessary for potential eating disorders in people with learning disabilities.
7. REFERENCES


8. APPENDICES

Appendix A: The Body Image Assessment

Appendix B: The Contour Drawing Rating Scale (Thompson & Gray, 1995)

Appendix C: Copies of Ethics Approval Letters

Appendix D: Information Sheet

Appendix E: Consent Form

Appendix F: Labels used by the participants to describe their own body shape.
APPENDIX A:
The Body Image Assessment
Body Image Assessment

1) We have talked together about things being different. Things can be different shape and size as well. These cards have pictures of squares on them. The squares are all different shapes from each other.

Can you place these squares in order for me? At this end put the card that you think shows the smallest square. At that end put the card that you think shows the biggest square. Between them place the cards in order so that the squares get bigger and bigger. Take as long as you want and tell me when you have finished.

(Demonstrate and leave 3, demonstrate and take away 4. Then 5 & 9 on their own)

Note order:

2) These cards in front of you have pictures of people on them:

Can you point to the two cards that show pictures of women?

Can you point to the two cards that show pictures of men?

Response:  Women: ✓ ✗  
            Men: ✓ ✗  

PsYchD in Clicinal PsychoLogy
**FIVE CARDS**

3) The men/women on these cards are all the same height. Can you see that? (Point) But their bodies are all different shapes:

Can you place all the cards in order for me? At this end put the card that you think shows the smallest person. At that end put the card that you think shows the biggest person. Between them place the cards in order so that the persons' body shapes get bigger and bigger. Take as long as you want and tell me when you have finished.

*Note order:*

---

4) Point to the card with a man/woman on it whose shape is most like you now?

*Card number:*

---

5) That is your shape now. Point to a card with a man/woman on it who is the same shape as you would like to be? It may be the same card or it may be different card.

*Card number:*

---

**NINE CARDS**

6) Can you place all the cards in order for me? At this end put the card that you think shows the smallest person. At that end put the card that you think shows the biggest person. Between them place the cards in order so that the persons' body shapes get bigger and bigger. Take as long as you want and tell me when you have finished.

*Note order:*
7) Point to the card with a man/woman on it whose shape is most like you now?

*Card number:*

8) That is your shape now. Point to a card with a man/woman on it who is the same shape as you would like to be? It may be the same card or it may be different card.

*Card number:*

9) What words would you use to tell me about the shape of your body?

*Response:*
10) I have used the words 'smallest and biggest' to talk about the shape of the people on the cards. What words would you use to tell me about the shape of the people on the cards?

Prompts:
(i) What words would you use to tell me about the people at this end? (Point to card nos 1 - 3)?
(ii) What words would you use to tell me about these people (Point to cards in middle)?
(iii) What words would you use to tell me about the people at this end? (Point to card nos 7 - 9)?

Response:
Demographic Information

DOB ____________________________ 

Age ____________________________

Gender __________________________

Ethnic group ______________________

Living arrangements ________________________________________

Developmental disorder _______________________________________

Dual diagnosis ______________________________________________

Height __________________________

Weight __________________________

BMI _____________________________

IQ score _________________________
APPENDIX B:
The Contour Drawing Rating Scale
(Thompson & Gray, 1995)
THE CONTOUR DRAWING RATING SCALE

(Thompson & Gray, 1995)
APPENDIX C:
Copies of Ethics Approval Letters
EAST SURREY LOCAL RESEARCH ETHICS COMMITTEE
Santhams,
West Park Hospital,
Horton Lane,
Epsom, Surrey,
KT19 8PB.

SH/AJR
Date: 12th June 2000.

To: Sarah Johnstone,
26 Ludlow Road,
Guildford, Surrey,
GU2 7NR.

Dear Ms Johnstone,

RE: THE ASSESSMENT OF BODY IMAGE IN A COMMUNITY POPULATION OF PEOPLE WITH MILD LEARNING DISABILITIES
REF: 04SJBI(240) - to be quoted on all future correspondence please

Thank you for your letter dated 31st May 2000 in response to ours of 22nd May which has now been reviewed in regard to the above research submission and I confirm that Chairman's Approval has been given to go ahead with this trial. The Committee would like to say that they were very impressed with the Patient Information Sheet and Consent Forms.

In future, the Committee would like to follow up all new trials. Therefore, we would be grateful if you could send us an update after a period of a year from the commencement of the study with the following details:-

1. Is the research still continuing?
2. If it is, which stage has it reached:-
   2.1. Data being collected
   2.2. Data being analysed
   2.3. Research being written up
   2.4. Research published.

N.B. If you are sending any Protocol Amendments to us, please ensure that you highlight the areas of change.

Thank you for your trouble.

Yours sincerely,

[Signature]
Selina Harris,
Manager - ESLREC

cc. JT
cc. MO

PsychD in Clinical Psychology

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Dear Miss Johnstone

The assessment of body image in a community population of people with mild learning disabilities (ACE/2000/55/Psych) – FAST-TRACK

I am writing to inform you that the Advisory Committee on Ethics has considered the above protocol under its 'Fast Track' procedure and has approved it on the understanding that the Ethics Guidelines are observed and the following condition is met:-

- That East Surrey Local Research Ethics Committee are informed of the proposed inclusion of volunteers from the Lockwood Day Centre in Guildford.

This letter of approval relates only to the study specified in your research protocol (ACE/2000/55/Psych). 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). I enclose a copy of the Ethics Guidelines for your information.

I should be grateful if you would confirm in writing your acceptance of the condition above.

Date of approval by the Advisory Committee on Ethics: 18 July 2000
Date of expiry of Advisory Committee on Ethics approval: 17 July 2005

Please inform me when the research has been completed.

Yours sincerely,

Professor Laurie King
Chairman, Advisory Committee on Ethics

cc: Professor L J King, Chairman, ACE
Dr V Hill, Principal Investigator, Dept of Psychology
Dr L Dowdney, Principal Investigator, Dept of Psychology
Dr K Dodd, Co-Investigator, Oaklands NHS Trust

JB/LJK/(ACE/2000/55/Psych)
APPENDIX D:

Information Sheet
Differences in Body Shape

Information sheet

My name is Sarah Johnstone. At the moment I am training to become a Clinical Psychologist. As part of my training, I am going to carry out a research project. I need to talk to lots of different people and hear what they say. I would like to ask you to take part in my research project. Before you decide, it is important for you to understand what the project is about and what it will mean to take part. Please take time to read this information carefully. You can discuss it with friends, relatives or staff first if you wish. Please ask if anything is not clear or if you would like more information.

What is the project about?
My project is called 'Differences in Body Shape'. To help you understand about my project, let us first look at how everybody is different from each other. One person may like watching TV, another person may like to read a book. People look different too. One person may have blond hair, another person may have brown hair. There are many other ways in which people look different from each other. People may be different in their body shape, for example one person may be slim, another person may be larger. This project looks at the differences in the shape of peoples' bodies. It asks what people think about the shape of their own bodies.

What will I have to do?
I would like to meet with you for about 45 minutes. We will start by talking together about how things and people can be different. I will then show you some pictures and ask you to put them in an order for me. I also will show you some pictures of people and will ask you what shape is most like you. I will ask you what shape you would like to be. I want to find out what you think about the pictures of the different people that I show you, and what you would say about the pictures. After talking about the pictures I would like to measure your height and weight.

As everybody is different from each other, I would also like to do a few puzzles and word games with you, to help us find out what things you are good at.
I may ask if I could meet up with you again after a few weeks for a second meeting. This would take less time, probably only 10 minutes. In this second meeting we would just look at the pictures together and talk about body shape.

Do I have to take part?
It is up to you to choose whether or not you want to take part. You DO NOT have to take part. If you are happy to take part, you will be given this information sheet to keep. You will also be asked to sign a form that says you have agreed to take part in the project. If you change your mind or want to stop any time that is OK. It will not affect you in any way if you do not want to take part or continue in the project.

Will other people know what I have said in the meeting?
All information collected will be kept secret. This means that nobody other than me will know the answers that you have said. I will not tell anyone your name.

If I get worried about your safety because of something you have said to me, I will talk to your key worker about how to keep you safe. I will tell you first if I am going to talk to your keyworker.

Do you have any other questions?
Please ask any questions that you want to when we meet. If there is anything you want to ask before, or if you think of anything you would like to ask me about the project after we have met, you can telephone me. My telephone number is 07971 594904.

In the meantime thank you very much for taking part in my project.

Sarah Johnstone
APPENDIX E:

Consent Form
CONSENT FORM

Title of project: Differences in Body Shape

Name of Researcher: Sarah Johnstone

Sarah Johnstone has told me about the project and I have seen the Information Sheet. I know that this project is about differences in peoples' body shape.

I know what I will have to do and I have had the chance to ask questions.

I understand that I can stop helping with this project at any time, without giving reasons, and that this will not affect me in any way. If I get upset we will stop what we are doing, and if I want, Sarah Johnstone will talk to my keyworker for me.

I understand that Sarah Johnstone will not tell anyone my name or what I have said. If Sarah Johnstone gets worried about my safety, she will talk to my keyworker about how to keep me safe.

I know that Sarah Johnstone will be writing things about her project and that other people will read this.

I agree to take part in the project.

Name of Person Taking Part Date Signature

Name of Researcher Date Signature
APPENDIX F:
Labels used by the participants to describe their own body shape.
Labels used associated with being 'overweight':

Big built
Big body
Quite large
Fat one
I'm heavy
Bit fat
Some people say I'm fat
Big
Fat tummy, got to lose weight.
Too fat, try to diet
Too fat, makes it difficult for me to walk
Quite big
Plumpish
People tell me I'm too big
Poggy, don't like the word fat
Big at the hips
Mum used to say "you look as if you're pregnant"
Bad for your heart
Chubby
Fat

Additional labels/comments:

 Doesn't matter whether you're fat or thin
I'd like to be skinny
Like my fat tummy
Weight goes up and down
Wouldn't like to be fat, wouldn't want to be called "fatty"
Friends tell me "you've lost weight and look fantastic"
People tell me to go on a diet