

**AN EXPLORATION OF SELF-CONSTRUCTS AND STEREOTYPES IN
PEOPLE WITH LEARNING DISABILITIES AND THEIR RELATIONSHIP
TO SELF-ESTEEM AND EMOTIONAL ADJUSTMENT**

Tamsin Arnold

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ABSTRACT

The way in which people with learning disabilities construe themselves and people with and without learning disabilities was investigated using the repertory grid technique. This is an assessment tool devised by Kelly (1955) as a means of exploring an individual's personal construct system. Relationships between a person's construing, the type of stereotype they hold of the learning disabled group, and their emotional adjustment were examined. Eleven elements were used in the repertory grid: two people with learning disabilities that the participant liked and two that they disliked; two people without learning disabilities that the participant liked and two that they disliked; the self; the social self (how others see them); and the stereotype of a person with learning disabilities (a person with learning disabilities in general). Emotional adjustment was explored using questionnaires that measure anger, depression, anxiety, and self-esteem.

It was found that people with learning disabilities construed people with learning disabilities significantly more favourably and closer to the ideal self than non-disabled people. People with learning disabilities construed themselves significantly more negatively than they construed either people with learning disabilities, non-disabled people, the social self, or the stereotype of learning disabled people. People with learning disabilities tended to construe themselves as more similar to people with learning disabilities than to non-disabled people, although this trend was not significant. The distance of the "self" element from the preferred poles of constructs was found to be significantly negatively correlated with self-esteem, but not with any

other measure of psychopathology. Depression and anxiety were found to be significantly correlated, as were depression and anxiety with low self-esteem. Other examinations of measures of emotional adjustment and their relationship to various aspects of construing did not reveal any significant associations.

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INTRODUCTION

Our perceptions of ourselves are the result in part of the reactions of others to us. This has important implications for people who are placed in a stigmatised group such as “the learning disabled”. This study uses Kelly’s repertory grid technique to investigate the extent to which people with learning disabilities distance themselves from negative stereotypes associated with the learning disabled, and to consider how this might impact on their levels of self-esteem and emotional adjustment. In this study there is an attempt to explore the interaction between three variables: 1) a person’s construction of themselves; 2) the impact of the stigma associated with belonging to a group with a negative social stereotype; 3) emotional adjustment, particularly as regards self-esteem.

In the first section of this chapter the advantages of adopting a personal construct framework as opposed to other theoretical frameworks commonly employed by people working in the field of learning disability are considered. Studies applying personal construct theory to people with disabilities in general, and learning disabilities in particular are reviewed.

In the second section, research on the impact of stigma on self-concept in people with learning disabilities is considered, along with the light that might be thrown on this subject by considering corresponding findings in the Personal Construct Theory literature looking at other client groups. Finally, the issues associated with the high rates of emotional

disorders that have been found to exist within the learning disabled population are explored (e.g. Koller *et al.*, 1983).

The present study considers how self constructs, stereotypes and emotional adjustment might be connected. The study uses a Personal Construct Theory framework in which to couch hypotheses about the way people see themselves, the way others see them, the stereotype, and how these might relate to levels of anxiety, depression, anger and self esteem.

WHY USE A PERSONAL CONSTRUCT THEORY APPROACH TO PEOPLE WITH LEARNING DISABILITIES?

Davis and Cunningham (1985) remark that by historical accident learning disability is included as a psychiatric category of which there are a range of definitions and subcategories. The American Association of Mental Deficiency, for example, defines learning disability as "subaverage general intellectual functioning which originates during the developmental period and is associated with impairment in one or more of the following: 1. maturation, 2. learning and 3. social adjustment." (Heber, 1959, p.46).

Whatever systems are considered, in principle the diagnosis is generally made on the basis of; 1. the age of onset, 2. intellectual performance and 3. deficits in adaptive behaviour. In practice, however, it can still be argued convincingly that it is intellectual performance alone that is the effective criterion (Seltzer, 1983)

On a functional basis, these systems do have administrative and scientific purposes in that they identify people to be provided with appropriate resources or included in research. However, little else is achieved and there is the ever present danger of labelling and pigeon-holing, which can both stereotype the individual and elicit stereotyped action from treatment resources. In Kelly's (1955) terms the attempt is made "to cram a whole live struggling client into a nosological category" without specifying the "lines of movement open to a person". In other words, such efforts do little to delineate the needs of people so diagnosed or to indicate effective intervention.

Davis and Cunningham (1985) point out that learning disability is currently used as a superordinate "constellatory" construct in that by defining a disorder, the person as a whole is defined in all aspects. The person so labelled is, therefore, considered generally unintelligent, socially inept and even, as was the view at one time, ineducable. At worst, the construct may be used "pre-emptively" so that the individual is seen as nothing but learning disabled. In either case, the person is seen as pathological in all aspects; he/she is a collection of disabilities and not, first and foremost, a *person* who also has a learning disability. Weakness is emphasised and strengths ignored. Because of intellectual impairment, all other characteristics of being a person, having individuality and being valuable are dismissed. Such classifications also focus upon the individual and by implication deny the social context generally, but particularly the family or other carers. Yet the family/care staff must be seen as an integral part of the situation and crucial to the solution.

Theoretical Frameworks Currently used in the Field

Theoretical frameworks used in the field of learning disability tend to fall into two main categories: medical/physiological and psychological. Within the medical/physiological framework, important contributions have been made in terms of classification of a number of distinct syndromes and in identification of underlying physical pathology and aetiological factors. The prime example is Down's Syndrome and the discovery of the chromosomal abnormality associated with it. Such findings have had some therapeutic impact as in the case of the early dietary treatment of children with phenylketonuria. However, the major advance has been preventive, as in the ability to screen for disorders such as Down's Syndrome and spina bifida during pregnancy and the efforts to increase immunity to rubella infection.

Since an estimated 80 per cent of people with a learning disability have no obvious physical pathology (Davis & Cunningham, 1985), and since medical intervention is of little value even when pathology has been diagnosed, more psychologically oriented understanding is necessary, if remedial intervention is to be undertaken. In general, the common theoretical approaches are almost entirely concerned with intellectual functioning, reflecting the classification schemes discussed earlier.

Intelligence

Within the global psychometric framework, the concept of intelligence, as a generalised ability, is central. This has had enormous influence within society in terms of both

assessment and classification, but it is difficult to see any explanatory significance. Since the most that has occurred is a number of contradictory factor-analytic classifications of the types of ability, all that has been achieved is a descriptive scheme which neither enables the prediction of intellectual dysfunction nor its remediation and which perpetuates the notion of generalised impairment.

Developmental Theory

There are several frameworks that emphasise developmental delay as opposed to specific deficits. Many of these tend to be purely descriptive and are associated with developmental testing. However, some theories do seem to offer more than a structural view. The theory of Piaget is a main example. This traces the development of intellectual functioning from the first movements of the child to the complex logicomathematical operations of scientific thinking. Like other approaches, it has suggested ways of assessing different levels of intellectual functioning. However, reviewers such as Fincham (1982) and Smedlund (1977) conclude that the theory is of little practical use because of, for example, the lack of conceptual clarity, the artificiality of tasks and its focus upon abstract structures as opposed to the child's behaviour in context. Thus, there is still no clear understanding of how change may be brought about.

Learning Theory

The only approach to have been of predictive value is that based upon the principle of operant conditioning. This approach has revolutionised the care and treatment of persons

with a learning disability. It has given a highly beneficial method of analysing the relationship between behavioural and environmental events that in turn generates methods of facilitating behaviour change (e.g. Yule and Carr, 1980). Learning disability is not seen as a gross, necessarily innate, non-remediable characteristic, and socio-environmental factors are manipulated to produce change. However, major disadvantages of this approach are that it is unable to consider the *experience* of people with disabilities or the *communications* between them and people such as parents and professionals who work with them (Davis, 1984).

Common to all of the above theories is the neglect of non-intellectual characteristics. Concepts such as personality, temperament, motivation and emotion are not even indexed in many major texts (e.g. Craft, 1979; Matson and Mulick, 1983). Nevertheless, some studies are available in which a variety of variables have been assessed using such methods as questionnaires, projective techniques, and the semantic differential (Clark, 1974). There is a small body of work on the self-concept (Schurr, Joiner and Towne, 1970), but more work is needed in this area (Gowans and Hulbert, 1983).

That there is this paucity of work is most surprising since personality and motivation are acknowledged to play a role in many cognitive tasks (Clarke and Clarke, 1974a). Zigler (1966), for example, has found evidence to support the view that performance differences between people with a learning disability and controls arise because of differences in motivation associated with impoverished experience and social deprivation. This is in line with Vygotsky's (1978) socio-cultural perspective of learning disability. He argues that as societies react to disability by isolating such persons from mainstream environments, so

such people are doubly disabled from experiences to develop their potential. Cromwell (1963) has emphasised the role of failure experiences and the generalised expectancy to fail. With Down's Syndrome infants strong concurrent relationships have been found between affective variables (e.g. expression of positive and negative emotion), self-recognition scores, and developmental quotient (DQ). These also predicted at a significant level DQ scores at 3 to 5 years (Motti, Cicchetti and Sroufe, 1983). Relationships have been found between a positive self-concept and, for example, academic achievement and paired associate learning (e.g. Wink, 1963). Nooe (1977) has even shown self-acceptance to correlate more highly than IQ with the degree of independent living achieved. Such findings not only endorse the importance of considering all aspects of people, but these latter studies in particular emphasise the significance of the person's own view of themselves starting in the earliest months of life.

The Normalisation Approach

The impact of political and social factors on attitudes towards people with learning disabilities and the types of services and treatment available to them should not be underestimated. The normalisation principle was defined by Wolfensberger (1972) as “the utilisation of culturally valued means in order to establish and/or maintain personal behaviours, experiences, and characteristics that are culturally normative or valued”(p.3). This represented a new philosophy in the field of learning disabilities, and attempted to tackle problems of devaluation and discrimination on the basis of difference. This approach has played a vital role in changing how services are organised and how staff

relate to clients. However, it does not provide specific assessment and treatment techniques relating to psychopathology in the individual.

Personal Construct Theory and its Advantages

Kelly argued that a person's view of the universe is obtained "through transparent patterns or templates which he creates and then attempts to fit over the realities of which the world is composed" (p.8-9); in other words, he construes. Construing is an active ongoing process in which we constantly try to give meaning to our world and to predict future events by operating like a scientist; making hypotheses, testing them out, and if necessary revising them on the basis of the evidence which we collect. By searching for repeated themes in our experience of the world, we provide ourselves with a basis for predicting future events. There is also a recognition of similarities between some events, or *elements* of the individual's world, which at the same time differentiate them from other events. In doing so, we develop a construction system which is composed of a finite number of bipolar *constructs*. The *emergent pole* of a construct indicates the way in which at least two elements are similar while the *contrast pole* defines their contrast with some other element or elements.

A person's constructs are organised into "a construction system embracing ordinal relationships between constructs" (Kelly, 1955, p.56) i.e. it is hierarchical. The relationship of one construct to others in the individual's construct system will indicate something of the construct's personal meaning and may allow aspects of the individual's behaviour to be predicted. The particular relationships between a person's constructs will

determine his or her predictions about the world, and these predictions may or may not be validated by subsequent events. Such experiences of validation or invalidation will lead to the strengthening or modification respectively of the predictions and constructions concerned.

Unlike the other frameworks, personal construct theory particularly respects the person sufficiently to pay attention to his/her own frame of reference. It does not imply a negative view of the person with a learning disability or emphasise pathology. On the contrary, his/her strengths are emphasised. The person with a learning disability is construed as someone attempting to make sense of events in order to anticipate and therefore adjust to them. He/she is seen as fundamentally motivated and operating like all other people and not qualitatively different. Those with a learning disability make discriminations, and build a set of constructs which are organised in some way and have the function of enabling anticipation and regulating behaviour.

Beail (1985b) argues that repertory grid technique offers us a way of investigating the meaning of a disability, both for a person with it and for those trying to relate to him or her. Yet very little use has been made of grid methods in either individual work or research with people who are physically or learning disabled. Numerous studies have established that physically disabled people are construed in a more negative light than able bodied/normal people (e.g. Altman, 1981; Bender, 1981). This negative construction portrays people with physical disabilities as capable of only a limited range of ability and behaviour. In Personal Construct Theory terms an individual's "being disabled" is construed in a constellatory or stereotyped way as it implies being less intelligent, less able

to make the right decisions, less realistic, less logical and less able to determine his/her own life than a non-disabled person (Safilios-Rothchild, 1976). These attitudes are widely held and have remained unchanged over the last twenty years (Furnham and Pendred, 1983). Professionals (nurses, physiotherapists, occupational therapists, psychologists and social workers) engaged in rehabilitation have also been shown to hold the same negative attitudes to those shown by the general population (Goodman *et al.*, 1963). These negative attitudes seem to have placed a limit on the use of repertory grid technique with disabled people - the task is considered to be beyond their capabilities.

Similar views are put forward in relation to using repertory grids with people with learning disabilities. Davis (1983) points out that people with learning disabilities are professionally and traditionally construed pre-emptively as nothing but "unintelligent". He goes on to argue that at best current views are constellatory in that the construct "low intelligence" immediately defines other relevant constructs, for example "socially maladjusted", "ineducable" and probably "too limited to use grids with". However, among the population of people with learning disabilities there exists a wide range of intellectual and social handicaps. From a Personal Construct Theory viewpoint it is argued that people with learning disabilities are like everyone else in that they have a personal construct system.

Davis and Cunningham (1985) argue that the theory has the advantage of being described systematically in clear ways which directly imply the appropriate assessment procedures that may be used. It is also predictive in terms of suggesting ways in which changes may be brought about. In this respect, it is similar to the learning theory approach, but it also

provides a methodology for exploring a persons' experience which is clearly lacking within traditional behavioural approaches. Indeed, personal construct theory can provide a means for viewing the person in a more holistic manner and in relation to other people such as parents and professionals. For proper understanding of another person, Kelly (1955) argued that one needed sociality. He argued that to the extent that one person construes the construction processes of another, he can play a role in a social process involving the other person. As we attempt to stand in the shoes of another and to look at the world through their eyes so we cease to construe them in terms of socially agreed constellatory or pre-emptive constructs. The Sociality Corollary enables one to make sense of the interaction between people with a learning disability and, for example, their parents without recourse to additional theory. Since parents or their substitutes are crucial to any possible remedial endeavours, the fact that they can be considered in the same terms as their child is a major strength of the theory.

In summary, there are a variety of frameworks that are used in the field of learning disability and these are useful in terms of describing and identifying people to be provided with services or included in research. However, with the exception of learning theory, they do not provide the means for predicting how changes may be brought about. Further, they carry the danger of exacerbating stereotypes and increasing power imbalances. All of the theories currently employed fail to take into account the person who has the learning disability. Although factors such as personality, motivation, self-concept and motivation have a significant effect on learning, development and adjustment, and are all given as much weight as intellectual characteristics in other client groups, current prevailing frameworks used in this field do not take these into account. It is argued that Personal

Construct Theory is able to redress this balance in that the person as a whole is considered rather than one dominant characteristic. Their disability can then be approached in the context of what it means to them and those around them. Although the use of this model with people with learning disabilities has been limited, a few studies have been undertaken and their findings are presented in the next section.

PERSONAL CONSTRUCT THEORY RESEARCH WITH PEOPLE WITH PHYSICAL AND LEARNING DISABILITIES

Although there has been some work on personal construct theory and families of people with learning disabilities and on the way professionals in the field construe their clients, to date very little research with the clients themselves has been conceived and conducted within a construct theory framework. In a search of the literature, only three completed studies of how people with a learning disability construe others were found.

Wooster (1970) supplied both elements (photographs of strangers) and constructs to adolescents in an ESN residential school. Oliver (1980) used photographs of familiar people to elicit constructs from adolescents with Down's Syndrome. Barton, Walton and Rowe (1976) elicited both elements and constructs from 26 patients who were mainly inpatients in a hospital for the mentally handicapped and had been referred for assessment because of behaviour problems.

All the studies showed not only that grids could be completed by people of very limited intellectual ability, but that the process was both useful and meaningful. It was reported

that the results made sense of what was known about the person and frequently suggested specific and realistic therapeutic goals for individual patients. In their paper, Barton *et al.* (1976) gave advice on how to modify the grid technique for use with people with learning disabilities based on their experience. They concluded that grid technique was found to have advantages over most of the commonly used methods of personality assessment for patients who are learning disabled. They argue that it requires little or no literacy or sustained concentration, it avoids using unintelligible or inappropriate terms, and it provides reliable and valid pictures of their construct systems. They also point out that check lists can provide a picture of social skills but that the grid technique could do likewise for problems of personality adjustment and stability. Intelligence and social quotients can be quite high, but personality problems may prevent a patient from functioning at their optimum level or in certain environments and so they felt that examination of the patient's world in terms of their constructs may prove a useful technique.

Barton *et al.* suggest that "as a general rule an IQ of 50 may be taken as the lower limit at which a grid can be completed unless the patient is verbally quite able and has lived in an environment encouraging verbal expression". However, Beail (1985) argues that what is important is not IQ or verbal expression but communication in its variety of forms - if the clinician and client can find a way of communicating then construct exploration can be attempted.

Oliver (1980) found that individuals had a very small number of highly interrelated clusters of constructs and this was confirmed by Wooster (1970) who found significantly fewer

clusters than for matched controls. The simplicity of the construct system is further indicated by the very high proportion of variance accounted for by the first component in the principal component analyses conducted by both Oliver (1980) and Barton *et al.* (1976). They also both found a tendency for elicited constructs to be "concrete". Barton *et al.* (1976) found no relationship between IQ and either the number of elements and constructs elicited or the variance of the first component. There were, however, interesting relationships between the content of the constructs elicited and the types of ward environment in which the person lived. They found that 92 per cent of their participants produced "bad-tempered" or "loses temper easily" constructs, contrasting with only 38 per cent using "friendly", the second most common. This may be related to the high levels of anger found in their sample of inpatients, many of whom were classified as having poor control of emotions, particularly anger.

Beail (1985b) has investigated the self-image of physically disabled people. He interviewed 30 people who were residents in homes providing accommodation for severely disabled people. Three interviewees also had additional learning disabilities. The study was concerned with the self-image of physically disabled people - particularly the relationship between the "self" and the "stereotype" (how the public see the disabled). He limited the number of elements to those he was specifically interested in: self, ideal self, public self, future self, self without my disability, and how the public see the disabled. Beail supplied twelve bipolar constructs (to limit possible problems with eliciting them from the subjects; for a debate on this issue see Adams-Webber, 1979). These were derived from a list compiled from a survey of semantic differential and grid studies of self and body image.

Beail found that overall, subjects had little difficulty completing the small grid. One problem which emerged was the choice of the element "self without disability". Five subjects, all of whom had a congenital disability, could not construe this element - it was outside their range of convenience i.e. none of their constructs were applicable to this element. As one woman put it: "I have no idea what it would be like to be able bodied and I don't want to know. I fear the day they find a cure." (Beail, 1985b, p.131).

Any study of self-concept in a group of people with physical and learning disabilities needs to take into account the fact that our perceptions of ourselves are the result in part of the reactions of others to us. This has important implications for people who are placed in a stigmatised group such as "the disabled" and leads us on to the question of stereotypes and the impact of stigma. Studies indicate, and our own experience tells us, that attitudes to such groups are negative (Altman, 1981). However, repertory grid and semantic differential studies of people who have been placed in a stigmatised category (such as "alcoholics" or the "mentally ill") have found that group members reject general identification with society's stereotype of their group (Bannister, 1965); Fransella, 1968a, 1977; Fransella and Adams, 1966; Hoy, 1973; O'Mahoney, 1982). Beail's study with the physically disabled showed that there was considerable variation between the "self" and the "stereotype" elements for this group as for other stigmatised groups. The means profile showed that in all but one case the "stereotype" was rated overall more negatively than the "self". Thus this group of disabled people rejected the general identification with the stereotype of "the disabled". However, Beail points out that the fact that this group of disabled people reject society's stereotype of them does not mean that they are unaffected

by it. The stereotype is imposed on a group by others and limits are set on their behaviour and alternatives open to individuals within the group.

In summary, studies have shown that repertory grids can be completed by people with learning disabilities and that the process yielded both useful and meaningful results. The technique may need to be modified so that it can be successfully accessed by this client group. Of particular interest to this study was the use of repertory grids to explore self-concept among people with physical disabilities; this group was found to reject the negative stereotype that is associated with their group. In the next section the negative attitudes with which people with learning disabilities are confronted and the responses of people with learning disabilities to this stigmatisation are considered in greater detail.

STIGMA AND PEOPLE WITH LEARNING DISABILITIES

Altman (1981) has argued that attitudes towards disabled people are important to individually handicapped persons on three different levels: first in their relationship with peers and significant others who, if they provide acceptance and support, can substantially contribute to the handicapped person's adjustment; second, in their interaction with professionals such as doctors, social workers, teachers and potential employers who are often controllers of services, opportunities and jobs which control the handicapped person's dependence on others; and third their interaction with the general public whose reactions to them in public are an important contributor to the handicapped person's self-esteem and self-confidence.

Goffman's (1963) work on stigma and "passing" has recently inspired considerable research in the area of learning disability. The impetus for this interest has been the trend towards closing institutions and the provision of alternative forms of care in the community for individuals with learning disabilities. There is a growing body of evidence that people with learning disabilities are aware of stigmatisation (e.g. Gibbons, 1985). For instance, Edgerton (1967) found that his cohort of ex-patients with learning disabilities expended considerable energy in trying to pass for "normal" and Gibbons reported the existence of a group concept problem: people with learning disabilities consider each other as inferior candidates for sharing social activities. This is in line with Goffman's (1963) hierarchies of stigma, in which stigmatised individuals derogate each other in order to maintain a fragile sense of self-acceptance.

Gibbons (1985) found that people with learning disabilities do tend to receive low ability attributions, as do other handicapped people or members of minority groups. These attributions also tend to influence the perceptions of other characteristics of disabled persons, including behaviours that are not specifically related to their handicap. Asch (1946) used the term "central trait" when referring to an important trait that can influence all of the impressions formed of a person by others (this is discussed in greater detail in the next section from a Personal Construct Theory viewpoint). When the trait involves intelligence, the stereotypes or expectations associated with it are very strong and very resistant to change.

Given the pessimistic nature of the results in the expectation research, it might be anticipated that this would be reflected in negative self-impressions among learning disabled persons. Actually, there is very little evidence to suggest that this is the case. Although some studies have found evidence of negative self-concepts among different stigmatised groups, the majority have found little or no difference from the general population, and there are even a few studies indicating a positive effect. Several studies of learning disabled children, for example, have found no difference between them and their nondisabled counterparts with respect to self-concept. In a few cases (e.g. Fine and Caldwell, 1967; Willy and McCandless, 1973), positive discrepancies have been found. These rather puzzling results led the authors (Willy and McCandless, 1973) to conclude that disabled children's self-concepts were "inaccurate, inflated, and unrealistic".

Although Fine and Caldwell did not elaborate on the characteristics of their sample, one possible explanation of their results is that the learning disabled children in their study were of a relatively low intelligence level. It seems to be the case, in fact, that *higher* level disabled persons tend to have *lower* self-concepts. This pattern was reported by McAfee and Cleland (1965), who suggested that higher level persons are more likely both to use nondisabled persons as a reference group and to be aware of their own shortcomings relative to a societal ideal.

Warner *et al.* (1973) found that less than 10% of the special-class students they surveyed characterised themselves as mentally retarded. This tendency to dissociate oneself from the learning disabled label is also the major theme of Edgerton's (1967) study of 48 learning disabled people who had been resettled into the community from a state hospital

in California. The case histories of these people indicated that they were all obsessed with the desire to deny their disability, or to “pass”, as Edgerton calls it. He believes that the stigma of having been adjudged learning disabled is totally unacceptable for most former institution residents because it prevents them from living a normal life outside the institution. He presents this opinion very clearly in the conclusion of his book: “The label of mental retardation not only serves as a humiliating, frustrating, and discrediting stigma in the conduct of one’s life in the community, but it also serves to lower one’s self-esteem to such a nadir of worthlessness that the life of a person so labelled is scarcely worth living”, (p.145).

Bogdan and Taylor (1976) carried out an in-depth interview with a person with learning disabilities whom they referred to as Ed. He was asked what it was like being learning disabled and living in a state institution. He did not find either situation very enjoyable and he showed a striking insight and understanding with regard to his status in the community and that of others like him. Talking about the reactions of others he said, “Sometimes I think the pain of being handicapped is that people give you so much love that it becomes a weight on you and a weight on them” (p.48). On the institutions he says, “Being in a state school, or having been in a state school isn’t fashionable and never will be. Deep down you want to avoid the institution” (p.49). Bogdan and Taylor’s article represents one of the few attempts in the literature to “go to the source” to find out what the disabled persons think about their label and their place in society. The results are often quite different from what the investigators expect and Bogdan and Taylor suggest, “People who are labelled retarded have their own understanding about themselves, their situations and

their experiences. These understandings are often different from the professionals’”, (p.51).

Reiss and Benson (1984) point out that people with learning disabilities experience negative social conditions for long periods in their lives. These include the stigmatising effects of being labelled learning disabled, rejection and ridicule, segregation, infantilisation, social disruption, restricted opportunities, and victimisation. Many people who are mildly or moderately disabled are highly aware of these negative social realities and can articulate them in detail during psychotherapy interviews.

How is it possible that stigmatised persons can maintain some semblance of positive self-regard when the behaviour of most people toward them is so decidedly negative? Obviously, this is a complex issue, and there are a number of factors involved, including the nature of the stigma, its visibility, and how debilitating it is. Some characteristics are simply less stigmatising than others, and it is easy to understand why they might not have much psychological effect on people who have them. Other types of stigma are potentially very debilitating socially, however, it would be enlightening to learn how people with severe stigmas are able to maintain a relatively favourable self-concept under these circumstances.

This issue has been looked at using a variety of theories. For example, Gibbons (1986) has considered the defence against stigma in social psychological terms and has discovered two types of social comparison (downward and lateral comparison) that serve to protect people with learning disabilities from the debilitating effects of stigma. Downward

comparison occurs when a person seeks out people who appear to have less of the trait or to be doing worse at the behaviour and to choose them as the primary reference group in order to boost threatened self esteem. Edgerton (1967) suggests that some people with mild learning disabilities engage in self-aggrandisement through comparison with others who appear to be more severely disabled. Lateral comparison tends to occur when people with more highly visible stigmas seek out others who are similarly stigmatised. Such comparisons are most likely to provide useful information that is not damaging to the ego (Gibbons, 1985).

Turner and Gallimore (1979) studied a cohort of mildly learning disabled adults residing in the community and found that they actively employed adaptive techniques to defend the integrity of their self-concepts. Moreover, there appeared to be some relationship between the nature of the coping strategies invoked and the individual's attitude towards his or her disability. Turner and Gallimore identified four such strategies: the "acceptors", who accepted "being handicapped" but enhanced their self-esteem by characteristically stratifying other learning disabled persons according to functioning capacity and comparing their own abilities and accomplishments to lower functioning individuals, and the "deniers", "avoiders", and "redefiners", who used various forms of strategic self-presentation to protect nondisabled self-conceptions. Deniers tended to view the world in conspiratorial terms, attributing their limitations or failures to the prejudicial attitudes of others, who never gave them a chance (i.e. blame attribution). Avoiders seemed content to assume they were passing as normal and saw the lack of challenge to that status as confirmation. Lastly, redefiners attributed their difficulties in life to other incapacities that they perceived as less stigmatising than mental deficiency (e.g. nervousness, poor vision,

speech problems), and they then used these to justify eliciting assistance from others (i.e. tactical dependency).

Two other frameworks that have been employed to look at the effects of stigma on people with learning disabilities are the consciousness raising and loss paradigms (Szivos & Griffiths, 1990). Stigma is defined by Goffman (1963) as the discrepancy between one's actual and virtual identity, that is, the difference between how one actually is (i.e. disabled) and how one is expected to be (i.e. competent, independent). Learning disability can therefore be experienced as a "loss" of virtual identity. Szivos and Griffiths (1990) suggest that one of the answers to the problem of stigmatised identity lies not in ignoring it or in "passing", but in discovering the meaning of the stigma.

The consciousness raising paradigm is a development of social identity theory (Tajfel, 1981), which proposes that disadvantaged group members have two main options when they cannot leave the group that is the source of the disadvantage. The first is to assimilate or to pass into the mainstream group, which has several unpleasant psychological consequences, such as disaffiliation from one's group, guilt, and derogation.

The second option is to attempt to construct a positive identity based on being different. It is this second option that is meant by the term consciousness raising. Other stigmatised groups have found that it is therapeutically useful to acknowledge and to "own" the stigma, whether it be skin colour, gender, or sexual orientation. Through exploration of the meaning of the stigma, disadvantaged group members have been able to develop a strong and positive group identity, thereby eliminating the group concept problem.

The loss paradigm can be described in relation to Kubler-Ross's 1970 book "On Death and Dying" in which she suggested that in order to come to terms with death, individuals must work through various difficult and painful emotions and that in so doing, they tend to pass through stages of shock, denial, anger, sadness, and acceptance. Later theorists and practitioners have appreciated the relevance of the paradigm to many other kinds of loss: bereavement, health, and the "loss" of the expected child when a child with handicaps is born. Although there is a large body of work on the response of parents to loss of normal identity in a child with handicaps (e.g. Byrne and Cunningham, 1985) there is little research on the response to the loss by the people with disabilities themselves.

Szivos and Griffiths (1990) argue that both the consciousness raising and loss paradigms imply that there are benefits to be gained in talking openly about stigmatised identity. They argue that for the loss paradigm, the benefits might be enabling the individual to come to an understanding and acceptance of the emotions associated with loss, recognising these emotions as being parts of normal rather than pathological processes, allowing alienating and defensive behaviour to be dropped, and coming to some sort of acceptance of the state of loss. Although the earliest work on loss found that dying patients can come to an "acceptance" of their impending death, work with the parents of children with handicaps has highlighted the difficulties in attaining truly positive feelings about the handicap. The loss always remains the loss: Szivos and Griffiths argue that the best that can be hoped for is an acceptance of the feelings involved.

For consciousness raising, they argue that the benefits might be seen to be in terms of clarifying labels and identifying the source of the stigma, reducing the confusion that is

generated when individuals encounter stigmatising behaviour together with “polite” disavowal of prejudice or that anything is wrong: shifting the source of blame from the self to society, increasing self-esteem by improving the status of the group, and increasing individuals’ sense of responsibility towards initiating action.

Szivos and Griffiths (1990) ran a group for people with learning disabilities who had low self esteem to explore and come to terms with the stigma they faced. Like Zetlin and Turner (1984), they found considerable variation in the strategies the group members used to cope with their handicap and concluded that coming to terms with a handicapped identity is an ongoing process. They argue that denial, far from being a simple thing that occurs in an all-or-nothing fashion, becomes a complex and dynamic process in the affective life of people with learning disabilities.

They questioned whether “acceptance” is ever completely possible for anyone with learning disabilities (at least anyone who understands the stigma attached to the description). They found that a kind of comparative acceptance (“I could have been worse, like some others”) or compensatory acceptance (“At least one person loved me better for being as I am”) was the best that could be achieved. An acknowledgement of their sadness or tolerance of their disability seemed to be as close to acceptance as they could get. They argue that stronger acceptance of one’s own strengths and weaknesses facilitates acceptance of other in-group members, thereby promoting stronger affiliation with the in-group and dissolving the group concept problems.

In summary, there have been very few attempts in the literature to “go to the source” and find out what people with learning disabilities think about stigma, stereotypes and their self-image. Studies that have explored this issue have found that people with learning disabilities are acutely aware of the stigma that surrounds their disability. This stigma reflects the negative stereotypes that have been found to exist with respect to this group. The extent to which these negative attitudes impact on self-esteem and self-concept is not clear; not all studies have found self-esteem and self concept to be particularly poor in people with learning disabilities. However, people with mild learning disabilities seem to have a poorer self concept than people with more severe learning disabilities.

A variety of theoretical frameworks for understanding the effects of stigma upon people with learning disabilities and how they might be helped to process these have been proposed. Personal Construct Theory has provided a useful insight into the nature and effects of negative stereotypes in other groups and might be a valuable addition to the field of learning disabilities. The next section will review the findings in this area.

A PERSONAL CONSTRUCT THEORY APPROACH TO THE IMPACT OF NEGATIVE STEREOTYPES ON THE STIGMATISED GROUP

There has been a substantial amount of research into stereotypes using a Personal Construct Theory approach. Fransella provides several examples of the way in which people construe themselves in relation to the stereotype of the group to which they belong (Fransella, 1977). She cites the example of a man serving a prison sentence for nine acts of arson who became depressed and was admitted to psychiatric hospital for treatment

(Fransella and Adams, 1966). Over a period of four months he was given four repertory grids and it was found that there was a significant negative correlation between the constructs *like me in character* and *the sort of person who is likely to commit arson*. Bannister (1965) reported the case of a woman who had a six-year history of agoraphobia. On the grid, the construct *people who can go anywhere with confidence* was orthogonal to all other constructs, including the self. This woman saw no relation between herself and her symptom.

Fransella (1968) found similar results for a group of eighteen stutterers - the self and the symptom again differed significantly and negatively, this time on a semantic differential. She argues that "..... it is one thing to "pretend" to oneself that he is not an arsonist, because no one can tell whether he is or is not simply by looking at him. But it is quite another thing to hide being a stutterer", (Fransella, 1977, p.39). She also found that stutterers shared the image of other stutterers with those who did not stutter and the image was "bad". However, when these people also completed a repertory grid she found that some stutterers did not see themselves like stutterers in general (like the arsonist), whilst some saw no relation between themselves and other people with their symptom (like the agoraphobic), and a small group did see themselves as stutterers. She argued that whether or not the stutterer saw himself as one could be related to the degree of difficulty he is likely to experience when he tries to give it up.

Hoy (1973) has found that "alcoholics" construe other "alcoholics" as *weak, sexually frustrated, lonely* and *unhappy* but not significantly like themselves as a group. As with

Fransella's stutterers there was no consistent positive or negative relationship between the self and the construct *alcoholics* for these fourteen men.

How might we apply these findings to the field of learning disability? All of these examples look at the self and the “symptom” in relation to stereotypes. The relationship between the self and the learning disability may seem at first sight to be of a different nature in that it is not something that the person is able to give up. However, Valerie Sinason (1992) makes a distinction between primary handicap which is the *actual* handicap, and secondary handicap which is the result of not dealing adequately with the primary handicap. She argues that there are three main areas where secondary handicap plays a part in an individual's difficulties. First, there is mild secondary handicap which occurs when individuals compliantly exacerbate their original handicap to keep the outer world happy with them, “for instance, some handicapped people behave like smiling pets for fear of offending those they are dependent on” (p.21). Second, there is opportunist handicap, whereby the handicap acts as a home for all the person's emotional and personality difficulties such as hatred or envy. Finally, there is handicap as a defence against trauma where the handicap is used in the service of the self to protect it against trauma. These three types of handicap might be considered as symptoms, and it is these that the client can choose to give up. Fransella predicts that the likelihood of seeing yourself as belonging to a group with a poor image is related to the degree of difficulty you would experience when you try to give it up. Although people with learning disabilities could possibly give up a secondary handicap, they would be unable to give up the primary handicap. It is therefore unlikely that they will see themselves as belonging to their stigmatised group.

Fransella (1977) looks at stereotypes from a personal construct theory viewpoint. She argues that within a given culture there will be certain similarities between individuals in the construction of certain events and that it is when we take a particular sub-system of constructions for granted and use them in a constellatory or pre-emptive way that we have the stereotype in operation. She remarks, "if society construes a certain group of people as **stutterers**, then the people making up that society will also see them as being **weak**, **unintelligent** and **lacking in ambition** or whatever the stereotype may be for that particular group. If the person is construed as a **stutterer** then he may be seen as **nothing but** a stutterer" (Fransella, 1977, p.41).

She goes on to point out that constructs are the bases of our anticipations about events in our life. When we hold a culturally common set of constructs, they lead us to have certain common expectations about the people to whom these constructs apply. Arsonists are all basically the same, so are alcoholics, people with Downs Syndrome, and so on. We characterise certain behaviours deviant in the first place, then make this an identifying characteristic of that person, call him by that name and construe him along with a set of common constructs used in a constellatory or pre-emptive fashion.

A prime example of commonality of construing of deviance may be found in psychiatry and its classificatory system. A person is pushed into a category which results in him ceasing to be an individual. He is now characterised by his behaviour. This makes life a lot easier for all concerned. There need not be expectations about, say, 100 different depressed people, but rather about two different classes of people, those with endogenous

and those with reactive depression. The same is true of people with learning disabilities. Commonality of construing exists between all psychiatrists so that they can communicate to each other about these stereotypical behaviours. Without such construing the discipline could not exist in its present form.

Personal Construct Theory is also able to account for the finding that not all alcoholics, stutterers and so forth see themselves in relation to their particular stereotyped group in the same way and nor will other members of society see them in the same stereotyped way. People construe others in common terms because each sees the other as an external figure characterised by his deviant or expected behaviour. But they may differ among themselves in how they view their own group since "each experiences a different person as the central figure (namely, himself)" (Kelly, 1955, p.55). Some will see a relationship between himself and the stereotype while others will not. The individual knows his own experiences. He knows his intentions and feelings. He knows what his behavioural experiments are all in aid of. For understanding to take place between two people we need sociality rather than commonality of construing: as we attempt to stand in the shoes of another and to look at the world through his/her eyes so we cease to construe him/her in terms of socially agreed constellatory or pre-emptive constructs. It is possible that the stereotypes associated with being learning disabled will be particularly hard to give up because it would be so painful to stand in the shoes of a person with learning disabilities.

Stereotyped Construing and Invalidation

Invalidation occurs when a person's prediction and the outcome he observes are construed as incompatible. If we see stereotyped construing as a set of constructs used in a constellatory or pre-emptive way and about which there is agreement between members of a given culture, then one would expect a certain amount of invalidation to occur in the normal course of events. Individuals will not always conform to our expectations. When this happens there are several courses of action open to one, in construct theory terms. We can just not "see" examples of invalidation. Or, we can construe contrary events and agree that something is amiss. We see the need for change but how an individual will deal with this situation will depend on the implications that such a change will have for him. He may be able to loosen his constellatory network of constructs, rearrange them or find out how to use them in a more propositional way ("any roundish mass can be considered, among other things, as a ball").

However, the contemplation of change can give rise to anxiety or threat. Anxiety has been defined by Kelly (1955) as the awareness that the events with which a man is confronted lie mostly outside the range of convenience of his construct system. Fransella (1977) points out that it is no good the stutterer elaborating his constellatory network of constructs to do with being a stutterer and realising they are "bad" if he has no alternative ways of behaving and experimenting with his world. Anxiety appears when such a construct network has to be abandoned because it is no longer useful and there is nothing to take its place. This is particularly pertinent to people with learning disabilities where it

is not possible to give up the learning disability completely (although, as Sinason has pointed out, any “secondary handicap” might be relinquished - see above).

Another result of the awareness of the need for change is threat: The awareness of an imminent comprehensive change in one's core structures (Kelly, 1955). Threat occurs when the construct(s) involved in the proposed change are superordinate and central to one's identity or else closely linked with core constructs: in other words, the person will have to undergo profound personal change.

If we accept the view that people on the whole do not wish to be construed as deviant, then they will be inclined to avoid behaviour that they think will lead others to construe them in a negative way. Social desirability seems to be involved in determining whether we see ourselves as others see us. Fransella argues that “we are unlikely to embrace the stereotype to “us” if it is evaluatively “bad””. Since most people in a given society relate deviance with undesirability, we are likely to construe our own deviant behaviour or “bad” habits as not part of “us”. Acceptance of the stereotype may occur when we see our own group as “good” and the opposite group as having undesirable implications (Fransella and Bannister, 1967).

So when society imposes its constellatory construct sub-system on a group of its members, it is not only defining the poles of those constructs on which the members must sit, defining appropriate behaviours, but also influencing core role constructs. The personally restricting nature of these construct sub-systems can be seen in how they deny the individual alternative ways of behaving. Fransella (1977) gives an example of a woman

who had taken part in a "consciousness-raising group" for women that was designed to help members look at their own attitudes and behaviours, to see how many of these are determined by the negative social stereotypes and how much women themselves were responsible for the continuance of stereotypes by conforming to them. The process was painful for this woman as she first elaborated the stereotype and realised that her behaviour was submissive, dependent and generally conformist. Although to be submissive and dependent was "bad" the only alternative this woman saw was to behave in terms of the masculine stereotype - she can polarise. But what exactly are the implications of being assertive and independent? She was distressed to find that there seemed to be no other alternatives available to her. Hence the occurrence of extreme anxiety in some members of the group. There may be a similar implication for consciousness-raising groups for people with learning disabilities.

But these socially agreed constellatory sub-systems also give us a defined frame within which to move. Sitting on those clearly defined poles of constructs we know what we are supposed to be and do within that context. But Fransella also points out that these stereotypes also serve to remind us of what we are *not* - "we know we are not mad by knowing what madness is" (Fransella, 1977, p.64). She suggests that perhaps the self is in large part the sum of our construed similarities and differences to our personal stereotypes.

"Me" is the extent to which I am like and unlike a host of commonly held and idiosyncratic constellatory or pre-emptive sets of constructs. My stereotypes help to define me.

In summary, the Personal Construct Theory approach has been applied to the area of stereotypes in a variety of groups. In all of these studies, the participants were found to reject the negative stereotype held for his/her group either by denying that the stereotype is negative or by denying that they belong to the group if it has a negative stereotype. Personal Construct Theory is able to explain how stereotypes are formed and why people do not necessarily see themselves in relation to their particular stereotyped group; they are construing from a position inside the stereotyped group rather than outside the group. In addition, social desirability effects mean that people will reject the stereotype when their group is seen as “bad”. The acceptance of a negative stereotype and/or the rejection of other people’s constructs can affect a person’s emotional adjustment. The next section considers the issues in assessing this degree of emotional adjustment and self concept in people with learning disabilities.

THE ASSESSMENT OF COGNITION AND EMOTION IN PEOPLE WITH LEARNING DISABILITIES

In the past there has been considerable pessimism surrounding the ability of people with intellectual disabilities to give valid expression to their feelings and emotions (See Jones, Walsh and Sturmey (1995) for a more detailed discussion). More recently, however, it is becoming increasingly clear not only that there exists a clear and full emotional life, even in people regarded as severely disabled, but there is growing confirmation that aspects of this emotional life are open to empirical exploration. Lindsay *et al.* (1984) demonstrated that a group of individuals with mild or moderate intellectual disabilities could show a high level

of consistency in their reports about their own emotions. They assessed a group of sixty-seven adults on a variety of self-report measures (The Zung Self-Rating Anxiety Scale; The Zung Depression Inventory; The General Health Questionnaire; and the Eysenck-Withers Personality Inventory) and found high levels of agreement across these measures.

They comment "The study showed an impressive degree of convergent validity in subjects' responses to the assessment of emotional experiences and feelings. Systems of anxiety, depression, and other emotional systems correlate extremely highly with each other. This would indicate that a self-report of a person with intellectual disability in relation to his or her emotional system may be extremely reliable and valid" (p.65).

In the past when assessing the private world of people with learning disabilities, people have usually asked carers and relatives (e.g. Laman & Reiss, 1987). A reasonably extensive literature has developed on emotional problems of clients using standard interviews with significant others or symptom check-lists filled out by staff members. However, recent developments in assessment techniques have moved towards more reliable and systematic methods of asking clients themselves to judge the extent and nature of their cognitive and emotional difficulties.

Lindsay and Michie (1988) and Michie and Lindsay (1988) reported work on the Zung Self-Rating Anxiety Scale (Zung, 1971) and the Zung Self-Rating Depression Scale, (Zung, 1965), two assessments used extensively with other populations. They found that standard presentations of the scales produced very low reliability scores and they redesigned the test with two major considerations in mind. Firstly, the language and concepts were simplified and put into local language to ensure understanding. Secondly

they truncated the graded multiple choice answers to a simple presence or absence of the symptom or feeling.

Kazdin, Matson and Senatore (1983) and Helsel and Matson (1988) have adapted the Zung Scales using an extensive explanatory preamble, some initial “trial” questions and a multiple choice format. The graded multiple choice options were accompanied by a bar graph which was a pictorial representation of the answers. All the above methods allowed subjects to respond reliably.

These studies demonstrate that if the investigator takes some care, then reliable and valid assessments of the private feelings and thoughts of people with learning disabilities can be gathered. However, it may be that the clinician will wish a more flexible instrument to judge problems and strengths and the nature of the self-concept. Gowans and Hulbert (1983) considered the difficulties of using standard tests with people with learning disabilities. They felt that imposing a preconceived structure on self-concept might force the client to consider himself in a novel or indeed foreign and unaccustomed manner. Such an assessment may omit areas which the individual him/herself might feel important. They suggested the repertory grid technique (Fransella and Bannister, 1977) might prove to be a useful method more sensitive to individual differences and personal considerations. For example, Oliver (1986), showed how repertory grid techniques could be useful in assessing self-concept. He showed how a 14-year-old girl with Down’s syndrome who had an IQ “in the 40s” could be helped, by the aid of photographs, to construct a grid which showed her as being able to recognise children with intellectual disability as being different from others. Of particular interest was the finding that she did not apply these

differences to herself. The relationship between her view of herself, her ideal self, and others was clear and a repetition of the ranking task showed a reliability on each construct of about 0.80 which suggested that “the girl was able to apply the constructs meaningfully” (p.25).

In summary, it has become increasingly clear that there exists a full emotional life even in people regarded as severely disabled. In the past, studies have used information from carers and staff, but there is now a small and growing body of research that consults people with learning disabilities themselves. This has led to the modification of a variety of scales that can be used to measure emotional adjustment. In order to look at self concept, the more flexible repertory grid method is advocated. Having established that people with learning disabilities do experience feelings and can reliably report them using these scales, it is important also to consider how pathology at this emotional level has been approached in the field of learning disabilities. The prevalence rates of psychopathology in this client group and the reaction of services to client needs are considered in the next section.

PSYCHOPATHOLOGY IN PEOPLE WITH LEARNING DISABILITIES

People with learning disabilities can experience novel stressful situations that foster emotional difficulties: for example, employment problems, financial difficulties, and interpersonal concerns may be overwhelming for individuals with possible psychological (e.g. social skill deficits), cognitive (e.g. lowered intellectual abilities), social (e.g. lack of structured support network), or biological (e.g. biochemical and genetic) vulnerabilities to

psychopathology. Nezu & Nezu (1994) feel that such combined vulnerabilities may partially explain the high prevalence rates of psychopathology among individuals with learning disabilities (Matson & Sevin, 1994; Nezu, Nezu & Gill-Weiss, 1992). Actual estimates of comorbidity (mental illness and learning disabilities as coexisting problems) have ranged across studies from 10% to 85% (Borthwick-Duffy, 1994). Despite the continually stated need for effective outpatient services for this population, and despite growing evidence that many outpatient psychotherapy strategies developed and tested with non-handicapped populations are potentially viable and effective for individuals with learning disabilities (Nezu & Nezu, 1994), few empirically based outpatient services exist and both research and scientifically based clinical practice have lagged far behind the social need. Nezu & Nezu (1994) suggest several reasons for this lack of attention. Firstly, they highlight the commonly held belief that people with learning disabilities are somehow immune to mental illness. As Fletcher (1988) noted, "the mildly retarded have been characterised as worry-free and thus mentally healthy. The severely retarded have been considered to express no feelings and therefore do not experience emotional stress" (p.255).

Secondly, they point out that there is a perception among many professionals that the existence of intellectual deficits takes precedence over the presence of psychiatric symptoms - the learning disability diagnostically overshadows any coexisting emotional disturbance or psychiatric diagnosis. A series of studies conducted by Reiss and his colleagues (Levitan & Reiss, 1983; Reiss, Levitan & Szysko, 1982; Reiss & Szysko, 1983) repeatedly demonstrated that mental health professionals were more likely to

attribute psychiatric symptoms to the learning disability, rather than to a psychiatric disturbance.

The third factor that Nezu & Nezu (1994) identify as contributing to the lack of empirical focus on psychotherapy evaluation concerning people with learning disabilities involves a certain therapist bias, particularly among psychoanalysts and client-centred therapists, who have tended to consider such clients to be inappropriate candidates for psychotherapy (Rogers & Dymond, 1954). Even cognitive therapists appear to hold this bias (e.g. Hollon, 1984). This perception has endured because these clients were seen as lacking the necessary intelligence to verbally discuss their problems in terms of psychodynamic or cognitive-based concepts. The notion has been supported by the observation that many psychotherapists are trained in mostly verbal, intellectually oriented strategies (Lewis & MacLean, 1982).

Finally, they note that the dichotomisation between mental health and learning disability services has served to minimise professional interest in developing effective outpatient psychotherapy protocols for people with learning disabilities. For example, people diagnosed with learning disabilities would likely be referred to a learning disability service.

However, access to the mental health system would be unlikely. Together these factors have led to a paucity of empirical investigations that document the effectiveness of specific strategies for different clinical problems experienced by such individuals.

During recent years, several systematic epidemiological investigations have explored the prevalence of psychiatric disturbance among children and adolescents with learning

disabilities (for example, Lund, 1985; Iverson and Fox, 1989). Between one-third and two-thirds of the individuals in these representative community samples exhibited a significant degree of psychopathology, a rate several times higher than that found among non-learning disabled comparison groups. Some variability in prevalence figures is present across studies, probably reflecting differences in assessment procedures, diagnostic criteria, and the degrees of learning disability represented in the subject samples. Bregman (1991) points out that the resultant findings must be considered preliminary until adequate standardisation procedures of the modified questionnaires are conducted with learning disabled individuals.

Studies of Depression in People with Learning Disabilities

In the past there was considerable debate as to whether people with learning disabilities were capable of experiencing affective disorders; some authors postulated that these individuals did not possess the psychological processes necessary for the development of depression (e.g. Gardner, 1967). More recent research indicates that people with learning disabilities do exhibit symptoms of affective disorders. Sovner and Hurley (1983) reviewed 25 studies describing occurrences of affective disorders in adolescents and adults with learning disabilities. They concluded that individuals with learning disabilities did experience the full range of affective disorders. Pawlarczyk and Beckwith (1987) also reviewed case studies of depression in individuals within the same age range. They found that people with learning disabilities evinced symptomatology corresponding to DSM-III criteria for depression. Reynolds (1985) found that symptomatology expressed by

depressed adults with learning disabilities was similar to that expressed by non-learning disabled persons. Sovner and Hurley (1983) also stated that there may be differences in symptomatology between persons with mild and moderate learning disabilities and those with severe and profound learning disabilities. They concluded that diagnoses of affective disorders can be made for both groups, though assessment techniques may differ. Benson and Ivins (1992), in their study of anger, depression and self-concept in adults with learning disabilities, found that subjects who reported low self-concepts also reported high levels of depression.

Although sufficient evidence has been gathered to indicate that learning disabled individuals do indeed experience depressive disorders, the specific characteristics of the disorders and the ways in which they are manifested across a wide range of functioning levels have not been determined. The types of problem behaviours may vary as a function of developmental level, chronological age, or other factors. Thus, the identification, assessment, and treatment of depression in learning disabled persons may require different methods for different subgroups of individuals (Matson, 1983).

Studies of Anxiety in People with Learning Disabilities

It may be difficult to define anxiety in individuals who have limited or no language or communication. For people with a mild learning disability there is less of a problem since anxiety would be defined in terms much the same as those employed for the general population. However, where language and cognition become more impoverished and

individuals are unable to explain their feelings or are less able to understand the concept of anxiety, then most judgements will depend to a greater degree on appearance and behaviour.

Three outpatient clinic surveys have found similar rates of occurrence: Philips and Williams (1975), Reid (1980) and Benson (1985) studied populations of learning disabled children and adults and found rates of anxiety ranging between 22% and 25%. The inpatient data on the frequency of occurrence of anxiety disorders also hover around the 20% to 25% range. In an extensive study that tracked all births in a British city and reported follow-up data 22 years later, Richardson, Katz, Koller, McLaren, and Rubenstein (1979) found that 17% of the learning disabled population could be described as “neurotic” and 26% as having a “neurotic disorder” in combination with another psychiatric disorder. By the term “neurotic disorder” the authors referred to “disturbance in emotions, nervous breakdowns, anxiety, need for tranquillisers, suicidal, self-destructive acts” (p.280). This latter study, though not utilising criteria of DSM-III and not specifying anxiety disorders, is probably the most informative study available in this area. It represents a longitudinal study and suggests that over one-fourth of learning disabled children exhibit nervous problems by early adulthood. In contrast, prevalence of anxiety for the non-learning disabled in Great Britain is estimated at 2% to 5%. Clearly, learning disabled people appear to be more susceptible to anxiety than non-learning disabled persons.

Matson and Barrett (1982) emphasise that *no* studies employed exacting criteria and that none examined “anxiety” in its various states, as detailed by DSM criteria. Despite this, it

seems that anxiety is more prevalent amongst learning disabled than non-disabled populations.

Studies of Anger in People with Learning Disabilities

Often problems in anger and aggression are managed rather than treated. By this it is meant that outside agencies impose control on the individual experiencing anger by using restraint; drug therapy or seclusion. This is distinct from treatment where the individual him/herself is given some means whereby they can control their own anger.

Benson and Ivins (1992) found that mildly learning disabled people were more likely to report anger than severe/moderately learning disabled people. Heavey *et al.* (1989) administered the School Anger Inventory and the Perceived Control at School Scale to learning disabled and non-disabled children and found higher anger levels in children with learning disabilities than non-disabled children. They also found that students who reported both a high level of anger and high perceived control were found to exhibit more negative behaviour than those with high anger and low perceived control. They speculate that students with high perceived control and high anger may feel able to act and see meaning in acting out their anger, whereas those with low perceived control and high anger may see acting out as futile or perhaps threatening to self.

Almost 10% of the subjects in the above study did not complete the anger inventory or gave invalid responses, whereas only one subject (n=130) had difficulty with the self-concept scale and none had a problem with the depression scale. They speculated that the

content of the anger items was provoking for some subjects and interfered with responding. In addition, a social desirability response bias may have been operating with the anger inventory. Individuals may believe that it is not appropriate to express anger and other negative emotions. The depression scale may not have been affected by this bias because its purpose is less transparent than the anger inventory and it is more symptom oriented. These considerations need to be borne in mind when investigating anger levels in this client group.

In summary, there has been a reluctance to acknowledge and respond to the high levels of psychopathology among people with learning disabilities for a variety of reasons. However, studies have revealed high levels of anger, depression, and anxiety in this client group. It is the aim of this study to look in greater detail at psychopathology in this client group using a Personal Construct Theory approach. The next section outlines the aims and hypotheses of the present study, that has been prompted by the issues that have been presented.

AIMS OF THE PRESENT STUDY

The high levels of psychopathology found in the learning disabled population mean that it is vital to get as much of an understanding as possible about the nature and genesis of these problems. The literature has revealed that people with learning disabilities not only belong to a group with a negative stereotype, but that they are acutely aware of the stigma associated with belonging to this group. To what extent might an awareness of this

negative stereotype account for the high levels of psychopathology found in this client group? The relationship between stigma and self concept appears to be a complex one and it appears that people with learning disabilities are able to maintain some semblance of positive regard despite the fact that the behaviour of most people towards them is often so decidedly negative. There may be a variety of strategies that people with learning disabilities use to protect themselves from the impact of stigmatisation. This study aims to explore how emotional adjustment and self esteem are related to the way people with learning disabilities deal with the effects of negative stereotypes.

The study uses a Personal Construct Theory approach because it is a model that takes the whole person into account; other frameworks are not able to explore the person's self concept in any detail. The major assessment technique derived from Personal Construct Theory is repertory grids which are highly flexible, consider the context rather than the individual in isolation, and can indicate problematic areas and suggest therapeutic methods for dealing with these. In addition, there now exist several assessment scales that have been modified for use with people with learning disabilities and have been shown to measure reliably various emotional states. This study used both repertory grids and the modified questionnaires. The other assessment that was used was the British Picture Vocabulary Scale (short form). This gave the investigator some indication of the cognitive level at which each participant was operating and how this was correlated with ability to complete a repertory grid.

In order to explore their awareness of the stereotype, the element "how people with learning disabilities are seen in general" was included in each repertory grid and was

compared with their views of learning disabled people that they knew, non-disabled people that they knew, their view of themselves, and how they thought they were perceived by other people.

Personal Construct Theory is able to predict what type of emotional reactions will occur in relation to what kind of problems in construing. In this respect, McCoy (1977) has defined anger, anxiety and depression in Personal Construct Theory terms. Anxiety has been defined as “the recognition that the events with which one is confronted lie outside the range of convenience of one’s construct system” (Kelly, 1955, p.495). McCoy views anxiety as a symptom, a state which is present when a person recognises being inescapably confronted with events to which one’s constructs do not adequately apply.

McCoy believes that anger is associated with hostility, which was defined by Kelly (1955) as “the continued effort to extort validation evidence in favour of a type of social prediction which has already proved itself a failure” (p.510). Anger is defined as “an awareness of the invalidation which leads to hostile behaviour, i.e., an attempt to force events into conformity so that the prediction should not have been a failure, and the construction should not have been invalidated” (p. 110). McCoy points out that that it is not possible at present to use Personal Construct Theory to predict that anger rather than anxiety and/or other states such as fear would follow invalidation. They are often found intermingled (Izard, 1972) in emotion studies. Invalidation should theoretically lead to anxiety, and from there to either greater extension or better definition of the construct system. Kelly (1961) suggests that a person may have explored both types of revision and landed on a difficult choice. The necessary revision may involve excavating and

overturning the very foundations of his construct system. It may seem easier to extort confirming evidence from the events. This later choice is called hostility. In this scheme, McCoy proposes that anger is the awareness of it and the preceding invalidation is the precipitating factor.

In relation to depression McCoy's views are also of interest to this study. She wonders whether "sadness is the opposite of "basking in reflected glory", reflected glory being implications linking self structures to the construction of glorified events" (p.112). If this were the case, then an awareness of belonging to a group that is negatively evaluated would lead to high levels of sadness/depression.

Kelly (1980) maintains that tight construing can lead to high levels of anxiety, hostility and depression. Tight construct organisation is reflected in the size of the first two components from principal component analysis of grids (Winter, 1988a). Kelly also notes that the inability to tolerate invalidation is likely to be particularly pronounced in the person whose superordinate constructs are so impermeable that they cannot accommodate inconsistent constructions. These views of anxiety, anger and depression are incorporated into the study's hypotheses, set out below.

It is hoped that in identifying the nature of these constructs, the relationships between them, and associated mood states, we might then work in a particular way to enable people to process their identity in their therapy and to track change using constructs and mood assessments.

Hypotheses of the Study

1. People with learning disabilities will construe people with learning disabilities less favourably than they construe non-disabled people.
2. People with learning disabilities will construe themselves as more similar to non-disabled people than to people with learning disabilities.
3. The more similar to the negative stereotype a person construes him/herself to be, the lower his/her self-esteem and the greater his/her depression.
4. The greater the discrepancy between the way a person construes him/herself and the way he/she feels they are construed by others, the higher he/she will score on the anger scale.
5. If a person has a poorly elaborated construction of him/herself, i.e. the element “self” is not construed in a complex way, he/she will show signs of anxiety.
6. The tighter a person construes in general (i.e. taking into account their construct system as a whole), the higher he/she will score on the depression and the anxiety scales.

In addition to testing these hypotheses, basic features of this client group's construing will be looked at in detail. Finally, intensive research methods such as the repertory grid technique produce interesting qualitative data which allows exploration of the individual in some depth and case examples will be used to illustrate findings in a more detailed manner.

METHOD

Participants

Inclusion Criteria

Thirty-nine people with mild learning disabilities were included in the study. All participants were between the ages of 27 and 45 years. It was felt that this age range would ensure that participants were as independent as they were ever likely to be and that they would be at a life stage where they would be working through a process of coming to terms with chronic disability. This would ensure some degree of homogeneity in the group and the presentation of similar issues.

Filling out a repertory grid requires a certain level of cognitive ability, verbal ability and concentration. Invitations to join the study were only made to those people known to have mild or moderate learning disabilities to control for this to some extent. If the participant was later found to be unable to carry out the practice trials for the grid due to limited cognitive ability, language skills or concentration levels, they were excluded from the study. The British Picture Vocabulary Scale (Short Form) was also carried out during the assessment so that we could establish some idea of the cognitive ability required to complete a repertory grid.

Clients who were recorded as having a major hearing, sight or memory impairment were excluded on the grounds that they would have difficulty with the particular repertory grid technique to be employed in this study.

Since the study is interested in the impact of learning disability on a person's construing and on their levels of anxiety, depression, self-esteem and anger, those registered as suffering from a psychiatric illness (other than anxiety or depression) were excluded from the study because it was felt that such participants might skew the results and that their grids would quite probably reflect major variables other than the stigma of being learning disabled.

The repertory grid requires that the participant is able to describe a number of people with and without learning disabilities. To ensure that the people involved in the study had a social circle wide enough to encompass the necessary individuals, only those who were attending a day centre, college, attended a group for the learning disabled, or who lived in a residential home were invited to join the study.

In sum, the inclusion criteria for the study were:

1. 27 to 45 years of age (inclusive).
2. A mild or moderate degree of learning disability.
3. Participants had to be in contact with other people with learning disabilities.
4. Those with a major hearing, sight or memory impairment were excluded.

5. Those with a major psychiatric diagnosis (other than anxiety or depression) were excluded.

Recruitment Process

Letters describing the study were sent to all people on the Westminster, Hammersmith & Fulham and Kensington & Chelsea Registers of People with Learning Disabilities who met the inclusion criteria. Letters were also sent to parents/caregivers so that they were aware that the person in their care had been contacted and why. Copies of the letters to clients and carers are provided in Appendix 2. Care Managers and Heads of Services were contacted so that they were aware that some of their clients had been asked to take part in the study. The response rate using this method was very poor (under 10%). The letter may have appeared daunting, obtaining answers to any queries requires a certain degree of assertion that this client group may not possess, and finally, filling the consent form out may have seemed a harder option than throwing it away if there were any doubts in the person's mind.

As a result of this poor response rate, the investigator adopted a different method of recruitment. This involved making direct contact with clients at various centres (MENCAP centres in the London area, Employment Support Services, and private housing groups). If the agencies were in agreement, the investigator attended the centres and gave a presentation to anyone who was interested in taking part in the study. This increased the response rate dramatically, and had the benefit of closely involving staff who

could invite those they thought most appropriate to attend the presentation. Participants did not have to return a form by post, and were simply asked to sign the consent form at the end of the presentation if they wanted to take part. Queries could be answered on the spot and doubts addressed. The other benefit of this method was that the prospective participants could meet the investigator before agreeing to answer their questions; this may have excluded the “fear of the unknown” factor.

Those who were willing to take part were requested to return a consent form (see Appendix 1) giving the investigators permission to contact them in person to arrange a convenient time to meet them at their day centre/college/home.

The sample

The final sample (i.e. participants who completed all of the research measures) constituted 39 individuals; 16 women (41%) and 23 men (59%). Their ages ranged from 26 years to 45 years, with a mean age of 36 years 6 months. In addition to this, fifteen other participants agreed to take part in the study but the investigator terminated the interviews early for various reasons and they were not included in the study. One participant was not able to understand the items on the depression scale and to think about his mood; one participant was unhappy about the ranking stage of the repertory grid and found it too hard to consider the elements in relation to each other along each dimension; seven participants found discussing their emotions too painful; one participant was unable to generate anything other than extremely concrete constructs that it would have been too difficult to rank people on (e.g. “brown hair”); two participants insisted that they did not

know what the term “learning disabled” (or any equivalent) meant and so were unable to use the element “a person with learning disabilities in general”; one participant was not able to generate enough constructs and was unwilling to continue trying; one participant who was contacted by post was not connected with any groups or services for people with learning disabilities and had attended a mainstream school and said he knew no one with learning disabilities that he could use for elements; one participant was found to be echolalic and so no meaningful responses could be elicited.

Ethical Issues

The study was approved by the ethics committees in the areas in which recruitment took place (Riverside, Parkside, and Harrow). Copies of the approval letters can be found in Appendix 4.

Participants were asked to give written consent allowing the investigator to contact them to arrange a meeting. At this meeting, they were given a full description of what the interview would involve before consent was requested and they were asked to sign the volunteer consent checklist. Copies of these two consent forms can be found in Appendix 3. In order to protect participant confidentiality, no names appeared on the questionnaires and code numbers were used to identify each participant. The investigator was particularly vigilant for signs of “wishing to please” or feelings of obligation on the volunteer’s part since these are so prevalent in this client group. Time was spent building up some rapport with the participant before the various assessments were carried out. It was important to avoid giving the expectation of long term social contact, and it was felt

that there was an ethical responsibility to make it clear that the relationship was of a temporary nature. If the participant was unable to concentrate or to understand what was required at any point during the interview, the interview was ended and the participant was excluded from the study.

If the participant became distressed by any of the questions asked during the study or if the investigator felt that the interview raised difficult issues for the participant, they were given the option to discontinue the interview and were offered a referral to the appropriate mental health team for further support.

Measures

Following the initial discussion clarifying the nature of the study, the following measures were administered:-

British Picture Vocabulary Scale (short form) (Dunn, Dunn, Whetton and Pintillie, 1982).

This was administered in order to assess the participant's cognitive ability. For the Wechsler Intelligence Scale for Children - Revised, Wechsler found the vocabulary subtest scores correlated more highly with Full Scale IQ scores than any other single subtest (Wechsler, 1974, p.47), suggesting that such tests measure not only a participant's vocabulary, but gives some indication of their cognitive ability in general. The BPVS was chosen because it is standardised, has been used with people with learning disabilities, and is quick to administer. The median value of the split-half reliabilities of the BPVS Short Form by age groups was .80

Revised Version of the Zung Anxiety Scale (Lindsay & Michie, 1988). This is a 20-item self-rating scale for anxiety. It has two response categories, “yes” and “no”. These are scored 0 and 1, with higher scores reflecting anxiety. Some of the scale items are scored positively for anxiety whereas others are reverse scored. Some of the items were: “do you feel afraid for no reason at all?”, and “do you feel weak and get tired easily?”. In this study, the revised version was employed as it has been used with people with learning disabilities in the past and has been standardised. To test whether response sets were occurring, Lindsay and Michie used both a no/yes presentation and a yes/no presentation. They found a correlation of .83 between these two presentations carried out three months apart. There was also a highly significant split-half reliability coefficient ($r=.69$).

Birleson Depressive Self-Rating Scale (Birleson, 1981). This is a 37-item scale developed for 7-12 year-old children. There are three response categories: *Most of the time*, *Sometimes*, and *Never*. These are scored, 0, 1, or 2 with the higher score reflecting depression. Some of the scale items are scored positively for depression whereas others are reverse scored. In the present study, a modified 18-item scale was used (Birleson, 1981). The measure was found to have a test-retest reliability of .80, showing a highly satisfactory degree of stability (Birleson, 1981). The individual items had correlations of between .65 and .95. The internal consistency, estimated by the split-half reliability coefficient, was found to be .86. The linearity of scale items was assessed by a factor analysis. One principal factor was found, accounting for 30% of the total variance. A rotated matrix produced 5 factors which together shared 61% of the total variance. This scale was found to discriminate between depressed and control groups of children (using a

cut-off score of 13 out of 18) and showed a high correlation ($r=.81$, $p<.001$) with the self-report Children's Depression Inventory (Asarnow & Carlson, 1985). Some of the items were: "Do you like to have fun?", and "Do you feel like crying?". The 18-item scale has been used in research with adults with learning disabilities (Benson & Ivins, 1992). In the present study, some clients found it hard to use the three response format so the investigator broke this down: firstly they were asked for a "yes" or "no" response and then, if they answered "yes", they were asked if it was "most of the time" or "sometimes", and if they answered "no", they were asked if it was "sometimes" or "never".

Childhood Inventory of Anger (CIA) (Finch *et al.*, 1983). Finch *et al.*'s original 71-item questionnaire of anger intensity was adapted by Hendryx (1983) and this shortened version was later used with adults with learning disabilities (Benson & Ivins, 1992). This shortened version was used in this study. Examples of the anger arousing situations included are: "Someone calls you a liar"; and "Your friends make fun of you". The respondent rates the intensity of anger on a 1 to 4 scale, where 1 = *That situation doesn't bother me*, 2 = *That bothers me, but I'm not too upset*, 3 = *I'm really angry*, and 4 = *I can't stand that, I'm furious!* Each response choice has a numbered stick-figure drawing that shows the degree of anger through body posture and facial expression. The scale is scored by summing the responses. The CIA has been used in research with adults with learning disabilities, and the mean score for this client group was found to be 99.8 (Benson & Ivins, 1992). The shortened, 35-item version was found to have a test-retest reliability of 0.62 for a 6-8 week period (Hendryx, 1983). Factor analysis of the responses to the 35-item scale indicated that a single factor solution accounted for much of the variance.

Rosenberg Self-Esteem Inventory (Rosenberg, 1965). This is a 10 item self-report scale of self-esteem to which the participant responds on a four-point scale of agreement. Half of the items are expressions of positive self-esteem (1, 3, 4, 7, 10) and half are negative (2, 5, 6, 8, 9). Items are scored from 1 to 4 in the direction of negative self-esteem. The responses are summed and scores fall within a range of 10 to 40. Low scores indicate high self-esteem. The Rosenberg measure is the most widely used measure of self-esteem and has been used successfully by the investigator in clinical work with people with learning disabilities in the past. The statements were changed to questions to make the scale more accessible to people with learning disabilities i.e. the statement “I wish I could have more respect for myself” was changed to the question “Do you wish you could have more respect for yourself?”.

Little data is available on the psychometric properties of the Rosenberg Self-esteem Scale even though it is widely used. However, Demo (1985) found a test-retest reliability of .85, and an internal consistency of .89. There has been no attempt to differentiate state and trait indices of self-esteem. Rosenberg (1989) found a mean score of 34.7 (S.D.=4.86) within a normal population, revealing that the scores are negatively skewed (they tend toward low self-esteem).

Repertory Grid (Kelly, 1955). Repertory grids were used to explore the participant’s constructions of themselves and the world around them. The technique used to elicit constructs and elements and then to rank them has been used with people with learning disabilities in the past (e.g. Barton *et al.* (1976)). The procedure is outlined in detail

below. Bonarius (1965), reviewing a number of studies that examined the stability of particular grid measures, found that many of them obtained test-retest correlations in the region of 0.8. With respect to construing of the self, which is particularly pertinent to this study, Sperlinger (1976) found a correlation of 0.95 between the distances of the self from other elements on two occasions of testing. That Repertory Test results may be predictive of behaviour was indicated by Kelly (1955), who noted that such results had been matched reliably with subjects' role-playing performance and Thematic Apperception Test protocols. Winter (1992) has reviewed studies of the validity of this technique, and argues that there is considerable evidence of the validity of repertory grid measures in relation to a wide range of characteristics and aspects of the behaviour of "normal" subjects.

For all of the measures used, the wording of the questionnaire items was changed from "I" to "You" because the questions were read to the subject (copies of the questionnaires are provided in Appendix 4). In addition, as the participants were adults, the wording of the questions was changed to refer to work/day centre rather than school where appropriate.

Repertory Grid Procedure

All participants completed a repertory grid, the method devised by Kelly (1955) for gaining access to an individual's personal construct system. As an assessment technique, it respects the individual, allowing the person to present his/her own construing rather than imposing a frame of reference. Since Kelly, the repertory grid technique has been modified and developed (Fransella & Bannister, 1977). The experiences of Barton et al (1976) in using the repertory grid with people with learning disabilities and of Salmon (1976) with children were drawn on in preparing the procedures used in this study.

The repertory grid completed by the participants was standardised in terms of the number of elements (people) and number of constructs to allow comparisons to be made between participants. Each grid contained eleven elements, seven that were learning disabled (including "self" and "how others see me"), and four that were not learning disabled. Eight constructs were elicited from each participant and the investigator provided a ninth one ("person I would like to be like"). People with learning disabilities find it hard to generate constructs and tend to use a limited number of constructs so we limited the constructs required for the grid to nine.

Participants were asked to talk about a representative sample of people with and without learning disabilities in their world. They were encouraged to articulate the important constructs used by them in understanding themselves and the people around them. They were asked to talk around the elements in a non-structured way, as recommended by Fransella and Bannister (1977) in response to the finding that Kelly's triadic method was

too complex for use by people with learning disabilities (Barton et al., 1976). Constructs could be extracted from the participant's description and then the contrast (opposite pole of the construct given) could be identified by asking the participant for the opposite of the construct.

Eliciting Elements

Participants were told that the researcher wanted to find out who were the important people in their lives and these would include people both with and without learning disabilities and people that they liked and people that they were not so keen on. They were asked to think of two people with learning disabilities that they liked and two people with learning disabilities that they did not like or felt indifferent towards. They were also asked to name two people without learning disabilities that they liked and two that they did not like or felt indifferent towards. Some participants found it very difficult to classify anyone as someone that they did not like. In order to get round this problem, the question was rephrased and they were asked to name someone that they liked, but not as much as they liked other people.

Three elements were supplied by the investigator; "self", "how others see me", and "a person with learning disabilities" in order to investigate how the person's construction of the self, perceived self and the person's stereotype of people with learning disabilities interact with each other and other elements. If participants were unable to understand what was meant by the term "learning disabled" (or equivalent terms), they were excluded from the study because they would not be able to apply their constructs to the element "a

person with learning disabilities” and it was assumed that they would not be affected by any stigma of the label because they did not know that the label existed.

Eliciting Constructs

There is considerable evidence that the constructs which are elicited from subjects individually are more personally meaningful to these subjects than are constructs supplied to them from other sources (Adams-Webber, 1979). Since the aim of this study is to explore the nature of the construing of people with learning disabilities, all but one of the constructs that were used were elicited, even though this reduces the degree of standardisation when making comparisons between different populations (such as angry and anxious individuals). The ninth construct (“someone I would like to be like”) was supplied by the investigator. To elicit the constructs, the investigator asked the participant to tell them a little bit about each of the people listed. The participant was encouraged to talk freely and to allow the constructs to emerge spontaneously. Words and phrases were checked for personal meaning in case the person had heard them used by other people and did not understand their meaning. For example, if the participant says a person is “OK”, is this just something they have heard people saying or do they have some understanding attached to it? It may be observed after a while that the person prefaces all comments about people by saying that they are “OK” and that this is not very meaningful in itself. But as Fransella & Bannister (1977) point out “it must be borne in mind that what may seem superficial or vague to you ... may be neither superficial nor vague to your subject”.

Questions used to encourage the production of constructs included:

- “what sort of person is -----?”
- “what is the best/worst thing about ----?”
- “when you say ---- is ----, what do you mean?”
- “why do you think ---- is ----?”
- “tell me a bit more about someone who is ----”
- “what else does ---- do that shows they are ----?”
- “what else does a ---- person do?”

It was important that the constructs that were elicited were neither too superordinate nor too specific. Constructs that are too superordinate make it impossible for the person to make discriminations between elements required by the ranking part of the procedure as the construct would be too general and overinclusive; as Fransella and Bannister (1977) point out, it would be like trying to rank different types of music on the construct “music - not music”. If the constructs are too specific, such as “takes me out to dinner”, it might be difficult to apply the construct to the other elements in the repertory grid.

To elicit the contrast pole, participants were asked questions such as “if someone is not ---, what are they like?”, “what would be a better way to deal with that?”. It was anticipated that some participants would not be able to produce a contrast pole for all constructs. In this case, the investigator filled in the space with a contrast of “not X”. Finally, preferred poles were identified by asking whether the participant would rather be the emergent pole or the contrast pole.

If the participant produced more than the eight constructs required, the first construct elicited for each element was selected. If this first construct had already been selected in relation to an earlier element, the next construct would be selected.

Grid Construction

The next stage in the process is to construct the grid. This can be done in one of three ways - dichotomising, rating or ranking. The choice of method will have an effect on the results of the analysis (Fransella and Bannister, 1977). The ranking technique was used here because it has been found to be the easiest technique for this client group to use (Beail, 1985).

The ranking method involves the elements being rank ordered along the construct. This removes the problem of skewed distributions that can occur in the other two methods. Beail (1985) comments that there is a tendency to judge the element in terms of similarity to one pole of the construct without giving consideration to the other pole. This can however be an advantage in those groups of people who find it difficult to produce a contrast pole, such as people with learning disabilities.

Slater (1977) points out that ranking imposes two constraints on the data. By assuming an equal distribution along the dimension, it forces the participant to distinguish each element from all the others for each construct and this may lead to exaggerated differences between elements, suppressing similarities that may be of psychological interest. Secondly, it causes all the constructs in the repertory grid to have the same mean and

variance. He also argues that it cannot be taken for granted that the elements are stretched evenly from pole to pole, especially when it is done from the emergent pole. It is also impossible to measure lopsidedness of construing, which has been found to be related to anxiety and other difficulties (Fransella and Bannister, 1977).

The participant was presented with the elements (printed, drawn, or otherwise symbolised) on cards. The symbols used if the participant could not read usually involved physical characteristics such as a moustache, spectacles, wheelchair, and so on. A few minutes were then spent teaching the person to recognise the elements. To check that each element was recognisable for the person, the investigator pointed to each card in turn and the participant was asked to say who it represented.

The elements generated by the person were laid out on the table in a random fashion to avoid suggesting a linear ordering. The participant was told that there were no right or wrong answers. The participant was then asked “which of these people is the most ----?” and that element was removed. They were then asked “now which of these people is the most ----?”, and so on until all of the elements had been ranked along that construct. If the participant found this part of the study difficult, each card was taken by the investigator in turn. To start with the participant had to decide which of two elements was “the most---”. Then a third card was taken and the person was asked if this person was “more ---” or “less ---” than each of the other two elements. This was done for each card so that they could be placed accurately in the rank. Three additional elements were supplied in turn by the investigator after the eight elicited elements had been ranked - “self”, “how others see me”, “how people with learning disabilities are seen in general”. It was felt that this would

be easier for participants because they only had to bear in mind the eight people that they knew well and they could then consider the three novel elements separately.

This procedure was repeated for each of the constructs that the person had generated earlier. The participant was also asked to rank each element on the construct “someone I would like to be like”/“someone I would not like to be like” in order to investigate the participant’s “ideal self” construct.

Occasionally, the participant found it hard to rank people using a construct because this construct was not really meaningful for him or her. In this case, a reserve construct that the participant had generated earlier was substituted. If the person found it hard to rank any but the first few elements along a construct, they were asked to rank them according to the contrast pole (i.e. the opposite construct) and participants worked back from this until all of the elements had been ranked.

The researcher watched for haphazard placing of elements or for position habits, such as always saying that the nearest element had the most of the characteristic, or repeatedly enquiring “is that right?”.

Construct Categorisation

Each elicited construct was categorised on the basis of Landfield's (1971) classification system with the following modifications: the construct dimension was categorised as a whole, rather than the two construct poles separately; each construct was forced into a category; multiple coding of a construct was not permitted, only the most pertinent category being used in each case. This system describes 20 categories of construct and the procedure for allocating constructs to categories. Some of the categories were excluded for the purposes of this study: some constructs that would come under the factual description category were not used in the repertory grids because they were too concrete and it would not have been possible to rank elements along them (e.g. "man"); self-referent constructs were not used because it would have been too difficult to rank the self along these dimensions (e.g. "talks to me"). In the latter case, if the participant felt that the construct could be generalised to people in general (e.g. "talks to people") then this construct was used instead. If the participant did not feel that the construct could be generalised, then the construct was discarded altogether and a new construct was elicited.

The following categories of constructs were used in this study:-

1. Social Interaction - any statement in which face-to-face, ongoing, continuing interaction or lack of face-to-face, ongoing, continuing interaction with others is clearly indicated (e.g. polite, withdrawn, aloof, a good guy).
2. Forcefulness - any statement denoting energy, overt expressiveness, persistence, intensity, or the opposite (e.g. aggressive, bigoted, intolerant, stubborn, easily influenced, passive, quiet, easygoing).

3. Organisation - any statement denoting either the state of or process of structuring, planning and organising, or the opposite (e.g. competent, good judgement, organised, disorganised, messy, reckless).
4. Self-sufficiency - any statement denoting independence, initiative, confidence, and ability to solve one's own problems or the opposite (e.g. independent, mature, thinks for self, dependent, a follower, immature).
5. Status - any statement where references are made to either status striving or to high prestige status symbols, or to a lack of these (e.g. educated, ambition, professional).
6. Factual description - a characteristic so described that most observers could agree that it is factual and not open to question (e.g. mother, always lived in town)
7. Intellective - any statement denoting intelligence or intellectual pursuits, or the opposite (e.g. bright, intelligent, dumb, naive).
8. Imagination - any statement denoting subjective activity which is supplemental to or divorced from reality, or its opposite (e.g. concrete, realistic).
9. Alternatives - (a) a subject uses more than one description, or (b) a description suggesting a strong openness or little receptivity to ideas (e.g. bigoted, dogmatic).
10. Sexual - any direct reference to sexual behaviour or implicit sexual behaviour (e.g. married, sexy).
11. Morality - any statement denoting religious or moral values (e.g. good, honest, loyal, trustworthy, bad, irresponsible, selfish).
12. External appearance - any statement describing a person's appearance which may be either more objective or subjective (e.g. short, ugly, red hair).
13. Emotional arousal - any statement denoting a transient or chronic readiness to react with stronger feelings (e.g. angry, anxious, cheerful, quick tempered).

- 14.Egoism - any statement denoting self importance (e.g. conceited, self centred, thinks he is smart).
- 15.Tenderness - any statement denoting susceptibility to softer feelings towards others or the opposite (e.g. considerate, devoted, gentle, kind, callous, cold, critical).
- 16.Time orientation - any statement denoting a state of mind which strongly implies an individual's future orientation and expectancy, or a past orientation and expectancy (e.g. optimistic, happy childhood).
- 17.Involvement - any statement denoting a commitment or dedication to and strong pursuit of an interest, occupation, way of life, philosophy, or lack of such (e.g. dedicated, enthusiastic, zest for life, indifferent, not interested in anything).
- 18.Extreme qualifiers - any adjective, adverb, or phrase which makes a description extreme (e.g. always, never).
- 19.Humour - any statement specifically denoting either the ability or inability to perceive, appreciate, or express that which is funny, amusing or ludicrous (e.g. witty, likes a joke, gloomy, grim).

The investigator went through each construct and decided which category it fitted into most clearly (if the investigator was unclear it was useful to consider the contrast pole to get an idea about the way in which the construct was being used).

Statistical Analysis

Relationship Between Elements and Preferred Poles of Constructs

Preferred poles were identified by asking whether the participant would rather lie at the emergent pole or the contrast pole. In order to examine how the self and the two sets of elements (elements with learning disabilities and non-disabled elements) were ranked with respect to the preferred poles of the constructs it was necessary to transform the raw grids.

The grids were transformed by reversing rankings on certain constructs so that the element closest to the preferred pole of each construct was always given the lowest rank (one), and the element closest to the non-preferred pole the highest rank, (eleven).

The participant was felt to have a positive stereotype of people with learning disabilities if the mean distance of the learning disabled elements from the preferred poles of the constructs was under 90. If the figure was over 90, they were deemed to have a negative stereotype of people with learning disabilities. This figure had to be calculated both for the people with learning disabilities that the participant knew, and the stereotype element “a person with learning disabilities in general” to see if there were any differences between the way a person evaluates the members of a group and the stereotype of the group as is the case in other populations (Tajfel, 1981).

Computer Analysis of the Repertory Grids

The repertory grids were analysed using the FLEXIGRID 5.2 computer package designed by Tschudi (1993). Each hypothesis was taken in turn and the appropriate statistical procedures carried out to consider the data in terms of this hypothesis. Output measures used were as follows:-

1. Angular distances (expressed in degrees, from 0 to 180). If the distance is low, the preferred pole of the construct is thought to characterise the element, if it is high then the unpreferred pole characterises the element.
2. Distances between elements (expressed as a score between 0 and 2). The lower the score, the greater the perceived similarity between the two elements. Distance scores are provided between all possible pairs of elements in each grid. The standardisation of the size of the repertory grids enabled these scores to be compared across participants.
3. Principal Components (expressed as a score between +1 and -1). This examines the pattern and the structure within each grid, transforming the original set of variables into a set of hypothetical variables which are uncorrelated and which explain as much of the total variation in the data with as few components as possible. The first principal component accounts for the largest amount of the total variation, and the second component, which is orthogonally related to the first, accounts for the maximum amount of the remaining total variation, and so on for the third component. The size of the first principal component can be used as an indication of the tightness or looseness of construing (Fransella and Bannister, 1977). This can be determined from the FLEXIGRID 5.2 output which provides the percentage of variance accounted for by

each component. The larger the percentage of variance accounted for by the first principal component, the more tightly the person is said to be construing.

Hypothesis 1 - People with learning disabilities will construe people with learning disabilities less favourably than they construe people without learning disabilities

To examine this hypothesis, the “relations between constructs and elements expressed as degrees” output table was used. Results were calculated by finding the average angular distance of the preferred poles from non-disabled elements and the average angular distance of the preferred poles from disabled elements. T-tests were then carried out to see whether people with learning disabilities were construed significantly more positively or negatively than non-disabled people.

Another measure of hypothesis 1 was taken by calculating the distance of the “ideal self” construct from non-disabled elements and the distance of the “ideal self” from disabled elements. Again, t-tests were carried out to see whether the person construes people with learning disabilities significantly more positively or negatively than non-disabled people.

Hypothesis 2 - People with learning disabilities will construe themselves as more similar to people without learning disabilities than to people with learning disabilities

To examine this hypothesis, the “Distance between elements” output table was used. The average distance of the self from non-disabled elements was calculated and the average distance of the self from disabled elements. This was calculated for each individual and then t-tests were carried out to see if the individual sees him/herself as significantly more like a person with learning disabilities or like a non-disabled person. The distance of the self from the stereotype element “a person with learning disabilities in general” was also examined in this way.

Hypothesis 3 - If a person construes people with learning disabilities negatively, and also construes him/herself as similar to people with learning disabilities, he/she will have a low self-esteem and will show signs of depression.

Each participant was allocated to one of the following groups: 1) holds a positive stereotype of people with learning disabilities and sees themselves as learning disabled; 2) holds a positive stereotype of people with learning disabilities and does not see themselves as learning disabled; 3) holds a negative stereotype of people with learning disabilities and sees themselves as learning disabled; 4) holds a negative stereotype of people with learning disabilities and does not see themselves as learning disabled.

A positive stereotype was deemed to be present if the mean distance of the learning disabled elements from the preferred poles of the constructs was less than 90; a negative

stereotype if the mean distance was greater than 90. This was calculated for both the stereotype element “a person with learning disabilities in general” and for the group of learning disabled elements known to the participant.

In order to decide whether the participant construed himself as learning disabled or non-disabled, distances from the learning disabled and non-disabled elements were compared.

If the “self” element lay closer to the learning disabled elements, he was assigned to the “construes himself as learning disabled” group; if the “self” element lay closer to the non-disabled elements, he was assigned to the “construes himself as non-disabled” group.

Because there may be differences in the way a person construes himself in relation to the stereotype of a group and the way he construes himself in relation to the members of that group (Tajfel, 1981), comparisons of distances of the “self” from the stereotype element “a person with learning disabilities in general” and the non-disabled elements was also carried out.

In order to ascertain whether being a member of a particular group was associated with depression levels with group 3 (has a negative stereotype and considers themselves to be learning disabled) carrying the highest risk of depression according to this hypothesis), independent sample t-tests were carried out with depression as the dependent variable. In addition a multiple regression was carried out to establish whether there was a significant interaction between the type of stereotype a person holds (stigma) and whether or not that person construes him/herself to be learning disabled (group).

Hypothesis 4 - The greater the discrepancy between the way a person construes him/herself and the way they feel they are construed by others, the higher he/she will score on the anxiety and/or the anger scale.

The average distance of the “how others see me” element from disabled elements was subtracted from the average distance of the “self” element from the disabled elements. The resulting figure was then correlated with the participant’s score on the Childhood Inventory of Anger and with their score on the Zung Anxiety Scale.

Hypothesis 5 - If a person has a poorly elaborated construction of him/herself, he/she will show signs of anxiety

To test this hypothesis, the “element loadings” output table was used. This gives the percentage of variance accounted for by each of the elements. The higher the percentage of variance accounted for by the “self” element, the more elaborated the construction of the self. This figure was then correlated with the Zung Anxiety Scale.

Hypothesis 6 - The tighter a person construes, the higher he/she will score on the depression, and/or the anxiety, and/or the anger scales.

To test this hypothesis, the percentage of variance accounted for by components 1 and 2 were used. The higher the percentage of variance accounted for by component 1, the tighter the person construes; the higher the percentage of variance accounted for by

component 2, the looser a person construes. These scores were each correlated with the participant's score on both the Birleson Depression Scale and the Zung Anxiety Scale.

RESULTS

Overview

The results are organised in ten sections. The first and second sections consider the nature and prevalence of psychopathology found amongst the participants, and the range of learning disability present across the sample. The next six sections consider each of the study's hypotheses in turn and present the results relating to these. The last two sections consider the more qualitative aspects of the data and present findings concerning the content of this population's construing, and some individual case examples.

Levels of psychopathology

There was a wide range of scores on all of the measures of emotional adjustment (see Table 1). Using the recommended cut off score of 13 for the Birleson Depression Scale, 46% of the participants were identified as depressed. The mean score for the Rosenberg Self-esteem Scale was 22.15, which reveals a much higher level of self-esteem in this population than in Rosenberg's (1989) normal population (mean=34.73).

Unfortunately, no cut off score for the Zung Anxiety Scale was found in the literature. Similarly, no normative data for the Childhood Inventory of Anger were found. It is

therefore not possible to establish whether the levels of anxiety and anger were higher, lower, or similar to those found in either “normal” or “neurotic” populations. However, for the purposes of this study some discriminations were made. The anxiety scores were divided into low anxiety (scores of 1 to 7), medium anxiety (scores of 8 to 14), and high anxiety (scores of 15 to 20). According to these criteria, 11 participants (28%) were found to have low anxiety levels, 19 participants (49%) were found to have a medium level of anxiety, and 9 participants (23%) were found to have high anxiety levels.

Table 1. Minimum, maximum and mean scores on the depression, anxiety, anger and self-esteem measures

Measure (possible range)	Mean	S.D.	Minimum	Maximum
Anxiety (0 - 20)	10.44	4.63	1.00	20.00
Depression (0 - 36)	13.15	7.00	1.00	35.00
Self-esteem (10 - 40)	22.15	6.50	11.00	40.00
Anger (35 - 140)	102.31	20.56	39.00	137.00

Although there was a significant correlation between anxiety and depression scores ($r=.71$; $p<.001$), between depression and self-esteem scores ($r=-.67$; $p<.001$), and between anxiety and self-esteem scores ($r=-.43$; $p<.01$), no other correlations between the various measures of psychopathology were found.

Participants' scores on the British Picture Vocabulary Scale

Scores on the British Picture Vocabulary Scale (BPVS) ranged from 9 (age equivalent, 4 years) to 29 (age equivalent, 16 years 11 months) with a mean score of 19.56 (S.D. = 5.59) (age equivalent, 9 years). Pearson values were calculated and revealed no correlations between a participant's score on the BPVS and their scores on the anxiety, depression, self-esteem, or anger measures.

Differences in the way people with learning disabilities construed people with and without learning disabilities

Hypothesis 1 predicted that people with learning disabilities would construe people with learning disabilities less favourably than they construed non-disabled people. However, the results here show that people with learning disabilities were construed significantly more positively (i.e. closer to the preferred poles of the constructs) than non-disabled people ($t(38) = -4.51$; $p < .001$). The mean distance from the preferred poles shows that people with learning disabilities are construed as lying closer to the preferred poles (mean = 77.43), whereas non-disabled people were construed as being equidistant from the preferred and non-preferred poles (mean = 91.94). Although there is a significant difference in the way people with and without learning disabilities are construed, this is not in the direction predicted and hypothesis 1 had to be rejected.

People with learning disabilities were construed more positively than the stereotype of a person with learning disabilities (see Table 2), but this difference was not statistically

significant ($t(38) = -1.55$; n.s.). The stereotype of a person with learning disabilities fell closer to the preferred poles of the constructs than did non-disabled people, but again this difference did not reach statistical significance ($t(38) = 1.05$; n.s.).

Table 2. Mean angular distances of learning disabled, non-disabled and stereotype elements from the preferred poles of constructs and significant differences between these

	Mean angular distance	S.D.	t (38)
Disabled vs non-disabled elements	77.43 91.94	12.72 11.78	-4.51***
Disabled elements vs. stereotype	77.43 85.86	12.72 28.38	-1.55
Non-disabled elements vs stereotype	91.94 85.86	11.78 28.38	1.05

*** $p < .001$

In addition to measuring the distance of learning disabled and non-disabled elements from the preferred poles, the distance from the ideal self was measured (see Table 3). Again, people with learning disabilities were construed significantly more positively (with respect to the ideal self construct) than non-disabled people ($t(38) = -4.84$; $p < .001$). People with learning disabilities were not construed as significantly closer to the ideal self than the stereotype of a person with learning disabilities ($t(38) = .05$; n.s.). However, this stereotype of a person with

learning disabilities was construed as significantly more positive (i.e. closer to the ideal self) than non-disabled people ($t(38) = -3.08$; $p < .01$).

Table 3. Mean angular distances of learning disabled, non-disabled and stereotype elements from the ideal self, and significant differences between these

	Mean angular distance	S.D.	t (38)
Learning disabled vs Non-disabled elements	76.83 97.43	18.00 15.01	-4.84***
Learning disabled elements vs stereotype	77.16 76.83	2.21 18.00	.05
Non-disabled elements vs stereotype	77.16 97.43	32.21 15.01	-3.08**

** $p < .01$

*** $p < .001$

Construction of the self in comparison to people with and without learning disabilities and the stereotype of a person with learning disabilities

Hypothesis 2 predicted that people with learning disabilities would construe themselves as more similar to non-disabled people than to the stereotype of people with learning disabilities. However, the results show that people with learning disabilities were found to construe themselves as more similar to people with learning disabilities than non-disabled people (see Table 4), but this trend was not statistically significant ($t(38) = 1.86$; $p < .10$). It

was therefore necessary to reject hypothesis 2, and the evidence seems to indicate that perhaps construing occurs in the direction opposite to that predicted. Participants did not construe themselves as being significantly more similar to people with learning disabilities than to the stereotype of a person with learning disabilities ($t(38) = .12$; n.s.) or more similar to non-disabled people than to the stereotype of a person with learning disabilities ($t(38) = 1.04$; n.s.).

Table 4. Mean distances between the self, people with and without learning disabilities, and the stereotype of a person with learning disabilities and significant differences between these

	Mean distance	S.D.	t (38)
self/learning disabled vs self/non-disabled elements	.99 .93	.14 .13	1.86
self/stereotype vs self/non- disabled elements	.99 .93	.36 .13	1.04
self/stereotype vs self/disabled elements	.99 .99	.36 .14	0.12

As indicated in Table 5, participants construed people with learning disabilities ($p < .01$), non-disabled people ($p < .01$), the stereotype of a person with learning disabilities ($p < .01$), and other people's view of them ($p < .05$) all significantly more positively than they construed themselves (as indicated by distance from preferred poles). The mean distance of the self from the preferred poles of constructs was found to be significantly correlated with a person's score on the Rosenberg Self-esteem Scale ($r = .39$; $p < .05$). However, the mean distance of the self from preferred poles was not found to be significantly correlated with a

person's score on the Birleson Depression Scale, the Childhood Inventory of Anger, or the Zung Anxiety Scale.

Table 5. Mean angular distances of self, social self, the stereotype of people with learning disabilities and people with and without learning disabilities from preferred poles of constructs

	Mean	S.D.	t (38)
non-disabled	91.94	11.78	-7.19***
elements vs self	118.62	17.85	
learning disabled	77.43	12.72	-9.85***
elements vs self	118.62	17.85	
stereotype vs self	85.86	28.38	-6.13***
	118.62	17.85	
self vs social self	118.62	17.85	2.62*
	108.56	25.95	

* p < .05

*** p < .001

Relationship between a person's construing and scores on the Birleson Depression Scale and the Rosenberg Self-esteem Scale

Hypothesis 3 predicted that the more similar to the negative stereotype a person construes him/herself to be, the lower his/her self-esteem and the greater his/her depression. In order to test this hypothesis, calculations were done using both people with learning disabilities that were named by the participant and whether they were seen positively or negatively, and using the stereotype "a person with learning disabilities in general" and whether this was seen positively or negatively. It was felt that this was necessary because the participants may have

regarded people with learning disabilities that they knew well as exceptions to the stereotype. If the mean distance of the elements from the preferred poles was under 90, they were deemed to lie in the positive half of the person's construct system and therefore this person was said to have a positive stereotype of people with learning disabilities. When the group of learning disabled elements that participants knew was used as a measure of the nature of their stereotype, 90% of participants were found to have a positive stereotype of this group. This meant that there were very few participants who fell into the two groups associated with a negative stereotype ($n=3$ and $n=1$) and no statistical tests were carried out using this criteria for this reason. However, when the element "a person with learning disabilities in general" was used as a measure, only 52% of them were found to have a positive stereotype.

In the same way, when exploring whether participants construed themselves as more like a learning disabled or non-disabled person, the distance of the self from non-disabled people was looked at in comparison to the stereotype of a learning disabled person in the first set of calculations, and in comparison to people with learning disabilities that they knew for the second set of calculations. The data show that 33% of participants considered themselves to be more similar to people with learning disabilities that they knew than to the non-disabled elements. When they considered themselves in relation to the stereotype of "a person with learning disabilities in general", 46% considered themselves to be more similar to this element than to the non-disabled people that they knew. Table 6 shows the results of the t-tests comparing groups where the criteria for both "group" and "stereotype" was based on "a person with learning disabilities in general" (rather than people with learning disabilities that were known to them).

In order to test this hypothesis, a multiple regression moderator analysis was carried out to test the prediction that there would be an interaction between the nature of the stereotype a person holds, and the group to which he sees himself belonging. After entering the variables “stereotype” and “group”, the addition of the interaction term (“stereotype x group”) was found not to lead to a significant increase in F ($F=.01$; n.s.): no significant interaction was found between the type of stereotype a person held and whether or not they considered themselves to be learning disabled.

In addition, independent samples t-tests revealed no significant differences in depression levels and self-esteem levels of people falling into the four groups suggested by hypothesis 3 (see Table 6): holds a positive stereotype of people with learning disabilities and construes themselves as learning disabled (group 1); holds a positive stereotype of people with learning disabilities and does not construe themselves as learning disabled (group 2); holds a negative stereotype of people with learning disabilities and construes themselves as learning disabled (group 3); holds a negative stereotype of people with learning disabilities and does not construe themselves as learning disabled (group 4). Hypothesis 3 therefore had to be rejected.

Table 6. Differences in mean depression scores and self-esteem scores for groups 1, 2, 3, and 4 (using the stereotype “a person with learning disabilities in general” to define type of stereotype and group to which they felt themselves to belong)

	Depression (mean)	S.D.	t (df)	Self-esteem (mean)	S.D.	t (df)
group 1 and 2	17.20 12.38	11.77 6.13	0.88 (4.7)	24.60 27.44	8.93 5.11	0.91 (19)
group 1 and 3	17.20 12.31	11.78 5.57	0.89 (4.7)	24.60 29.08	8.93 6.46	1.19 (16)
group 1 and 4	17.20 13.80	11.78 8.17	0.53 (8)	24.60 29.20	8.93 8.79	0.82 (8)
group 2 and 4	12.38 13.80	6.13 8.17	-0.42 (19)	27.44 29.20	5.11 8.79	0.57 (19)
group 2 and 3	12.38 12.31	6.13 5.57	0.03 (27)	27.44 29.08	5.11 6.46	-0.76 (27)
group 3 and 4	13.80 12.31	8.17 5.57	0.45 (16)	29.08 29.20	6.46 8.79	0.03 (16)

Group 1: positive stereotype/learning disabled Group 2: positive stereotype/not learning disabled

Group 3: negative stereotype/learning disabled Group 4: negative stereotype/not learning disabled

Relationship between a person’s construing and scores on the Childhood Inventory of Anger and the Zung Anxiety Scale

Hypothesis 4 predicted that the greater the discrepancy between the way a person construes him/herself and the way they feel they are construed by others, the higher he/she will score on the anger scale and/or the anxiety scale. Pearson values were calculated and revealed no significant correlations between a person’s score on the CIA ($r=.09$; n.s.) or the Zung Anxiety Scale ($r=.10$; n.s.) and the discrepancy between the way a person construes himself

and his/her construction of how others see him/her. Hypothesis 4 therefore had to be rejected.

Relationship between the person's construction of self and scores on the Zung Anxiety Scale

Hypothesis 5 predicted that if a person has a poorly elaborated construction of him/herself, he/she will show signs of anxiety. There was no significant correlation between the degree to which a person's construction of self was elaborated, as reflected in the percentage of variance accounted for by the "self" element, and that person's score on the Zung Anxiety Scale ($r=.14$; n.s.). Hypothesis 5 therefore had to be rejected.

Relationship between the tightness of a person's construing and scores on the Birleson Depression Scale and the Zung Anxiety Scale

Hypothesis 6 predicted that tight construing would be correlated with high scores on the depression scale and/or on the anxiety scale. A person's scores on the Birleson Depression Scale ($r=.00$; n.s.) and Zung Anxiety Scale ($r=.03$; n.s.) were not found to be correlated with the tightness of their construing, as indicated by the size of component 1 and of component 2. Hypothesis 6 therefore had to be rejected.

The mean total variance accounted for by the first principal component was found to be 61.9%. This is much higher than figures found in Ryle & Breen's (1972) samples of "normal" people (39.4%) and "neurotic" people (41.9%). The combined size of components 1 and 2 was also much higher in this study (79.04%) than it was for either the "normal" population (59.3%) or the "neurotic" population (64.8%) in the aforementioned study.

Construct Categorisation

Out of Landfield's (1971) nineteen categories, several categories of constructs were not used by these learning disabled participants. The categories of factual description and external appearance might have contained more constructs if these had not been restricted by the investigator, but some were excluded on the basis that they were too concrete for all of the elements to be ranked along that dimension (for example, it is impossible to rank people along the construct "man"). All self-referent constructs were excluded for the similar reason that it was impossible to rank the "self" and the "social self" elements on constructs that refer to the self (e.g. "talks to me"). However, other constructs that were not restricted by the investigator were still never used by the participants. These were status constructs, imagination constructs, closed to alternatives constructs, time orientation constructs and extreme qualifiers constructs. Percentages of constructs falling into each of the remaining categories can be seen in Table 7 below. These are compared with figures found in other studies; Landfield's (1971) study using normal college students, and Winter's (1979) study using "neurotic" patients awaiting therapy. The most common construct categories used by people with learning disabilities were forcefulness (20.8%), social interaction (17%), and tenderness (27%).

The constructs most commonly elicited from this population were those referring to the degree to which someone was perceived to be helpful, to be bossy, to be angry, to force ideas onto someone rather than listen to others' points of view, and to be kind.

Table 7. The categories of constructs used by participants with learning disabilities, college students, and a “neurotic” sample (expressed as a percentage of the total number of constructs produced by all of the participants).

Category	Current study (n=39)	Normal sample (n=30)	Neurotic sample (n=58)
Tenderness	27.0%	9.0%	13.9%
Forcefulness	20.8%	20.0%	16.7%
Social interaction	17.0%	12.0%	8.3%
Emotional arousal	9.9%	7.0%	6.6%
Morality	7.7%	6.0%	6.4%
Self-sufficiency	3.8%	5.0%	13.9%
Egoism	2.6%	3.0%	1.8%
Intellective	2.6%	5.0%	2.8%
Involvement	2.6%	6.0%	4.2%
Organisation	1.9%	6.0%	6.9%
External appear.	1.6%	1.0%	0.7%
Humour	1.6%	2.0%	0.9%
Factual description	0.6%	1.0%	2.9%
Alternatives	0	5.0%	1.8%
Status	0	5.0%	2.5%
Imagination	0	1.0%	1.8%
Time orientation	0	1.0%	0.7%
Extreme qualifiers	0	3.0%	0.7%
Self reference	-	0	4.5%

Presentation of Idiographic Data

In this section the repertory grids of some of the participants will be presented in order to demonstrate in a more idiographic manner some of the findings. The repertory grid technique is able to reveal the way in which an individual construes him/herself and his/her

interpersonal world, although it must be recognised that any one repertory grid will only contain a sample of the personal construct system of that individual.

FLEXIGRID 5.2 enables a visual map of elements and constructs to be plotted using the component loadings. The first and second principal components are drawn orthogonally and the elements plotted in relation to these, using the loadings as the two co-ordinates.

Participants were categorised depending on whether they construed the stereotype element “a person with learning disabilities in general” in a positive or negative way, and whether they considered themselves to be learning disabled or not (i.e. whether they construed themselves as more like the learning disabled people who appeared in the grid or more like the non-disabled people). One repertory grid from each of the following groups has been presented and discussed in some detail: those who held a positive stereotype of people with learning disabilities and considered themselves to be learning disabled (n=8); those who held a positive stereotype of people with learning disabilities but did not consider themselves to belong to this group (n=12); those with a negative stereotype of people with learning disabilities and considered themselves to belong to this group (n=5); and those with a negative stereotype who did not consider themselves to belong to this group (n=14). These grids cannot be said to be representative since each person’s construct system was very different. The first example will be gone through in some detail for the benefit of the reader who is not familiar with this mode of presentation.

1. Mr W - Positive stereotype of people with learning disabilities and construes himself as learning disabled in comparison with people with learning disabilities who are known to him (but not in terms of “people with learning disabilities in general”)

Mr W is a 36 year old man living independently. He was one of the few participants to have responded to the postal request asking people to join the study. He had a score of 16 on the British Picture Vocabulary Scale (age equivalent 7 years 2 months), 23 out of 40 on the Rosenberg Self-esteem Scale, 7 out of 36 on the Birleson Depression Scale, 10 out of 20 on the Zung Anxiety Scale, and 118 out of 140 on the Childhood Inventory of Anger. He therefore shows no significant depression or anxiety, a self-esteem score that was close to the mean for the group, and a relatively high score on the anger measure. Only two of the eight emergent construct poles he generated were negative (i.e. the unpreferred pole) and his constructs fell into the forcefulness, emotional arousal, egoism, morality, tenderness, and social interaction categories.

A diagrammatic representation of Mr W's repertory grid is shown in Figure 1. The first principal component forms the horizontal axis and the second forms the vertical axis. Both the elicited and contrast poles of the constructs are shown, with these being located at 180 degrees apart from each other (i.e. on the opposite side of the circle). Mr W was unusual in comparison to the other participants of the study in that he had a loosely organised construct system, with only 38% of the variance accounted for by component 1. At one end of the first principal component lie the construct poles “selfish”, “miserable”, “someone I would not like to be like”, and “unfit” and two elements lie at this end of this component - the stereotype of a person with learning disabilities and a disliked non-disabled element. The self and the two

liked non-disabled elements lie at the other end of this component. His dissociation from the stereotype of people with learning disabilities on this component may act as a protective factor against depressive and anxiety problems. The social self is located far from the origin of the plot, suggesting that this was ranked in an extreme way that was characterised by the elements “gives people a chance”, “difficult”, “quiet” and a “worrier”. However, there is a relatively large distance between the social self and the self, which may account for the high score that Mr W achieved on the anger measure. The final four elements (the two disliked learning disabled elements, a liked learning disabled element, and a disliked non-disabled element) all lie in a cluster nearer the centre of the grid.

2. Ms C - Positive stereotype of people with learning disabilities and does not construe herself as learning disabled in comparison to people with learning disabilities who are known to her (but does in comparison to the stereotype)

Ms C is a 40 year old woman living with a friend in an independent home. She had recently got divorced and had agreed to take part in the study in the hope of receiving some help in return. She was expressing suicidal thoughts and was referred to the local services for people with learning disabilities as a result of the information obtained in the research interview. She scored 27 on the British Picture Vocabulary Scale (age equivalent 14 years 9 months), 10 on the Rosenberg Self-esteem Scale (the lowest possible score), 35 out of a possible 36 on the Birleson Depression Scale, 19 out of a possible 20 on the Zung Anxiety Scale, and 109 out of 140 on the Childhood Inventory of Anger. This illustrates how anxiety, depression and self-esteem are all closely related in this client group, as in others.

Half of the emergent construct poles Ms C generated were positive and the other half were negative (in relation to the preferred poles). A striking number (50%) of the constructs fell into the tenderness category, the others fell into the external appearance, intellective, egoism, and organisation categories. No significant relationship between tightness of construing and depression was found in the group of participants as a whole. However, it may of interest that, of all the case examples given here, Ms C was the tightest construer, with 57% of the variance accounted for by component 1 and she also had the highest score on the depression and self-esteem measures. The cluster of construct poles that load onto the first principal component are “clever”, “can’t talk to them”, “selfish”, “unwilling to help”, “kind”, “ugly”, “wouldn’t like to be like them”, and “not worldly wise” (see Figure 2). The elements falling closest to these constructs are the two disliked people with learning disabilities. The four liked elements lie at the opposite end of this component. The self lies more on the second principal component which is characterised by “good memory”, whereas the disliked non-disabled element lies at the opposite end of this component. There is quite a large distance between the self and the social self which could account for Ms C’s high scores on the anxiety and the anger measures, although no significant relationship between these two factors were found for the group as a whole. The self element is fairly isolated from the other elements and this has been found to be associated with depression (Ashworth *et al.*, 1982) and may also contribute to the mood difficulties in this case. It would also be interesting to look at the dilemmas arising around being a “kind” person.

3. Mr S - Negative stereotype of people with learning disabilities and construed himself as learning disabled both in comparison to people with learning disabilities who were known to him, and in comparison to “a person with learning disabilities in general”

Mr S is a 40 year old man who lives in a residential home. He spends much of his time at a local day centre in the company of other people with learning disabilities. Mr S needed a lot of encouragement to elicit disliked non-disabled elements. Five out of the eight constructs he generated were negative (i.e. the unpreferred pole) and fitted into the morality, forcefulness, emotional arousal, and tenderness categories. He scored 11 on the Birleson Depression Scale (this does not reach the cut off point), 9 on the Zung Anxiety Scale, 99 on the Childhood Inventory of Anger, and 35 on the Rosenberg Self-esteem Scale. All of these reveal a good degree of emotional adjustment in comparison to the other participants in the study. He scored 23 on the British Picture Vocabulary Scale (age equivalent 11 years 6 months).

A diagrammatic representation of Mr S's grid can be seen in Figure 3. It can be seen that there is a clear cluster of constructs which load highly onto the first principal component - “bad”, “noisy”, “kind”, “rough”, “tells people off”, “sad”, and “bossy”. The elements that are located at this end of the component are all disliked and one is learning disabled, whereas the other two are not. These two disliked non-disabled elements lie fairly close together in the conceptual space. The self, social self (“how others see me” element), and the stereotype of people with learning disabilities are all at the contrasting end of this component (“kind”, “helpful”, “good as gold”, “quiet”, “not rough”, “nice”, “loses their temper”). There are

clearly some conflicts here, with “kind” being very highly correlated with the construct pole “rough” ($r=0.7$), and this is likely to represent a problematic area for Mr S.

The self and social self elements lie fairly close together in the conceptual space and this might explain why Mr S did not score significantly highly on the anxiety or anger scales. The fact that the self and social self lie near the preferred poles of these constructs would account for Mr S’s high score on the self-esteem scale and for his relatively low score on the depression scale. The two liked non-disabled elements lie close together and load more highly on the second principal component, at the end which has the construct poles “strict” and “someone I would like to be like” and the other disliked person with learning disabilities lies at the opposite end of this component, near the construct poles “someone I would not like to be like” and “happy”. The last two elements are the two liked people with learning disabilities and these lie close together and near the centre of the grid, suggesting that these elements are not very salient. It seems then that liked learning disabled elements, and liked and disliked non-disabled elements and the self/social self all lie in discrete parts of Mr S’s conceptual space.

4. Miss P - Negative stereotype of people with learning disabilities and does not construe herself as learning disabled either in relation to people with learning disabilities who are known to her or in relation to “a person with learning disabilities in general”

Miss P is a 40 year old woman living in a residential home who spends a lot of her time at a local day centre. She scored 16 on the British Picture Vocabulary Scale (age equivalent 7

years 2 months), 16 on the depression scale (which lies over the cut off point), 20 on the Rosenberg Self-esteem Scale, 6 on the anxiety scale, and 116 on the Childhood Inventory of Anger. Her relatively low score on the self-esteem measure reflects the significant score on the depression measure. Half of the emergent construct poles that she generated were negative (i.e. the unpreferred pole). Half of her constructs fell into the tenderness category, with the remainder of them falling into the social interaction, emotional arousal, organisation, and forcefulness categories.

Miss P had a relatively flexible construct system, with 49% of the variance accounted for by component 1. The four disliked elements all lay at one end of the first principal component which was characterised by the construct poles “not nice”, “someone I would like to be like”, “don’t do things for people”, “spiteful”, “gets in moods”, “doesn’t care” and “makes trouble” (see Figure 4). The social self element and the stereotype of a person with learning disabilities lay at the other end of this component and were characterised as “honest”, “caring”, “not moody”, “nice”, “kind”, “someone I would not like to be like”, and “talks to people”.

The liked elements are characterised more by the second principal component as was the stereotype of a person with learning disabilities. The two liked non-disabled elements and one of the liked learning disabled elements lie near the construct poles “helps people” and “puts things right”, whilst the other liked disabled element lies nearer the construct pole “not nice”. The nearest construct to the “self” element is “someone I would not like to be like” and this may account for her low self-esteem and depression. Further investigation would be necessary to reveal why the construct pole “someone I would not like to be like” lies so close

to other more seemingly positive construct poles such as “kind”, “nice” and “talks to people”, all of which were identified by Miss P as the preferred poles of the constructs in question.

Figure 1. Graph showing the elements and constructs elicited from Mr W in relation to principal components 1 and 2

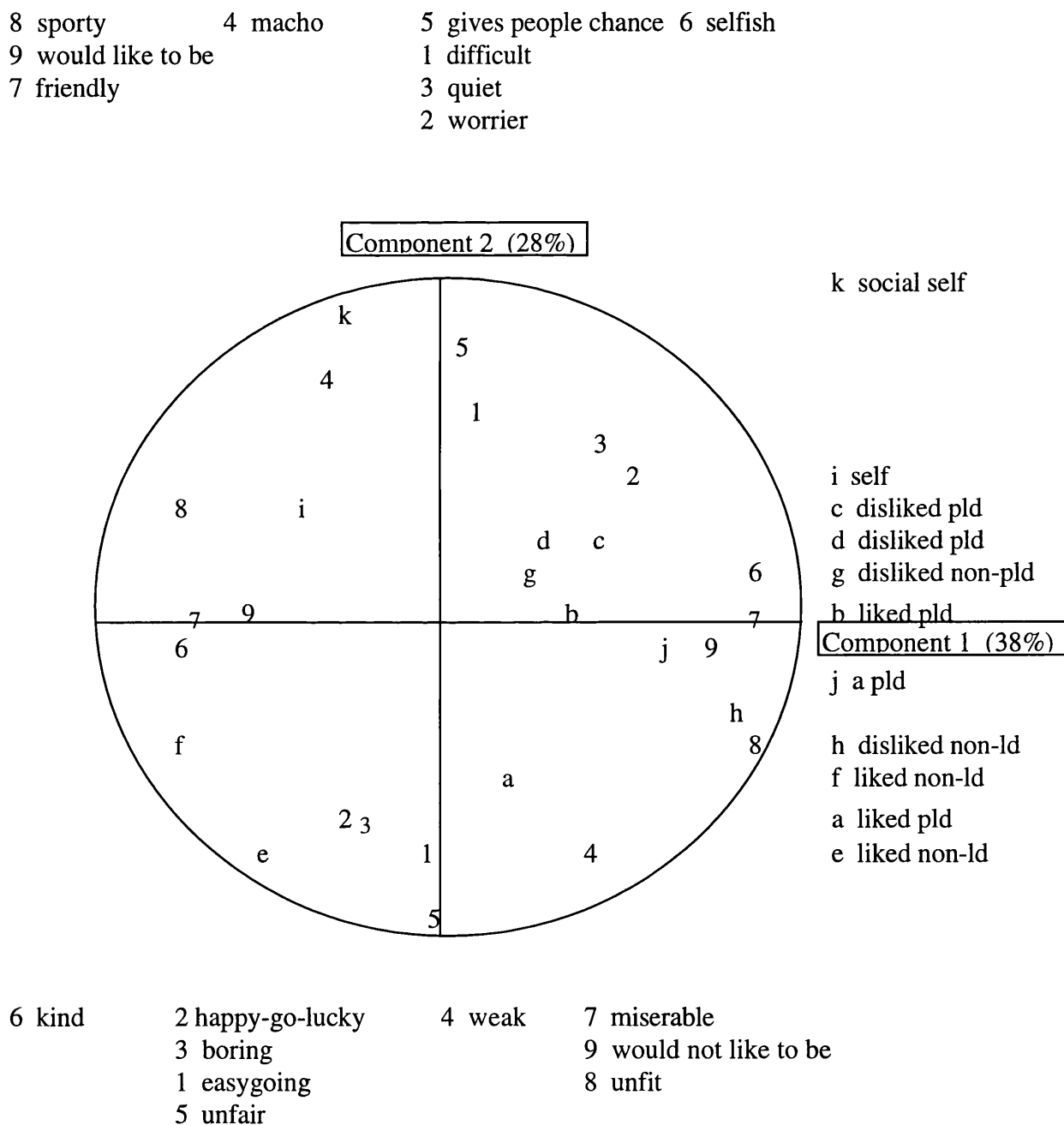
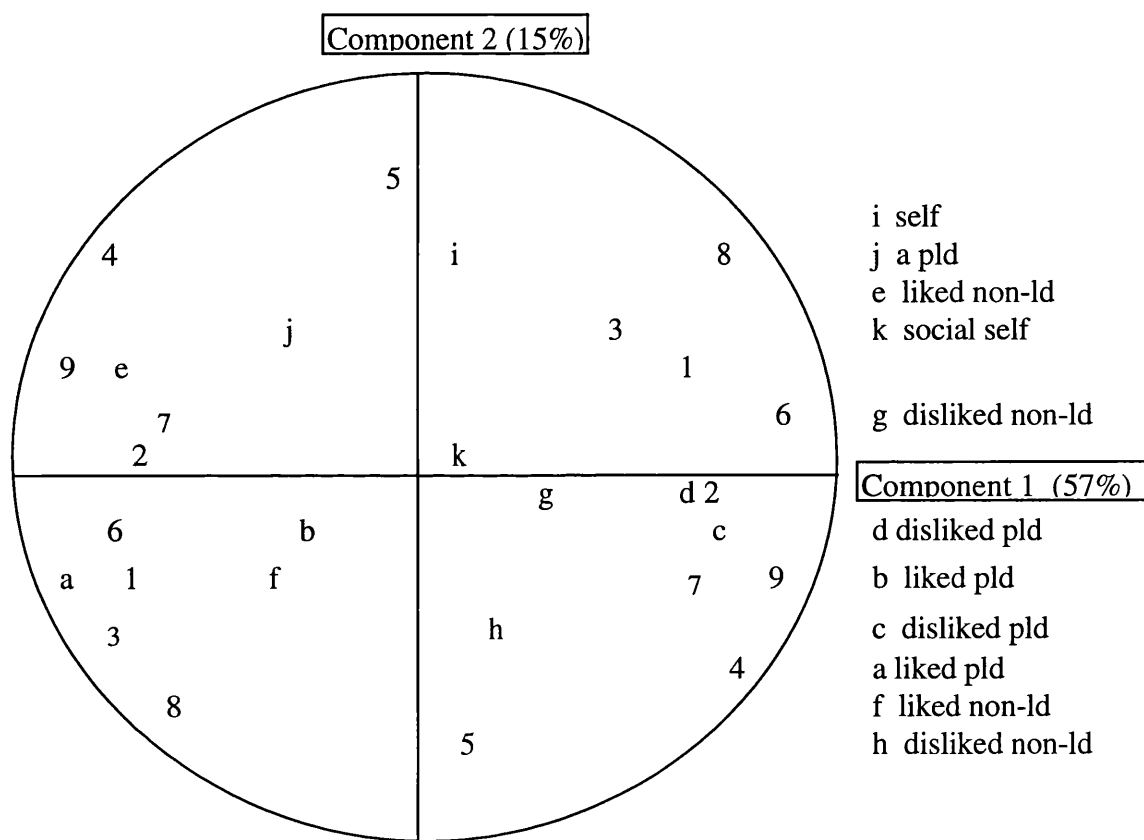


Figure 2. Graph showing the elements and constructs elicited from Ms C in relation to principal components 1 and 2

4 know-it-all
9 would like to be
7 good looking
2 unkind

5 good memory

8 clever
3 can't talk to them
1 selfish
6 unwilling to help



6 willing to help
1 caring
3 can talk to them
8 stupid

5 forgetful

2 kind
7 ugly
9 wouldn't like to be
4 not worldly wise

Figure 3. Graph showing the elements and constructs elicited from Mr S in relation to principal components 1 and 2

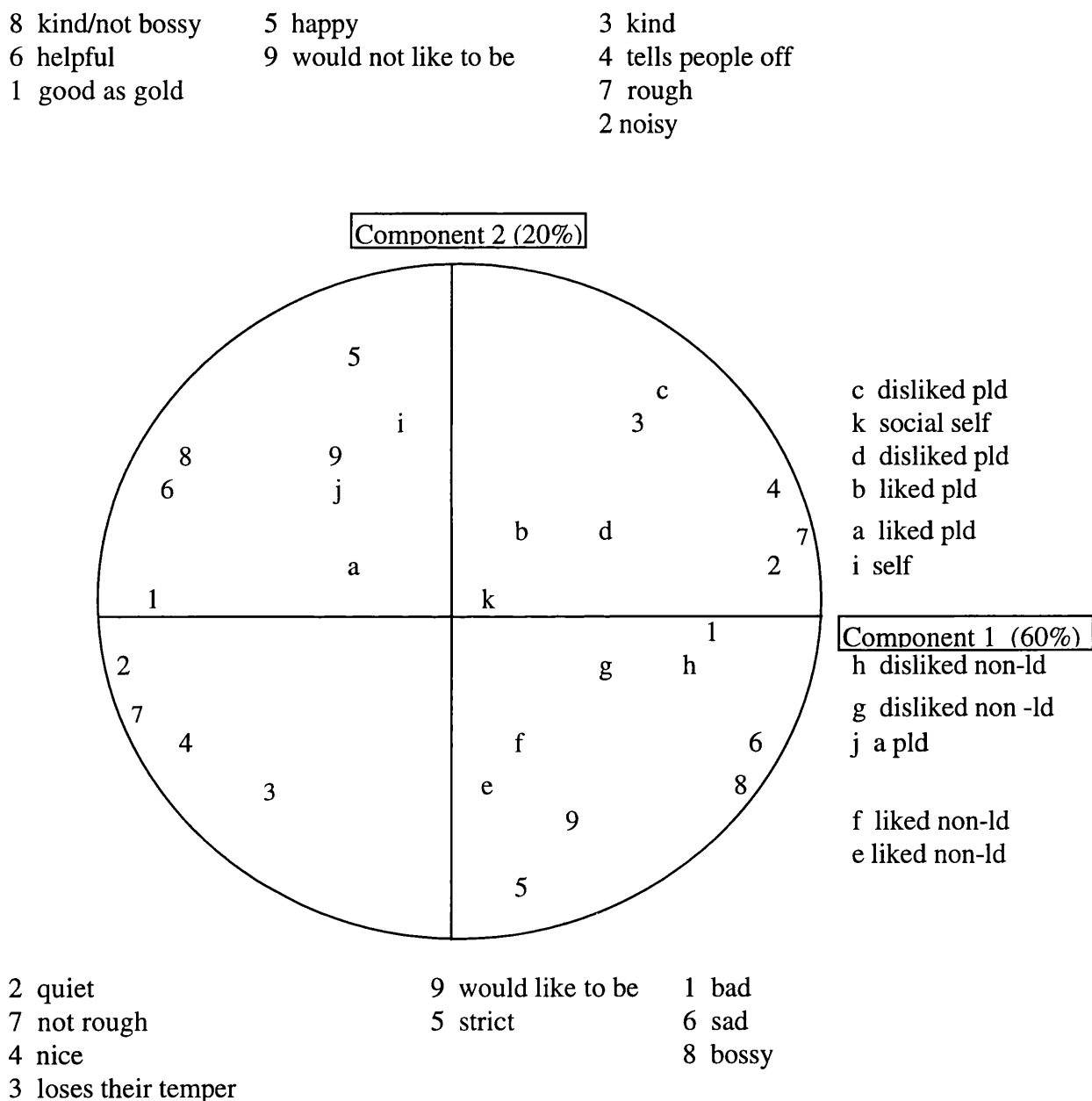
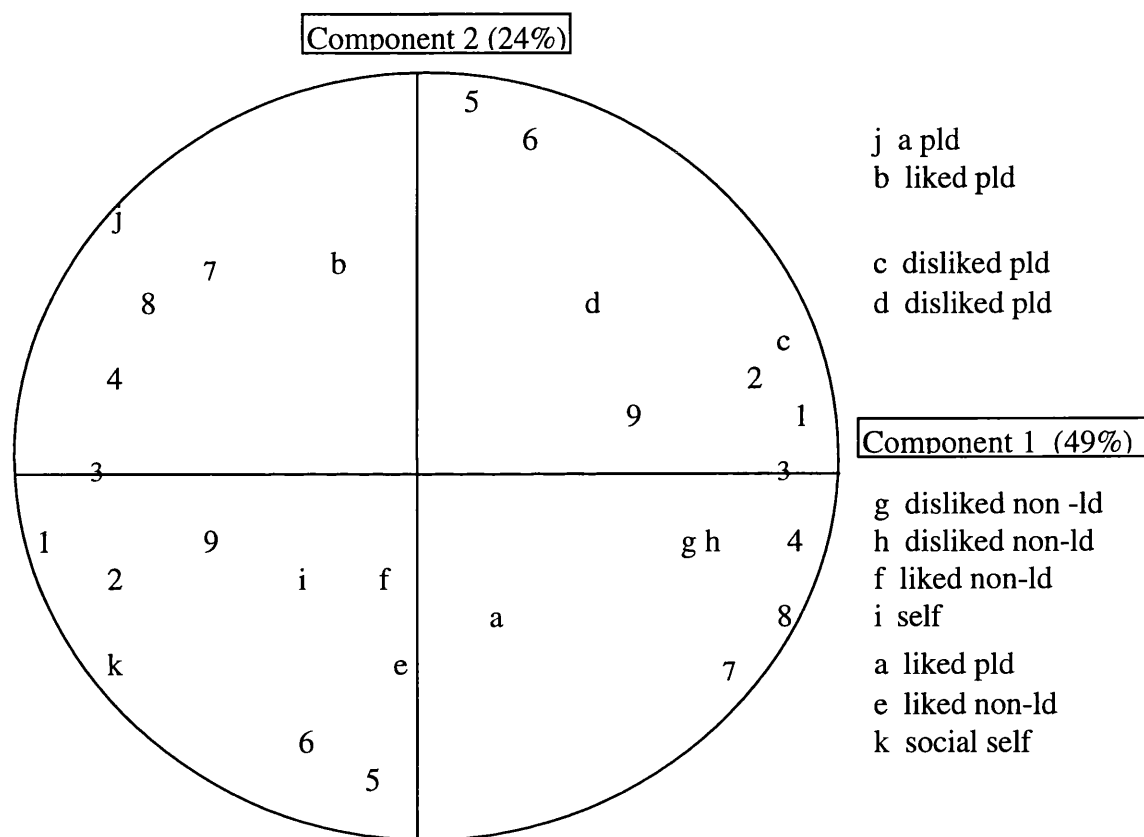


Figure 4. Graph showing the elements and constructs elicited from Ms P in relation to principal components 1 and 2

7 honest
8 caring
4 kind/not moody

5 not nice
6 not nice

2 not nice
9 would like to be
1 don't do things for people
3 spiteful



3 nice
1 kind
9 wouldn't like to be
2 talks to people

6 helps people
5 puts things right

4 gets in moods
8 doesn't care
7 makes trouble

DISCUSSION

OVERVIEW

The way in which people with learning disabilities construe themselves and people with and without learning disabilities was investigated using the repertory grid technique. This is an assessment tool devised by Kelly (1955) as a means of exploring an individual's personal construct system. Relationships between a person's construing, the type of stereotype they hold of the learning disabled group, and their emotional adjustment were examined. Eleven elements were used in the repertory grid: two people with learning disabilities that the participant liked and two that they disliked; two people without learning disabilities that the participant liked and two that they disliked; the self; the social self (how others see them); and the stereotype of a person with learning disabilities (a person with learning disabilities in general). Emotional adjustment was explored using questionnaires that measure anger, anxiety, depression, and self-esteem.

It was found that people with learning disabilities construed people with learning disabilities significantly more favourably and closer to the ideal self than non-disabled people. People with learning disabilities construed themselves significantly more negatively than they construed either people with learning disabilities, non-disabled people, the social self, or the stereotype of learning disabled people. People with

learning disabilities tended to construe themselves as more similar to people with learning disabilities than to non-disabled people, although this trend was not significant. The distance of the “self” element from the preferred poles of constructs was found to be significantly negatively correlated with self-esteem, but not with any other measure of psychopathology. Depression and anxiety were found to be significantly correlated, as were depression and anxiety with low self-esteem. Other examinations of measures of emotional adjustment and their relationship to various aspects of construing did not reveal any significant associations.

This chapter will consider in turn each of the major findings, based on the hypotheses put forward at the start of the thesis. These findings will be discussed in the light of relevant literature and conclusions drawn. The chapter will then go on to consider the methodological issues, delineating both the strengths and weaknesses of the research design and the measures used. Bearing these considerations in mind, implications for future research will be discussed. Finally, the clinical implications of the study will be explored.

DISCUSSION OF THE MAIN FINDINGS

Levels of Psychopathology

The various measures employed in this study revealed a wide range in the degree of emotional adjustment of the participants who took part. The most striking finding

was that 46% of the participants were identified as depressed, which is significantly higher than the 3% to 7% rates found in the general population (Paykel, 1989). There was a highly significant correlation between depression and low self-esteem, and depression and anxiety, a finding which has been obtained in the non-disabled population and in other studies with people with learning disabilities (Benson & Ivins, 1992).

The self-esteem scores seemed to be particularly high in this population compared to Rosenberg's (1989) figures for a normal population. This is particularly remarkable in that the measure seems to be negatively skewed. Past studies with respect to self-esteem levels in other stigmatised groups have found a similar high level of self-esteem. Despite a strong theoretical support for the prediction that members of a stigmatised groups have lower self-esteem than nonstigmatised individuals, empirical evidence for this is scarce. With respect to Blacks, a host of studies have concluded that Blacks have levels of self-esteem equal to or higher than that of Whites (see Hoelter, 1983 for a review of the literature). Some studies have also found that self-esteem is not consistently lower among those who are developmentally or learning disabled (Gibbons, 1985). Indeed several studies have provided evidence of higher self-esteem among stigmatised than among nonstigmatised groups, including learning disabled individuals (Fine & Caldwell, 1967).

The findings in this study then seem to support the findings from other studies that prejudice against members of stigmatised groups generally does not result in lowered self-esteem. These data contradict findings derived from the self-fulfilling prophecy,

and efficacy-based self-esteem theoretical approaches. This is not to say, however, that prejudice and discrimination are not in other ways psychologically harmful to the victim. Indeed, members of stigmatised groups may differ from members of more advantaged groups on other psychological dimensions such as task-specific self-confidence, performance expectancies, achievement motivation, and susceptibility to certain forms of mental and physical illness.

Crocker & Major (1989) suggest three mechanisms or processes by which stigmatised individuals may protect their self-esteem: (a) attributing negative feedback to prejudice against their group rather than to internal, stable, and global causes; (b) selectively comparing their outcomes with those of members of their own group whose outcomes will also be relatively poor, rather than making comparisons with a more advantaged outgroup; (c) selectively devaluing those attributes on which their group typically fares poorly and valuing those attributes on which their group excels. It is possible that some or all of these mechanisms were being employed by the participants in this study. In particular, there does seem to be some evidence that the third mechanism was being applied in some form by this population in that constructs relating to status, and intelligence were rarely, if ever employed by participants. This is discussed in greater detail below.

According to the study's criteria, 23% of the participants suffered from high anxiety levels (a score of 15 and above), which is in concordance with the findings from other studies with this population (e.g. Reid, 1980). Although the anger levels found in the study seem to be fairly high, it is not possible to say whether these levels are

significantly higher than those found in the non-disabled population. However, other studies have found higher levels of anger in the learning disabled population (Heavey *et al.*, 1989). It is interesting to note that many of the participants were eager to discuss their angry feelings and welcomed the opportunity to do so. There were a few exceptions where participants found the questions hard and sometimes denied any significant level of anger.

Scores on the British Picture Vocabulary Scale (BPVS) were not correlated with levels of psychopathology, suggesting that degree of learning disability was not affecting the degree of emotional adjustment in these participants and that those with mild learning disabilities and those with moderate learning disabilities were experiencing similar levels of emotional difficulty.

People with learning disabilities' construction of themselves, non-disabled people and people with learning disabilities

The finding that people with learning disabilities were construed significantly more positively than non-disabled people was surprising. The fact that people with learning disabilities were construed as lying closer to the preferred poles than non-disabled people and that people with learning disabilities were construed as lying closer to the "ideal self" than non-disabled people indicates the consistency of this finding, and may serve as evidence for the reliable way in which the technique was being used by the participants. Previous work using repertory grids with other stereotyped groups (Fransella, 1968; Hoy, 1973) has suggested that members of a stereotyped group

share the same negative view of the stereotyped group as others but do not construe themselves as belonging to this group. Davis (1983) has argued that people with learning disabilities are construed more negatively than non-disabled people. The question is, why is this view not shared by people with learning disabilities themselves, in accordance with the pattern found in other stigmatised populations?

Other studies have found that people with learning disabilities do construe people with learning disabilities unfavourably. A study by Marvell (1992) found that people with learning disabilities construed non-disabled elements more favourably than learning disabled elements. The current finding that people with learning disabilities are construed more favourably than non-disabled people may reflect differences in the samples used in the present study and Marvell's study, or it may represent a significant shift in the thinking of this group. In either case, the current data show that for this particular group of people with learning disabilities, people with learning disabilities are construed more favourably than non-disabled people. Although it could be argued that there is an element of denial in this construction of their interpersonal world, this nevertheless does not take away from the fact that this sample appears to hold a significantly different view of people with a learning disability. This finding is contrary to what would be predicted on the basis of findings in relation to other stigmatised groups, and past findings in relation to the learning disabled group.

If this were to represent a shift, in order to understand how it occurred it might be useful to consider the way in which groups manage and reconstruct their stigmas.

Social protest movements, such as “People First”, play a major role in social change. These movements involve public affirmation of pride in oneself and solidarity with others who have been socially and culturally downgraded or stigmatised (Merton, 1972). The development of group identification and strong communal feelings is critical to the emergence of social protest movements. As individuals become increasingly conscious of their personal stigma, they often become aware that the stigma encompasses more than themselves alone. As they begin to make contact with others like themselves, a change takes place in their perception of their stigma (Zola, 1979). What they previously considered to be a personal problem has become a social issue. It is possible that the “People First” movement and the increases in advocacy services and so on have started to produce such a change in this population.

Although relationships **between** individuals are a major component in understanding stigma, it is important to remember that these relationships occur in a sociocultural and historical context that shapes the nature of such relationships. Recent changes in professional attitudes and policies towards people with learning disabilities such as deinstitutionalisation, the acknowledgement that such people experience the full range of emotions, and the setting up of consciousness raising and assertiveness groups, reveal how changes have occurred at an institutional level. It is possible that these changes have fostered similar shifts in the concept of the group of people with which they are concerned.

The question arises as to how much the individual who is affected by stigma is able to control for the degree to which he feels stigmatised or inferior. Certainly a national

pride did not lessen the persecution of the Jews nor of blacks in South Africa.

However, the knowledge that the responsibility for being stigmatised does not lie with oneself is important. There have been women, elderly adults, gay people, disabled people, and many others who at some point realised that their fundamental similarities outweighed and outnumbered their differences. Perhaps we are seeing here some sign of this reattribution.

It is interesting to note that constructs relating to status and intelligence are never or rarely used by the group. This might suggest the engagement in one of the possible options suggested by Tajfel (1981) for dealing with the difficulties that may arise if being a member of the group does not contribute positively to one's social identity. He suggested that it may be possible to re-interpret some of the attributes of the group to make remaining a member of it more acceptable. Crocker & Major (1989) also suggest that one's self-esteem as a member of a stigmatised group may be maintained by selectively devaluing those attributes of the group on which it compares badly with more desired groups. This seems to mark a move to comparing themselves to non-disabled people in terms of attributes that they have in common rather than attributes that mark them out as different.

Factors such as the "People First" movement could have had an impact in other ways. For example, a drive to empower people with learning disabilities and to encourage them to voice their opinions may have enabled them to express negative opinions about non-disabled people that they would have kept to themselves in the past. In addition, an awareness of this drive to empower this population may have created

some kind of social desirability effect - “I am expected to be positive about people with learning disabilities”. This may have affected the way in which elements were ranked on the various constructs.

Previous studies (e.g. Marvell, 1992) have found that people with learning disabilities construe themselves as more similar to non-disabled people than to people with learning disabilities. This finding was not replicated by this study which found a trend in the opposite direction i.e. people with learning disabilities construe themselves as more similar to people with learning disabilities. This may mark another shift in the way that people with learning disabilities construe themselves. If so, it is possibly a direct result of the earlier finding that they construe people with learning disabilities more positively than non-disabled people. If the group is no longer considered in such a negative light, members of the group are less likely to need to construe themselves as very different from this group. Further research is needed to further investigate these findings and to establish whether they represent a real shift in thinking within the learning disabled population as a whole.

All of these findings however have to be interpreted with caution and it is important to bear in mind that we are dealing in means. If one looks at each participant in turn it is possible to discern several distinct groups. The study found that 90% of the participants positively construed the people with learning disabilities that they knew, but only 52% of them thought that the stereotype of “a person with learning disabilities in general” was positive. This suggests that they are aware of the stereotype but regard members of this group that they know as exceptions to the

stereotype. In relation to whether or not they considered themselves to be learning disabled, 33% of participants considered themselves to be more similar to the learning disabled people that they knew rather than non-disabled people. When they considered themselves in relation to the stereotype of “a person with learning disabilities in general” and the non-disabled people that they knew, 46% considered themselves to be more similar to the former. It is possible that this reflects a phenomenon known as the “looking glass self”, a term coined by the sociologist George Horton Cooley (1956) to refer to the fact that our own conceptions of ourselves are largely a reflection of what other people around us say and think about us.

Relationships between a person’s construing and their levels of emotional adjustment

There was no support in the data for the hypothesis that the more similar to the negative stereotype a person construes him/herself to be, the lower his/her self-esteem and the greater his/her depression. Similarly, there was no support for the hypothesis that a large discrepancy between the way a person construes himself and the way he feels he is construed by others would lead to a large score on the anger or the anxiety scales. Nezu and Nezu (1994) have argued that people with learning disabilities experience a number of stressful situations that foster emotional difficulties such as employment problems, financial difficulties, poor problem-solving skills, and interpersonal concerns. These alone may explain the high prevalence rates of psychopathology among people with learning disabilities found in this and other studies (Matson & Sevin, 1994). It is possible that, although an awareness of the

negative stereotype contributes to the level of a person's emotional adjustment, this contribution is relatively small in comparison to these other contributing factors which were not controlled for in this study.

It is possible that methodological issues may also have some bearing on these findings. Flynn (1986) has pointed out that there are difficulties inherent in interviewing this population. A review of the past literature reveals how important it is for there to be a trusting relationship that has been built up over time, especially when many of the questions are so personal, as in this study. The reliability of some of the responses to the anxiety, anger and depression scales could be questioned in this respect. Some of the questions (such as "Do you feel that you cannot carry on?", "Do you feel very lonely?") may stir up very powerful feelings and are very unlikely to be questions that they have been asked before, especially on the first meeting with someone they have never met before. At times a participant would seem to be answering the questions in an honest and open way, and then they would find a question particularly distressing and for the rest of the scale they would simply respond in an automatic way, that seemed not to involve any self-examination, denying any painful feelings. These problems could be addressed in a clinical setting because a relationship could be established and there could be some ongoing support with issues that the person found distressing.

The investigator also found some problems with the measures of psychopathology. These are considered in more detail below, but it is possible that problems with understanding what the items were trying to ascertain, and difficulties in admitting to

“taboo” feelings such as anger, and sharing distressing thoughts with a stranger may have affected the reliability of these measures. Finally, the cut-off points used to assign people to groups in order to test the third hypothesis were, like all cut-off points, rather artificial. People were assigned to groups “positive stereotype” or “negative stereotype” and “regards themselves as learning disabled” or “regards themselves as non-disabled”. In reality, many people placed themselves somewhere in the middle of both of these categories, rather than at extreme poles. It is possible that lying in this grey area may have afforded people some protection from the effects of the negative stereotype, and this would not be reflected in the results because of the cut-off points that were chosen.

One pattern that the investigator noticed was that the “social self” element (how others see me) of the grids seemed to have been hard to rank. It was introduced once the self and other elements had been ranked and clients would either use it in an extreme way, putting it at the top or bottom of the ranked cards, or they would put it immediately next to the “self” element, perhaps because they were only able to consider how others see them in relation to the self and not in relation to the other elements in the grid. If this was the case, this could explain the non-significance of the results relating to hypothesis 4.

With respect to how people with learning disabilities construe the “self” element, the findings were less optimistic than those relating to people with learning disabilities generally. People with learning disabilities were found to construe themselves significantly more negatively than they construed people with learning disabilities

($p < .01$), the stereotype of a person with learning disabilities ($p < .01$), non-disabled people ($p < .01$), and the “social self” ($p < .02$). It seems then that even if their evaluation of the group to which they belong has become more positive, this does not seem to have positive effects on their own self-concept. It is possible that they do not consider themselves in relation to any group and only consider themselves in isolation and that negative experiences such as repeated failure, unemployment, low self-sufficiency and feelings of dependency contribute to the individual’s poor evaluation of himself.

It is interesting to note however, that the distance of the “self” from the preferred poles was not related to any of the measures of psychopathology other than self-esteem. It is surprising that it is not also closely associated with a person’s level of depression. Once again, this may reflect possible problems with the reliability of some of the measures used in the study. Further investigation is needed in order to try to gain a deeper understanding of the interrelationships between various aspects of a person’s construing and their psychopathology.

Structural aspects of construing

It is not clear why the degree of elaboration of the construction of the self is not related to anxiety levels, as personal construct theory would have predicted. A poorly elaborated construction of the self would lead to many events falling outside the range of convenience of the construct, and would therefore be expected to lead to anxiety.

Again, it is possible that other factors, such as interpersonal difficulties and life events, contribute more to a person's anxiety level than the degree to which their self construct is elaborated and these other factors were not controlled for in this study.

Kelly (1955) proposed that constructs are organised into a complex hierarchical structure which can be more or less tightly organised. The size of the first principal component indicates how tightly a person's construct system is organised in this respect. There has been very little empirical investigation of this aspect of construing in the learning disabled population. Oliver (1980) found that participants with learning disabilities had a very small number of highly interrelated clusters of constructs. Barton *et al.* (1976) found a very high proportion of variance accounted for by the first component (58%). This figure was found to be even higher in this study (62%). Tight construing was not found to be related to measures on the anxiety and depression scales, despite the fact these have been found to be significantly correlated in other studies. Ryle & Breen (1972) found that the total variance accounted for by the first two principal components combined was greater in "neurotic" patients than controls. The mean size for components 1 and 2 combined in this study was significantly larger than that found in Ryle & Breen's "neurotic" and "normal" samples. Ryle and Breen (1972) suggest that the high percentage of variance accounted for by the first principal component in their neurotic sample suggests an inflexible and one-dimensional view of the world. This study is not directly comparable with Ryle & Breen's in view of the different size of grids used - their grid was larger and this would automatically reduce the percentage of variance accounted for by component 1. However, even taking this into account, it seems that

this population does show tight construing and more so than in a “neurotic” population. Although they also show a high level of depression, the two do not appear to be related (unlike in other populations) and further investigation needs to be carried out in order to understand why this might be.

With respect to the structural aspects of construing, it is also important to consider developmental factors. It has been found that as children get older they make increasing discriminations between elements; there is more recognition of “shades of grey” and an increase in the “psychological length” of the construct with younger children only making use of the extreme ends (Applebee, 1976). Whether the construing of people with learning disabilities is tighter due to a delay in the development of such discriminatory abilities or for other reasons is not clear.

Content of construing

The results reveal some interesting differences in the content of construing found amongst people with learning disabilities compared to a normal population (Landfield, 1971) and a neurotic population (Winter, 1979). Although no direct comparisons can be made because some of the categories used by these other two studies were not used in this study (such as self-reference, and comparatives), some differences seem to suggest themselves. The most striking difference is the number of tenderness constructs that people with learning disabilities generated (27%) in comparison with the normal (9%) and the neurotic population (15%). Even allowing for differences in

the categories used, this figure is appreciably larger than that found in the other groups. This would suggest that people with learning disabilities are construing their world far more in respect of the warmth and tenderness or lack of it than these other groups. The social interaction category also seems to have been used more by people with learning disabilities (17%) than it was by the normal (12%) or the neurotic (8%) groups. This again suggests that it is the interpersonal dimension that is at the forefront of their minds. The other category that was used a great deal by people with learning disabilities was that of forcefulness (21%). However, this was not used significantly more by this population than by the other two groups. It should be noted that in terms of ranks, the three most frequent categories in the present sample were also the most frequent in the “normal” sample, and were within the four most frequent in the “neurotic” sample. This indicates that people with learning disabilities are using relatively similar sorts of constructs to normal and neurotic populations, although the precise balance might be different.

The following issues in particular came across as being important to many of the participants: being kind and talking to people rather than being too busy or impatient to listen; helping people learn when they cannot do something rather than making fun of them or telling them what to do without teaching them in the process; being angry rather than tolerant; listening to the person with a learning disability’s point of view rather than forcing their own view onto them.

Categories of construct that were noticeably missing or under-used by people with learning disabilities were the time orientation, imagination, status, involvement, self-

sufficiency and intellectual categories. The time orientation and imagination categories could represent more abstract constructs that are harder for this population to use. The other four categories all represent dimensions on which this group is unlikely to be positively evaluated and it may be that this is why they are split off from this population's personal construct system in an attempt to protect their self-esteem.

Although elicited constructs are an interesting source of information, one aspect that is worth considering in relation to categories of constructs is that of verbal labels. It is tempting to assume that the verbal label for the construct matches the individual's internal representation of this construct. This may not be the case. It is possible that, if the person has developed very good verbal skills, they may be using quite sophisticated verbal labels but have little comprehension of their meaning. It is also possible that a person can develop a sophisticated construct system, but does not have the verbal skills with which to express it.

Kelly (1955) makes a distinction between constructs and verbal labels - a construct is a discrimination, "like a reference axis, a basic dimension of appraisal, often un verbalised, frequently unsymbolised and occasionally un signified in any manner except by the elemental processes it governs" (p. 235). Salmon (1976) suggests that children may offer more superficial and readily available constructs since they may be less capable of drawing on abstract, perhaps infrequently verbalised constructs, which they may possess and make use of. This may also be the case among people with learning disabilities. One difficulty with exploring construct systems is that we are forced to focus on the more easily verbalised and accessible constructs. The person

with learning disabilities may make use of psychological constructs, but the elicitation procedures only access the less abstract and less sophisticated types of constructs.

METHODOLOGICAL ISSUES

The sample

In addition to age requirements and the exclusion of anyone with a major psychiatric diagnosis, the study required that participants had only mild learning disabilities, could read names on cards, and could concentrate enough to rank eleven people with respect to a trait. This subset of the learning disabled population might have very different issues to other clients whose learning disabilities were more severe. It must therefore be recognised that the results of this study are limited in their generalisability to other sections of the learning disabled population. However, it might be argued that in those with a severe learning disability, an awareness of the negative stereotype of people with learning disabilities may be less acute (or even may be lacking completely) and so this stereotype would have less impact on severely learning disabled people, making the findings less relevant to this group. It is not clear, however, whether the findings could be generalised to, say, those with moderate learning disabilities who are aware of the negative stereotype but may have trouble communicating this awareness and expressing how this impacts upon their lives.

There are other sections of the learning disabled population that may not be represented by the findings of this study. People with mild learning disabilities tend to lose contact with learning disability services once they have left school and those who remain in contact with services tend to be those with more severe problems. Since this study was concerned with 27 to 45 year olds, and recruited them through registers and learning disability services in various areas, those people with mild learning disabilities who have less need for services and who are functioning at a higher level would probably not have been reached by this method of recruitment.

It was difficult to recruit participants for a variety of reasons that appear to relate to this group in particular, and these should be taken into consideration in future research with this group. With respect to postal recruitment, the ethics committees required that potential participants were given detailed information about the study and this may have been daunting for them. For confidentiality reasons the letters were sent out by the Register organisers, and were addressed "Dear client", which was very impersonal and was unlikely to encourage replies. The poor response led the investigator to approach centres for people with learning disabilities so that people could meet the person they would have to speak with, questions and concerns could be addressed on the spot, and participants were only required to give the investigator their telephone number rather than filling out forms and returning them which was often felt to be too demanding. This method of recruitment proved to be far more successful with this particular client group.

The repertory grid technique

(i) General comments: The repertory grid technique was found to be an extremely useful assessment measure for use with this population. Several of the participants scored under 10 (which is roughly equivalent to a four year level) on the BPVS, indicating that participants with a relatively low verbal ability are able to successfully use the repertory grid assessment technique. Winter (1992) remarks that one of the outstanding features of the repertory grid technique is its flexibility, the major limit on its range of application being the ingenuity of the investigator. Although the repertory grid procedure used cards with the elements written on them for this study, people without reading skills might be able to use this technique using photographs or symbols. Communication can take place in a variety of ways, and in a clinical situation it would be possible to spend more time exploring with the client the nature of their constructs and the way they see the people around them. Brumfitt (1985) made an important point about pre-verbal and non-verbal construing in aphasic patients who still seem to have the potential to construe in this way. Frequently pre- and non-verbal construing relates to bodily sensations, the “gut reactions” that are difficult even for a normal speaker to articulate. There may therefore be useful means of construing which are inaccessible via spoken language strategies.

The repertory grid technique’s idiographic emphasis, and the possibility of using it with illiterate people, distinguishes it from questionnaire measures, while it offers greater objectivity than most projective techniques. The face validity of many of the grid measures was low, and they may be able to reveal aspects of construing at low

levels of awareness, thus providing access to information which is unlikely to be revealed in an interview. Lastly, unlike many nomothetic procedures, the repertory grid was generally found to be acceptable to clients, who often remarked that it was an enjoyable procedure, and that it was thought provoking, which may be therapeutic in itself.

It would have been interesting to have supplemented the questionnaires and the repertory grid with an unstructured interview about how the participant saw themselves, people with learning disabilities, and the view of them held by a variety of other people (family, friends, staff and so on). Many of the participants joined the study because they wanted to talk about their thoughts and feelings - the structured questionnaires and the grid did not really allow them to do this in the way they might have expected. This type of unstructured discussion may have been perceived as more client-centred rather than research-centred and could have been a useful way to establish rapport before the personal questions in the questionnaires were presented. It would also have given some context in which to interpret the findings.

(ii) Eliciting elements: The main difficulty encountered in the elicitation of elements was that whilst participants had no problems in producing liked elements, they found it very difficult to produce disliked people, particularly in the non-disabled element set, often firmly denying that they knew anyone that they did not like. This was also found to be the case in the Marvell (1992) study. Participants obviously found it difficult to admit such negative feelings to someone that they had not met before and with whom a trusting relationship had not had a chance to develop. There may also

have been some social desirability effect operating here, with participants feeling that it is not good to dislike people. In order to get around this problem, the investigator would ask someone to name someone that they liked but not as much as they liked everyone else. It was then easier for participants to name someone. Once a name had been given it seemed that ranking people very negatively was not difficult and there was no hesitation at this point in the interview.

There was some scepticism that the participants would be able to use the element “how others see me”. However, all of them were able to work with this element (with some encouragement and some explanation, for example “do other people think that you are more helpful than you really are or less helpful than you really are?”). This may reflect an awareness that they are constantly being assessed and that decisions about their present circumstances and their future are based on other people’s opinions of them. It is possible that they are more aware of how others see them than are people without learning disabilities. In fact, the extreme reactions of others to their disability (exclusion, polite disavowal, over-protectiveness and so on) might be very hard to miss. However, although they were able to acknowledge that other people might hold a different view of them, some of them seemed to have more difficulty when it came to ranking this “meta” element in relation to the more real and immediate elements represented by the people that they knew.

(iii) Eliciting constructs: People with learning disabilities have been found to be concrete thinkers and this might lead to concerns about using this form of assessment with this population. However, only one of the participants was excluded because

their constructs were too limited to be used in the repertory grid (for example, “man”, “black” and “teacher” are not constructs that people can be ranked on, they either meet the criteria or they do not). It is possible that such participants produced concrete constructs because they were “safer” than more abstract constructs (it is easier to tell a stranger that someone is a “man” or is “OK” than to tell them that they are “helpful” or “bossy”, both of which say something about the speaker as well as the person they are referring to). If there had been more time to build up a trusting relationship with the participants, the constructs produced may have been less concrete and they may also have been more negative. It is essential that the utility of this tool with more severe degrees of disability is established and future research in this area is warranted.

For some people, producing eight different constructs and their respective contrast poles was difficult and they would start to repeat or produce very similar constructs after a few main ones had emerged. It was not clear whether this was due to a simplicity of their construct systems or a lack of the verbal skills required to make more subtle distinctions between people.

It was not always clear whether a similar idea but phrased differently actually represented a different construct or not. The investigator had to enquire as to whether they were the same or different and go by the participant’s response. A further difficulty arose in the attempts to elicit contrast poles. Most of the participants found this hard and it was difficult to convey what was required, especially because very few of them understood the word “opposite”. Many of the

construct poles elicited were positive ones, and there was a tendency to use a global term for the contrast poles of these such as “not nice” or “bad”, so that many different constructs shared the same contrast pole. Kelly (1955) suggested that one pole of a construct may be submerged, that is not available to consciousness, and this may be due to its anxiety provoking nature. With people with learning disabilities it may be that the holding of negative perceptions, particularly of people on whom they are dependent, may be very anxiety provoking. Using a more global term or prefixing the construct with the word “not” may require less exploration of what exactly the negative contrast might be, and might then produce less anxiety.

It is important to recognise the context in which the elicitation of elements and constructs is carried out. Both participants and investigators bring past experiences, attitudes and expectations into the research situation. It would be unreasonable to assume that these do not have an effect on the sort of information that is produced.

(iv) Ranking the grid: The task of ranking eleven elements along a construct dimension is not an easy one. It requires the participant to make fine discriminations between people, using constructs that they may not have applied to some of these people before and judging them according to one dimension in isolation. These are not judgements that we make at any other time. Kelly (1955) remarked that a construct only has meaning within a context but participants in a study such as this are required to make judgements about people out of context. They are also expected to

bring together people in their minds who may be from different aspects and times of their lives and who they have never considered in relation to each other before.

The use of a “ladder” of cards helped some participants, and asking them to consider each new element in relation to just one element that had already been placed on the ladder made the task of ranking much easier. It is hard to know how reliably the elements were being ranked in this study, although Oliver (1986) found a test-retest reliability coefficient of 0.80 in a single-case study. Participants often found it easy to rank the first two and the two at the opposite pole, but found it difficult to use the intermediate “greyer” section of the dimension. This might suggest the operation of splitting mechanisms in these participants i.e. a tendency to view people either as “devils” or as “saints”.

(v) Statistical analysis of the grid: A number of writers have expressed concerns about the use of highly complex computer technology which gives the impression that the repertory grid technique is a precise scientific instrument. The output from the computer analysis of each repertory grid was complex and was only as good as the elicitation procedure itself. Easterby-Smith (1981) writes that there is a “danger people will become lured by the availability of figures ... which are highly abstract and which have no behavioural significance”. These precautionary words need to be borne in mind when considering the analysis of this form of data.

General issues related to interviewing people with learning disabilities

Some of the issues concerning the best way to conduct interviews with this population have already been discussed in the light of the lack of significant results concerning the relationship between a person's construing and their emotional adjustment.

However, there are some further points that are of interest. Most participants took between 1½-2 hours to complete the interview but many were reluctant to extend beyond the initial session if it took them some time to answer the questions. This is in direct conflict with the commonly held view that people with learning disabilities cannot concentrate and "stay on task" for long periods of time. The diverse nature of the tasks that a participant was required to put his mind to over the two hour period may have meant that attention was more easily maintained. Although this is an important finding, the length of the interview did have its drawbacks. Sometimes participants became quite tired and their concentration was lapsing a little by the time they were required to rank the elements (the most cognitively challenging part of the study). Ideally, the research would have involved one to two sessions building up a rapport with the client, and two sessions to complete the questionnaires and the grid. However, it would have been harder to recruit people for four sessions than one, and there were limits on the investigator's time.

Measures of psychopathology

There were some problems with the questionnaires themselves. Some participants found it hard to respond to the 35 items on the anger questionnaire, especially if they had high anger levels. The investigator pointed out that all of the items were situations that are known to make people angry, but being in contact with this emotion for such a long period was particularly difficult, and a shorter questionnaire that had some neutral items interspersed amongst the anger items might have been less distressing. Some participants avoided the emotions that were brought up by the questionnaire by replying “well, that has never happened to me so it is hard to tell” or “well, you just have to accept it so there is no point getting angry”.

Some of the items on the anxiety scale do not necessarily elicit responses relating to anxiety and so responses should be examined at the time of interviewing to ensure that the investigator is accessing only relevant information. For example, one item asks if the person has stomach aches and some of the women responded that they did but on clarification they were referring to menstrual pain and they did not experience other types of stomach ache - this would have been a false positive response. Another item enquires about back pain and one participant responded that he did suffer from this, but on further questioning this was only after a fall, and he had never had back pain other than this.

There were other problems with words not being known to participants. Several participants did not understand the words “proud”, “qualities”, “energy” “worth” in

the Rosenberg Self-esteem Inventory and so the concept had to be elaborated by the investigator. Some did not understand the term “dizzy” in the Zung Anxiety Scale and several were unsure about the terms “look forward to things” and feeling “so sad you can hardly stand it” in the Birlson Self-Rating Depression Scale. It was also felt by the investigator that the question of sleeping well would be more usefully divided into several questions that look at problems with getting to sleep, waking during the night, early morning waking and feeling well-rested before one can be sure about whether or not the participant sleeps well. These are the things that the investigator wants the client to consider, but this is not clear in the questionnaire.

RECOMMENDATIONS FOR FUTURE RESEARCH

Other than the recruitment and methodological issues that need to be taken into account when working with this client group, there are several issues which would be an interesting focus for future research. This study asked clients to predict how others saw them. However, it is highly likely that different people see them in different ways and it would be useful to consider this by asking how the different significant people in their lives construe them - their parents, their siblings, their friends, staff, professionals, and so on. Do they present differently to different people? Do they respond differently to these different views of them? Or do they fulfil one person's view of them more than others?

It would also be interesting to ask them how they would like others to see them and respond to them. This may reveal ways in which staff, professionals and families can help them, or may reveal unrealistic wishes that need to be addressed. It would also be interesting to use a similar grid with families, staff and professionals, in order to investigate their actual views of people with learning disabilities, and how they feel people with learning disabilities view them. This might reveal areas in which there are core conflicts between a person and those that surround him. If some of these clashes can be understood, it might be possible to address them in some way.

CLINICAL IMPLICATIONS

The results of this study confirm the opinion of others who have used the repertory grid technique with this client population, that is that it is an effective and informative assessment tool that can be used with people with mild learning disabilities. The evidence seems to suggest that this technique might also be appropriate for people with moderate learning disabilities, if the investigator is creative and imaginative enough to find a way to communicate with the participant about his constructs. The information that was produced using this technique was able to give some very clear insights into the way people construe themselves in relation to the people around them, and in relation to their disability. The technique could therefore provide a useful starting point for any therapeutic intervention with clients from this population in order to identify where difficulties and conflicts may exist. Participants found the

procedure interesting, thought provoking, and respectful, which is not always the case with other procedures used in assessing people with learning disabilities.

The findings also add to the evidence that prevalence rates of psychopathology in this population are elevated in comparison to the non-disabled population. Although the issue of dual diagnosis has been receiving more attention in the past few years, it is important that this trend continues and that therapies that are available to other client groups (such as cognitive and family therapies) are adapted and made equally available to people with learning disabilities. Without these advances in the mental health services offered to this population, people with learning disabilities will continue to be handicapped by the inflexibility of the services open to them.

Modifications of measures of psychopathology mark a move in this direction.

However, this study suggests that some caution needs to be exercised in relation to these and that the investigator cannot assume that the respondent knows what information to consider when answering the question. Careful exploration of the response is recommended so that false positives, or false negatives are not given.

Without normative data for these measures, it is difficult to assess this population's emotional symptomatology in relation to that of a "normal" or a "neurotic" population, and to draw comparisons or identify differences. Normative data and the identification of cut-off points would make it possible for such measures to be used on a more routine basis in services for people with learning disabilities in order to screen for mental health problems.

The findings of this study suggest that the kind of work that is being carried out in consciousness-raising groups, and in other forums (Szivos & Griffiths, 1990), is having some impact on the way in which this group of people construe themselves in relation to non-disabled people. It is only by continuing the move to construe people in all their aspects, and to encourage them to shift the source of the stigma from the self to the society that the impact of the negative stereotype associated with this group will be lessened. This responsibility lies equally with staff and carers and with people with learning disabilities themselves. It is important that the impact of this negative stereotype is not the sole focus of change, and that other factors that may have a more direct influence on this population's emotional health are also addressed, such as interpersonal difficulties, unemployment, and motivational factors.

Low levels of self-esteem have been found to be related to a sense of isolation and a feeling that one does not belong to any group. Low self-esteem was found to be highly correlated with depression and anxiety, both of which were present to a large degree in this population. It might be that self-esteem needs to be addressed in any therapeutic work with anxious or depressed patients in this population. It has been found that the one form of treatment that reduces the perceived distance between self and others is group therapy (Yalom, 1970). The realisation that you are not the only one in the world who is experiencing such difficult thoughts and feelings has been identified by patients as being one of the most active therapeutic ingredients of such groups. Group therapy might therefore prove to be a beneficial form of treatment for such patients.

The main finding that people with learning disabilities do not construe people with learning disabilities more negatively than non-disabled people is a surprising one, and may not be a view shared by professionals working with this client group. This could have implications for therapeutic work that takes place between staff and people with learning disabilities. From the personal construct theory viewpoint, the form of therapy which a patient is likely to find most meaningful, and in which his participation is likely to be most effective, would be expected to be that which is closest to the focus of convenience of his personal construct system. Similarly, the ability of the patient and therapist to construe each other's construct processes might be regarded as crucial to the success of the therapy. To quote Kelly (1955), "rather than deplore the client's inadequate conceptualisation of psychotherapy, we need to understand his own personal construction of change if we are to help him bring about change" (p.124). There is much that we, as professionals, need to learn about the way in which people with learning disabilities construe their worlds, and about how this is different from the way we think they construe their worlds, before we can improve the kind of therapeutic help we are able to offer them.

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CONSTRUCTS AND THEIR CATEGORIES

Emotional Arousal (31)

Enjoys life (1)
Enjoys themselves (1)
Happy (2)
Cheerful (1)
Happy-go-lucky (1)
Jovial (1)
Fed-up (1)
Moody (3)
Misery guts (1)
Grumpy (1)
Goes over the top (1)
Flips their lid (1)
Gets annoyed easily (1)
Angry (8)
Gets cross (1)
Loses their temper (1)
Gets into tempers (1)
Gets annoyed (1)
Gets in moods (1)
Bad tempered (1)
Has a temper (1)

Social Interaction (53)

Keeps themselves to themselves (3)
Wants to be left alone (1)
Shy (1)
Withdrawn (1)
Talks to people (4)
Chats to people (1)
Communicative (1)
Talks about what they've done (1)
Asks about people (1)
A good chap (1)
A good bloke (1)
Decent (1)
Aggressive (1)
Nasty (2)

Horrible (1)
Doesn't give people what they want (1)
Rude (3)
Unrespectful (1)
Polite (2)
Nice (4)
Pleasant (1)
Good natured (1)
Friendly (4)
Nice to get on with (1)
Sociable (1)
Easy (1)
Different (1)
Scrounger (1)
Likes a lot of attention (1)
Spends time with me (1)
Cuddly (1)
Makes other people happy (1)
Good fun (1)
Funny (1)
Fun to be with (1)
Have fun with them (1)
Someone you can mess about with (1)
Tries to get the best of people (1)

Forcefulness (65)

Got a lot of interests (1)
Strict (3)
Fussy (1)
Bossy (9)
Bosses people about (1)
Tells people what to do (1)
Orders me about (1)
Bully (2)
Macho (1)
Tough (1)
Doesn't give people room to talk (1)
Talks too much (1)
Noisy (1)
Talks a lot but says very little (1)
Outspoken (1)
Stubborn (3)
Arrogant (1)
Wouldn't take no for an answer (1)
Have to do it their way (1)
Doesn't listen to your point of view (1)
Doesn't listen to people (1)
Won't take friends advice (1)

Makes decisions without checking with a person (1)
Doesn't ask if it's OK with you (1)
Goes behind people's backs (1)
Listens to people (1)
Quiet (4)
Doesn't have much to say (1)
Don't stick up for themselves (1)
Easygoing (5)
No bother (1)
Lets me win (1)
A character (1)
Interesting (1)
Energetic (1)
Sporty (2)
Troublemaker (1)
Makes trouble (1)
Gets into fights (1)
Fights (1)
Won't leave me alone (1)
Doesn't leave people alone (1)
Nuisance (1)
Pain in the neck (1)
Gets on people's nerves (1)

Intellective (8)

Intelligent (2)
Ignorant (2)
Stupid (1)
Slow to take things in (1)
Can learn from them (1)
Slow (1)

External Appearance (5)

Attractive (1)
Good looking (1)
Ugly (1)
Fat (1)
Unclean (1)

Self-sufficiency (12)

Can go out alone (1)
Speaks own mind (1)
Knows what's going on (1)
Worthless (1)
Mucks about (1)

Mad (1)
Needs help (1)
Unable to help themselves (1)
Relies on others (1)
Wants to be with people all the time (1)
Annoying (1)
Doesn't look after themselves (1)

Tenderness (84)

Understanding (4)
Someone I can talk to (1)
Can talk to them (1)
Good to talk to (1)
Good listener (3)
Caring (3)
Lovable (1)
Maternal (1)
Willing to help (1)
Helpful (11)
Helps people (4)
Helps you out (1)
Helps sort out problems (1)
Helps with problems (1)
Sorts out problems (1)
Helps people with their difficulties (1)
Helps you out when you're in trouble (1)
Tries to help you learn (1)
Helps people calm down (1)
Looks after people (1)
Backs you up (1)
Patient (1)
Trusts me to be able to do things (1)
Supportive (1)
Thoughtful (1)
Considerate (1)
Gentle (1)
Gentleman (1)
Lovely (1)
Warm (1)
Kind (12)
Unkind (1)
Not kind (1)
Makes fun of people (2)
Teases me (1)
Takes the mickey (1)
Winds people up (2)
Doesn't care (1)
Doesn't like being bothered (1)

Doesn't care about people's problems (1)
Tells people off (4)
Goes on about things (1)
Selfish (1)
Silly (1)
Spiteful (1)
Dangerous (1)
Rough (1)
A brute (1)

Egoism (8)

Know-it-all (1)
Thinks they know it all (1)
Gets up on high (1)
Bangs on about things (1)
Big headed (1)
Thinks they are a hit with the opposite sex (1)
Talks about their problems (1)
Just thinks about themselves (1)

Organisation (6)

Forgetful (1)
Scruffy (1)
Messy (1)
Can't make up her mind (1)
Puts things right (1)
Gets things organised (1)

Morality(24)

Unfair (1)
Takes things out on others (1)
Tell-tale (1)
Not honest (1)
Crafty (1)
Bad (2)
Dirty (1)
Wicked (1)
No gooder (1)
Honest (1)
Good (5)
Good as gold (1)
Good to people (1)
Can be trusted (1)
Says they'll do something and doesn't (1)
Doesn't keep promises (1)
Lets people down (1)

Not reliable (1)
Generous (1)

Factual Description (2)

Likes music (2)

Sexual (1)

Dirty (1)

Involvement (8)

Down to earth (1)
Good worker (1)
Works hard (2)
Lazy (1)
Not very keen (1)
Sticks up for people (2)

Humour (5)

Sense of humour (1)
A laugh (1)
Joker (1)
Makes me laugh (1)
Makes people laugh (1)

Appendix 2

Dear Client

I am writing to ask whether you would take part in some research about how people who have disabilities see themselves, how they fit into the world around them and the feelings that they have. This study might help people who work with people with disabilities to understand them better. If you are not interested in taking part in this study then that is fine and you can ignore this letter.

If you would like to take part, I would like to meet you to explain the project and make sure you are happy to take part and to talk about important parts of your life and your feelings. What we talk about will be kept between ourselves, but if there is something you are worried about, we can talk to someone else about it too if you want. If you decide that you do not want to go on with the study, you can stop at any time.

If you have any questions about the study that you would like to discuss, you (or someone who supports you) can contact Jack Piachaud (Consultant Psychiatrist) on 0181-962-4051 or Huw Williams (Clinical Psychologist) on 0181-962-4332.

If you would like to help us with this study, please would you send back the form in the stamped envelope, or ask someone to return it for you. I will then call you to arrange a meeting.

Thank you for your help, and I hope to talk to you soon.

Yours sincerely

Tamsin Arnold
Clinical Psychologist in Training

Appendix 2 (cont.)

Dear Carer

I am presently conducting some research into how people with disabilities see themselves and the way they fit into the world around them and how this might be connected to the feelings that they have. It is hoped that this study might help people who work with people with disabilities to understand the difficult feelings that people with disabilities sometimes have. This understanding may help us find better ways to help people who have these difficult feelings.

I enclose a letter to the person in your care to ask whether they would be willing to participate in this study. This would involve a meeting with me, a trainee Clinical Psychologist, to explain the project and to check that the participant understands what is involved and is happy with this. We would then spend some time discussing what the participant considers to be important aspects of their life and their feelings. Anything said during these two meetings is private and confidential. If at any point they decide that they do not want to continue they can drop out of the study. If during the study it is felt by the participant that they would like to discuss issues/feelings that arise during the interview in more depth, they could be referred to the Psychology Department for further support.

If they agree to participate in this study, I will write and inform their GP. If you have any questions about the study that you would like to discuss, please do not hesitate to contact Jack Piachaud (Consultant Psychiatrist) on 0181-962-4051 or Huw Williams (Clinical Psychologist) on 0181-962-4332.

If the person in your care feels that they would be willing to take part in the study, they should return the enclosed consent form, which should also be signed by yourself, in the pre-paid envelope.

Thanking you for your time and help in this matter.

Yours sincerely

Tamsin Arnold

Clinical Psychologist in Training

CONSENT FORM
AGREEMENT TO PARTICIPATE IN RESEARCH PROJECT

I agree to take part in the research project “An exploration of self-constructs and stereotypes of people with disabilities and their relationship to self-esteem and emotional adjustment”. I understand what I will be asked to talk about. If know I can stop at any time if I do not want to go on with the study.

My name is:

My telephone number is:

Signature of carer:

Date:

.....

To be filled in by investigator, at the initial meeting:

Investigator's statement:

I have explained the nature, demands and foreseeable risks of the above research to the subject:

Signature:

Date:

Appendix 3 (cont.)

VOLUNTEER CONSENT CHECKLIST

The participant or principal carer should complete the whole of this sheet him/herself.

(please cross out as necessary)

Have you been asked to consent for yourself or on behalf of someone else? YES/NO

Have you read the letter detailing the nature of the study? YES/NO

Have you had an opportunity to ask questions and discuss this study? YES/NO

Have you received satisfactory answers to all of your questions? YES/NO

Have you received enough information about the study? YES/NO

Who have you spoken to?

Dr/Ms/Mr

Do you understand that your decision to consent is entirely voluntary and that you are free to withdraw from the study at any time, without having to give a reason for withdrawing and without affecting your future receipt of services? YES/NO

Do you agree to take part in this study? YES/NO

Signed: Date:

CLIENT NAME (BLOCK LETTERS):

Signed: Date:

CARER NAME (BLOCK LETTERS):

Appendix 4

REVISED VERSION OF THE ZUNG ANXIETY SCALE (Lindsay & Michie 1988)

[Supplementary questions marked * are used if a participant doesn't appear to understand the question.]

- | | | | |
|-----|---|-----|----|
| 1. | Do you feel more nervous and anxious than usual? | Yes | no |
| | [*Do you feel more jumpy or shaky than usual, do you feel your tummy nervous and upset?] | | |
| 2. | Do you feel afraid for no reason at all? | Yes | no |
| 3. | Do you get upset easily or feel panicky? | Yes | no |
| 4. | Do you feel you are falling apart and going to pieces? | Yes | no |
| | [*Do you feel that everything is going wrong and there is nothing you can do about it?, do you feel you can't cope/carry on with things anymore?] | | |
| 5. | Do you feel that everything is alright and nothing bad will happen? | Yes | no |
| | [*Do you worry in case anything terrible might happen, do you feel everything is going to be fine?] | | |
| 6. | Do your arms and legs shake and tremble? | Yes | no |
| 7. | Are you bothered by headaches, neck and back pains? | Yes | no |
| | [*Are you bothered by a sore head, a sore neck or a sore back?] | | |
| 8. | Do you feel weak and get tired easily? | Yes | no |
| 9. | Do you feel calm and can you sit still easily? | Yes | no |
| 10. | Can you feel your heart beating fast? | Yes | no |
| 11. | Are you bothered by dizzy spells? | Yes | no |
| 12. | Do you have fainting spells or feel like it? | Yes | no |
| | [*Do you feel you are going to fall down because you are weak or dizzy?] | | |
| 13. | Can you breathe in and out easily? | Yes | no |
| 14. | Do you get feelings of numbness and tingling in your fingers and toes? | Yes | no |
| 15. | Are you bothered by stomach aches or indigestion? | Yes | no |
| | [*Are you bothered by a sore stomach, do you ever get a burning feeling in the middle of your chest?] | | |

Appendix 4 (cont.)

- | | | | |
|-----|--|-----|----|
| 16. | Do you have to empty your bladder often?
[*Do you have to go to the toilet to pee a lot?] | Yes | no |
| 17. | Are your hands usually dry and warm? | Yes | no |
| 18. | Does your face get hot and go red? | Yes | no |
| 19. | Do you fall asleep easily and get a good nights rest? | Yes | no |
| 20. | Do you have nightmares? | Yes | no |

Appendix 4 (cont.)

The Adapted Birleson Self-Rating Depression Scale (Benson & Ivins 1992)

Instructions: Please answer as honestly as you can. The statements refer to how you feel. There are no right answers.

	Mostly	Sometimes	Never
1. I look forward to things as much as I used to.....
2. I sleep very well.....
3. I feel like crying.....
4. I like to have fun.....
5. I feel like running away.....
6. I get stomach-aches.....
7. I have lots of energy.....
8. I enjoy my food.....
9. I can stick up for myself.....
10. I think life isn't worth living.....
11. I am good at things I do.....
12. I enjoy the things I do as much as I used to.....
13. I like talking with my family.....
14. I have horrible dreams.....
15. I feel very lonely.....
16. I am easily cheered up (become happier).....
17. I feel so sad I can hardly stand it.....
18. I feel very bored.....

Appendix 4 (cont.)

ROSENBERG INVENTORY

Instructions: please read the following statements. Then tick the term which best describes how that statement relates to you.

		Strongly agree	Agree	Disagree	Strongly disagree
1.	On the whole, I am satisfied with myself	.....	.....	.....	.....
2.	At times I think that I am no good at all	.....	.....	.....	.....
3.	I feel that I have a number of good qualities	.....	.....	.....	.....
4.	I am able to do things as well as most other people	.....	.....	.....	.....
5.	I feel I do not have much to be proud of	.....	.....	.....	.....
6.	I certainly feel useless at times	.....	.....	.....	.....
7.	I feel that I am a person of worth, at least on an equal plane with others	.....	.....	.....	.....
8.	I wish I could have more respect for myself	.....	.....	.....	.....
9.	All in all, I am inclined to feel that I am a failure	.....	.....	.....	.....
10.	I take a positive attitude towards myself	.....	.....	.....	.....

THANK YOU FOR YOUR HELP.

Appendix 4 (cont.)

Instructions for Self Report Anger inventory

I have got a long list here of the kind of things that make people feel angry. Some of these will have happened to you and some of them will not. As I read each one I want you to imagine how you would feel if that happened to you. I have got some pictures here to help you decide how you would feel. You might feel like the man in picture number one. He is not angry, can you see by his face? He does not care and the situation does not even bother him. You might feel like the man in picture number two. He is a little bit angry, can you see by his face? The situation bothers him but he is not too angry about it. You might feel like the man in picture number three. He is angry, can you see by his face? And finally, you might feel like the man in picture number four. He is furious or very very angry, can you see by his face?

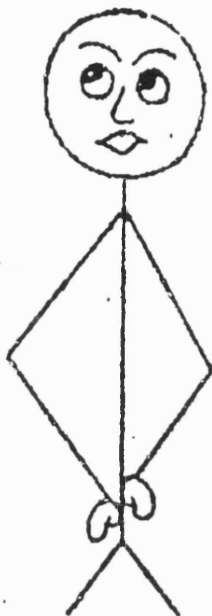
OK, so which one would you point to if you were a little bit angry? And which one would you point to if you were very very angry? And which one would you point to if you did not feel angry? And which one would you point to if you felt angry?

Great. So for each one that I read you, I want you to imagine how you would feel if it happened to you and then point to the picture on the chart.

1.

NOT ANGRY

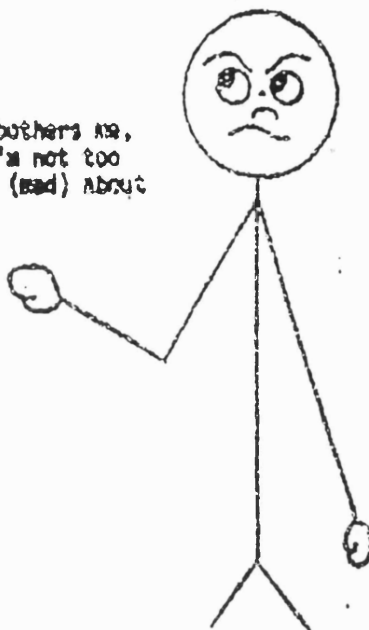
I don't care. That situation doesn't even bother me.



2.

A LITTLE BIT ANGRY

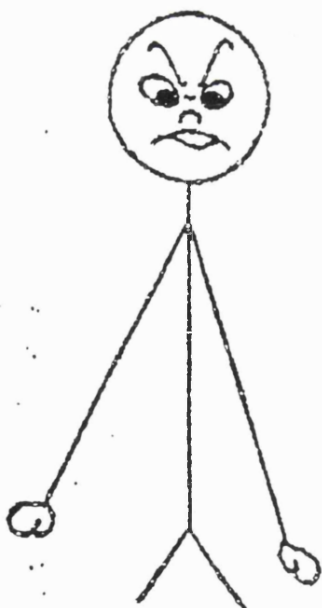
That bothers me, but I'm not too angry (mad) about it.



3.

ANGRY

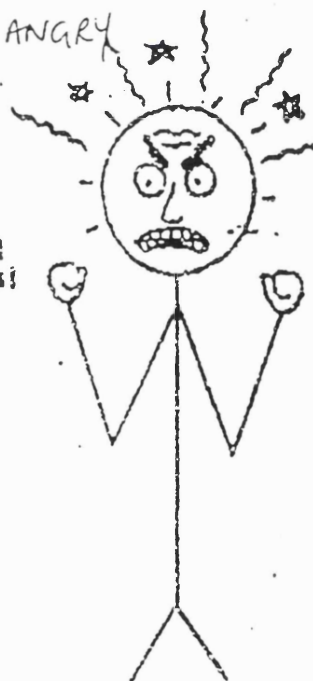
It's really mad (angry).



4.

VERY VERY ANGRY

I can't stand that! I'm furious!



Appendix 4 (cont.)

SELF REPORT ANGER INVENTORY

- | | | | | | |
|---|---|---|---|-----|---|
| 1 | 2 | 3 | 4 | 1. | You have been working very hard for your job because your boss said you could stop when you had finished. When you are almost done someone gives you a lot more work to do. |
| 1 | 2 | 3 | 4 | 2. | You know that you are right about something, but your keyworker or your parent insists that you are wrong. |
| 1 | 2 | 3 | 4 | 3. | Your friends make fun of you. |
| 1 | 2 | 3 | 4 | 4. | Being blamed for something that was not your fault. |
| 1 | 2 | 3 | 4 | 5. | You start to tell someone a joke and you forget how it goes. |
| 1 | 2 | 3 | 4 | 6. | You put your only 50 pence piece in the coke machine and it takes your money. |
| 1 | 2 | 3 | 4 | 7. | Someone cuts in front of you in the queue. |
| 1 | 2 | 3 | 4 | 8. | You order what you want to eat at a restaurant and the waitress tells you that you can't have it. |
| 1 | 2 | 3 | 4 | 9. | Your friends say that they are going to come over on Saturday and they do not come. |
| 1 | 2 | 3 | 4 | 10. | You are staying up late to see a special programme on TV but you fall asleep before it comes on. |
| 1 | 2 | 3 | 4 | 11. | You are walking in the park and a policeman tells you to go home and doesn't tell you why. |
| 1 | 2 | 3 | 4 | 12. | Someone calls you a liar. |
| 1 | 2 | 3 | 4 | 13. | You are told that you have to do extra chores this weekend. |
| 1 | 2 | 3 | 4 | 14. | While it is raining you are walking down the street and a car splashes you with mud as it drives by. |
| 1 | 2 | 3 | 4 | 15. | Being told that you don't know enough to be able to do something. |
| 1 | 2 | 3 | 4 | 16. | The boss' favourite worker gets all the good jobs at work. |
| 1 | 2 | 3 | 4 | 17. | You tell someone a real secret and they blab it to everyone. |

- 1 2 3 4 18. You are playing a game and everyone on the other side tries to cheat.
- 1 2 3 4 19. You ask a friend to do something for you and they say "No".
- 1 2 3 4 20. You are watching TV and someone turns it to another channel.
- 1 2 3 4 21. You see someone take your canned drink and drink it when they know they aren't supposed to.
- 1 2 3 4 22. You are promised a new job and you don't get it.
- 1 2 3 4 23. Your friends are playing a game but won't let you play too.
- 1 2 3 4 24. Somebody punches you.
- 1 2 3 4 25. Being told "I warned you not to do it" once something goes wrong.
- 1 2 3 4 26. A keyworker yells at you, tells you off, and embarrasses you in front of other people.
- 1 2 3 4 27. After your work all morning, your boss gives you all your work back and says it is wrong.
- 1 2 3 4 28. At your work you are told to do something you hate, like cleaning the bathroom, because the job "had to be done".
- 1 2 3 4 29. You are told that you have to work overtime even though you had something planned for this evening.
- 1 2 3 4 30. You want to go to sleep but the people next door keep making noise.
- 1 2 3 4 31. You accidentally bump into a stranger and he/she threatens to beat you up if you get near him again.
- 1 2 3 4 32. Seeing your parents fight or have a big argument.
- 1 2 3 4 33. You accidentally knock something off a table and it breaks.
- 1 2 3 4 34. You take out your wallet and find that your money has been stolen.
- 1 2 3 4 35. Someone tells your boss or your parents that you did something wrong.

HEALTH AUTHORITY

60 Eastbourne Terrace
London W2 6LK

60 Eastbourne Terrace
London W2 6LK
Telephone 0171 725 3333
Fax 0171 725 3398

ST MARY'S LOCAL RESEARCH ETHICS COMMITTEE

St Mary's Hospital

Acrow East, South Wharf Road, London W2

tel: 0171 725 6514 fax: 0171 725 1860

Tuesday, 9 July 1996

Tamsin Arnold
14a Murray Road
Ealing, London
W5 4XS.

Dear Ms Arnold

EC3380 An exploration of self constructs and stereotypes in people with learning disabilities and their relationship to self esteem and emotional adjustment..

ETHICS COMMITTEE NUMBER MUST BE USED IN ALL COMMUNICATION

I am pleased to say that the above project has now been approved by the St Mary's Local Research Ethics Committee. This approval is given on the understanding that the researcher(s) will observe strict confidentiality over the medical and personal records of these patients. It is suggested that this be achieved by avoidance of the subject's name or initials in the communication data. In the case of hospital patients, this can be done by using the hospital record number and in general practice, the National Insurance number or a code agreed with the relevant GP.

It should be noted :

1. The Ethics Committee's decision does not cover any resource implications which may be involved in your project.
2. The Ethics Committee should be informed of any unforeseen development, amendments or changes in protocol that may occur during the course of your investigations.
Please quote the above EC number in any correspondence.
3. Where research involves computer data, this may be subject to the Data Protection Act.

Appendix 5 (cont.)

KENSINGTON, CHELSEA & WESTMINSTER HEALTH AUTHORITY

4. The GPs of any volunteers taking part in research projects should be aware of their patients' participation.
5. Every care should be taken to obtain the volunteer's informed consent to participate in the research project with the necessary help being provided for volunteers with language difficulties.

May I take this opportunity of informing you that, in accordance with guidelines set down by the Department of Health and the Royal College of Physicians, we will require details of the progress of your project in twelve months' time and every year thereafter for the life of the project, and I will send you the appropriate form for completion.

If you have need to contact us further regarding your project, please quote the EC number as specified in the heading.

Yours sincerely



Dr Rodney Rivers
CHAIRMAN TO ST MARY'S LOCAL RESEARCH ETHICS COMMITTEE

RIVERSIDE RESEARCH ETHICS COMMITTEE

CHELSEA & WESTMINSTER HOSPITAL
Lower Ground Floor Pharmacy Offices
369 Fulham Road London SW10 9NH
Tel: 0181 846 6855 Fax: 0181 846 6860

Ms Tamsin Arnold
Clinical Psychologist in Training
14a Murray Road
Ealing
London W5 4XS

14th January 1997

Dear Ms Arnold

RREC 1247 - An exploration of self-constructs and stereotypes in people with learning disabilities and their relationship to self-esteem and emotional adjustment.

I am writing to inform you that the above study has been considered and approved by Chairman's Action.

Please note the following conditions which form part of this approval:

- [1] This approval is for one year only. For projects with an expected duration of more than one year, a letter from the principal investigator will be required in order to further extend consent. This will enable the Committee to maintain a full record of research.
- [2] Any changes to the protocol must be notified to the Committee. Such changes may not be implemented without the Committee's approval.
- [3] The Committee should be notified immediately of any serious adverse events or if the entire study is terminated prematurely.
- [4] You are responsible for consulting with colleagues and/or other groups who may be involved or affected by the research, e.g., extra work for laboratories. Approval by the Committee for your project does not remove your responsibility to negotiate such factors with your colleagues.
- [5] You must ensure that nursing and other staff are made aware that research in progress on patients with whom they are concerned has been approved by the Committee.

Cont/2...

Appendix 5 (cont.)

Cont/2..RREC 1247 - An exploration of self-constructs and stereotypes in people with learning disabilities and their relationship to self-esteem and emotional adjustment.

- [6] Pharmacy must be told about any drugs and all drug trials, and must be given the responsibility of receiving and dispensing any trial drug.
- [7] The Committee must be advised when a project is concluded and should be sent one copy of any publication arising from your study, or a summary if there is to be no publication.

May I take this opportunity to wish you well in your research. However, if any doubts or problems of an unexpected nature arise, please feel free to contact me at any time.

Yours sincerely

J. Nigel Harcourt-Webster

J Nigel Harcourt-Webster MD FRCPATH
Chairman - RREC

Seen and Approved	
Submission and letter 6-01-97	Signed J. N. Harcourt-Webster. Initials:
Protocol Application to St. Mary's REC. & approval letter	Signed J. N. Harcourt-Webster. Initials:
Information Sheet Letter to clients & carers.	Signed J. N. Harcourt-Webster. Initials:
Consent Form Volunteer	Signed J. N. Harcourt-Webster. Initials:
Questionnaires	Signed J. N. Harcourt-Webster. Initials:
Letter of Indemnity	Signed — Initials:
CTX/DDX/Licence	Signed — Initials:

HARROW RESEARCH ETHICS COMMITTEE

(Chairman: Dr David Lubel)

Room 6BB 014

Northwick Park Hospital

Tel: 0181-869-2688

Fax: 0181-869-2174



NORTHWICK PARK & ST MARK'S
NHS TRUST
WATFORD ROAD HARROW
MIDDLESEX HA1 3UJ

Appendix 5 (cont.)

9 April 1997

Ms Tamsin Arnold
14a Murray Road
Ealing W5 4XS

Dear Tamsin

Ethical Submission No. 2297: Self esteem & emotional adjustment of people with learning difficulties

I refer to the message which I left on your answering machine a couple of weeks ago and am pleased to confirm that this project has been approved by Chairman's action. However, you should still continue your valiant efforts to satisfy our Scientific Advisory Group. Dr Handler has picked up the point which the Committee made about approaches by a trainee and I think that the Committee simply had in mind that the letter to potential subjects should come from your supervisor who should explain that interviews etc would be carried out by yourself.

I hope that this is helpful.

Yours sincerely,

Brian Saperia
Secretary

ULSCS INPUT FORM - FULL CATALOGUING
[ULSCS - 10]

CONTROL NUMBER	+ RI +	X	2	8	2	3	7	9	0	4	4	#		
INFORMATION	008 \$a	S	I	9	9	7					\$b	e	n	
CODES	\$l	e	n	g	\$p	W							#	
AUTHOR	1	0	0	.	10	\$a	Arnold \$h Tamsin							#
COLLECTIVE OR UNIFORM TITLE	2	4		.		\$a								#
TITLE	245.13	\$a	An exploration of self-constructs and stereotypes in people with learning disabilities and their relationship to self-esteem and emotional adjustment \$e Tamsin Arnold											#
PART/VOLUME TITLE	248.													#
EDITION	250.	\$a												#
PUBLICATION AND DISTRIBUTION	260.	\$a	London											#
		\$b	[unpublished]											#
		\$c	1997											#
PHYSICAL DESCRIPTION	300.	\$a	f2 \$hv \$c3cm											#
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NOTES	5	0	2	\$a Doctorate in Clinical Psychology, University College London, 1997 505 \$a Contents: Vol.1. Text - Vol.2. Case reports	#
SUBJECT HEADINGS	6	5	0	\$a Learning disabilities & Psychological aspects 650 \$a Self-esteem & Psychological aspects 650 \$a Adjustment disorders & Psychological aspects	#
ADDED ENTRIES	7			\$a	#
SERIES ADDED ENTRIES	8	4	0	\$a	#
CLASSIFICATIONS	9	5	0	\$a 951 \$a 952 \$c 981.00 \$aZ	#
LOCATIONS	9	9	0	\$a 991 \$a 992 \$c	
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SITE CODES	994			\$a	
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